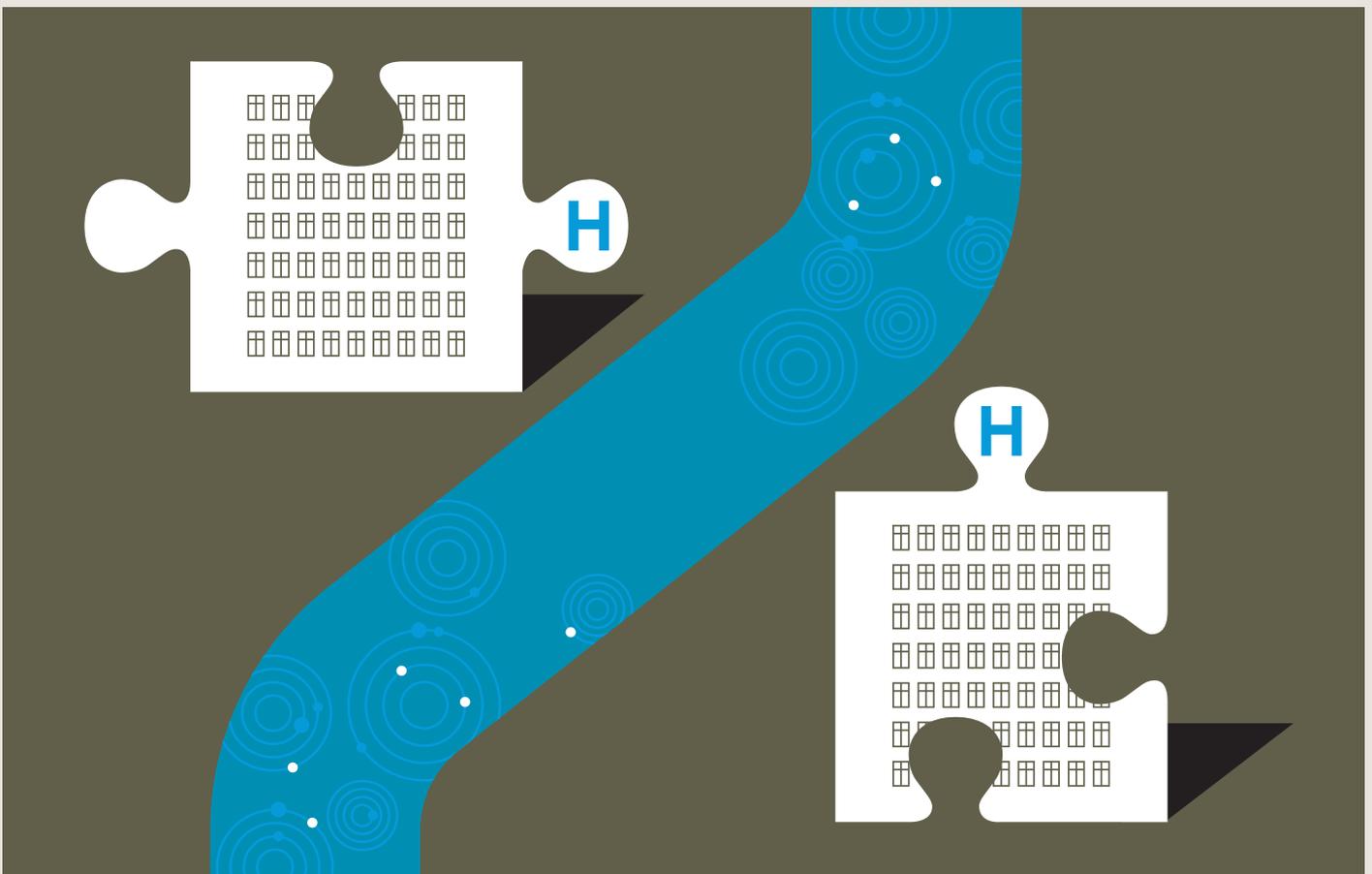


Mergers in the NHS

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

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Policy analysis

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On 29 November 2011, the boards of Poole Hospital NHS Foundation Trust (PHFT) and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (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. In June 2012, the Office of Fair Trading (OFT) notified Monitor that it had decided to carry out an investigation under Part 3 of the Enterprise Act 2002 and Monitor provided the OFT with advice on whether the merger would create relevant customer benefits in December 2013. In January 2013, the OFT decided to refer the case to the Competition Commission (CC). In October 2013, the CC announced that it would prohibit the proposed merger. This report is a case study describing what happened, and in particular the role of the OFT and the CC as these were the regulatory bodies relevant to the decision on the proposed merger. Their functions have since themselves been merged as part of the new Competition and Markets Authority (CMA) on 1 April 2014.*

* For reference, a list of the acronyms used in this report is available on page 90.

Mergers have occurred for decades in the NHS, although the evidence, such as it is, suggests the benefits they set out to achieve tend not to be realised.¹ The introduction of competition into the provision of NHS-funded hospital care in England has meant that the work of NHS providers and commissioners has become increasingly exposed to competition regulation. The proposed merger of PHFT and RBCHFT was subject to review by the competition authorities under the Enterprise Act 2002. The Health and Social Care Act 2012 confirmed the arrangements for making decisions about mergers involving NHS foundation trusts (FTs) and set out Monitor's statutory duty to provide advice to the OFT (now the CMA) on the benefits of any such merger. These arrangements have their roots in the Enterprise Act 2002.

The decision of the CC to prohibit the proposed merger generated much press coverage, debate and had a significant impact on the local health economy. The conclusion drawn by many in the NHS was that the way competition policy was being enacted was at best confusing and at worst blocking needed service reconfiguration in the NHS. Indeed Monitor's chief executive acknowledged in subsequent evidence to the Public Accounts Committee that what had happened in Bournemouth and Poole had been 'unsatisfactory for many reasons' and that if Monitor had engaged at an earlier stage in the process the overall result may have been different.² Separately, the Health Select Committee recommended that the government should review the

circumstances of the Bournemouth and Poole merger case to ensure any unnecessary obstacles to needed service change were removed.³

While the case has been frequently cited in commentary on competition policy, an independent analysis has not emerged. This report aims to help fill the gap and aid learning for the future. This work has not been about second guessing the CC's analysis or judgement. There can be no doubt that the CC's analysis was comprehensive, robust and the subsequent report fulfilled its statutory obligations. Rather, the question examined here is whether the process that the regulators had to follow produced a result that was in the best interest of patients with regard to improving the quality of care, in particular whether the relative weight given to considerations of competition relative to other factors was appropriate.

This report draws on the perspectives of the main parties involved in the merger decision-making process – including local providers and commissioners – based on interviews undertaken during 2014. The individuals concerned agreed to be interviewed on the basis of anonymity. Inclusion of the quotes does not necessarily represent endorsement of the position by the authors but instead reflects views, opinions and thoughts of a group of individuals (and not their employing organisations) on the process.

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 Trust⁴ and service-level reconfigurations between the Royal Free London NHS Foundation Trust and University College London Hospitals NHS Foundation Trust.^{5,6} The CMA is currently investigating the anticipated acquisition by Chelsea and Westminster Hospital NHS Foundation Trust of West Middlesex University Hospital NHS Trust.⁷ All of these cases will provide additional learning and we understand that NHS Providers (a membership organisation for NHS public provider trusts, formerly the Foundation Trust Network) is undertaking some work to provide a practical briefing on the merger assessment process for its members.

The report is structured as follows:

- **Chapter 2 outlines a brief history of competition policy in the NHS**
- **Chapter 3 outlines the legislative process for merger control in the NHS**
- **Chapter 4 considers the Bournemouth and Poole case specifically**
- **Chapter 5 considers broader system implications from the case**
- **Chapter 6 summarises broad conclusions.**

An *In brief* summary of the report is also available on the Health Foundation's website: www.health.org.uk/nhsmergers

A brief history of competition policy in the NHS

2

This chapter outlines the development of competition policy in the NHS in recent years and provides context for the changing merger control regime. Annex A provides additional detail. Discussion of the Bournemouth and Poole case begins from Chapter 4 onwards. This chapter does not attempt comprehensively to assess the pros and cons of competition among providers of clinical care but instead sets out the historical and legal context in which the merger decision-making framework is set.

Mergers have occurred in the NHS since 1948, independent of competition policy. However, the introduction of competition into the NHS has meant that the work of providers and commissioners has become increasingly exposed to competition regulation. With regard to merger control, NHS foundation trusts are now subject to regulation by the Competition and Markets Authority, which was established on 1 April 2014.

For the last 15 years and until recently, a broad consensus has emerged between the main political parties that there is a role for competition between providers of NHS-funded care. It is a relatively recent development that mergers involving NHS foundation trusts should be subject to control by the competition regulators, bringing decision-making process on such mergers into line with those in sectors such as retail or utility companies. However, while the policy direction in the NHS in England has been to encourage more competition among providers of clinical care, this hasn't always proved popular. The debate has become polarised, but there is evidence to suggest that such competition can be beneficial for patients. For example, the Office for Health Economics assembled a commission in 2011 to consider the circumstances in which competition between health care providers might be feasible and might be expected to yield benefits. The report recognised that competition in the NHS could be controversial but concluded that in the right circumstances it can be used to prompt better health care. Significantly, the report suggested that there was no evidence that competition hampers integration of care, but there was evidence that competition with regulated prices has improved the quality of some NHS services (although the evidence is limited).⁸

The debate on competition has become highly charged in recent years, and was particularly intense during the passage of the Health and Social Care Act 2012 (although it should be noted that in the context of the merger regime for FTs, the Act largely confirmed the application of the Enterprise Act 2002).

For example, during the second reading of the Bill in the House of Commons, the Shadow Secretary of State for Health John Healy MP suggested that:

‘The debate at the heart of this Bill is about whether full-blown competition, based on price and ruled by competition law, is the right basis for our NHS. That is why Labour Members oppose this Bill. We want the NHS run on the basis of what is best for patients, not what is best for the market. We want the NHS to be driven by the ethos of public service, not by the economics of forced competition. We will defend to the end a health service that is there for all, fair for all and free to all who need it when they need it.’⁹

In fact some of the most significant advances in exposing clinical care in the NHS to competition occurred during previous Labour as well as Conservative governments. In the same debate Minister of State for Health Simon Burns MP suggested that the Coalition government’s plans for reforming the NHS were ‘*an extension of the policies of the previous administrations, notably the Blair and Brown governments*’ and that the policies were evolutionary not revolutionary.¹⁰ However, despite divergence in policy on structure, competition and increased provider diversity among the four UK countries, there is no obvious divergence of performance using very broad indicators.¹¹

Evolution of competition policy, 1989–2010

One place to start a brief review of competition is the Conservative government’s 1989 white paper *Working for Patients* which outlined some of the most radical reforms in the history of the NHS. The white paper proposed the creation of an internal market within the NHS and paved the way for the split between purchasing (ie commissioning) and the provision of services in the NHS. The white paper also established the concept of GPs holding practice-level budgets to purchase secondary care services, as well as the model of self-governing NHS trusts.¹²

Before coming to power in 1997, the Labour Party campaigned to abolish the internal market in health care which had been created by the Conservatives,¹³ but in the end chose to retain the split between purchasers and providers with an increased focus on partnership working between providers underpinned by robust performance management.¹⁴

The *NHS Plan* published in 2000 outlined significant changes to how health care in England was to be organised, with the intention of modernising the service. The government committed to large-scale investment linked to widespread reform. Significantly, the proposals marked a significant development in the role of the independent sector in the provision of NHS-funded care. The *NHS Plan* committed to more constructive engagement with the public sector in a bid to end the ‘stand-off between the NHS and private sector providers of health care.’ The government suggested that the private and voluntary sectors would have a role to play in ensuring patients received the full benefit of the increased investment in the NHS.¹⁵ In particular, the Plan led to the development of independent sector treatment centres (ISTCs) to provide fast, pre-booked surgery and diagnostic tests for NHS-funded patients by separating scheduled treatment from emergency care. Treatment centres were run both by the NHS and by the independent sector. Independent sector

providers were to add capacity in part to reduce waiting times.¹⁶ In 2003, the first ISTC – the Birkdale Clinic – was opened in Daventry.

Yet despite the intended policy, an independent evaluation concluded that there had not been a large expansion in the quantity of for-profit or third-sector activity by the time of the 2010 general election.¹⁷ Furthermore, this slow growth occurred against a background of significant consolidation in the NHS hospital sector between 1997 and 2006 – thus reducing the potential for competition. Of around 223 acute hospitals in 1997, 122 merged between 1997 and 2006.¹

The *NHS Plan* also outlined proposals to give clinicians and managers greater freedoms to run local services. The concept of foundation trusts (FTs) was first introduced in 2002 and was intended to give top-performing hospital trusts the opportunity for more independence.¹⁸ NHS FTs were established in law under the Health and Social Care (Community Health and Standards) Act 2003.

Unlike NHS trusts, FTs were independent organisations that were not subject to direction from the Secretary of State for Health. FTs were established as public benefit corporations whose primary purpose was to provide goods and services for the purposes of the health service in England. FTs were given greater financial freedoms: they could retain surpluses, were able to borrow funding for capital investment from more sources and had greater flexibility with regard to remuneration of staff. The legislation provided for an independent regulator (later known as Monitor) to monitor the performance of FTs.¹⁹ The first 10 FTs were established on 1 April 2004. The changing status of FTs was to have significant implications for the application of competition legislation to the NHS.

Competition under the Coalition government, 2010 onwards

Early days of the Coalition

On 6 May 2010, the general election resulted in a hung parliament. After five days of negotiations between the Liberal Democrats and the Conservative Party, agreement was reached on a range of issues on 11 May 2010. The initial agreement majored on economic policy and references to the NHS were limited to a commitment that funding should increase in real terms in each year of the parliament.²⁰

The more comprehensive *Our programme for government*, published later that month, gave more clues as to the Coalition government's plans for health. For example, with regard to choice and competition, the government committed to increasing the involvement of independent and voluntary sector providers and to give every patient the power to choose any provider as long as they could meet NHS standards for nationally set NHS prices or tariffs.²¹ Just eight weeks later, in July 2010, the publication of the white paper *Equity and excellence: Liberating the NHS* made it clear that major reorganisation was on its way.²²

Equity and excellence: Liberating the NHS

The white paper *Equity and excellence: Liberating the NHS* set out the government's vision for a reformed health service. Aside from structural reform (the abolition of strategic health authorities and primary care trusts and their replacement with the NHS Commissioning Board and GP

consortia) one of the central themes of the white paper was patient choice. The government made a commitment to increasing significantly the offer of choice across a range of services.

The white paper made it clear that increasing the diversity of supply of providers of clinical care was a key objective. The government aimed to allow any willing provider to provide services (as appropriate) thereby 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 FT regulator). Monitor was to become an economic regulator with responsibility for promoting competition, regulating prices and safeguarding the continuity of services.²²

In October 2010, the government set out further detail in *Liberating the NHS: greater choice and control*. The government outlined its plans to implement a policy of 'any willing provider'. This would enable patients to choose from any provider in England that offered a clinically appropriate service, could meet the quality standards expected of NHS providers and could deliver services for the national NHS tariff price.* The government reiterated its commitment to extend choice of provider to all health care services (and not just for the first hospital appointment). In particular, there was a focus on increasing choice of provider for mental health, diagnostic services, long-term conditions and end-of-life care.²³

* The NHS tariff comprises a set of nationally set prices for the delivery of certain health care services.

In December, the government published its response to the consultation exercise on *Equity and excellence*, acknowledging that competition was the issue that most divided respondents. The response noted that trade unions and existing NHS organisations and professionals had been most likely to object on principle to the idea of increased competition in clinical care. In contrast, social enterprises, voluntary providers and the independent sector were supportive of the plans to remove barriers to market entry. The government was keen to assert that the reforms simply developed existing policy on competition stating that: 'A common assertion in many responses was that the Government's reforms were the most radical changes to the health service for decades, or even since the founding of the NHS... The Government disagrees.'²⁴

The Health and Social Care Act 2012: Competition takes centre stage

The Bill's passage through the House of Commons

The Health and Social Care Bill as introduced on 19 January 2011 gave effect to the policies set out in *Equity and excellence*. Part 3 of the Bill was dedicated to the economic regulation of health and adult social care services and was to become one of the most controversial aspects of the Bill. Part 3 set out Monitor's overarching duties and responsibilities. The Bill gave Monitor powers to:

- ensure competition and patient choice would operate effectively
- run a system of licensing of providers
- define designated services (the Bill set out mechanisms to ensure the continuity of such services in the event of failure)
- set pricing in conjunction with the NHS Commissioning Board
- introduce failure arrangements.

With respect to competition, Monitor was to be given concurrent powers with the Office of Fair Trading (OFT) to apply the Competition Act 1998 (allowing Monitor to investigate anti-competitive practice) and the Enterprise Act 2002 (in relation to market investigation references).²⁵

The Health and Social Care Bill had its second reading in the House of Commons on 31 January 2011. Part 3 of the Bill (economic regulation of health and social care) was debated extensively. The Labour Party intended to oppose the Bill.⁹

As opposition to the Health and Social Care Bill grew, delegates at the Liberal Democrat Conference passed a motion on 12 March 2011 which demanded significant amendments and criticised the government's '*damaging and unjustified market-based approach to reform*'. The conference called upon Liberal Democrats in parliament to amend the Bill to rule out any competition based on price, to allow private providers only where there was no risk of 'cherry picking' profitable services and to provide for an NHS which would promote quality and equity and not the market.²⁶

After 28 sittings of the Public Bill Committee, the first committee-stage process was concluded on 31 March 2011. Opposition amendments were not successful but the government put forward an amendment that would remove the ability of Monitor to set maximum prices and clarified that Monitor would not be able to vary prices by reference to whether a provider was in public or private ownership. The amendment was meant to clarify that the government's position was that competition in the NHS should be based on quality and not on price.²⁷

The 'pause'

On 6 April 2011, the government launched the NHS Future Forum to consider further the implications of the Health and Social Care Bill. Choice and competition was one of four themes to be considered, with the Secretary of State suggesting that:

*'First, we need to make sure that we have the right sort of competition in the Health Service. Not competition for its own sake, not cherry picking the lowest hanging fruit, not giving preference to the private sector over and above NHS or charities.'*²⁸

In June, the NHS Future Forum published its recommendations, with Sir Stephen Bubb (Chair of the Forum's Choice and Competition work stream) concluding that it would be an error to assume that properly regulated competition would pose a threat to the NHS as a universal service. However, the report noted concerns that competition might work against efforts to integrate care and that competition might compromise patient care. The report recommended stronger safeguards against the unintended effects of competition and that Monitor's primary duty should not be to promote competition *per se* but instead to protect and promote the best interests of patients. The Future Forum also recommended there should be safeguards to prevent providers from 'cherry picking' where it could distort the market or undermine quality.²⁹

In response, the government committed to amending the Bill with regard to competition and choice in a number of areas.

- The Bill would rule out any deliberate policy to increase or maintain the market share of any particular sector.
- Monitor’s core duties would be focused on protecting and promoting patients’ interests and not on the promotion of competition as an end in itself.
- The Bill would include additional safeguards against cherry picking and price competition.
- Monitor’s powers would be limited with regard to its ability to take action against commissioners.
- Monitor would be required to enable integration of services for patients.
- The duties on commissioners to promote integrated services would be strengthened.³⁰

Following an additional committee stage, the Bill cleared the House of Commons on 7 September 2011.

The Bill’s passage through the House of Lords

After extensive debate on the Bill in the House of Lords, starting in October 2011, in February 2012 the government outlined amendments which would be made at Lords Report Stage. A number of these were relevant to the development of competition in the NHS. The amendments would:

- allow Monitor to use its licensing powers to support integration and cooperation where it was in the interest of patients
- amend the existing provisions in the Bill in relation to the Competition Commission’s (CC’s) powers to conduct seven-yearly reviews of the health sector to focus on the effectiveness, not the development, of competition; peers had expressed concern that the original wording would have provided a disproportionate incentive on Monitor to develop competition
- amend the existing provisions in the Bill to require Monitor to consult on how it would enforce regulations concerned with procurement, patient choice and anti-competitive behaviour.³¹

During the Lords Report Stage, the government also accepted a number of significant amendments relating to the application of competition law. The first amendment required Monitor to provide advice to the OFT on benefits resulting from NHS provider mergers involving an NHS FT. The intention behind this amendment was to attempt to distinguish the NHS from commercial organisations such as retailers. In accepting the amendment, Earl Howe, the Parliamentary Under Secretary (Department of Health), reassured the House that the paramount consideration for the OFT in reviewing FT mergers would be the impact on patients’ interests ‘including the interests of patients in securing sustainable access to a comprehensive health service.’³² The second amendment removed the requirement for the CC to review the development of competition in the provision of health care services for the purposes of the NHS. It was felt that prescribed reviews would have placed too great an emphasis on the pursuit of competition itself.³³

The Health and Social Care Act 2012 finally received Royal Assent on 27 March 2012. Part 3 of the Act (which set out provisions relating to the regulation of health and adult care services) had been subject to a number of amendments and had changed compared to the version of the Bill as introduced on 19 January 2011. There were no longer references to ‘economic regulation’ and the focus was on ‘sector regulation’.

Box 1 outlines the provisions in the Act with respect to competition and the role of Monitor. In April 2012, Secretary of State Andrew Lansley sent a letter to all FT chief executives outlining the fact that FTs should have genuine operational independence to meet the needs of local commissioners. With regard to mergers, the letter stated: *‘you will also be able to merge with, or acquire, other NHS FTs and NHS trusts without the explicit approval of Monitor, and without a burdensome legislative process’*.³⁴

Box 1: Sector regulation under the Health and Social Care Act 2012

Part 3 of the Health and Social Care Act 2012 sets out provisions for regulation of health and adult social care services in England and defines the role of the sector regulator (Monitor). The Act outlines 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. With respect to competition, Monitor was given concurrent powers with the Office of Fair Trading (OFT) to apply the Competition Act 1998 (allowing Monitor to investigate anti-competitive practice) and the Enterprise Act 2002 (in relation to market investigations). The Health and Social Care Act gives Monitor powers to:

- run a system of licensing of providers of NHS services
- set and enforce requirements to secure continued provision of NHS services
- regulate prices for NHS services through a national tariff in conjunction with the NHS Commissioning Board
- secure continuity of NHS services provided by companies through a process of ‘special administration’ and establish funding mechanisms to enable trust special administrators
- secure continued access to NHS services establish funding mechanisms to enable trust special administrators to secure continued access to NHS services.

The Act gives the Secretary of State delegated powers to make regulations which would place requirements on commissioners with respect to good practice in procurement, patient choice, anti-competitive conduct and conflicts of interest.

Competition regulations: more controversy

The Health and Social Care Act 2012 gave the Secretary of State delegated powers to make regulations that would place requirements on commissioners with respect to good practice in procurement, patient choice, anti-competitive conduct and conflicts of interest. The regulations – known as Section 75 regulations – generated considerable controversy. However, many principles contained within the regulations had their roots in existing guidance which had been issued to the NHS from 2007 onwards.

As part of the 2008/09 NHS Operating Framework, the Department of Health published the Principles and Rules for Co-operation and Competition (PRCC) in December 2007. The PRCC was intended to set out the expected behaviours and rules governing cooperation and competition. As well as announcing plans to develop an independent Competition Panel the document set out 10 principles that would apply from April 2008 (see Box 2).

Box 2: Principles and Rules for Co-operation and Competition (PRCC) (2007)

1. Commissioners should commission services from the providers best placed to meet the needs of their population.
2. Providers and commissioners should cooperate to ensure patient experience was seamless.
3. Commissioning and procurement should be transparent.
4. Commissioners and providers should foster patient choice and provide appropriate information.
5. Appropriate promotional activity was encouraged if in line with patients' best interests.
6. Providers must promote equality and not discriminate against patients.
7. Payment regimes should be transparent and fair.
8. Financial intervention should be transparent and fair.
9. Mergers and acquisitions were permissible when demonstrated to be in the best interest of patients and taxpayers and sufficient choice and competition remained.
10. Vertical integration* was permissible when demonstrated to be in the best interest of patients and taxpayers and 'sufficient choice' and competition remained.

* Vertical integration tends to involve collaboration on non-competing services (for example, between a hospital and primary care services provided by a general practitioner).

† The exact meaning of 'sufficient choice' was not defined clearly in the PRCC.

The PRCC stated that making the system operate effectively in the interest of patients would sometimes require encouraging more competition through the purchase of NHS-funded care from new (non-NHS) providers but at other times would require enforcing cooperation between providers. Key provisions included a requirement that commissioners should contract with the provider best able to meet the needs of their local population and both commissioners and providers were required to foster patient choice. With regard to mergers and acquisitions, the guidance stated that these transactions were acceptable when in the best interest of patients and taxpayers as long as sufficient[†] choice and competition remained to ensure high quality services.³⁵

In July 2010, the Department of Health updated the PRCC to take into account the Coalition government's plans outlined in *Equity and excellence: Liberating the NHS*. While the 10 principles remained similar to those published in 2007, the role of choice and competition within the NHS was strengthened. In 2007, one of the principles related to fostering choice. In the revised guidelines, commissioners and providers would be required to promote patient choice with specific reference to the policy of 'any willing provider' (later 'any qualified provider').

There was a new requirement stating that commissioners and providers should not reach agreements which would restrict commissioner or patient choice of providers against the interests of patients or taxpayers. The document also outlined guidance which aimed to prevent individual providers from unreasonably refusing to supply services and cited circumstances where established providers attempted to restrict choice or competition by refusing to accept or provide services.³⁶

On 11 February 2013, the Secretary of State made the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 – otherwise known as the Section 75 Regulations. The regulations replaced the PRCC but while they maintained many of the same principles, they attracted parliamentary opposition.³⁷

The regulations required the NHS Commissioning Board and clinical commissioning groups (CCGs) to ensure good practice in relation to the procurement of NHS health care services and required commissioners to prevent anti-competitive behaviour and to ensure the protection of patients' rights to make choices.³⁸ The House of Lords Secondary Legislation Scrutiny Committee published its report on the regulations on 7 March 2013. The committee concluded that the regulations would require commissioners to use competitive tendering for more services and that the regulations marked a significant change. The committee noted that there was widespread concern in the health sector and that the Department of Health might find implementation challenging.³⁹ Four days later the government laid amended regulations in parliament against a background of opposition and the prospect of a Liberal Democrat revolt.

The amended regulations made it clearer that there would not be a requirement to put all contracts out to competitive tender, Monitor would not have the power to force competitive tendering and commissioners should be free to use integration where it was in the interest of patients.⁴⁰ Labour peers attempted to annul the revised regulations during a debate on 24 April 2013. Lord Hunt of King's Heath suggested that the regulations were part of a 'drive to shift the culture of the NHS from a public service into a public marketplace.'⁴¹ Earl Howe countered by saying that:

'one area of the law that we have not changed one iota is the law relating to competitive tendering... these regulations usher in nothing new at all... there is no government agenda to privatise NHS services – quite the contrary'.⁴²

The motion was defeated by 254 votes to 146.⁴³

Throughout 2014, competition in the NHS again became a highly contentious issue. In March 2014, the Labour Party published a consultation document on its ideas for health policy. It also committed to repealing the Health and Social Care Act 2012, suggesting that Labour would 'deliver an NHS that valued collaboration over competition'.

Summary

As this chapter shows, competition policy in the NHS has evolved over the past 25 years. The controversial 'Section 75 Regulations' have their roots in the 2007 Principles and Rules for Co-operation and Competition (PRCC). Likewise, the regime for merger control has become more formalised over time, with the Health and Social Care Act 2012 making it explicit that FTs would be subject to a decision-making process by the competition authorities. In addition, the Act extended the role of Monitor from that of the independent regulator of FTs to the sector regulator for health.

Merger control in the NHS

3

* At phase 1 the CMA has a duty to refer for an in-depth 'Phase 2' investigation any relevant merger situation where it believes that it is or may be the case that the merger has resulted or may be expected to result in a substantial lessening of competition (SLC). At phase 2, the CMA conducts a more detailed analysis to determine whether a relevant merger situation has resulted or may be expected to result in a SLC and if so, whether it should take action to remedy any 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 – £15m, community services – £35m and £70m in the case of acute and mental health trusts).

This chapter describes the role of the Office of Fair Trading (OFT) and the Competition Commission (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. While the CMA is a unitary authority, the reforms have preserved the separation between phase one (formerly carried out by OFT) and phase two (formerly carried out by the CC) in merger cases.*

The Health and Social Care Act 2012 did not establish a system of merger control in the NHS but instead sought to confirm the legal position relating to the application of existing competition legislation. The policy today has its roots in the early 2000s with the decision to establish foundation trusts (FTs) and the government's reforms of the competition authorities which were underpinned by 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 FTs. Prior to the Act, the government suggested that the OFT already had jurisdiction to review mergers between FTs under the Enterprise Act. However, there was legal uncertainty as to when that applied in individual cases as applicable mergers† were reviewed by the Co-operation and Competition Panel (CCP).⁴⁴

The CCP was formally established on 30 January 2009 and its role was to investigate potential breaches of the Principles and Rules of Co-operation and Competition (PRCC) as well as reviewing proposed mergers and advising on the wider development of cooperation, patient choice and competition within the NHS.⁴⁴ In practice, the CCP expected that mergers involving NHS trusts would be primarily examined by the CCP and mergers between independent sector providers of services to the NHS would primarily be examined by the OFT.⁴⁶

The Health and Social Care Act ultimately provided for a system of merger control involving NHS FTs whereby 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 also advise on other matters relevant to the merger although the Health and Social Care Act 2012 did not specifically mention competition assessment as one of them. The OFT was obliged to consider the advice from Monitor as part of its general public duties.⁴⁷ The relationship between the OFT and the CC was established through the Enterprise Act 2002.

In addition to the UK merger control regime, there is also a European element to consider. Mergers would fall under the remit of the European Commission if they satisfied one of two thresholds unless each of the undertakings concerned achieves more than two-thirds of its aggregate EU-wide turnover within one and the same Member State:⁴⁸

1. the combined aggregate worldwide turnover of all the undertakings concerned is more than €5bn, and the aggregate EU-wide turnover of each of at least two of those undertakings is more than €250m.
2. the combined aggregate worldwide turnover of all the undertakings concerned is more than €2.5bn, and
 - in each of at least three Member States, the combined aggregate turnover of those undertakings is more than €100m
 - in each of at least three of the Member States included for the purposes above, the aggregate turnover of each of at least two of the undertakings concerned is more than €25m
 - the aggregate EU-wide turnover of at least two of the undertakings concerned is more than €100m.

This report does not attempt to examine European-wide merger control processes.

The Enterprise Act 2002

In 2001, the government announced reforms which were intended to improve the productivity of the UK economy. One of the proposals involved radical reform of the UK competition regime – the government wanted to allow competition authorities independence to investigate specific or ‘sectoral’ markets using clear competition principles as well as providing a strong legal basis for competition authorities to promote competition.⁴⁹ These reforms were enacted through the Enterprise Act 2002.

The Act gave more independence to the competition authorities – the OFT and the CC – and established a new merger regime where decisions would be taken by these authorities against a competition-based test rather than a public-interest test. Previously, statutory questions focused around whether there was a monopoly situation and who that monopoly favoured⁵⁰ as well as considering whether transactions operated (or might have been expected to have operated) against the public interest.⁵¹

The reforms removed ministers from the decision-making process for most merger decisions and were intended to ensure that decisions on mergers were taken by those best qualified to make them and would not be influenced by political considerations.⁵⁰ The 2002 Act provided for final decisions on most mergers to be taken by the OFT or by the CC rather than the Secretary of State.*

The Act also provided for mergers to be considered against a new test. Under the Act, the authorities had to consider whether a merger would result in a ‘substantial lessening of competition’ (SLC). However, the Act set out a regime for the investigation of mergers that raised matters of public interest, in addition to competition and customer benefit concerns. Specified public interest considerations include national security, the interests of maintaining the stability of UK financial considerations and issues relating to the media.⁵²

* As an exception, the Secretary of State for Business, Innovation and Skills (formerly Department of Trade and Industry) is able to have a decision-making role on mergers which raise defined public interest considerations such as national security.

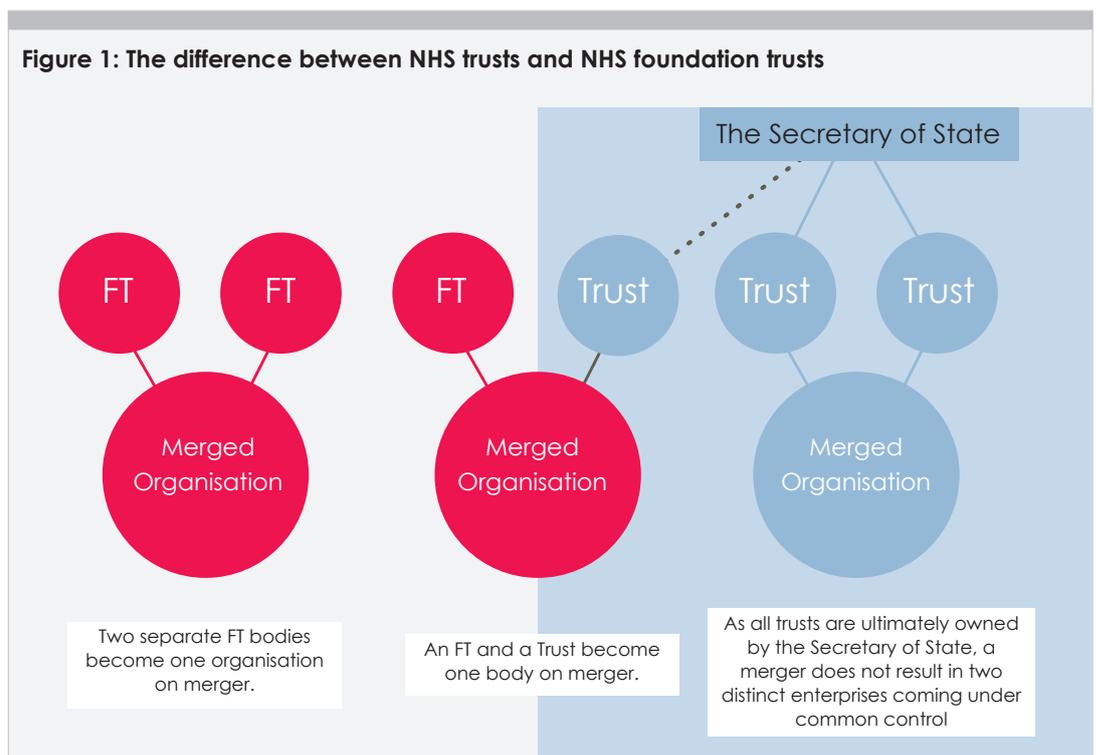
The Enterprise Act imposed a duty on the OFT to refer mergers to the CC for further investigation if a merger fell under the definition of a ‘relevant merger situation’ and it believed that it was or may have been the case that the merger had resulted or might have been expected to result in a SLC. As discussed on page 21, the OFT did not need to make a referral to the CC under a number of circumstances. Once a referral was made, the CC would conduct a full investigation. If the CC found a merger had or might be expected to result in a SLC (the main test), it could prohibit the merger or impose remedies (ie imposing measures to mitigate or prevent any SLC identified). The CC took into account customer benefits resulting from the merger in setting remedies.⁵²

What constitutes a relevant merger situation?

A ‘relevant merger situation’ under the Enterprise Act 2002 occurs when two or more enterprises cease to be distinct and either:

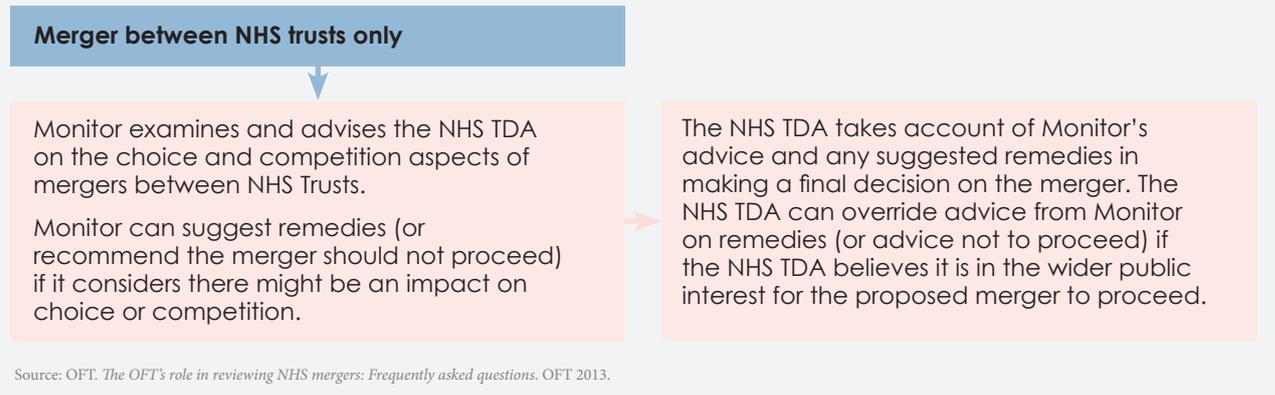
- the value of UK turnover of the enterprise which is being acquired exceeds £70m (known as the ‘turnover test’) or
- the enterprises together supply or acquire at least 25% of all those particular goods or services supplied in the UK or in a substantial part of it (known as the ‘share of supply test’).

With regard to the NHS, mergers between two NHS trusts are not considered to be a relevant merger situation under the Enterprise Act 2002. This is because ultimately the Secretary of State is considered to be in control of both organisations – NHS providers being part of a national system – so a merger would not result in two distinct enterprises coming under common control. In contrast, a merger involving FTs (public benefit corporations with income-generating powers which are viewed as independent bodies) at an organisational level (rather than service level) may create a situation where two or more enterprises cease to be distinct.⁵³ Figure 1 illustrates this difference.



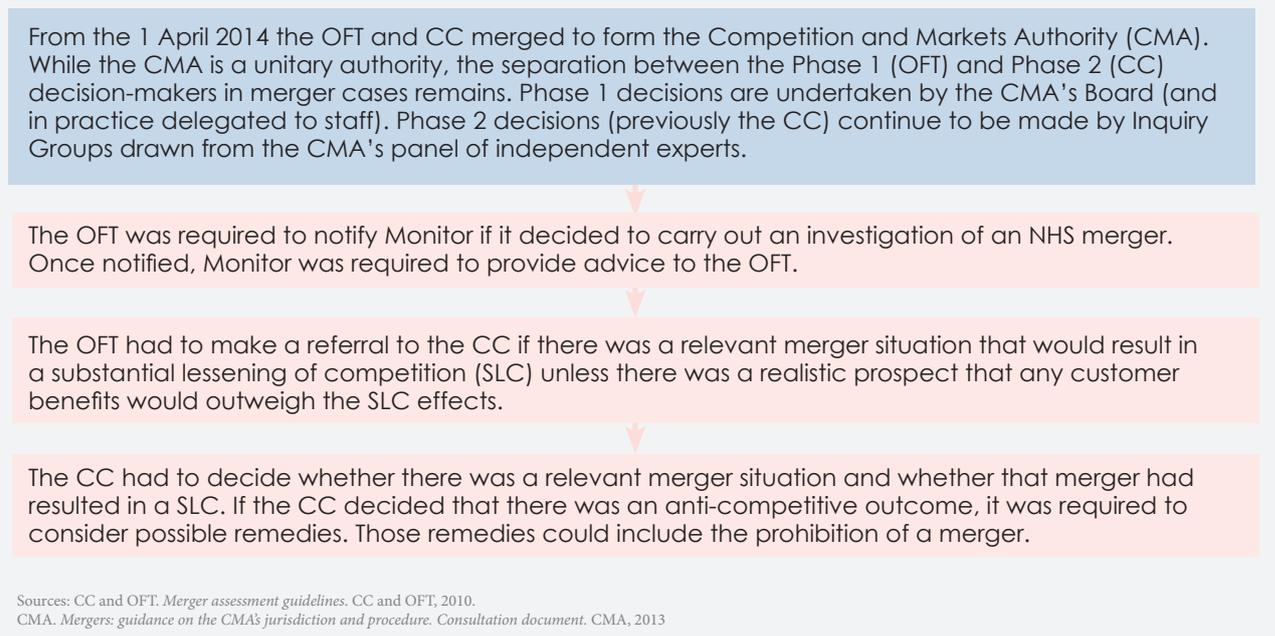
For NHS trusts, Monitor examines and advises the NHS Trust Development Authority (NHS TDA) regarding a merger between two or more NHS trusts. Monitor is able to suggest remedies if it considers there might be an impact on patient choice or competition. The NHS TDA takes account of Monitor's advice and any suggested remedies in making a final decision on the merger. The NHS TDA can override advice from Monitor on remedies (or advice not to proceed) if the NHS TDA believes it is in the wider public interest for the proposed merger to proceed.⁵³ Figure 2 gives an outline of this process.

Figure 2: Merger control process: NHS trusts



For FTs, considered to be independent entities, the merger control regime as prescribed under the Enterprise Act 2002 applies. The OFT was required to notify Monitor if it had decided to carry out an investigation into a merger involving a NHS FT. Once notified, Monitor had a specific statutory role to provide advice to the OFT. After initial investigation by the OFT (taking into account Monitor's contribution to the OFT investigation), the OFT could then refer the proposed merger for investigation by the CC. This process is summarised in Figure 3 below.

Figure 3: Merger Control Regime: Office of Fair Trading (OFT) and Competition Commission (CC)



The role of the Office of Fair Trading and the Competition Commission in merger decisions

Figure 4 below summarises the respective decision-making processes of the former OFT and the CC. The tests have remained the same under the Competition and Markets Authority, which was established on 1 April 2014.

Figure 4: Merger control process: Office of Fair Trading (OFT) and Competition Commission (CC) roles

A relevant merger situation under the Enterprise Act occurs when two or more enterprises cease to be distinct and either:

- a. the value or UK turnover of the enterprise which is being acquired exceeds £70m (known as 'the turnover test'); or
- b. the enterprises together supply or acquire at least 25 per cent of all those particular goods or services supplied in the UK or in a substantial part of it (known as 'the share of supply test').

Office of Fair Trading (OFT) duty to refer

The OFT had a duty to refer completed and anticipated mergers to the CC for investigation if it believed that it was or may have been the case that

1. a relevant merger situation had been or would be created; and
2. the creation of that situation had resulted, or was expected to result, in a substantial lessening of competition (SLC) within a market or markets in the UK for goods or services.

The OFT applied a 'realistic prospect' threshold.

Counterfactual

The OFT considered the effect of the merger compared with the most competitive counterfactual and generally adopted the prevailing conditions. However, the OFT could assess the merger against an alternative counterfactual where the prospect of prevailing conditions continuing was not realistic (eg an exiting firm). For the OFT to accept the exiting firm argument, it would need compelling evidence to believe that the firm would exit the market and that there was no substantially less anti-competitive purchaser for the firm.

The OFT could decide not to refer if it believed that:

- the market concerned was not of sufficient importance to justify the reference;
- any relevant customer benefits (RCBs) outweighed the SLC and any adverse effects of the SLC; and
- in the case of an anticipated merger, the arrangements concerned were not sufficiently far advanced.

Relevant customer benefits

RCBs are benefits in the form of lower prices, higher quality or greater choice of goods or services, or greater innovation in relation to such goods or services.

The OFT/CC had to believe that:

- a. the benefit would accrue within a reasonable timeframe as a result of the merger
- b. the benefit would be unlikely to accrue without the merger or similar SLC.

The Competition Commission (CC) had to decide two questions:

1. Had a relevant merger situation been (or would have been) created?
2. If so, had the creation of that merger situation resulted (or was expected to result) in a significant lessening of competition (SLC) within any market or markets in the UK for goods or services?

The CC applied a balance of probabilities threshold. It was looking to understand if it was more likely than not that a SLC would result.

Counterfactual

The CC could examine several possible scenarios but only the most likely scenario was selected as the counterfactual. In considering the counterfactual the CC considered whether the firm would have exited (through failure) and if so:

- a. whether there would have been an alternative purchaser for the firm or its assets and
- b. what would have happened to the 'sales' of the firm if it had exited.

Remedies

If the CC decided that there was an anti-competitive outcome, it considered possible remedies by deciding what if any action should be taken by the CC or others for the purpose of remedying, mitigating or preventing the SLC concerned or any adverse affects arising from the SLC.

The CC had to have regard to the need to achieve as comprehensive solution to the SLC as was reasonable and practicable and sought to ensure that no remedy was disproportionate. The CC could also have regard to any RCBs arising from the merger. The merger parties were expected to provide convincing evidence regarding the nature and scale of RCBs.

From 1 April 2014 the OFT and CC merged to form the Competition and Markets Authority (CMA). While the CMA is a unitary authority, the separation between the phase 1 (OFT) and phase 2 (CC) decision makers in merger cases remains. Phase 1 decisions are undertaken by the CMA's board (and in practice delegated to staff). Phase 2 decisions, as was the case with the CC, are made by inquiry groups drawn from the CMA's panel of independent experts.

Source: Competition Commission and Office of Fair Trading. *Merger assessment guidelines*. CC and OFT; 2010.

Office of Fair Trading (OFT)

The OFT considered the effect of the merger compared with the most competitive counterfactual* and generally adopted the prevailing conditions of competition (ie the pre-merger situation). However, the OFT could assess the merger against an alternative counterfactual where the prospect of prevailing conditions continuing was not realistic, for example in the case of an exiting firm (see 'The exiting firm test' on page 22). For the OFT to accept the exiting firm argument, it would need compelling evidence to believe that the firm

* Counterfactual = The CMA looks at the likely effects of the merger against what would happen without the merger

would exit the market and that there was no substantially less anti-competitive purchaser for the firm. For example, even if a firm was to exit, there might be other buyers of the firm which might produce a better outcome for competition than the proposed merger party.⁵²

The OFT had a duty to refer completed and anticipated mergers to the CC for investigation if it believed that:

- a relevant merger situation had been or would have been created, and
- it was or might have been the case that the merger had resulted, or might have been expected to result, in a substantial lessening of competition (SLC) within a market or markets in the UK for goods or services.

The OFT could decide not to refer if it believed that:

- the market concerned was not of sufficient importance to justify the reference
- any relevant customer benefits outweighed the SLC and any adverse effects of the SLC, and
- in the case of an anticipated merger, the arrangements concerned were not sufficiently far advanced.

The term ‘relevant customer benefits’ (RCBs) has a specific statutory meaning. RCBs are benefits in the form of:

- lower prices, higher quality or greater choice of goods or services; or
- greater innovation in relation to such goods or services.

At both phase 1 and phase 2, benefits are only considered once it has been established that a relevant merger situation might result in a substantial lessening of competition.

The Competition Commission (CC)

In the event of a referral from the OFT, the CC had to decide two questions:

- Had a relevant merger situation been (or would have been) created)?
- If so, had the creation of that merger situation resulted (or would be expected to result) in a substantial lessening of competition (SLC) within any market or markets in the UK for goods or services?

The CC applied a balance of probabilities threshold that looked to understand if it was more likely than not that a SLC would result. The CC could examine several possible scenarios but only the most likely scenario was selected as the counterfactual. In considering the counterfactual the CC considered whether the firm would have exited (through failure) and if so:

- whether there would have been an alternative purchaser for the firm or its assets, and
- what would have happened to the ‘sales’ of the firm if it had exited.

If the CC decided that there was an anti-competitive outcome, it would then consider possible remedies by deciding what, if any, action should be taken by the CC or others for the purpose of remedying, mitigating or preventing the SLC concerned or any adverse effects arising from the SLC. Box 3 outlines guidance from Monitor on indemnifying RCBs.

Box 3: Recent guidance on relevant customer benefits (RCBs)

Monitor has recently published guidance which suggests that when assessing benefits, the organisation will consider the following points.

- Is the proposed change likely to represent a real improvement in quality, choice or innovation of services for patients or value for money for commissioners?
- Is the proposed change likely to be realised within a reasonable period as a result of the merger?
- Is the proposed change unlikely to accrue without the merger or a similar lessening of competition?⁵⁴

RCBs only apply if the benefit would accrue within a reasonable timeframe as a result of the merger and the benefit would be unlikely to accrue without the merger or a similar SLC. The CMA has since issued guidance which outlines the types of benefits that providers have previously submitted, including higher quality services through:

- service reconfiguration
- implementing a particular care model
- increased consultant or staff cover
- access to equipment
- greater innovation through research and development.⁵⁵

Monitor has given further guidance on how trusts considering merger might identify the benefits for the issues above. As an example, to show that service reconfiguration will improve the quality of services, merger parties would need to:

- provide details of the reconfiguration proposed
- identify the services and patients affected (including any effects on inter-dependent services)
- explain the quality improvements arising from the reconfiguration
- explain the timeframe for implementation
- clarify why benefits would be realised more effectively or quickly through merger rather than other means.⁵⁴

The CC had to have regard to the need to achieve as comprehensive a solution to the SLC as was reasonable, practicable and proportionate. In doing so the CC could have regard to any relevant customer benefits arising from the merger. The merger parties were expected to provide convincing evidence regarding the nature and scale of relevant customer benefits.

The exiting firm test

The 'failing or exiting firm' test is not unique to merger and acquisition processes in the UK. Indeed, the Organisation for Economic Co-operation and Development (OECD) held an international roundtable in 2009 to discuss the role of the failing firm defence given the tough economic situation facing most western countries. This test exists in most OECD jurisdictions and allows for anti-competitive mergers in some situations if the target organisation is in dire straits financially and the only other option would be market exit.⁵⁶ The test is relevant to the Bournemouth and Poole case as the trusts contended (at phase 2 – the CC phase) that Poole Hospital NHS Foundation Trust (PHFT) would be likely to exit the market due to financial failure and thus the appropriate counterfactual to review the merger would be one where PHFT exited the market. This argument was not put forward during the OFT (phase 1) process. Determining a counterfactual against which to carry out a competitive assessment is not a separate test but is one of a number of assessments carried

out in relation to determining whether a relevant merger situation might be expected to result in a SLC.

The OFT only cleared a transaction based on ‘exiting firm’ claims where there was sufficient evidence to suggest the inevitable exit of the target business without the merger and that there was no realistic alternative that was substantially less anti-competitive. The OFT required compelling evidence that the prospect of prevailing conditions continuing was not realistic before it could adopt an alternative counterfactual.⁵² In considering this test, the OFT might conclude that in some cases it might be better (with respect to intensity of competition) for the organisation to fail and for the remaining players to compete for its market share.⁵⁷

For the OFT to accept the exiting firm test, it would need to believe (based on compelling evidence) that the firm’s market exit was inevitable and that there was no substantially less anti-competitive purchaser for the firm or its assets. The OFT would then consider whether the exit of the firm would result in a substantially less anti-competitive outcome than the merger.

For an organisation to be considered a ‘failing firm’ by the CC, the CC needed to be satisfied that that the firm would be unable to meet its financial obligations in the near future and that the firm would be unable to restructure itself successfully. In reaching a decision on the exiting firm test, the CC would need to review whether any other persons might have acquired the firm and how the sales of the failing firm would be redistributed among competitors.⁵⁸

Further joint guidance in 2010 advised that the three main issues of focus for the regulatory bodies when considering an exiting organisation would be:

- whether the firm would exit (through financial failure or other causes)
- whether there would be an alternative purchaser for the firm or its assets
- what might happen to the ‘sales’ of the organisation in the event of its exit.⁵²

In the UK, there have only been a handful of cases where the OFT or the CMA has accepted a ‘failing firm’ defence for an anti-competitive merger or acquisition. One recent example was HMV’s acquisition of 15 Zavvi stores following Zavvi’s administration.⁵⁷

To help clarify these arrangements in the health care sector, in October 2013 (after the decision by the CC to prohibit the Bournemouth and Poole merger) Monitor, the OFT and the CC issued a joint statement which suggested that where hospitals were demonstrably failing, the authorities might conclude that the proposed merger would have no impact on patients because merger would be no worse in terms of choice and competition than if the hospitals did not merge. Where hospitals were in clinical or financial difficulty, Monitor (and the NHS TDA in the case of NHS trusts) would be closely involved with the hospitals concerned and the competition authority would place significant weight on Monitor’s advice.⁵⁹

More recent guidance issued in July 2014 suggested that the CMA would consider the following with regard to NHS mergers:

- whether the provider would exit (through failure or otherwise)

- whether there would be an alternative acquirer for the provider's assets other than the acquirer under consideration
- where the patients and the commissioner contracts of the provider would go to in the event of the provider's exit.

* The phrase 'have regard to' appears a lot in guidance documents or legislation. It effectively means 'give due consideration to an issue'.

In considering whether a provider would exit, the CMA would have regard to* the trust special administration (TSA) regime, the legal mechanism to deal with significantly challenged NHS trusts or NHS foundation trusts (ie the NHS failure regime). The document suggested that in the vast majority of instances where NHS providers faced financial difficulties, there was little or no risk that these providers would go through the TSA process and exit the market in the short to medium term. It also advised that in the absence of sufficient evidence relating to exit, merging providers may wish to consider making submissions as to whether one of the providers is less likely to be a strong alternative choice for patients or commissioners due to financial constraints. In addition to market exit by individual providers, the CMA could consider exit of specific services. Changes to services could be led by providers, commissioners or as a result of regulatory action (ie by the Care Quality Commission or the TSA). The CMA would examine evidence provided by the merging providers and/or other stakeholders to determine why the provider would have exited the service.⁵⁵

It should be noted however, that there is nothing to suggest that the CMA believes that it would be impossible to exit the market. The sample of cases in the NHS the CMA has examined to date has been small and in principle it might be possible for an NHS provider to exit in accordance with the criteria used more broadly by the CMA. In addition, aside from the formal exiting firm tests, the CMA is able to take into account whether an organisation might be less likely to be a strong competitor based on financial or clinical difficulties. Guidance suggests that where the evidence is not sufficient for the CMA to adopt an exiting provider or service counterfactual, it will take into account evidence on financial or clinical difficulties in its competitive assessment.⁵⁵ In the case of the decision on the proposed acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust by Frimley Park Hospital NHS Foundation Trust, the CMA considered the exiting provider text. While the CMA did not consider that it was appropriate to assess the merger against a counterfactual other than the prevailing conditions of competition, in its competitive assessment it did take into account the financial and clinical difficulties identified in relation to Heatherwood and Wexham Park Hospitals NHS Foundation Trust.⁴

For the CMA to accept an exiting provider argument at phrase 1, it would need compelling evidence to believe that **provider exit was inevitable** and that it was confident there was no substantially less anti-competitive acquirer for the assets. At phase 2, the CMA considers the **likelihood** of provider exit. If the CMA considers that there may be alternative acquirers, it will try to identify them and take this into account when considering the counterfactual.⁵⁵

Table 1: Exiting provider tests, adapted from the CMA's guidance on the review of NHS mergers⁵⁵

Tests	Points to consider
Would the provider exit?	<ul style="list-style-type: none"> • In considering whether a provider might exit (i.e be dissolved), the CMA would consider the inevitability of provider exit at phase 1 and the likelihood of provider exit at phase 2. • The CMA would have regard to the regulatory regime for NHS providers and the TSA process which could result in the dissolution of a provider.
Would there be an alternative acquirer for the provider's assets?	<ul style="list-style-type: none"> • The CMA would consider whether the provider would go through the CMA process and be dissolved absent the merger. In doing so, it will consider the financial position and reports and/or views of regulators. • If a TSA process is sufficiently advanced that dissolution is the likely recommendation, this will be relevant evidence of dissolution. • In the event that dissolution appears inevitable (phase 1) or the most likely outcome (phase 2), the CMA would then consider the alternative options available to the trust special administrator. • The CMA would consider evidence supporting any claims that the merger under consideration was the only possible merger. • The CMA would take into account any submissions as to why another provider would not have delivered safe, clinical service or not done so on a financially viable basis.
Where would the patient and commissioner contracts of the provider go?	<ul style="list-style-type: none"> • If there was no alternative or less anti-competitive acquirer, the CMA would consider what would happen to the commissioner contracts and patients of the provider (in the event that the entity was dissolved and in the absence of the merger). • The CMA would consider whether the services would be redistributed among remaining providers and if so how. If patient activity was most likely to be spread across a number of providers, merger might have an impact on competition. In contrast, if activity might be expected to switch to the acquiring provider, the impact on competition might be limited.

At what point should the authorities be involved in a relevant merger situation?

As noted above, the CMA is able to look at anticipated or completed mergers and it is possible to complete a merger without prior clearance by the CMA.⁶⁰ However, it is clearly in the interests of NHS providers to engage with Monitor and the CMA early on in the process of undertaking a significant transaction. Guidance from Monitor explains that transactions should only progress where evidence is very clearly established that they are in the overall interest of patients. Where a trust formally notifies the CMA of a transaction, early advice from Monitor should provide a good level of preparation for the CMA review process.⁶¹ If a trust chooses to complete a merger without prior clearance by the CMA, the CMA could decide to review the merger up to four months after the merger is completed or made public. The CMA has broad powers to prevent or unwind actions by the merged parties such as the transfer of services or the establishment of joint governance.

Guidance clearly suggests that to avoid pre-merger integration concerns, merger providers should not:

- transfer ownership of control of all parts of their business or assets
- carry out actions which impair their abilities to compete with each other going forward
- make substantive changes to their organisational structure or management responsibilities
- make changes to service provision together or
- merge service lines or parts of the business or use a single set of branding.⁶⁰

Summary

As this chapter shows, the merger regime is complex and the questions the competition authorities are required to consider apply across a broad set of sectors and industries. The merger decision-making process is provided for by the Enterprise Act 2002 and not the Health and Social Care Act 2012.

The process for mergers involving NHS FTs differs from that involving only NHS trusts. The former are seen as autonomous organisations whereas the latter are considered to be ultimately responsible to the Secretary of State. While the regulatory regime is effectively the same, NHS trusts are viewed differently to NHS FTs due to being under Secretary of State control.

When undertaking the competitive assessment, essentially the competition authorities (now the CMA) have 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 a SLC?
- If there is a SLC do any relevant customer benefits outweigh the SLC concerned and any adverse effects of the SLC?*

At phase 2 (previously CC)

- Has a relevant merger situation been or will be created?
- If so, would the creation of that situation result or may 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.⁵⁵

On the face of it, these considerations are not dissimilar to the NHS's four reconfiguration tests (strong public and patient engagement, consistency with the need for patient choice, clear clinical evidence base and support from commissioners). However, for mergers the first test is competition (or the lack thereof) with consideration of benefits coming later in the process.

More recent guidance from the CMA and Monitor has sought to clarify some areas of confusion and provide additional detail to NHS FTs on the evidence they will need to provide as part of the merger review process. However, there is still some ambiguity around the point at which an NHS provider could be considered an 'exiting firm' prior to the TSA process being activated. The CMA explicitly states in its guidance that in the absence of sufficient evidence relating to exit, merging providers may wish to consider making submissions as to whether one of the providers might be less likely to exercise a strong competitive constraint through clinical or financial difficulties. As further cases are considered by the CMA more detail is likely to become available. It should be noted however, that there is nothing to suggest that the CMA believes that it would be impossible to exit the market. The sample of cases to date has been small and in principle it might be possible for an NHS provider to exit in accordance with the criteria used more broadly by the CMA.

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

The Bournemouth and Poole case

4

A brief introduction to the Bournemouth and Poole case

On 29 November 2011, the Boards of Poole Hospital NHS Foundation Trust (PHFT) and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (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. At this time, the Health and Social Care Bill was midway through its parliamentary passage and had cleared the House of Commons. At that stage, it was not certain that the provisions on competition and sector regulation would be passed into legislation unscathed. Furthermore the local commissioning system was in a state of flux due to the likely abolition of primary care trust commissioning bodies (although it should be noted that once established both Dorset Clinical Commissioning Group and NHS England were explicit supporters of the merger). The Act eventually received royal assent in March 2012.

In June 2012, the Office of Fair Trading (OFT) notified Monitor that it had decided to carry out an investigation of the merger under Part 3 of the Enterprise Act 2002 and Monitor provided advice to the OFT in December 2012. In January 2013, the OFT decided to refer the case to the Competition Commission (CC). In October 2013, the CC announced that it would prohibit the proposed merger.

The following chapter outlines in more detail the process both trusts went through in pursuit of the proposed merger. It highlights discussion points from interviews with individuals involved locally. Over the course of February 2014, interviews were held with 10 senior representatives from the following organisations:

- Poole Hospital NHS Foundation Trust
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Dorset Clinical Commissioning Group
- West Hampshire Clinical Commissioning Group
- NHS England, Wessex.

The sample size is small and the views of the individuals interviewed do not necessarily reflect a wider organisational position nor is there a universal 'local position' on the merger process, potential impact, or the outcome of the decisions by the regulatory authorities. Participants were asked questions

about the following themes: context, their experience of the regulatory process, and learning for the wider system.

The individuals concerned agreed to be interviewed on the basis of anonymity. Direct quotes have been included but small edits have been made to preserve participants' anonymity. Inclusion of the quotes does not necessarily represent endorsement of the position by the authors but instead reflects the individual's views, opinions and thoughts. It is important to emphasise that the quotes represent a collection of individual views which do not necessarily represent a corporate view of any of the parties. Indeed, there are views expressed which disagree with each other both within and across individual organisations.

Prior to the interviews, desk research was carried out to identify areas for questioning, with interview questions divided into themes of (1) context (2) financial position (3) regulatory process (4) next steps for the area and (5) system implications. The interviews were transcribed and main discussion points were identified following analysis of the transcripts. These points included:

- the geographic and financial context of the two trusts
- the catalyst for the decision to pursue a merger
- the level of understanding of the process to be followed
- the process of engaging with the competition authorities
- the aftermath of the merger decision.

Background

The geographic context

Poole Hospital NHS Foundation Trust (PHFT) is a 635-bed acute general hospital operating on one site, which mainly serves the 272,000 people living in Poole, East Dorset and Purbeck. The trust 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. It also provides specialist services such as cancer care across Dorset.⁶²

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT) is a 601-bed trust operating across two sites. It serves a total population of around 550,000 covering Bournemouth, Christchurch, East Dorset and part of the New Forest in Hampshire. Some specialist services are provided across a wider catchment area, covering Poole, the Purbecks and South Wiltshire.⁶³

The primary commissioner for both providers is Dorset Clinical Commissioning Group (Dorset CCG). In 2011/12 RBCHFT's total income was £239.8m and PHFT's total income was £195m.⁶⁴ West Hampshire Clinical Commissioning Group (West Hampshire CCG) also has an interest with the two trusts being used by the population in one of its six localities. West Hampshire CCG commissions approximately £22m of services from RBCHFT and £3–4m from PHFT.⁶⁵

The two trusts are approximately eight miles apart and their potential local competitors are spread across a wide geography. Acute hospital providers operating within the region include Dorset County Hospital, Salisbury District Hospital, University Hospital Southampton and Yeovil District Hospital. Analysis by the Competition Commission (CC) suggested that there was little

overlap between the catchment areas of the parties (Bournemouth and Poole) and the acute hospitals listed above. A drive time of 28 minutes from Poole Hospital and 21 minutes from Bournemouth would provide a catchment area covering 90% of referrals. The CC's analysis suggested that a drive time of 22 minutes for PHFT and 17 minutes for RBCHFT appeared to be sufficiently representative of the typical drive time of the merging trusts' patients (see Table 2). The parties disputed this suggesting that 41–60 minutes' drive time would be more appropriate.⁶⁶

Table 2: Competition Commission's analysis of drive time and distance from the two hospital

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

At a basic level, the geographic spread of the acute hospital sites in the region limits the degree of provider choice within a 'reasonable' travel time (although the definition of reasonable is not clear). Research suggests that for hospital care most patients would choose their local provider and providers and GPs consider their patients to be loyal to the local hospital.⁶⁷ However, research suggests that patients do take into account both location and quality. For example, a study examining the choice of hospital for elective hip replacements using Hospital Episode Statistics data suggests that hospital demand declines with distance but that there are important quality dimensions of choice with demand increasing with quality.⁶⁸

The distance between the two FTs and their competitors was to become a critical factor in the CC's conclusion that a merger would result in a SLC. As one local interviewee put it:

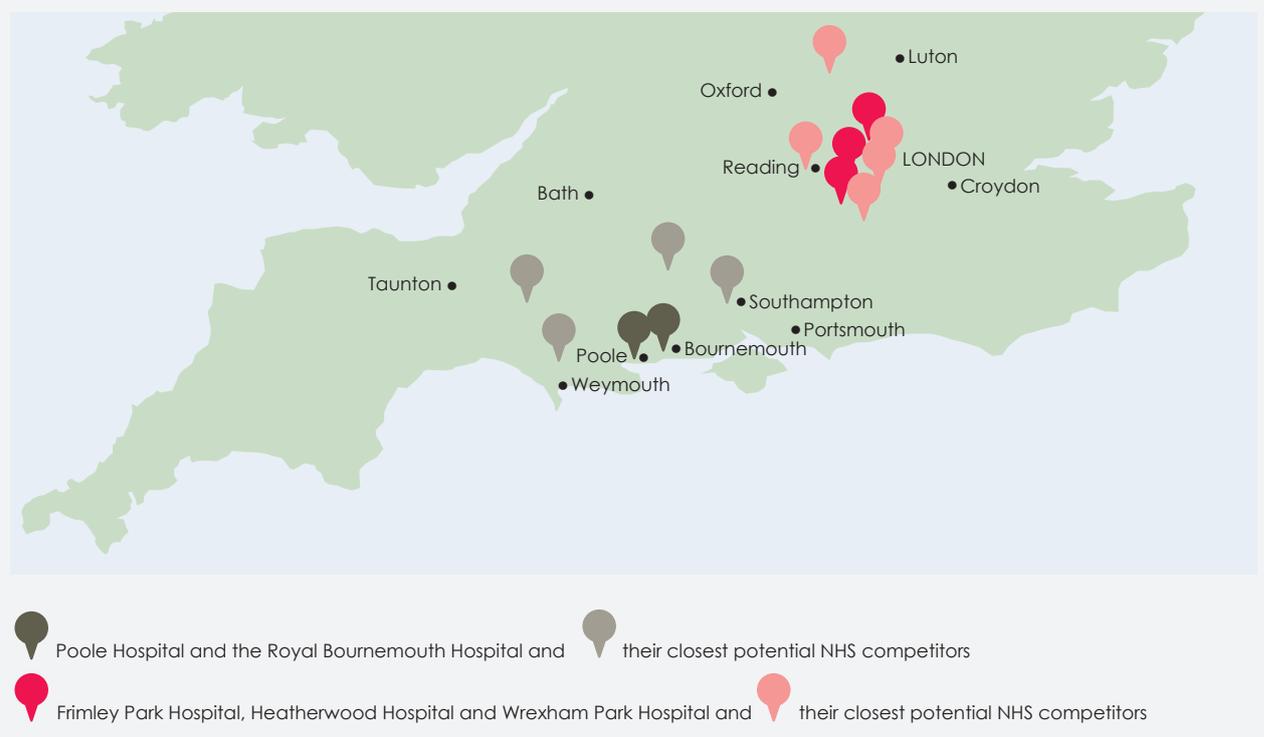
'If we wanted to merge with Norfolk and Norwich, it wouldn't have been an issue. There'd be no benefit but there'd be no competition issue... It's two different issues, isn't it? The fact that we were six miles apart for competition regulators is a very bad thing. The fact that we're six miles apart [with respect] to NHS reconfiguration is a fantastic thing because we can actually reconfigure clinical services because the distances are shorter.'

One interview participant also noted that the sea provided an additional barrier.

‘The fact that we’ve got the sea to our backs meant there wasn’t really a 360 [degree] opportunity for competition. Anywhere with the sea about means the only competition you’re likely to have is inland and there just weren’t enough, in their mind, providers that were close enough. If you were in London, [then] you’ve got a different situation.’

The geographic spread is demonstrated more clearly in Figure 5 which shows the location of the Royal Bournemouth Hospital and Poole Hospital sites compared with the potential competitors named above. As comparison, the map also shows the locations of the acute hospital sites linked to Heatherwood and Wexham Park Hospitals NHS Foundation Trust and Frimley Park Hospital NHS Foundation Trust: the two organisations have recently received approval from the Competition and Markets Authority (CMA) to merge on the basis that there would not be a material reduction in competition between hospitals in the area and that there are currently a number of other strongly performing NHS hospitals located nearby.⁶⁹ It is clear from the map below that the trusts involved in the merger of Frimley Park and Heatherwood and Wexham are surrounded by potential competitors.

Figure 5: Map of NHS competitors – Bournemouth and Poole merger and the Frimley Park and Wexham merger



In its guidance published in July 2014, the CMA is ultimately responsible for assessing whether there are geographical areas where the merging providers appear to be each other’s closest competitors or where patients have little or no choice of other providers for any services.⁵⁵

A number of interviewees questioned whether it was right always to compare a merger situation with the historical precedent (ie would competition be reduced for a defined population under the proposals relative to the existing situation) rather than comparing the situation against other areas nationally.

'But they were looking at competition very much in the Poole and Bournemouth connotation and saying, "You've got two in there don't lose it." I suppose our take was, "That's kind of ridiculous when you look at some of the other big towns [such as] Brighton and Portsmouth, where it's already a single trust. Are you going to break them up saying "You must have choice there?" It seemed an un-level playing field to us, and if anything we felt that surely that's anti-competitive to the Poole and Bournemouth population that we can't get a bigger trust to compete with some of the other big ones.'

'The other thing that I felt quite strongly about was that they were applying a level of competition that just doesn't exist elsewhere in the country. Other than possibly London, is there anywhere else in the country where patients should have the choice of two hospitals eight miles apart? The whole point is that most populations are served by one large DGH [district general hospital] and a number of community hospitals. We happen to have two smaller DGH sites eight miles apart and I think that even if they completely lost one of them, I don't think the population would be having less choice than anyone else in the country. I think at the moment the Dorset people have got an awful lot of choice that doesn't apply to the rest of the country and actually is unaffordable going forward given our economic situation now.'

'Bournemouth and Poole don't need two hospitals; they just happen to have two hospitals. The ideal would be a single hospital somewhere.'

The argument that a bigger trust could compete more effectively with other trusts may be taken into account in merger analysis as a 'rivalry enhancing' efficiency. However, while there was a reference to being able to compete more effectively with the University Hospital Southampton NHS Foundation Trust (UHSFT) for maternity services,⁷⁰ this point was not made particularly strongly by the parties. It should also be noted that the CC did consider the likely future financial position of the trusts as part of its assessment.

Given the geographic distribution of the other acute hospital trusts in the area, there is a question as to why there are two district general hospitals within such close proximity. The evidence submitted to the CC explains some of the historical background. In the 1980s, Poole Hospital was the main hospital in the area. The Royal Bournemouth Hospital was built in 1989 after some discussions as to whether another large hospital was needed so close to the existing site at Poole.

The two hospitals were set up to work in a complementary way to serve the population of East Dorset and in 1989 they were directly managed by the East Dorset Health Authority. But soon after the Royal Bournemouth Hospital was built, the NHS was reformed in the early 1990s to create the division of purchasing and providing functions (as outlined in chapter 2) and set up hospitals as NHS trusts. At this time, Dorset Health Authority was established as purchaser and the two hospitals became independent provider trusts with

independent decision-making boards. A review of acute services was carried out in the 1990s which sought to ensure the most appropriate distribution of services. For example, paediatrics and maternity remained together at Poole whereas other surgical services were provided at Bournemouth. The trusts were encouraged to work together and a large number of clinicians divided their time between the two hospitals.⁷¹

This position was outlined in the interviews by a number of participants. One interviewee explained the historic division between the two hospital trusts. Broadly speaking, one of the hospitals was configured to focus on elective activity and the other non-elective.

'Poole is an unusual trust, in that it is primarily a provider of emergency services. We have one of the highest percentages of non-elective activity in the country and that arises from a very clear decision... in the early 1990s, where we were part of a single health authority. The decision was taken to have one of the two hospitals in Bournemouth and Poole focus on primarily elective activity – and that was Bournemouth – and have the other hospital focus primarily on emergency activity. This was long before national tariffs existed and long before FTs existed, so decisions could be taken more easily, in my view, by the health authority. Orthopaedic electives went to Bournemouth, cardiology in the main went to Bournemouth and trauma came to be centralised in Poole, maternity centralised in Poole, apart from a midwife-led unit, and cancer in the main centralised in Poole. We always had tended to regard ourselves as two halves of a single organisation and there's little history of active competition between the two organisations.'

Analysis by the CC suggested that PHFT did have an above average proportion of non-elective activity but it was not necessarily unique. The CC also found that there was evidence of competition between the two trusts in 34 outpatient services where the proposed merger might have been expected to result in a SLC. This included services such as geriatric medicine and general surgery as well as maternity and one private inpatient service (cardiology).⁶⁶

Financial performance

The RBCHFT was authorised as a FT on 1 April 2005. Its financial position has historically been strong and Monitor has not taken regulatory action against the trust.⁷² For the 2012/13 financial year, the RBCHFT had a balance of £54.2m and achieved a surplus of income over expenditure of £3.6m (1.4% of its £249m turnover).⁷³

In contrast, PHFT was authorised as a FT in November 2007 and in July 2010 was subject to regulatory action by Monitor due to a significant breach in complying with its licence. The trust was found to have failed to have complied with its general duty to exercise functions effectively, efficiently and economically, and in its governance duty.⁷⁴ Monitor noted that in the 2009/10 financial year, the trust reported a deficit of £4.5m which was a significant departure from a planned surplus of £2.1m. The overspend was in part due to a focus on achieving a maximum of 13 weeks

referral to treatment time (RTT), unpaid activity in excess of contract levels and unachieved cash-releasing efficiency savings.⁷⁵ PHFT was removed from being in significant breach on 23 January 2012 having substantially improved its financial position and put in place stronger leadership at board level.⁷⁴

* In accounting, impairment is a decrease in the value of an asset.

For the 2012/13 financial year, the trust ended with an operating deficit of £8.44m. However, this included impairment* of £9.73m following revaluation of property, plant and equipment and the trust had a year-end surplus of £1.29m before the revaluation of the estate. The trust had an income in 2012/13 of £202m.⁷⁶

† Monitor assesses foundation trusts on their governance and on their financial risk. The continuity of services rating (rated between 1 and 4) shows how great the risk is that a foundation trust will fail to carry on as a going concern.

At June 2014, both trusts had a 'continuity of service'[†] rating of 4 (the least risk) and a status of 'no evident concerns' regarding their governance ratings. However, one of the major objectives of the proposed merger was to secure the financial sustainability of Poole with the trust having projected a deficit of circa £8m in 2014/15 and £14m in 2015/16.⁷⁷

A number of interviewees suggested that the distribution of services between the two trusts was a critical factor in determining the difference in their respective financial positions. Most interviewees suggested that the split had been more advantageous for Bournemouth on the basis that national tariff prices for elective services created more surplus than those for non-elective services. However, the CC's analysis did not suggest that PHFT would be more vulnerable to financial pressure than many other foundation trusts because of its size or case mix.⁶⁶

'I think although there is not very good, hard evidence to prove it, most directors of NHS organisations would agree that the case mix [at Poole] is not a profitable case mix. I think perhaps it needs more scientific analysis to prove that, but if you talk to most FDs [financial directors], they would agree that they make most of their money out of elective orthopaedics and interventional cardiology. They cross-subsidise services such as maternity and trauma to a certain extent. Within a single DGH that probably doesn't matter, but where you split them up, as you have done with Bournemouth and Poole, that creates a problem.'

'I would argue that if you were doing the reconfiguration today, in the same way it happened 20 years ago, there is no way you would do what happened 20 years ago, because it's not a financially sustainable split. Of course, those changes were made pre-tariff and everything else but, if you were doing it today, you certainly wouldn't do it that way, I would argue.'

PHFT submitted data to the CC from Dr Foster for 127 FTs in support of their claim that Poole had the second highest proportion of non-elective inpatient activity once specialist and community FTs were excluded. The closest comparator was Bolton NHS Foundation Trust which has faced considerable financial difficulty.⁶⁶ From August 2012, Bolton has been subject to enforcement action by Monitor in part due to a deteriorating financial position. For the 2012/13 financial year, Bolton reported a deficit of £14.4m with an overall deficit of £28.2m following costs relating to impairment and restructuring. The trust moved from a cash balance of £7.6m in 2011/12 to a balance of £0.3m at the end of 2012/13.⁷⁸

While the CC acknowledged that PHFT had an above average case mix of non-elective services, it concluded there was not enough evidence that this would necessarily lead to PHFT facing greater financial pressure than many other FTs.⁶⁶ Subsequently, Monitor and NHS England have acknowledged reports that urgent and emergency care services might be loss making. However, both organisations point to the limited evidence on the extent to which providers cross-subsidise urgent and emergency care services using income from services that created surpluses. Given the limited evidence, both organisations can only suggest that the costs of non-elective services appear to be rising faster than activity levels.⁷⁹ In July 2014, NHS England and Monitor published a consultation on a revised national tariff payment system for 2015/16.⁸⁰

Financial impact of service mix

In their original submission to the CC, RBCHFT and PHFT (referred to as the two parties) suggested that the national policy of imposing a cap on the national tariff for non-elective admissions had a negative effect on the profitability of services for emergency work.⁶⁴ This cap, or ‘marginal tariff’, was introduced in 2010/11 as a response to concerns about growth in the volume of patients being admitted as emergencies. Admissions above a baseline rate set in 2008/09 were only paid at 30% of the normal price.⁷⁹ However, in the case of Poole, the CC found that the trust had not exceeded the volume of services provided in 2008/09⁶⁶ which effectively meant that the trust’s activity did not reach a level which would have made the 30% marginal rate apply.

Interview feedback corroborated the CC’s view that the 30% marginal rate had not been the cause of the trust’s financial difficulties.

‘The 30% tariff hasn’t had an impact, but because of our case mix, looking back, we have never made the excess profits that some DGHs have. They have been caused partly by the tariff, but more importantly, they’ve been caused by the increase in activity in elective areas.’

As the quote above demonstrates, the issue might not be the profitability (or lack thereof) of non-elective services but rather the ability that Bournemouth had as an early wave FT to generate a surplus from expanding elective activity.

‘I think, Bournemouth went early as a foundation trust... and moved to a “payment by results” baseline very quickly. In the earlier years the tariff was more generous than it is now. Bournemouth by having large cardiac services and orthopaedic services tended to [have] the services that were generating a lot of money.’

‘Poole became a FT a lot later and their case mix has been more on the non-elective side, where the 30% margin on the tariff applied. They also had... maternity as well and children’s services. These seem to be services with which there isn’t so much within the tariff for them.’

‘It meant Bournemouth built up large cash reserves. It still has huge cash reserves – Poole never really got that reserve built up. So it’s always been a tighter financial environment in Poole than it has

in Bournemouth. Poole particularly has been in a tighter financial position and the market they were in was more difficult for them to grow in and try and trade out of.

The financial and historical context above is important when considering the rationale for the merger and the actions and dynamics of the key actors within the local health economy.

An introduction to the Bournemouth and Poole merger proposal

Minutes from the board meeting of PHFT on 29 June 2011 explained the chairman and the chief executive had met with their counterparts at RBCHFT to discuss closer joint working. In parallel, staff at both trusts were told that the boards intended to explore the merits of closer collaboration including the possibility of a merger, stating that ‘it is clear the NHS needs to think differently about how services are developed, delivered and managed.’⁸¹

In August 2011, a joint working programme had commenced, with McKinsey appointed as independent consultants to support the work. Three joint workshops were held in September 2011 (board-to-board, joint clinical and joint governor) with follow-up workshops taking place in October and early November.⁸²

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 continue to provide and develop excellent clinical services. At this time, the Health and Social Care Bill was midway through its parliamentary passage and had cleared the House of Commons. At that stage, it was not certain that the provisions on competition and sector regulation would be passed in legislation unscathed and the local commissioning system was in a state of flux due to the likely abolition of primary care trust commissioning bodies.

On 22 June 2012, the OFT notified Monitor that it had decided to carry out an investigation under the Enterprise Act 2002. It was from this point onwards that the two trusts were to become ‘guinea pigs’ for the new merger control process which ultimately resulted in the CC’s decision to prohibit the merger on 17 October 2013. This process took nearly two years from the initial announcement by the boards in 2011. Table 3 overleaf shows the high level timeline of the merger review process. However, it would be misleading to suggest that this timeline would be in any way typical of new merger proposals.

The timing of PHFT and RBCHFT’s proposed meant that two organisations as well as the regulatory system had to navigate a changing legislative landscape and a climate of uncertainty.

Table 3: 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.

What was the catalyst for the decision to pursue a merger?

The intention to merge was announced by the two trust boards in November 2011. However, feedback from the interviews suggests that merger had been considered locally for some years and that merger between the two trusts had been a relatively constant topic of discussion over the previous decade.

'As we've moved towards foundation trusts, there was an obvious direction of travel which would probably mean fewer [of them]. That never actually happened, but observers of the system felt there were at least one too many organisations in Dorset at the time. That's going back 10 years, before any of us were foundation trusts. At the time, we expected that to happen through the process, but it didn't; we all became individual foundation trusts one by one. Dorset was one of the first all foundation trust health economies.'

'The merger discussions never went away. It's been a permanent discussion; it's never been far away from the top of the agenda. The two boards had earlier come to an informal understanding of working together and moving towards some sort of at least strategic alliance, if not more.'

In short, the decision to pursue a merger had been an item for discussion locally long before 2011. However, there were some mixed messages from interviewees relating to the rationale for pursuing a merger in 2011. While one participant suggested *'it was finance. Very much finance'* most interviewees said it was to sustain the quality of clinical services at the trusts and overall financial viability. As one said: *'The logic is that we needed to make – and still do – some clinical changes that I believe [the] merger would facilitate. Those*

clinical changes still need to happen but we can't do it through merger.' Another added: 'Finance was a component but, actually, the real driver was about providing better quality care to patients and more clinically sustainable services being established for the population overall.'

'I think clinical sustainability was and still is the biggest threat. Obviously you can't separate the two, because if we had all the money in the world then we could probably address clinical sustainability, we'd just double up everything. The two are connected, but we couldn't see a way of achieving clinical sustainability and financial sustainability at the same time, and we couldn't actually either, because even if we could afford lots more [clinical] consultants; they don't exist. The two were intrinsically linked.'

'Both organisations, over the coming three years, needed to realise savings of between £25m and £30m per organisation. We recognised that those savings were likely to be better attained through coming together. The second major driver was associated with the fact that we wanted to deliver more consultant-led services. If you take our two accident departments, we both had six consultants each. The model, going forward, certainly in advance of the 'Key Area Review', was to move towards a consultant-delivered major accident department. Then, the second department was likely to be a minor injuries department. Getting to that position, as two separate organisations, was going to be incredibly difficult because neither organisation nor the population at large wanted to give up their services. As a merged organisation, we could effectively drive that forward in a much more effective way. The third reason for merging was associated with the fact that we needed to sort out, again, the reconfiguration of some services to ensure that they stayed within Dorset. The fourth consideration was the fact that, particularly for Poole, they needed to invest in certain services that they were going to find impossible to invest in with the absence of the merger, particularly in terms of capital developments. The maternity unit was an obvious example.'

The interviewees suggest that the decision to pursue a merger was driven by the two local trusts and not the health economy as a whole. In some ways, this is perhaps unsurprising as during November 2011, the commissioning system was already in flux in preparation for the changes which would follow the Health and Social Care Act 2012's royal assent. However, interviewees suggested it pointed to a system which was still 'provider-centric' in nature. *'It was entirely a provider decision at that stage. I suppose it's worth saying that merger of Bournemouth and Poole has been an agenda item for as long as I can remember,'* said one. Another said: *'I think it was a provider decision. The regulators were not involved in the original discussions at all and then the commissioners would have been seen as later in the process.'*

'It was absolutely driven by the two providers. Both providers recognised that financial and clinical sustainability was at risk. Poole's financial situation was clear then; two and a half years ago the board was clear about what the financial projections looked like.'

‘There is still a provider-centric conversation that happens everywhere about everything. It doesn’t matter what it’s about, providers are still viewed as the centre of the health service. I mean, if you just arrived in this country you wouldn’t think that there is anything that went on in health care outside hospitals.’

With the benefit of hindsight, the benefits case might have been stronger if the merger had been commissioner-led rather than provider-led, but given the degree of change and transition in the commissioning system it could be argued that the providers had the right to determine their own destiny and to work towards sustainability on their own terms. One of the critical decisions taken early on was the degree to which form should follow function or vice versa. Following advice, the trusts took the decision to pursue merger prior to detailed discussions about functions and before undertaking a public consultation on service reconfiguration.

‘Both boards recognised that sustainability – financially and clinically – needed to be addressed. Once we’d undertaken that work, [the consultancy] were involved and the recommendation was that we should pursue a merger with an approach that said, “merge first, reconfigure after” on the basis of, perhaps, lessons learnt previously by [the consultancy] and others that to make some of the difficult reconfiguration decisions, you need a single directing line, a single board, a single group of doctors, so that there wasn’t necessarily seen to be a winner or loser financially in any of these decisions. That’s when we pursued it and, as I say, although finance was a key part, it certainly wasn’t the only reason for doing it.’

On the basis of such advice (and it should be noted that the trusts received further advice from experienced competition and legal experts), one can see why this ‘merge first, reconfigure later’ approach was tempting, particularly given that mergers had been a discussion topic for some time. However, this approach was not necessarily conducive to providing the level of evidence on patient benefit that was required, given the initial focus appeared to be on form rather than function (although it is not the case that providers need to have reconfigured prior to merger, parties do however need to be in a position to provide robust evidence on benefits where a merger raises competition concerns). The interviews do suggest that while quality of services (and ultimately patient benefit) was a key consideration, the role of finance comes out as an important factor in the decision to pursue the merger.

Understanding of the process to be followed

It was clear from the interviews that there was a lack of clarity regarding the decision-making process which was to be followed to pursue a merger and certainly a lack of appreciation as to the level of evidence that would be required. The interviews suggest that there was some confusion about whether the process set out by the Co-operation and Competition Panel (CCP) would be followed or instead that set out by the OFT and CC.

‘There was quite a lot faffing around because no one knew [what the process would entail]. We weren’t getting any advice other than, perhaps, from the competition lawyers and, as we all know, the competition regulator already had the power and it wasn’t the

Health and Social Care Act per se that gave them the power. We were increasingly starting to think, “We’re probably going to have to go to the OFT”. We spent quite a lot of time not knowing which process we would be going through and eventually we were told that we had to go through to the OFT.’

‘Before we engaged in the process, we did not have significant insight into precisely how that process would unfold. That insight evolved at a fairly early stage through some of the advisers that we employed, who helped us consider both the OFT and the CC phase.’

It was recognised by a number of the interviewees that the process was to be a learning test case for everyone involved including the trusts, Monitor and competition authorities.

‘Of course, a FT to FT merger was setting a precedent; so, they were learning very much, particularly the legal advisers, at the same time and trying to work not only with the competition process and [the] health [sector] for the first time, but with the lens of how the OFT would look at us. Also, Monitor obviously had their new remit, so they were still learning about how they would take us through their processes as well. Post the Health and Social Care Act, we were working with new regulatory bodies that were learning things for the first time.’

Annex B outlines selected extracts taken from trust board meetings held between October 2011 and May 2012. The minutes corroborate suggestions in the interviews that the process to be followed emerged over time rather than being clear at the outset.

Early stages: involvement by the Co-operation and Competition Panel, Monitor and Office of Fair Trading

The trusts liaised with Monitor and, from an early stage, the Co-operation and Competition Panel (CCP) and then the Office of Fair Trading (OFT). The trust board minutes from January 2012 suggest that Monitor was reluctant to provide advice to the parties on competition issues arising from the merger. From March 2012, the parties started preparing a submission for the OFT which was submitted on 29 May. Minutes from the 27 June board meeting at PHFT then outline that the OFT had requested a full business case earlier than had been anticipated.⁸³ In parallel, the trusts were working with Monitor to understand how it would deal with the merger both as the regulator of FTs (for licensing purposes) and its new functions as sector regulator under the Health and Social Care Act 2012.

Minutes of the RBCHFT board meeting held on 8 June 2012 explained that the trusts had received an indication from Monitor as to how it would approach the merger and there were two paths. Either the trusts would need to go through the process used for aspirant trusts or Monitor could produce a risk assessment in addition to a vote on the merger by both trusts’ council of governors. Both trusts were keen to influence Monitor to adopt the second option.⁸⁴ The approach adopted would have depended on whether the merger took place prior to 1 April 2013 as the Health and Social Care Act 2012 introduced changes to how Monitor could assess transactions.

On 22 June 2012 the OFT formally notified Monitor that they had decided to carry out an investigation.⁸⁴ Minutes from the RBCHFT board meeting held on 13 July 2012 confirmed that it was likely that the OFT would refer the case to the Competition Commission (CC).⁸⁵ Minutes from PHFT's board meeting held on 25 July outlined that Monitor had asked the CCP to review the merger benefits case on their behalf.⁸⁶ Monitor provided advice to the OFT on the potential benefits of the merger on 7 December 2012.

In the business case, the parties had outlined potential benefits following service reconfiguration in five core areas: maternity, haematology, accident and emergency, acute general surgery and cardiology. However, we understand from the interviews that the trusts did not focus on detailed analysis of the benefits of service change because of the advice to 'merge first and reconfigure later'. In the words of interviewees:

'We put together a benefits case rather quickly, because we hadn't thought about what the benefits of merger were, other than financial stability, and it seemed the right thing to do anyway.'

'Because of this basis of "merge first, reconfigure later", our benefits case was very much at a strategic level. The problem is that when we submitted that benefits case to the CCP, they were quite critical of it, saying, "We don't think this needs a merger to deliver". That was submitted to the OFT and was our 'Achilles heel' throughout the next two years.'

Monitor and the CCP concluded that the proposed merger was likely to deliver relevant customer benefits (RCB) for some patients in the form of higher quality maternity and cardiology services. However, Monitor was less convinced by the benefits proposed for the other three services. In particular, Monitor believed that:

- the benefits for haematology services were likely to be delivered through commissioner-led reconfiguration regardless of the proposed merger
- there would be a commissioner-led review of urgent care services which would occur regardless of merger
- the proposed reconfiguration of acute general surgery services was unlikely to improve services in the long term.

In addition, Monitor was not convinced the trusts had provided sufficient evidence of the proposed financial savings or service improvements that would be delivered by the proposed merger.⁸⁷ It is worth saying that Monitor has since been clear that NHS FTs are expected to engage early on when considering options such as a merger and that patient benefit should be carefully considered by all parties involved.⁵⁴ More recent guidance from Monitor states that where merger parties and/or commissioners submit that benefits will be delivered by reconfiguration, they do not expect public consultation to have commenced. However, for extensive proposals (for example accident and emergency reconfiguration), Monitor would expect the parties to have:

- determined what the preferred proposal is and, where relevant, provided evidence of the need for change

- developed a model of care by engaging with clinicians and other stakeholders
- produced an assessment of the clinical advantages (and any disadvantages) alongside robust financial data.⁵⁴

One of the suggested areas of benefit was reconfiguration of accident and emergency services. The constant tension for the trusts was that if they had determined a preferred option (ie openly stating that there should be one emergency department and that this should be located at x site) it might have potentially pre-empted the outcome from public consultation.

Because Monitor and the CCP were not convinced of the proposed patient benefits put forward, the two trusts further developed the benefits case in parallel to the formal assessment by the OFT. It was acknowledged by a number of the interview participants that the presentation of the benefits to patients to the CCP and then to the OFT by the trusts during the early stages of the process could have been stronger.

The OFT was required to refer the case to the CC if it believed that

- a relevant merger situation had been created^{*}
- it was or may have been the case that the merger had resulted or might have been expected to result in a substantial lessening of competition (SLC).

The OFT did have the powers not to refer to the CC if any RCB in relation to the creation of the relevant merger situation concerned outweighed the SLC and any potential adverse effects.

The OFT's assessment was that a merger would result in SLC with regard to the provision of routine elective care specialities: rheumatology, rehabilitation, general medicine, general surgery, geriatric medicine, dermatology, clinical haematology, oral and maxillofacial surgery, cardiology, palliative medicine and cardiothoracic surgery. The OFT found the merger might have led to a SLC with regard to the provision of medical oncology, gynaecology, vascular surgery, neurology, ear, nose and throat, trauma, orthopaedics and non-elective services.

The OFT suggested it was:

*'[Concerned] 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.'*⁸⁸

In its report, the OFT suggested it had taken due account of the advice from Monitor given its sectoral expertise and its statutory advisory role. The OFT noted that Monitor did accept that some RCBs may accrue to patients in the form of higher quality maternity and cardiology services, but that Monitor had raised doubts over the other proposed benefits.

Based on the evidence presented and the doubts articulated by Monitor, the OFT could not be satisfied that the RCBs would outweigh the identified SLCs. It was therefore required to make a referral to the CC.⁸⁸ On 8 January 2013 the decision was taken to refer the merger case to the CC.

^{*} The OFT was able to make a reference (as can the CMA now) for completed and anticipated mergers.

Given the lukewarm assessment by Monitor on the extent of the potential benefits, there is a question about whether the merger process should have been discontinued at this point. It is easier to view this decision in hindsight and with the knowledge that the merger was finally prohibited. It is important to highlight that the position was reviewed formally and regularly at board level at both trusts. The minutes of PHFT's board meeting on 24 July 2013 show that in response to the CC's provisional findings report, it had been agreed to 'mount the best possible case to persuade the CC that merger provided benefits for the local population that outweighed the harm caused by reductions in competition'.⁸⁹

The interviews suggest the trusts did consider abandoning the process midway through but decided that it was worthwhile continuing.

'I think we should have walked away at that point [following Monitor's advice to the OFT], in retrospect.'

'There was always an absolute chance that we would not get through, however, both boards felt so passionate that it was the right thing for patients that we felt that we had to. A number of times we took stock but we thought it would be wrong to not pursue this absolutely because it was right for patients so we just carried on, even though we knew there was a risk. It was the solution so we worked hard to try to make it work.'

'I think it was inevitable quite early on in the process that they were going to reach the conclusion that they did. Therefore, we did consider whether we would withdraw from the process. The difficulty in [doing that] was that we did not have a final outcome, and that we had spent a considerable amount of money without getting to that final outcome. It did not, at that point, move us any further forward.'

The 'considerable amount of money' referred to was referred to as being approximately £5m by a number of interviewees. This figure comprised consultancy fees, organisation development, internal advisors and so on.

Freedom of Information requests made by Incisive Health regarding the costs incurred during the merger control process showed that the combined figure from both trusts was £4.98m (of which £4m was funded by NHS South West). However, most of these costs were incurred in preparing for the merger rather than the competition assessment process itself.⁹⁰

The Competition Commission

The Competition Commission (CC) process commenced following the referral from the OFT in January 2013. The two trusts jointly submitted an initial submission (published on 9 April 2013) and an additional submission outlining the potential benefits (published on 3 June 2013). One of the first considerations by the CC (after determining whether it was a relevant merger situation) was whether the merger had resulted or might have been expected to result in a substantial lessening of competition (SLC). The initial submission by the parties thus focused specifically on the issue of SLC.

Provisional findings were published in July 2013 and the final outcome was published in October 2013. The two trusts had the opportunity to submit 'potential remedies', ie action to mitigate against the potential SLC in August 2013.

Initial submission

The exiting firm test

Alongside arguments in relation to the level of overlap and cooperation between the trusts, one of the key arguments put forward to counter the issue of SLC was that the appropriate counterfactual should be that Poole would exit the market (due to financial failure) and that the CC should use the ‘exiting firm’ scenario as the counterfactual. The parties suggested that due to Poole’s forecast deficit, the only realistic scenario for the counterfactual would be Poole’s ‘exit’ due to financial failure. If this counterfactual were applied, it would negate any SLC if Bournemouth was most likely to take over the services vacated because of Poole’s exit.⁶⁴ As we discussed in chapter 3, parties in previous merger decisions have had little luck with convincing competition authorities that the exiting firm test applies. However, it is important to note that there is nothing in guidance to suggest that an NHS provider could never meet the requirements of the exiting provider test. The parties did not put forward the ‘exiting firm’ argument until the CC stage.

On 1 May 2013, the chief executive of PHFT wrote to Monitor outlining his concerns that without the merger, the trust would be unlikely to be able to continue as a going concern due to a projected deficit of circa £14m by 2015/16 and the inevitability of ending up in the failure regime. On 24 May 2013, Monitor opened a formal investigation into the trust’s compliance with its licence with regard to financial sustainability and governance.⁷⁷ One year later on 2 April 2014, Monitor closed the investigation on the basis that it believed that the trust’s leadership was taking appropriate action to improve the state of its finances.⁹¹

There was recognition among a number of the interviewees that it would be difficult to convince the CC that Poole was an ‘exiting firm’ because of the approach to dealing with failure (and potential exit) in the NHS as opposed to that of a commercial company.

‘No matter what they [Monitor] did, if the CC’s test is exiting or failing firm, then we were never going to achieve it, no matter what Monitor said.’

‘The competition regulators see the failing firm or the exiting firm, whatever jargon is used, as being a bit like Comet or Woolworths. You go bust, your assets are frozen and you exit the market. That never happens in the NHS. There are different problems with financial failure but it’s not assets frozen, pay off your creditors, exit the market and because we weren’t doing that, they weren’t denying that we were going to have financial problems but we weren’t an exiting firm.’

‘There’s a big issue around how the competition regulators judge financial failure in the NHS as opposed to commercially. What the CC said is, “Well, the NHS will bail you out because we read the newspapers and that’s what happens” and, of course, that’s true. We were never going to exit the market but our argument was that’s a dreadful use of taxpayer’s money because, actually, the CCGs could be spending this on service development improvement, rather than just keeping us going.’

In the case of the Poole and Bournemouth merger, the parties suggested that should merger not take place, the appropriate counterfactual should be the exit of PHFT due to financial instability. The CC rejected this argument on the basis that the CC felt that Monitor would be unlikely to place the parties 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. In addition, the CC considered Poole's structure including its size and case mix and financial forecast.⁶⁶

Competitive effects of the merger

On competition, the trusts highlighted the fact that they could not compete with each other on price and outlined why they felt competition was limited between the two trusts (see Table 4).⁶⁴ However, it is important to recognise that for those services subject to the NHS national tariff, the providers would have been competing on quality rather than price. For the 2012/13 financial year, the national mandatory tariff would have been payable by commissioners for day cases, ordinary elective and non-elective admitted patient care, attendances and some procedures in outpatients and accident and emergency services.⁹² There is also a distinction between competition in the health care markets (where there is direct patient choice between services) and competition for the market (where commissioners put services out to tender). The Office of Health Economics' report on competition in the NHS suggests that competition is feasible across a range of 'services' but that the nature of the 'customer' can affect some dimensions of competition (including demand factors, ease of acquiring information, short-term supply factors, political/institutional factors and cost factors). Competition is feasible whichever of these is the decision making customer, but the nature of the customer can affect how some dimensions of competition are thought about.⁸

It should be noted that inclusion of the parties' presentation of evidence in this report does not represent an endorsement of their position. The parties were tasked with presenting evidence to support their views and it was ultimately the CC who would assess the evidence in line with its legislative tests.

The initial submission by the trusts to the CC suggested that there would be benefits of a merger both to taxpayers and patients. With regard to patients, the trusts suggested that the population could not sustain more than one local provider and that a minimum number of procedures needed to be performed each year in order to deliver safe services. With regard to benefits to the taxpayer, the parties suggested that the fixed costs involved in sustaining two separate providers were not sustainable.⁶⁴

The initial submission grouped benefits into four headline themes.

- **Improving access, safety and quality of care** in five clinical areas: cardiology, acute general surgery, accident and emergency, haematology and maternity.
- **Delivering financial savings** through economies of scale: the parties suggested the merger would generate £20m savings.

- **Enhancing the sustainability of services:** the parties suggested that as a larger entity, they would find it easier to recruit and train key clinical staff and merger would better support the provision of 24/7 services and appropriate staff rotas.
- **Unlocking capital resources to support provision of health care:** the parties suggested that the merger would unlock capital resources and would facilitate a more efficient allocation of capital investment across both sites.⁶⁴

With regard to the expected financial savings, the submission cites figures from November 2012, supplied by PwC, which suggested that over three years, the trusts would be able to make approximately £8.6m in merger-specific savings with an additional £13.6m savings identified as being highly unlikely without the merger. The submission also highlighted a set of figures produced some months later which suggested that merger-specific savings would be approximately £17m over three years.⁶⁴

A subsequent submission outlined the proposed benefits in more detail. The trusts focused on the existing five clinical areas outlined above as well as financial resilience. The following section includes the additional detail on benefits presented at this stage in the process.

Table 4: Initial submission to the Competition Commission: the trusts' rationale for competition limits by service type

Service type	The parties' rationale for competitive constraint
Non-elective	Patients in need of urgent treatment are taken to the nearest clinically appropriate provider (ie there was no choice). Provision is driven by patient access requirements. Commissioners prefer a managed rather than market-driven approach. The trusts suggested commissioners had no intention of reconfiguring services in the absence of the merger.
Specialised services	It would be clinically inappropriate to compete for specialised services in a relatively low population such as Dorset. The specialised services provided by the parties involve significant investment in specialised equipment and training. Awarding contracts to a rival provider would involve 'stranding' assets at significant taxpayer expense.
Elective inpatient and outpatient care	The parties suggested they were not competitors for the majority of elective inpatient and outpatient services as local commissioning practices had been designed to be complementary. PHFT had focused on non-elective care whereas RBCHFT had been more focused on elective care. The parties suggested that for outpatient, diagnostics and day patient procedures, there were a wide range of potential competitors including community hospitals and GP practices.
Community services	The parties predominately concentrate on elective care and their provision is small relative to Dorset Healthcare NHS Foundation Trust which provides mental health and community services.
Private services	The parties suggested that the proportion of their clinical income (less than 2%) was so small that it would not give rise to a SLC, particularly when the market share of local private hospitals was taken into consideration. Also the parties focused on different clinical areas for their private work.

Maternity

The trusts explained that a midwife-led maternity service was provided at Bournemouth. The service was provided without input from medical staff or support from neonatal intensive care. At the time of submission, 38.57 full-time equivalent midwives worked at the unit which was close to the minimum required by the Royal College of Midwives to run a maternity unit of this type. However, low numbers of births (an average of 1.5 per day) and a high midwife to mother ratio of 1:14 meant that the midwives were underused. Bournemouth did not have the specialist equipment and staff to deal with complications in labour and routinely transferred mothers to Poole. The parties highlighted a recent settlement which paid out £7.1m to a family of a child born with severe disability as a result of Bournemouth not being able to transfer the child fast enough to a hospital with neonatal intensive care.

Poole provided a midwife-led unit which was co-located with a consultant-led obstetric service and neonatal intensive care for high risk mothers and babies. At the time of submission, Poole had a midwife to mother ratio of 1:33.5 and could not hire additional staff due to national shortages and challenging finances. Poole's maternity unit required capital investment and in the longer term the trust would need to invest in a new maternity unit.

The parties suggested that under the merger the two services would be consolidated and midwifery resource would be pooled, thereby creating more flexibility to deploy midwives and to support home births. The parties would invest in rebuilding a new maternity unit which was likely to take place within five years of the merger.

Cardiology

The trusts explained that Bournemouth ran two cardiology rotas (general cardiology and primary percutaneous coronary intervention (PPCI)). The service was run by 10 consultants and there was emergency cover 24/7 although out of hours, cardiologists were not present in hospital but were on call. The trust had four cardiac catheter laboratories which enabled it to carry out procedures such as PPCI.

Poole did not have a dedicated cardiology rota but employed four cardiologists on an acute medical rota. Poole was not providing the recommended consultant cover. Poole did not have a catheter laboratory and patients who required PPCI were transferred to Bournemouth. However, Poole did have two stress echo specialists which Bournemouth did not.

The parties cited a range of benefits following merger as the trusts intended to create a single dedicated rota that would span both sites. The trusts cited improved safety across both sites (at Poole there would be 24/7 cover and patients on the Bournemouth site would have access to Poole's stress echo specialists). The trusts also cited general benefits derived from greater specialisation among cardiologists as the combined throughput of patients would be larger.

The parties also countered the suggestion by Monitor in its advice to the OFT that commissioners were conducting a review which would determine the nature of any further reconfiguration of cardiology services in Dorset. The parties suggested that commissioners were investigating clinical requirements rather than service configuration.

Haematology

The parties outlined that both Bournemouth and Poole provided inpatient haematology services for complex cases and stem cell transplantation within Dorset. In the view of the parties, neither trust had a sufficient number of patients to reach the recommended scale for the provision of efficient haematology services.

Following the merger, the parties proposed creating a combined haematology rota which would provide improved cover and greater specialism.

Accident and emergency

Both trusts provided accident and emergency services. They each employed five full-time equivalent consultants and provided consultant cover of 12 hours per day during the week and 3 or 4.5 hours per day during the weekend on alternate weekends. Outside these hours, consultant input was provided on an on-call basis. Coverage did not meet expected guidelines (24/7 coverage is recommended but the required level of 16 hour coverage, seven days a week would require a minimum of 12 full-time equivalent consultants). The trusts suggested that neither organisation would be able to hire the additional consultant cover (due to availability and cost). Both trusts were aiming to recruit an additional consultant but were finding the process difficult.

The parties suggested that as a result of the merger patients would benefit from better consultant cover, increased consultant specialisation and better supervision of junior doctors. The parties suggested that commissioners would find it difficult to achieve the same outcomes without a merger because given the importance of A&E services for direct revenue and for follow-on patient activity, it would be unlikely that the parties would reach an agreement on reconfiguration without the merger. The parties also noted that while commissioners were exploring options for limiting demand for A&E services, they were not considering plans for structural change at the point of submission.

Emergency surgery

The trusts outlined that Bournemouth had eight full-time equivalent surgeons on the emergency surgery rota while Poole had 5.5 full-time equivalent surgeons participating in the delivery of independent, duplicated 24/7 emergency surgery rotas. Neither party was able to provide:

- a 24/7 consultant-led emergency service with consultants free from elective commitments while on-call for emergencies
- an all-day dedicated theatre on standby for emergencies
- training in laparoscopic surgery for all surgeons on the emergency rota
- appropriate staffing levels for middle grade doctors.

The parties suggested that following merger, an integrated emergency surgery rota would enable the merged trust to separate consultant delivery of elective care from emergency duties and would provide more opportunities for consolidating expertise and specialisation.⁷⁰

Competition Commission's provisional findings

As noted above, interviewees suggested that the benefits case changed significantly by the time material was submitted to the Competition Commission (CC) but that the advice from Monitor was based on the trust's original submission to the Co-operation and Competition Panel (CCP). As outlined in chapter 3, Monitor was only required to provide advice to the OFT during phase 1. The CC took into account the changes to the proposed business case.

'Although it [the benefits case] did get more detailed, that's not really what the CCP saw and therefore the expert advice that was going to the OFT and the CC.'

'Because nobody had really done it before, the complexity of it is huge. Certainly by the time it got to the CC the benefit case at this point was hugely different to what was being discussed really with the CCP'

It should be noted that the CC took into account these differences in their final report, suggesting that while the five RCBs identified by the parties had remained constant, some aspects of the parties' claims had changed. In the case of maternity, the reconfiguration proposal was withdrawn and this proposal had been previously accepted by Monitor as a RCB.⁶⁶

On 11 July 2013, the CC published its interim findings.

The CC provisionally concluded that the proposed merger would be expected to result in a SLC in:

- 20 elective inpatient services
- 36 outpatient services
- maternity
- cardiology (a private service).

The parties had put forward the 'exiting firm' counterfactual. The CC's provisional conclusion was that Poole's financial failure was not sufficiently certain to form part of the counterfactual and even if Poole's financial failure had been certain, it would not have inevitably qualified as an 'exiting firm' due to the limited number of providers who had been through the special administration regime.⁹³

At this point in the process, the parties were given the opportunity to submit 'remedies' as a response to concerns about the likelihood of a SLC and respond to the CC's provisional findings. It was at this stage that the CC would take RCB into account.

Response to the provisional findings

In their response to the provisional findings, the two trusts suggested that the CC had overstated the impact of competition. The trusts highlighted the following issues.

- Outpatient services were characterised by low barriers to entry and these services would remain contestable after the merger. Such services could

take the form of community hospitals or other regional providers renting space in community hospital premises or GP premises.

- The degree of competition was overstated for elective inpatient services as most patients were unlikely to respond to small but significant changes in quality and those patients who were responsive would travel further than 20–30 minutes. However, it should be noted that a patient survey conducted by the CC found that, of those patients who were aware of choice (n=117 (RBCHFT patients) and 117 (PHFT patients)), 48% of RBCHFT patients and 47% of PHFT patients would switch to another hospital if their waiting times were to increase by two weeks (regardless of the original waiting time).⁶⁶
- The maternity services offered across both sites were very different and the most fundamental choice facing an expectant mother was whether she would be willing to give birth in a midwife-led unit which did not offer obstetric cover for mothers and babies at high risk of complications. The unwillingness of many mothers to give birth without such provision would limit Bournemouth's ability to expand and Poole was already over recommended bed occupancy rates and did not have the capacity to accommodate further increases in demand.⁹⁴

Restating the benefits case

The parties also made an additional statement as to the potential benefits of the merger.⁹⁵ This document contained more detail (albeit heavily caveated with respect to future consultation requirements) on the preferred site location for some of the reconfigured services. The trusts specified that the preferred option would be for the new maternity unit and haematology services to be based at Poole. However, they were agnostic about the site for the major accident and emergency unit. The two trusts also submitted a letter in support from 65 consultants from PHFT arguing that the main clinical benefits would be difficult or impossible to bring about without the merger and that refusal to authorise the merger would result in adverse outcomes for patients.⁹⁶

Accident and emergency

In addition to the benefits which had been previously stated, the document specified that the parties would consult on their preferred option of predominately locating consultants on one site and developing a major/minor model of accident and emergency across both hospital sites.

Emergency surgery

Subject to consultation, the parties specified that emergency surgery would be co-located with the major accident and emergency centre on one site. The document listed broadly similar benefits to the previous submission.

Cardiology

The document specified that both sites would continue to provide cardiology services and the benefits would arise from a single rota rather than consolidation on one site. Following the merger, the trusts suggested that all patients with acute cardiac problems would be admitted to Bournemouth which had superior facilities.

Maternity

The parties highlighted the poor state of the maternity unit at Poole which realistically could only be used for another five years. Poole also suffered from staffing shortages. Bournemouth's service was underused, loss making and was unable to provide a service for women and babies with a high risk of complications. The trust highlighted improved staffing through a consolidated rota, more flexibility to provide home births and improved facilities for women. Previous submissions were more explicit about reconfiguration of services – it was not clear from this document whether this was an omission or a retraction by the trust. However, the CC's final report stated that in August 2013, the parties explained that they were no longer proposing reconfiguration as a benefit of the merger and that reconfiguration had been disregarded as a potential benefit demonstrating that the maternity reconfiguration had indeed been withdrawn.⁶⁶

Haematology

The parties suggested the provision of a consolidated inpatient haematology service at Poole would ensure the service was co-located with oncology and would provide better senior cover, greater specialisation (due to increased volume) and better patient outcomes. The parties suggested that without merger, the service would end up being commissioned outside Dorset due to a limited ability of the trusts as single entities to provide the necessary investment.⁹⁵

Suggested remedies

In response to the concerns outlined by the CC, the parties were given the opportunity to suggest some potential remedies to the SLC identified.

The two trusts proposed that measurement of the 'friends and family test'^{*} would provide local commissioners with a means to measure the quality of care (essentially through a measure of patient experience of care). The parties proposed the establishment of an escalation mechanism whereby commissioners would be able to put services out to tender if the friends and family score dropped below a specific threshold.⁹⁵

While the parties mentioned some developments which might help to improve quality such as new duties on commissioners, the arguments were not particularly convincing and the trusts missed an opportunity to highlight recent reforms around the Care Quality Commission (CQC) and in particular the reintroduction of quality ratings and more stringent inspection. It is difficult to imagine that these remedies would have been accepted in any sector.

In reaching its final decision, the CC considered whether there might be structural remedies (such as partial divestiture) other than the prohibition of the merger that could be an alternative solution to counter the SLC. The parties did not put forward structural remedies and the CC considered that the services affected by the SLCs would not have been easily divisible from the rest of the merged parties' activity.⁶⁶

* The 'friends and family test' asks people if they would recommend the services they have used to other people

The interviewees were asked specifically about this final submission and why the evidence appeared so weak. The interviews suggest that there was a degree of fatigue but that there was also a limit as to how far the trusts were willing to offer 'structural' remedies as opposed to 'behavioural' remedies as there was a risk that structural remedies (such as divesting services or allowing competitors to use facilities) carried risks to financial sustainability.

'That was our weakest moment, without doubt. We'd given up by then. When it came to remedies, it was a complete farce to suggest friends and family. I'm embarrassed to have been involved.'

'They [the CC] don't like behavioural remedies at all. I guess the friends and family was a behavioural thing. They rarely like behavioural remedies, they like structural and we didn't think we could offer up any structural remedies that wouldn't impact on the loss of income, which would cause us a problem with Monitor.'

'No I think they missed the remedies bit entirely... I think people had given up the ghost at that point to be honest. I think both trusts thought it [their business case] was already sunk.'

'The Competition Commission really favoured structural rather than behavioural remedies. A structural remedy was: "We will divest ourselves of these services and hand them over to someone else". The real significant lessening of competition was all around the revenue-generating, profit-making or surplus-generating services. If we were to say – "Actually, you have identified 36 outpatient services and 18 inpatient or day care services, so we will hand over some of these" – we were simply going to make the new organisation not just clinically, but also financially, unsustainable. There were some real issues. Alternatively, if we did not hand over the services but we said to another provider, "Come on in, use our facilities and compete against us" the Competition Commission would have been open to that, but it would have been not just irresponsible, but also punitively damaging, for us to have opened up our facilities to someone else.'

While the quotes from the interviewees suggest that the CC strongly favoured structural remedies, and that an option might have been to divest some services, it does not appear from the CC's final report that this option was considered to be necessarily effective given the difficulty of separating interconnected services. The issue raises an interesting point about the extent to which the operating entity of a hospital and its estates and facilities are one and the same thing.

Competition Commission's final report

The CC published its final report on 17 October 2013. Having reviewed the evidence, the CC concluded that the proposed merger might be expected to result in a substantial lessening of competition (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). The CC reiterated its earlier view that the appropriate counterfactual was not the exit of Poole but rather that the two trusts would continue as separate entities. Once the CC had concluded that there was likely

to be a SLC if the proposed merger went ahead, the CC considered whether the merger would be likely to give rise to relevant customer benefits (RCBs) and whether any action should be taken to remedy, mitigate or prevent the SLC or any adverse effects. Following its investigations, the CC concluded that the merger would not result in RCBs in the five clinical areas proposed by the trusts, nor did the CC believe that broader clinical benefits, financial savings, merger-avoided costs, merger-enabled investments, the creation of a more balanced portfolio of services and cost savings to commissioners constituted RCBs. Table 5 below outlines the CC's rationale for rejecting each of the proposed benefits.⁶⁶ For further information on how the CC undertook its analysis on service overlap, Appendix G of their final report contains details of the methods used for the analysis. Appendix M outlines a detailed account of its decision-making process for determining whether the benefits put forward by the parties would represent RCBs under the Enterprise Act 2002.

Table 5: Summary of the Competition Commission's rationale for rejecting the relevant customer benefits proposed by PHFT and RBCHFT

Service type	The parties' rationale for competitive constraint
Maternity	<ul style="list-style-type: none"> The CC considered the new maternity unit would not need to be operational until 2017/18 (and that therefore a decision was not needed immediately) and noted that the challenging financial climate might put a strain on the capital budget of the merged organisation. The CC noted that the parties did not have a clear plan for the new maternity unit and had not prepared their analysis of the proposed investment. This meant that issues relating to the location of clinically interdependent services had not been resolved. The CC noted that the maternity unit investment was not anticipated to deliver a significant level of savings and limited evidence of the revenue effects had been presented as the plan had not been fully developed. The CC suggested that existing investment in the refurbishment of the existing maternity unit at PHFT would mean that a new unit would not be required immediately. The CC did not feel that the parties had explained how a combined rota would be implemented nor how this would be a benefit to patients.
Cardiology	The CC did not think a merger was required to establish a single dedicated rota of cardiologists across both sites. The CC also noted that consolidation of acute cardiac inpatient admissions at Bournemouth would not require a merger as in part this had already started to occur.
Haematology	The CC was not convinced the merged entity would proceed with the reconfiguration and did not think the benefits would be likely to accrue.
A&E and emergency surgery	The CC concluded that the trusts had not produced a detailed enough model of care addressing the benefits and drawbacks of A&E/emergency surgery reconfiguration and noted that interrelated services would also need to be reconfigured.
Other benefits (financial and broader clinical benefits)	The CC did not find that these proposals would be likely to result in relevant customer benefits under the meaning of the Enterprise Act.

The CC confirmed that it did not believe that the proposed behavioural remedy (the friends and family test) would be an effective remedy to the SLC and given its findings that the proposed benefits would not constitute RCBs, the Commission named ‘prohibition’ of the merger as the only effective remedy to its competition concerns.

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.⁹⁷

With hindsight did the trusts think they could have done anything differently?

The interview participants were asked whether, with hindsight, they could have provided more evidence which might have given the CC additional reassurance on the benefits case. The responses from the interviewees suggest that they felt the bar of evidence was too high for the stage they were at.

‘We produced a huge amount of evidence to the point that it was possible at that time. I don’t know whether we could have [done anything differently].’

‘I thought it was way too high [the bar of evidence]. I emailed the CC saying: “This is not a good use of public funds to have done the level of detail that you expect in that benefits case at this stage in the process”. I said, “I would be going back to the trusts challenging them ‘why are you spending public money on all that stuff knowing that the merger could be blocked?’ What you’re doing now you would have to do on all the options, otherwise you’ll be knocked over at consultation stage”. So I thought they got that quite wrong.’

‘It sounded that they would [have] wanted to see drawings being progressed. That’s hundreds of thousands of pounds’ worth of architects’ and quantity surveyor fees with such a risk in it [not happening]. That was something that you do afterwards. [But] they just didn’t believe that it would happen. That’s the problem. You could invest a huge amount of money in doing what they would like to see to give them a bit more confidence that it might happen but that’s quite an investment to make on the basis that it could still get rejected.’

‘The real dilemmas there were that we were going to bring services together and they wanted to know on which sites. Subsequent to all of that, they said, “There are types of things that we would want to know about the maternity unit. Can we have sight of the planning permission that you have gained from the local authority? Can we have sight of the tender documentation and all the plans?” Now, if we had not consulted on where those services were going to be, then, we could not provide some of that information.’

‘I think one of the sad things was that in the end it sounded like they just didn’t believe us, they didn’t believe that it would happen. I think that’s a bit of a value judgement really. After all this data and all this analysis that, in the end, it implies they just didn’t believe you. That is irritating.’

'If the bar was set that high in terms of the level of confidence that the benefits would accrue, at the stage we were at in the development and with the public consultation, no trust would have got through the process on the benefits alone.'

All of the above suggests that the parties thought that level of evidence that would be required by the competition authorities regarding the articulation of benefits was extremely high. From that position, it would be difficult to justify using public funds, for example to commission architects for building designs, when there was a risk that the merger might be blocked. However, it is worth pointing out that the CC in its final report highlighted the level of evidence it would have expected to have seen for more extensive benefit proposals such as accident and emergency reconfiguration:

- determination of the preferred proposal and evidence of the need for change
- establishment of the groups necessary to evaluate the benefit, including for example a clinical advisory group, programme board and any other commissioner decision-making bodies
- development of a model of care in consultation with the relevant groups above
- an assessment of clinical benefits (and any disbenefits) as well as a robust assessment of the financial and economic viability of the plans.

The CC noted that the steps above were not prescriptive but instead informative and also outlined that it did not expect the parties to have publicly consulted on the benefits for patients or to have taken a firm decision to proceed.⁶⁶ The guidance above does not indicate that the trusts were expected to have produced detailed architects' plans but does highlight a potential miscommunication or lack of clarity on the process to be followed by the trusts.

The Competition and Markets Authority (CMA) has since issued guidance outlining that the level of information that would be required to prove that providers would actually undertake their planned proposals would vary on a case-by-case basis. The absence of the following actions may not prevent the CMA from concluding that the benefit is expected to arise:

- undertaken or started a public consultation
- taken a firm decision to proceed with the benefits
- implemented or started to implement the benefits.⁵⁵

Monitor has stated explicitly that parties would not be expected to have started or completed public consultation on a proposed reconfiguration or taken a firm decision to proceed.⁵⁴

The CMA guidance suggests that for more extensive benefit proposals (such as accident and emergency reconfiguration), the CMA would expect that for each benefit of the merger put forward the providers would have to have:

- determined what the preferred proposal is and where relevant provided evidence of the need for change

- discussed plans with clinicians and commissioners
- developed a model of care (a plan for the way in which services would be delivered following reconfiguration) by engaging with clinicians of the merging providers and relevant commissioners as well as clinical experts and any relevant advisory groups
- produced an assessment of the clinical advantages (and any disadvantages) as well as a robust assessment of the financial or economic viability of the plans.⁵⁵

What happened after the proposed merger was rejected

While merger was prohibited as a potential solution, many of the clinical issues faced by the trusts are still in need of reform. Following the prohibition of the merger, Dorset CCG embarked on a commissioner-led clinical service review. The specification was taken to the CCG's board on 21 May 2014 with the aim of tendering for a provider to consider questions of both demand (eg, what are patients' needs) and supply (eg, how should services be configured).⁹⁸ A number of interview participants suggested that implementation of the review's recommendations would be extremely challenging.

'The question is: how do you actually implement it [the clinical service review]? When you decide, we're going to have two... not three [of a specific service], how do you go from where we are now to that? That's what needs the work... Anybody could put a blueprint out for what services should look like, but nobody is saying how they're going to be achieved. Merger could have achieved it, because there you then have a single authority.'

'I think there are some issues that the local community and local clinicians know are not okay on an ongoing basis. Most of the time they will find a way to work around it to make sure that individual patients are not compromised... The fact the Competition Commission has said they can't merge, we've got to find another way of getting the workforce to cover off that site. Now, that will still have the same result, won't it? It can't be provided from both sites but they've just made it more difficult for people.'

'We're now going to have to have a commissioner-led approach to it, which you could argue should have been the process at the start. So we're now going to go through that, but coming to that view has cost us probably two years... The really difficult things that we had to do in the merger in terms of bringing some of the services together, we're still going to have to do and it will be a lot more painful to do, because of the winners and losers and trusts wanting [to preserve] their own self interests.'

There is some disagreement among the interviewees as to the value of the clinical services review, given the perception that the key problems identified through the merger case will likely be the issues to be considered through the review. That said, it is clear that all of the comments reflected on the challenges of implementing reconfiguration (rather than the process of determining the right service models).

Whatever one's view on the potential benefits of merger, the local area is about to go through a challenging process where outstanding leadership will be needed to achieve the necessary changes. Chapter 5 reflects on the role of commissioners in this process and suggests that their voice should have been far stronger in the merger proposals. This change process will be compounded in particular by the financial challenges facing PHFT. When asked whether interview participants felt Poole was sustainable, one participant said: *'No. It already isn't. It's just a question of when it runs out of cash.'*

'Left to itself, the answer for Poole would be going into administration. That's not acceptable. We can't have chaos in the community over that and it's really important that the local community works together to look at win-win solutions for everybody. That's in the interest of the patients.'

'The financial situation is dire and we have no clear strategy and [Poole is] not sustainable. If you knew the consequences, the counterfactual, then the merger not going ahead was very depressing.'

The clinical services review was launched publicly in October 2014. The review will look across Dorset exploring how the challenges of financial pressures and increasing demand can be solved before they impact on the quality of care provided. The review will encompass a design stage (including a review of current services and the creation of a blueprint for the future) and a public consultation.⁹⁹

Summary

This chapter looked at key elements of the merger process from the perspective of the local parties. It was clear that there was some uncertainty about the process to be followed from the start. One of the key decisions was to follow the advice of *'merge first, reconfigure later'*. This was to encourage the parties onto a path which suggested that form would follow function and perhaps contributed to the delay in producing a convincing benefits case. However, the decision was taken for practical reasons. There was a strong sense through the interviews that reconfiguration would be more successful as one united organisation rather than two separate (and in some cases competing) bodies.

Should the outcome of the clinical services review recommend reconfigurations that meet the merger threshold, there is a case for an early review of the verdict to prohibit the merger. The undertaking not to merge for 10 years should not prevent further consideration of merger if greater evidence of patient benefit can be articulated.

Chapter 5 discusses in more detail issues relating to the merger process itself, the role of the competition authorities, the role of commissioners and the role of regulators.

Chapter 4 outlined the story of the proposed merger by Bournemouth and Poole, the process they went through and the key dates and milestones. This chapter takes some of the themes which emerged for broader discussion. This chapter focuses on:

- the overall process
- the role of commissioners in merger decision making
- the role of Monitor
- the role of the competition authorities.

The overall process

The proposed merger was first announced in November 2011, midway through the parliamentary passage of the Health and Social Care Bill, which received royal assent in March 2012. Three months later, in June 2012, the Office of Fair Trading (OFT) notified Monitor that it intended to carry out an investigation of the merger under the Enterprise Act 2002. In January 2013, the OFT announced its decision to refer the merger to the Competition Commission (CC) and on 17 October the CC published its final decision on the merger. This was a long and burdensome process.

It was very unfortunate timing that Bournemouth and Poole pursued their proposal to merge at a time of considerable turbulence in the NHS. From the 1 April 2013, strategic health authorities and primary care trusts were abolished, with the NHS Commissioning Board (now known as NHS England) and clinical commissioning groups (CCGs) taking their place. The transition period for the commissioning system brought with it instability and uncertainty. However, it was not only the administrative structures of the NHS that changed; the roles of the sector regulator were also in flux. As a result of the Health and Social Care Act 2012, Monitor's role changed significantly from the independent regulator of foundation trusts (FTs) to the sector regulator for health care. At the same time, it incorporated the functions of the Co-operation and Competition Panel (CCP). These changes (and the preparation for them) were occurring at the same time that the parties were considering how to present a robust case to the regulatory authorities.

To an extent, this level of turbulence is unlikely to be repeated, but it is highly likely to have resulted in an overlong, tortuous and unclear process – costing significant sums in consultancy, as well as placing a large burden on the parties

to supply information to the CC – and which could have been avoided or appropriately aborted at an earlier stage.

‘Merge first, reconfigure later’

The advice at the outset given by the consultancy (based on previous merger experience) – as reported by interviewees – of ‘merge first and reconfigure later’ was (with the benefit of hindsight) a critical decision with regard to the final negative outcome for the parties. A key question is whether there could/should have been advice at the beginning from statutory bodies, rather than consultancies, as to the optimal route for service change given local circumstances.

It should be noted that the guidance does not state that ‘merge first, reconfigure later’ would be problematic. However, with this approach it is vital that it is possible to articulate the benefits in sufficient detail from the start.

It was clear from later submissions to the CC that local commissioners also believed there would be advantages to merging first and reconfiguring services later. Dorset CCG stated it believed that consultation on service reconfiguration would be a quicker and easier process with a merged organisation. West Hampshire CCG thought reconfiguration of services within one organisation would be easier to manage than with two (although merger wouldn’t necessarily make the consultation process easier).⁶⁶

However, a proposal for a service reconfiguration might still have been viewed by the competition authorities as a proposal for merger if it met the jurisdictional tests outlined in the Enterprise Act 2002. And even if the competition authorities had allowed the merger, this would not have negated the need for the two trusts to consult with the public regarding reconfiguring services nor avoided a formal scrutiny process by the local authority. Figure 6 below outlines the steps involved in service reconfigurations.

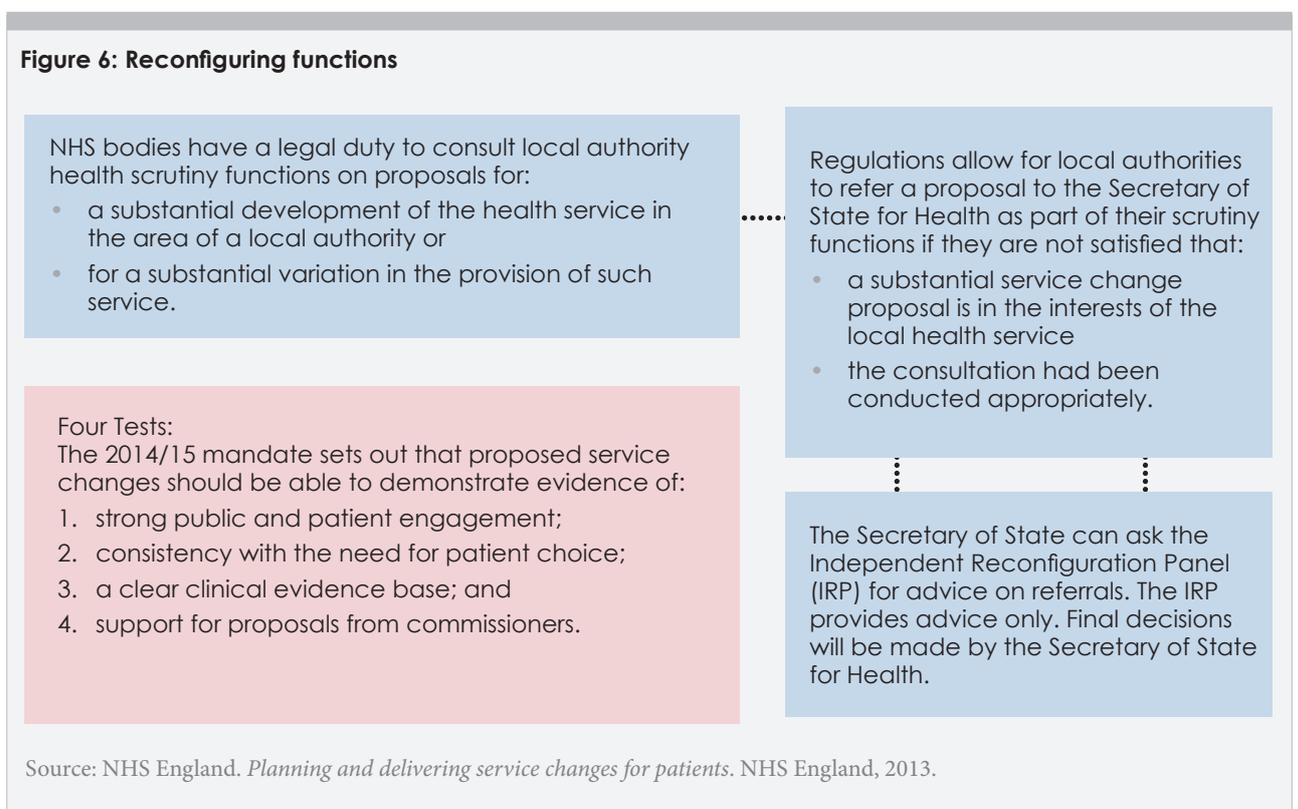
The 2014/15 mandate to the NHS set out that proposed service changes should be able to demonstrate evidence of strong public and patient involvement, consistency with the need for patient choice, a clear clinical evidence base and support for proposals from commissioners.¹⁰⁰ Should a referral be made to the independent reconfiguration panel (IRP) following a referral from a local authority, the IRP would consider whether the proposals would provide safe, sustainable and accessible services. It would take into account the following:

- clinical and service quality
- current or likely impact of patients’ choices and the rigour of public involvement and consultation
- views and future referral needs of local GPs who commission services, the wider configuration of the NHS and other local services
- other national policies (including guidance on service change)
- other issues as directed by Ministers in relation to service reconfigurations.¹⁰¹

A reconfiguration involving service consolidation which was under the £70m turnover test might have the Secretary of State as the final arbiter after

receiving advice from the IRP as per the process. While this process might still apply for mergers above the threshold in parallel to the competition authority process, the fact that there is no explicit public interest test for health care providers, as there is for other sectors such as defence (thereby giving the Secretary of State additional powers), does seem to be an anomaly.

When asked whether the Secretary of State should have powers of veto, there was not a universal view among the interviewees. However, there was a strong view that a broader set of criteria would have been beneficial and that while the CC's findings should have been taken into account, the final decision should have rested with another body or individual (be it the Secretary of State or an independent panel) who would consider evidence and views from across the system (including NHS England, the Care Quality Commission (CQC), Monitor, local parties and stakeholders and so on). One interviewee suggested that the current process was conflicted stating that: *'somebody else should say whether the benefits outweigh the loss of competition, not the champion of competition – that just seems a conflict of interest to me'*.



The role of commissioners in decision making

It is not clear that commissioners played a strong enough role in the construction of the proposal for the merger, or the decision-making process with the regulatory authorities in the period up to January 2013. The interviews suggest that there was limited engagement with the OFT, although during the CC's call for evidence process, local commissioners strongly supported the proposed merger. It is not clear whether this was because of lack of clarity by the commissioners in the process to be followed, faulty advice, or lack of engagement for other reasons (such as priorities to close down primary care trusts and develop CCGs resulting from the Health and Social Care Act 2012).

In January 2013, the area director for the Wessex Area Team (NHS England) wrote to the CC on behalf of all the local commissioners to *'express the strongest possible support for the merger'*. The letter suggested that services would otherwise not be financially or clinically sustainable in the long term and that if the merger did not go ahead there would be greater risks for the local population.¹⁰²

In February 2013, this view was supported by the NHS Commissioning Board's (now NHS England) South of England Regional Team. A letter from this team to the CC suggested that the benefits of merger could be significant in terms of the experience of care and measureable quality indicators. The letter also suggested that there would be clinical benefits of integrating urgent care and maternity services where the risk of unsafe care for patients was at its highest. The Regional Team's view was that multiple clinical governance systems (ie accountability to two organisational boards through executive processes) could create confusion and add risk.¹⁰³

In March 2013 Dorset CCG emphasised to the CC that there was also local commissioner support for the merger, noting that the financial position of PHFT was unsustainable and that it had exhausted cost improvement plans on a large scale. It was also noted that post-merger, the organisation would have been a medium sized organisation and that other trusts servicing comparable populations had multiple sites under one organisation.¹⁰⁴

While the views of commissioners were referenced by the CC, the degree to which they were taken into account is unclear, as is whether commissioners should be viewed as a special group with regard to merger decisions. The white paper *Equity and Excellence: Liberating the NHS* suggested that powers and responsibility for commissioning health care for a local population would be devolved to those working locally²² and guidance from NHS England suggests that it is for commissioners to decide how best to secure services that meet patients' needs and improve the quality and efficiency of services.¹⁰⁵ The interviews with commissioners suggested that there was some concern that local decision makers were unable to influence the final outcome on merger.

'So if you look at the way things were conducted and the decision that came out [it] completely, absolutely overruled the commissioner perspective.'

'I found it quite shocking – and still find it shocking – that when you do have a local community joined up with commissioners and providers and the [local authority] councillors and local stakeholders all saying the same thing – that this is in the interest of local people – I find it astounding and shocking that an external body comes in and stops that. [when that happens] on the ground of these [reasons], which I find very nebulous. I found it astounding. Another key point is that I find it really shocking that the views of local stakeholders, commissioners, providers, GPs, local authorities, local people – all of that is trumped by this external Competition Commission.'

'I've never known two providers be so joined up and then the wider NHS provider support it and the commissioners support it and the

neighbouring commissioners support it – this is about as unified an approach or answer you will ever get from the NHS. If we take the view that the CCG represents the GPs who are the commissioners who represent their practices – the population, the customer – said it supported it, even though it wasn't necessarily the solution to everything. We thought it was the right direction of travel and fully supported it and made that view expressly clear to the Competition Commission. Yes, they asked us so they knew we supported it, but I don't think it really carried anywhere near enough weight.'

'The CC say they were taking them [the views of commissioners] into account but, I would say, they were taken into account and ignored. I was disappointed at how little weight the CC gave to the views of commissioners or to the NHS basically.'

'So actually if you think about it logically and I know things are never this neat, but from the CC's perspective why would they not have taken more account of what the people buying services on behalf of patients were saying than they were about something else? It just seems illogical, but I think it's the regime.'

The strength of feeling among the interviewees on this point was clear. There is an argument to suggest that commissioners are not always the best advocates for patients as consumers and that there should be independent scrutiny of local decisions. For example, commissioners and other stakeholders will have been involved in a number of mergers across England, yet many have failed to achieve gains other than activity reductions.¹ In addition, there are lots of references in the interviews to the views of local people but it appears that the evidence on whether the population wanted the merger was more limited. Indeed the letters the CC received from members of the public included some negative views.

On the other hand there is a legitimate question as to whether national bodies should be able to override the priorities of local commissioners. This relates to a separate question as to what should be the relative weight given to types of evidence in merger decisions? To oversimplify the position, commissioners may use pragmatism and experience in their evidence, whereas regulators may be applying a particular theory (as to the benefits of competition) and empirical evidence relevant to that theory. Many of the local participants acknowledged that merger would not be an easy, straightforward process but still thought that this would be the best solution for the population based on long-term knowledge of the demographics, finances, history and relationships across the area. The interviewees were all senior staff with many years of experience. However, one of the challenges of accepting commissioner's positive endorsements of the proposed merger was that they were not able to give an assessment of specific proposals until after the merger when more information would become available. Instead they were only able to offer support for the principles of the changed proposed.⁶⁶

Amending the legislation to require Monitor to have regard to the views of commissioners when submitting its advice to the CMA, and for the CMA to have regard specifically to the views of commissioners might (if only

materially) alter the balance. Both bodies already have to consider the views of commissioners. For example, Monitor states that it will pay particular attention to the informed views of clinicians and local commissioners on specific improvements proposed by the parties⁵⁴ and the CMA states that it gathers information from various sources including commissioners.⁶⁰ Be that as it may, giving the views of clinical commissioning groups or NHS England additional statutory weight might better support the articulation of local/population needs from the commissioning process.

Yet as noted by some interviewees, the question was not only about the relative weight of national to local bodies in the decision-making process, but also of the weight of influence of providers over commissioners.

'There is still a provider-centric conversation that happens everywhere about everything. It doesn't matter what it's about, the providers are still viewed as the centre of the health service.'

'Well I think this is again back to the conversation, I mean if you just arrived in this country you wouldn't think that there is anything that went on in health care outside hospitals.'

The role of Monitor

As outlined in chapter 4, Monitor was responsible for providing advice to the OFT (once notified by the OFT that it had opened a merger investigation) on the potential benefits of the merger. They did so on 7 December 2012.

Monitor resubmitted this summary of its advice to the CC and provided an additional submission on the reimbursement system for NHS-funded routine elective services. During this time, Monitor was being reformed itself with its duties and functions having been significantly expanded by the Health and Social Care Act 2012. A number of interviewees thought Monitor could have played a stronger role in advising the trusts on the whole process and in presenting to the competition authorities a more supportive view on the potential benefits. However, there was recognition that Monitor was learning in parallel and the subsequent announcements in October 2013 about Monitor's role in future mergers were thought to be helpful.⁵⁹ In addition, there was a view by the parties that there were competing internal views within Monitor:

'I remember that we were waiting for a report back from Monitor, giving their views of the merger and that was very disappointing. I still, to this day, don't know why they did that. I've heard different arguments. One argument is that Monitor has actually got, there's two parts of Monitor and you've got one part that's trying to deal with the sustainability and the ongoing, are you going to be an ongoing concern? Then there's another which is looking at competition.'

'I think they were pleased with us, that having come out of financial difficulty we were making a very mature decision to merge. They were quite pleased with that. They were supportive of the merger, but I don't think they knew what to advise us.' [It should be noted that Monitor does not agree with this statement.]

'I think there were two side of Monitor. There's the pragmatists and the theorists, the accountants and performance people, [who] were, I think, supportive of the merger, [and thought that] it was a sensible solution. Then you have, of course, the competition bit and I think there's an enormous gulf between the two. Monitor may say, "We're all joined up and there's no problems" but there was a difference.'

'They had an important role, as the regulator, where they were both the sector regulator and our regulator, and they were trying to run with a new system. They were trying to be supportive at one level and at the same time, work with a new, evolving system in relation to competition.'

'You should have had the national Monitor team there, you should have had NHS England there. Instead it was left to the Wessex area team and Dorset CCG to do it, and for a case that was going to set so much going forward, that felt fundamentally wrong.'

Since the decision on the proposed merger of Bournemouth and Poole by the CC, Monitor has published a consultation on a number of proposed changes to how the organisation would work with NHS foundation trusts (FTs) that are planning mergers. In its response to the consultation on 12 May 2014, Monitor set out a clear approach to clarify to parties the process involved. This included how Monitor would engage with NHS FTs at an early stage in the process, provide a view on the extent to which the proposed transaction might raise competition issues, and undertake an assessment of how the changes would benefit patients.¹⁰⁶

Further guidance was issued in July 2014 which outlined a framework for significant mergers and acquisitions. The framework focused on four stages, with the first two stages taking place prior to any assessment by the CMA.

At stage one, a trust may be asked to submit documents to Monitor including documents outlining the strategic rationale for the transaction, the strategic options analysis and other information considered by the trusts. After a review of the submissions by Monitor, officials will request a meeting with board members to seek to understand the rationale in more detail. If after the meeting Monitor has concerns about competition issues, the trust(s) will be informed and Monitor will suggest what the trust(s) can do to determine more precisely the nature and extent of competition issues.

At stage two, Monitor and the trusts have the opportunity to determine whether the case is robust and practicable and this stage will inform the decision of the trusts on whether or not the CMA should be notified. Monitor's risk assessment team will request submissions including the finalised strategic options analysis and the main outline business case. The review at this stage will involve a number of meetings and interviews at the trust(s) as well as separate discussions with the CQC and commissioners. Monitor will then write to the trust(s) identifying any strategic business issues needing more attention and outlining their view on whether the transaction is likely to give rise to any competition issues. Transactions should only proceed past this point if they do not raise competition issues or the adverse effects are outweighed by the benefits.¹⁰⁷

This process is evidently clearer and more structured than the process that RBCHFT and PHFT went through. The new process was used by Monitor in assessing Frimley Park Hospital NHS Foundation Trust's acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust, which was recently cleared by the CMA.

It appears that the intention is for Monitor to act as a buffer, making it unlikely that a NHS merger would reach the CMA stage in the future if there was a risk that it could ultimately be prohibited. However the CMA is the ultimate decision maker and Monitor's role is merely advisory so there is no guarantee that Monitor's support of a proposal would result in a successful decision (although the CMA will place significant weight on Monitor's advice). Monitor's increased role is clearly to be welcomed. In addition, Monitor has worked closely with the CMA to ensure the NHS merger process is better understood and operates as quickly and as effectively as possible. As part of that work Monitor has:

- published a short guide to the competition review of NHS mergers for managers and providers¹⁰⁸
- published updated guidance on merger benefits and transactions⁵⁴
- held engagement events (with the CMA) to discuss mergers with NHS FTs.

The role of the competition authorities

Depth of analysis

A number of the interviewees described the analysis by the Competition Commission (CC) as 'impressive' and 'extremely thorough'. Indeed, there can be no doubts that the CC produced robust analysis in order to justify the final decision against the legislative tests and looked at issues such as case mix, referral data and activity data and investigated topics central to the NHS such as the trust special administration regime and payment mechanisms. However, there is a question as to whether the scope of the analysis was appropriately comprehensive for consideration of NHS merger decisions.

'The CC did a thorough job, there's no question about it. It seems to me they did their job really very well, very thoroughly, they followed it to the letter. It goes back to whether that is the right process for this sort of thing.'

'They are no fools. They were impressive, to be honest. So to scrutinise it was the right thing to do. But to do it on one small aspect, namely competition, wasn't perhaps the right thing to do.'

'The Competition Commission should have had the gumption and insight to see that this was not the time to flex their muscles. This should not have been the example, they'd have many others that they could have got involved in.'

Considerations of competition relative to other factors

A number of interviewees thought the role of competition had played too great a part in the decision-making process by the CC and that the underlying strong assumption was that competition between providers and choice for patients was the main lever driving up quality of health care.

'Everything that's about competition is good therefore anything that detracts from that competition has to be worse. I think patients are best served when organisations work together and I believe in integrated services, I believe in collaboration.'

'Some of the effort here should have been spent actually on the benefits bit as opposed to the competition bit. There was a huge effort on the competition side, which like I say, I think was totally irrelevant – just ridiculous really.'

'It was a cultural thing for us because we're used to having relationships with people, not doing it through lawyers all the time. We felt frustrated that clearly, from some of the questions they were asking, they were way off the mark in [them] having an understanding of the business. And actually, if we'd probably sat down with them for a workshop for a day, we could have addressed some of those issues that from our point of view were bizarre. But you couldn't do that. It was all written or through advisers.'

[It has subsequently been suggested that the parties did have the opportunity to present oral evidence to decision makers at the CC.]

The CC did review other issues that might improve the quality of care for patients (see 'The role of quality regulation and other improvement levers' overleaf). However a number of interviewees expressed concern that not enough weight was attached to these other levers as reflected in the CC's final report.

'I made the very point to them that all the guidance comes from individual clinicians pushing the boundaries, which [then] becomes guidance. The reason our services improve is because the doctors are constantly trying to improve the care that they deliver. I almost implied that it was offensive to say otherwise.'

Similarly, a number of the interview participants thought that the role of patient choice had been overstated in the assessment of patient benefits arising from competition (although as mentioned in previous chapters, the evidence shows that patients do exercise choice).

'I think really understanding what this choice agenda is all about and where people actually want to have to choice. I think that would be really, really interesting, because it won't be about location.'

'I think it's the FT regime which gives the illusion of a market, which gives the illusion of separate businesses that is just not founded in its true depth. There is an element of it that's there, of course, but it isn't there really.'

'Shipman to me is an absolute example. They loved him to bits and then what was said about him, people just believe what they believe.'

'It goes back to what we said about choice. When I choose to go to a supermarket I have certain things that I will choose based on my experience. But if I got it wrong about the quality of bacon at Sainsbury's versus Waitrose, it really doesn't matter. But health is not the same. However much we try and force people to make choices, 80% of the population aren't going anywhere near a hospital and don't know how to make those judgements.'

'The vast majority of people – to be honest, if you talk about it what they want – what they want is the closest hospital. I have a community hospital three miles from my practice; everybody wants to have even brain surgery done there if they could possibly have it. So closeness is the most important thing to the vast majority of people. The second question they ask is, "where would you go doctor?" There is all that personal issue [to consider].'

'I think the bit that's more meaningful around choice is, "Can I access the service when I need to access the service?" – not where it will be. So a choice for most of us is probably, "Can I go there on a Saturday when I'm not working?" "Can I go in the period in the evening when I'm not working?" Not which location. But that's the least aspect of choices we paid attention to.'

The role of quality regulation and other improvement levers

While a number of the interviewees suggested that, from their perspective, the CC was primarily focused on competition considerations, the CC did review other drivers of quality such as the role of commissioners, guidance from Royal Colleges, recommendations regarding professional standards and the role of regulatory and quality oversight from organisations such as NICE and the CQC.

However, a number of interviews expressed some concern about the weight that was applied to professional, regulatory and commissioning levers. It is easy to have some sympathy with this position when reviewing the final report by the CC. These issues had clearly been considered but compared to the analysis of competition concerns, there appeared to be minimal attention directed towards these levers. The CC concluded that regulation was seen in many sectors as second best to competition and that differing levers of quality between regulated and acute hospitals demonstrated that there was scope for factors other than regulation to drive quality.⁶⁶ This is a reasonable assumption but there is some doubt as to the evidence base on the impact of competition over and above other drivers of system policy. For example, research published by the Nuffield Trust and the Health Foundation suggests that across the four UK countries, there is no evidence to link the divergence in policy on structure, competition and increased provider diversity to a matching divergence on performance.¹¹

'They were quite clear that they believe that competition improves quality and safety and that merger would reduce competition and risk us saying, "Now that we're not competing, we will let our standards slip." [For them] it was only competition that improved services.'

While it is clear that other quality drivers were referenced, the space dedicated to factors such as regulation was somewhat limited in the final report. The CMA has a narrow legislative test which it is required to work against in making merger assessment decisions. It is accepted that competition is only one lever that can improve quality in the NHS but it is the test that the organisation is legally required to consider. The narrow test could be viewed as being problematic given the empirical literature in health care. Six months after the decision on Bournemouth and Poole, the OFT published an analysis of the theoretical and empirical literature. This review noted 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 notes that for health care, empirical studies suggest that competition leads to improvements in some measures of quality when prices are regulated.¹⁰⁹ The review did not 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 boosted by better availability of data on performance), nor whether the relationship between competition and quality outcomes in the literature was causative or merely associative.

We suggest a much more probing analysis is now needed, carried out by Monitor or an independent agency with considerable expertise in the sector. Furthermore, until more robust empirical evidence is available on the causative link between competition and quality in the NHS, we suggest that mergers might be better assessed on a broader set of initial criteria more appropriate to the sector.

Burden of the process on the parties

The parties found much of process required by the CC difficult and burdensome. There were two main problems from the parties' perspective. First was the requirement by the CC for the parties to sign undertakings in March 2013 which required them to appoint independent observers and to provide the CC with advance notice of joint meetings and associated papers. The second was the level of data collection required. Without the prior written consent of the CC, the trusts were unable to:

- proceed with steps towards the merger
- discuss or pursue joint bids or tenders to provide services
- discuss, jointly plan or cooperate in respect of renewal, extension or variation of each party's 2012/13 Department of Health standard contract or new/future standard contracts with the commissioner
- discuss with each other, jointly plan or negotiate, or cooperate in respect of any licences to be granted to either of the parties by Monitor
- discuss with each other, jointly plan or otherwise pursue together the application to jointly achieve university hospital status
- discuss with each other, jointly plan, or otherwise pursue together the recruitment of any staff, including consultants

- discuss with each other, jointly plan, or otherwise pursue together changes to the terms and conditions of employment of the current staff at either trust
- discuss with each other, jointly plan or otherwise pursue the sharing of staff, including consultants, other than as already implemented on 28 January 2013 pursuant to the relevant service level agreement
- discuss with each other, jointly plan or otherwise pursue the joint procurement of goods or services other than as already implemented on 28 January 2013 and pursuant to the relevant service level agreement
- implement any shared banking service.

The trusts were also required to provide the Commission with:

- any documents and communications referring to the merger that are issued to members or future members (which could include employees, governors and advisors)
- advance notice (five days) of documents of communications issued to staff regarding changes to terms and conditions linked to the merger
- guidance in relation to information sharing provided to individuals prior to the implementation of the merger
- any memorandums of understanding
- any documents brought to the Commission's attention by the independent observers.

The trusts were required to appoint independent observers who would attend any meetings attended by employees, directors, governors and advisers to plan, discuss or otherwise pursue the implementation of the merger. The observers were required to review documents sent in advance of meetings.¹¹⁰ One interviewee said: 'We got ourselves into trouble a couple of times by having meetings that they were concerned about and we didn't report through and we [then] got a legal letter'. When asked about this process, many of the responses suggested that this process was inappropriate, difficult and burdensome:

'I think they became so nervous of the close relationship that we had, that they then told us that we had to have independent observers to check joint meeting papers and attend joint meetings. That was burdensome, administratively painful and cost us money. It was their anxiety. It just made you feel – [and] it's not something you normally feel in the NHS – that you were up to no good. They were suspicious of [something] and [again] it's not something you normally experience in the NHS because, quite often, there's no personal gain, no shareholder gain. I certainly found that quite strange.'

'Essentially, we were not allowed to connect or progress any of the Monitor applications because they were concerned that we were merging by stealth, essentially, and that they would have to unravel that if we were not allowed to proceed. We had to appoint independent observers and we had to run a huge process of monitoring any conversation or meeting that took place in order to prepare our application to Monitor.'*

* 'Monitor applications' refer to the process the trusts would need to have gone through to vary their licence to become a new, merged FT.

'It became difficult. [Our] doctors were saying, "Can we do this? Can we meet about this?" because they were worried about what would happen. It was unhelpful but the CC was very clear they didn't want to do anything that would stop or impact on the quality of clinical care. What it actually impacted on was our ability to develop an integrated business plan for what we thought was the Monitor process after a decision [due to be made] by the CC.'
[The undertakings did permit information to be shared for the purpose of preparing the integrated business plan when shared with the independent observer.]

'Although we paid for independent observers, their role was to give the CC assurance that we were not sharing any business secrets or that we were not doing anything that we should not have been doing in terms of working together. There was very limited value in spending money to support that function; it was an unnecessary frustration of working together.'

The second major problem was the huge burden of data collection imposed on the parties by the CC. The parties had no protection from what many saw as excessive requests, given other claims on their time in a period of financial challenge.

'We submitted half a billion sets of data on outpatients, 40 million on inpatients, tens of thousands of written pages of evidence, a huge amount.'

'There was always this feeling that you were guilty until proven innocent. It wasn't a [mistake] in the data, it wasn't a classic NHS mess up but, if there was something slightly strange [in the data], it was because we were up to no good. You then got challenged on that. There was a feeling that they just didn't believe what we were saying.'

'We worked out that they asked us for over 500 million data lines. In addition to that, we would have provided tens of thousands of pages of evidence. They would have asked many hundreds of questions... With quick turnarounds, if we didn't do it within the timeline, they would extend the process. They were in control.'

'There was a period when we were getting requests every single day for a quick turnaround of information. I didn't know exactly why they wanted it and I didn't know what they were going to make of it when they got it and we weren't asked to sense check any of the decisions around that data, but I'm sure they knew what they were doing.'

'Yes, it was very burdened; it was a massive, massive burden.'

There was also some concern about data protection issues and requests for data at a patient level:

'They were saying, "We can give you an enforcement notice under the powers of this, that and whatever". In the end we said, "Well actually we'd rather have the enforcement notice thank you, we'd rather you instruct us to do it with those powers than we voluntarily just give [that data] up". We were grateful they did it in the end because we felt really nervous in providing that amount of data.'

One of the challenges here is in how one might interpret a merger which includes NHS bodies. Had the two parties been private sector, commercial organisations, it would be difficult to argue with the concept of undertakings designed to protect consumers from collusion. Equally, one would expect the competition authorities to probe and analyse the claims made by parties intending to merge. This again highlights a potential clash in how NHS FTs are viewed and the extent to which they should be considered as independent organisations as opposed to being considered part of a large NHS chain.

The counterfactual

As noted in chapter 3, the OFT (at phase 1) had to consider whether it was or may have been the case that the merger resulted or may have been expected to result in a SLC. The CC (at phase 2) had to consider whether the creation of that situation [relevant merger situation] had resulted or may have been expected to result in a substantial lessening of. In doing so both regulatory authorities would assess the merger against an alternative counterfactual.

In the case of the Bournemouth and Poole merger, the parties suggested (at the phase 2 CC stage) that should merger not take place, the appropriate counterfactual should be the exit of PHFT due to financial instability. For the CC to accept this ‘exiting firm’ argument, it needed to believe that Poole’s exit from the market was the most likely outcome. The CC rejected this argument on the basis that the CC felt that Monitor would be unlikely to place the parties 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. In addition, the CC considered Poole’s structure including its size and case mix and financial case mix.⁶⁶

It is important to note that there is nothing in guidance to suggest that an NHS provider could never meet the requirements of the exiting provider test. However, this points to an apparent inconsistency of argument at a system level, which was then reflected within the assessment of the merger by the CMA. On the one hand FTs are considered as autonomous going concerns for competition policy to apply (see Figure 1 in chapter 3). On the other hand, they are ultimately considered to be part of a public system (or indeed a large ‘firm’) which gives subsidy to prevent failure and ‘exit’.

It is true that the formal trust special administration (TSA) process is used rarely but to a certain degree, avoiding administration sometimes relies on state subsidies to achieve social as well as economic objectives. As an example, the NHS FT sector reported a deficit of £167m for Q1 of 2014/15 against a planned deficit of £80m and the likelihood that the NHS FT sector would end the current financial year with an overall deficit.¹¹¹

Key Points

- The trusts were required to sign undertakings prohibiting the merger for a decade (without the explicit permissions of the competition authorities). If the outcome of the commissioner-led clinical services review suggests that merger would indeed be in the best interest of the local population, those undertakings should be viewed flexibly and the two trusts should have another opportunity to put their case forward.
- The system needs to clarify what role foundation trusts (and indeed NHS trusts) have. Are they part of a larger NHS ‘chain’ or are they really independent organisations? This is not an academic question but instead a fundamental question at the heart of how the NHS should be managed and regulated in practice.
- We are not convinced that the evidence base is strong enough on the role of competition relative to other drivers of quality. We think that 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.
- While tweaks to the legislative decision-making process should be considered, these could be done within the existing legislative framework.
- As the regulatory system becomes more complex to navigate, the clear winners are external advisers. Building a central pool of legal, competition and reconfiguration experts within the NHS may be a more cost-effective way of supporting local NHS organisations to navigate a complex and ever changing landscape.

Was the Competition Commission (CC) right to prohibit the merger given the terms of its statutory obligations? The CC conducted an extremely thorough analysis and was not convinced that the proposed benefits were relevant customer benefits and therefore could not consider an alternative ‘remedy’ to prohibition of the merger. There is an argument that the level of evidence required by the CC to prove benefits would have been unattainable for the two trusts at the time. In addition, the response from the sector regulator Monitor had been lukewarm.

In hindsight, there are questions as to whether the merger process should have been allowed to continue. New guidance from Monitor suggests that it would play a stronger role in the merger process in future and that it is unlikely that proposed mergers would make it to the Competition and Markets Authority (CMA) unless the customer benefits case was strong enough (although as already noted, endorsement from Monitor does not provide a guarantee of a successful outcome at the CMA level as its legislative role is only advisory). This is to be welcomed and should avoid protracted and costly analysis of merger decisions which are unlikely to be accepted by the competition authorities.

However, while the decision may have been technically and legislatively appropriate, it is harder to see that the process to reach it was ideal. While the merger tests are directed at understanding the impact of merger on patients, the decision-making process was time-consuming, burdensome and costly. While the analysis from the CC was no doubt comprehensive, there is an argument that it was perhaps not proportionate. Some of the interview participants suggested that too much of the analysis was spent on establishing whether there had been a substantial lessening of competition or not. As one interviewee put it: *'If they'd asked anyone, everyone would have sat there and would have said "well yes, of course there is, why are we even here?"'* This view stemmed from confusion among the parties as to what extent the decision-making process was focused on the reduction of competition versus the analysis of potential benefits.

At a basic level, moving from two trusts to one trust is likely to result in a substantial lessening of competition (SLC) in an area of limited competition (although there will be merger cases where the authorities determine that SLC is unlikely to result such as the proposed merger of Heatherwood and Wexham Park Hospitals NHS Foundation Trust and Frimley Park Hospital NHS Foundation Trust). In the case of Bournemouth and Poole, the trusts happened to be in a geographic area with limited competition and were located within a short drive time of each other. For historical reasons, the two hospitals were originally configured to be complementary, not to be standalone entities.

It would be incorrect to suggest that the trusts' benefit case was irrefutable. However, a number of the participants thought that the CC required a level of evidence that they simply could not provide at that point in time. For example, a number of interviewees suggested they would have needed planning permission for the new maternity unit, detailed rotas and so on [although this does not appear to be the case from the subsequent guidance that has been published].

'I would have been horrified if the trust had spent the amount of money that would have been needed to have come up with the detailed benefits case – to the level of rota level and staff – doing all that prior to the merger even being given the go ahead. I think it put the trusts into an absolutely impossible position. How much public money do you spend without getting the nod [to merge]?'

There has to be a balance between evidence, value for money and pragmatism and early engagement with Monitor in the future will support NHS FTs to decide whether they should devote resources to developing a formal benefits case.

Fundamentally, while the merger was rejected, the need for reconfiguration at least has not disappeared. Local managers felt that this process would now be much, much harder. The phrase ‘winner and loser mentality’ was frequently used in the interviews. It was felt that the two trusts would come together to work through service reconfiguration in a far more cohesive and constructive fashion if they were not in competition for services.

Given the financial challenges facing the system and the need to close the estimated funding gap of £30bn a year by 2021,¹¹² is it really right for a decision on NHS mergers to be made on the basis of historical precedent rather than focusing on the best possible service design for the future? This is particularly concerning given that radical service change is needed in many areas if the NHS is to have any chance of closing gaps in finance and the quality of care.

Financial considerations and the role of foundation trusts

It is testament to the difficult financial situation that the NHS faces that despite PHFT’s negative financial prognosis, the trust is by no means in ‘basket-case’ territory. The CC was arguably correct that the trust did not meet its exiting firm test, which has a very specific definition in legislation. Its view that the trust was unlikely to be placed into special administration was also proved correct based on Monitor’s subsequent closure of its investigation into the trust. However, there did appear to be an assumption by the CC that Dorset CCG would need to continue to provide subsidies to the trust.

Despite the CCG suggesting that those subsidies were unlikely to be able to continue, the CC concluded that the position on subsidies was uncertain as Dorset CCG may be faced with the choice of providing ongoing subsidies to avoid financial constraints which might affect the quality of services at Poole.⁶⁶ While that may be correct, it may not be in the interests of the taxpayer to assume that trusts in financial difficulty will always be subject to a subsidy. Despite the CMA’s assurance that, where the evidence is not sufficient to adopt an exiting firm counterfactual, it will take into account evidence of clinical and/or financial difficulties in its competition assessment,⁵⁵ a formal mechanism to consider financial sustainability short of failure (as per the NHS trust special administration regime) or the exiting firm test (as per the Enterprise Act 2002) may be useful.

More broadly, the CC’s report also highlights inconsistencies in the way the system regards FTs and reflects inconsistent messaging at a national policy level. The system needs to clarify what role FTs (and indeed NHS trusts) have. Are they part of a larger NHS ‘chain’ or are they really independent organisations? It feels like the system applies different rules and norms at different times to NHS providers and the landscape is confusing. On the one hand we expect FTs to operate in a quasi-market, competing for patients and referrals, but on the other, they can be expected to act in the greater good for their population and for the NHS as a whole against their own financial interests (eg, in supporting the shifting of care to the local community). This is not an academic question but instead is at the heart of how the NHS should be managed and regulated in practice. The recent review by Sir David Dalton¹¹³ 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 this report raises on the Bournemouth and Poole case.

There is still a lack of recognition among the public that the NHS is no longer a monopoly provider. Aside from the merger process, there was a strong sense from the interviewees that the role of markets and choice had perhaps been overplayed (although there is evidence to suggest that patients do exercise choice). This view in many ways is of more fundamental concern than the technical detail of merger decision making. Choice and competition have been hard-wired into the health system but evidence suggests that patients – or indeed system managers – do not necessarily act in the way that policy makers expect them to. Among the interviewees, there was a clear view that choice was important in terms of access and location but not necessarily in terms of organisational entity or ownership.

Merge first, reconfigure later

It could be argued that it would have been better to reconfigure (and consult) first and merge later. However, the trusts were acting on the advice they received that merging first would be most likely to deliver the identified benefits. It was clear from the interviews that there was some concern that if the parties had attempted to reconfigure services first they may still be captured by competition law and the jurisdiction of the competition authorities if the services to be reconfigured met the £70m turnover test or the share of supply test. This issue appeared to place the trusts in a ‘chicken and egg’ situation, but further guidance from Monitor and the CMA has clarified that public consultation is not a prerequisite for a positive decision on a proposed merger.

The interviews suggest that in the early stages of the merger process the potential benefits to patients were not set out to a level that would be convincing to the competition authorities. In part, this was because the parties were not given clear advice as to the extent and type of evidence needed at what stage. Subsequently, Monitor and the CMA have set out guidance to help clarify the process for FTs contemplating a merger, and both Monitor and the CMA have issued guidance on what might appropriately be considered by them as patient (or ‘relevant customer’) benefits.

It is now far clearer that the concept of ‘merge first, reconfigure later’ is not necessarily a strategy that will easily facilitate a robust articulation of patient benefit in areas of limited competition. It should be noted that the guidance does not state that ‘merge first, reconfigure later’ would be problematic. However, with this approach it is vital that it is possible to articulate the benefits in sufficient detail and large-scale service reconfiguration (and the articulation of its benefits) appears to be an area where the NHS needs to strengthen its skills and capabilities at a system level. Currently, the process presents lucrative opportunities for paid advisers or consultants who may not be neutral. Building a central pool of legal, competition and reconfiguration experts within the NHS may be a more cost-effective way of supporting local NHS organisations to navigate a complex and ever changing landscape.

More broadly, the case highlights differences between a common view in the NHS that merger is an effective solution and the competition authorities who are required to take a dispassionate view based on empirical but more often theoretical grounds. Mergers are not infrequently proposed in the wider NHS as a route to achieve more financially and clinically sustainable services. However, the empirical evidence, such as it is, does not necessarily show benefits of mergers.¹ Merger is not a panacea – evidence suggests that mergers do not tend to achieve the benefits they set out to. For example, Gaynor et al looked at the impact of the 112 NHS hospital mergers which occurred between 1997 and 2006 but found little evidence that mergers achieved gains other than a reduction in activity. While admissions and staff numbers fell relative to the pre-merger position, labour productivity did not rise and financial deficits increased. While most measures of quality were unchanged, the researchers could not demonstrate quality improvements that would offset the poorer financial performance.¹

However, the local parties were not blind to the challenges. Many of the interviewees recognised that merger would not always be the most appropriate solution and acknowledged the potential risks. That said, it was clear that most of the interviewees felt that a merger would be the best mechanism for achieving the change that was needed locally and articulated this passionately. There was understandably still a lot of anger that the recommendations of local staff had been overridden by a decision by an external regulator. Given the history of close collaboration between the parties, if any pairing of trusts was going to buck the trend and make merger work, these might have been the trusts to do it. The close proximity would have facilitated cross-site working and a number of services or clinicians already operated across both sites.

The legislative framework

It is not clear that much thought was given to the potential implications of the Enterprise Act 2002 on the NHS back in the early 2000s. The language of the associated white paper *A world class competition regime* was of ‘championing competition’ on the basis that ‘*competition between firms protects consumers*’.⁵⁰ But at the time it was also agreed that judgements by the competition authorities in certain sectors, such as defence, could be overridden by the Secretary of State (in the public interest) because industries in these sectors had economic as well as non-economic (ie state security) objectives. The health sector, specifically the NHS, was not thought of at the time as needing this ultimate public interest ‘override’, despite there being clear social objectives as well as economic objectives to providers of NHS care.

To a certain extent, the process for considering health service mergers is bound by legislation which applies across a range of sectors and business. Starting from scratch is unlikely to be appropriate but there may be mechanisms such as adding NHS mergers to the list of public interest cases (thereby giving powers of veto to the Secretary of State) which might provide reassurance to the sector. Additionally, while we do not dispute the potential role that competition could play in improving NHS services, we are not convinced that the evidence base is strong enough on the role of competition relative to other drivers of quality. We think that it is right that there is some external scrutiny of merger decisions and accept that competition assessment should

* The CMA is required to take into the views of Commissioners already but we suggest that their views could be given additional weight above their current status.

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 (thereby putting local commissioners on the same footing as Monitor^{*}) might be an improvement on the current process which was not conceived in the early 2000s with the NHS in mind. There is scope to refine the process within the current legislative framework rather than through more radical change.

In many ways the Bournemouth and Poole merger case was unique and the timing and its status as a ‘test case’ make it less likely that the decision-making process for future mergers will be as difficult. However, it is a lost opportunity that there was not a method for evaluating or researching the process as it happened. This report attempts to make a start. Given that the system has had an opportunity to learn from the Bournemouth and Poole case, we think that the two trusts should have the same opportunity to benefit from more recent advice and guidance. The trusts were required to sign undertakings prohibiting the merger for a decade (without the explicit permissions of the competition authorities). If the outcome of the commissioner-led clinical services review suggests that merger would indeed be in the best interest of the local population, those undertakings should be viewed flexibly and the two trusts should have another opportunity to put their case forward.

We were struck by the goodwill, attention and experience of all who took part in the interviews and we hope that the local managers can overcome the disappointment regarding the merger situation and work through the challenging period ahead to produce a successful outcome for the local population.

Annex A: Development of competition in the NHS: 1980–2010

7

Development of competition during the 1980s

From the mid-1980s, the NHS faced considerable financial pressure and low levels of quality and efficiency created dissatisfaction.¹¹⁴ As part of a drive to extend the choice of providers available to patients, the Conservative government implemented policies which aimed to expand the provision of private medical insurance. The option of paying for private medical care had always existed alongside the NHS but the numbers of people taking out private medical insurance were relatively low in the 1970s. In 1979 when Margaret Thatcher became prime minister, the figure had grown to 2,765,000 individuals and over the 1980s this increased significantly to 6,692,000 individuals in 1990.¹¹⁵ However, while Thatcher was keen to support the expansion of the private health insurance sector, she was keen to emphasise that this expansion was not incompatible with the protection of the NHS. Speaking to the Conservative party conference in 1982, she stated:

‘Our opponents’ picture of us as a party that doesn’t care about the Health Service is utterly untrue, and is particularly ridiculous from the Labour Party. Of course we welcome the growth of private health insurance. There is no contradiction between that and supporting the National Health Service. It brings in more money, it helps to reduce the waiting lists, and it stimulates new treatments and techniques.’¹¹⁶

In parallel with the efforts to expand the private insurance market, the Conservative governments of the 1980s made efforts to encourage greater supplier diversity in the provision of ancillary services such as cleaning and laundry services. In 1983 the government issued guidance which required authorities to offer contracts for ancillary services to the private sector. Initially, private contractors struggled to match NHS prices as their services were VAT applicable but by 1986 health authorities were able to reclaim back the VAT and requirements for private contractors to match NHS terms and conditions were relaxed.¹¹⁷ The privatisation of ancillary services was controversial and the Conservatives did not attempt to extend compulsory tendering to clinical services. However, private provision of residential care began to grow during this period.

The internal market is born

In the late 1980s, widespread structural reform of the NHS was proposed following the publication of *Working for Patients*, the Conservative government 1989 white paper which introduced the internal market, separating purchasing and provision.¹² The 1989 reforms were arguably some of the most significant in the history of the NHS.

The white paper suggested the district health authorities (the NHS bodies responsible for assessing local health need and administering hospital and community services at the time) should have a responsibility to purchase the best possible services. This might mean an authority purchasing services from hospitals in other districts as well as from the private sector. The white paper was also positive about the role the private sector could play, citing its competitive tendering exercise for ancillary services as having been a success. The government suggested that there was scope for wider use of competitive tendering beyond non-clinical services and health authorities were expected to consider private providers as part of their purchasing role. The white paper also introduced GP fundholding whereby large GP practices would be able to apply for their own budgets to procure services directly from hospitals.¹²

The government suggested that money should follow the patient across administrative boundaries. Previously there was no relationship between the amount of money an authority received and the number of patients its hospitals treated. There were therefore limited incentives for hospitals to take on additional work or to improve productivity. The 1989 white paper also proposed the creation of self-governing NHS hospital trusts. NHS hospital trusts would earn revenue from the services they provided and would have additional freedoms such as the ability to employ their own staff and to borrow money.¹²

Over the course of 1989, the British Medical Association ran a widespread campaign against the government's proposed reforms to the NHS. One poster ran with the slogan 'What do you call a man who ignores medical advice? Mr Clarke'. The other depicted a driverless steamroller with the caption 'Mrs Thatcher's plans for the NHS'.¹¹⁸ The campaign had a significant impact on the public leaving some fearful that the introduction of the internal market would remove the principle of 'free at the point of use' from the NHS¹¹⁹ and there were concerns within the Conservative Party about the public reaction to the reforms. Thatcher allegedly wanted to postpone the reforms until after the forthcoming election in 1992, saying to Kenneth Clarke (the former Secretary of State) '*it's you I'm holding responsible if my NHS reforms don't work*'.¹²⁰ Nevertheless, the National Health Service and Community Care Act 1990 received royal assent on 29 June 1990¹²¹ and the NHS internal market was born.

Competition under the Labour government 1997–2000: crossing the Rubicon

When the Labour government first came to power in 1997, it was critical of the introduction of the internal market. Indeed, the Labour Party Manifesto made a specific commitment to ending the Conservative's internal market in health care, suggesting that: '*Under the Tories, the administrative costs of purchasing care have undermined provision and the market system has distorted*

*clinical priorities. Labour will cut costs by removing the bureaucratic processes of the internal market.*¹³ Later that year, the white paper *The new NHS: modern and dependable* set out how the government intended to abolish the Conservatives' internal market (although it planned to keep the purchaser/provider split) and would replace it with a system based on partnership and driven by performance management.¹⁴

As the government's plans for the NHS developed, the concept of patient choice was to become a major driver of health policy during the period. While choice under the Conservatives had focused on increasing access to private insurance, choice under Labour was focused on increasing choice for NHS patients and was to be a catalyst for increasing provider diversity in the NHS. In September 1999, in his speech to the Labour Party conference, the Prime Minister Tony Blair stated that:

*'A predecessor of mine famously said she wanted to be able to go into the hospital of her choice, "on the day I want, at the time I want, with the doctor I want". That was Margaret Thatcher's argument for going private. I want to go to the hospital of my choice, on the day I want, at the time I want. And I want it on the NHS.'*¹²²

One year later, the *NHS Plan* was published under Alan Milburn's tenure as Secretary of State. The Plan outlined significant changes to how health care in England was to be organised, with the intention of modernising the service. The government committed to large-scale investment in the NHS as well as reforms which were intended to ensure the increased resources would maximise the potential benefit to the patients and public. Significantly, the proposals marked the 'crossing of the Rubicon' regarding the role of the private sector in NHS-funded care. The government committed to a concordat between private providers and the NHS to make better use of the facilities in the private sector with a particular focus on collaborative working in elective, critical and intermediate care. There was also a commitment to develop diagnostic and treatment centres in partnership with the private sector. These centres were intended to separate routine hospital surgery from emergency work to facilitate a reduction in waiting times.¹⁵

Competition under the Labour government 2000–2010: a decade of change

The power of choice

The *NHS Plan* committed to strengthening the role of patient choice with a commitment to ensure patients could book every hospital and elective admission at a convenient date and time. Running through the *NHS Plan* was the desire to wage a 'war on waiting'. In December 2001, the government announced proposals to give patients a choice about where they received their NHS care. From July 2002, patients who had been waiting for more than six months for heart surgery would be able to choose an alternative provider.¹²³

Patient choice was gradually extended until 2008 when all patients registered with an English GP were given the right to choose from any NHS-funded provider following a referral for routine, elective hospital services (see Table A1 overleaf).¹²⁴ In a speech to the New Health Network in January 2002, the then Secretary of State Alan Milburn suggested that as capacity expanded,

choice would grow with patients choosing hospitals instead of hospitals choosing patients.¹²⁵ In parallel, the government wanted to reform payment mechanisms to ensure providers were offered the right incentives to make best use of the available capacity within the system. In *Delivering the NHS Plan: next steps on investment, next steps on reform* the government outlined plans to introduce a system of ‘payment by results’ for the 2003/04 financial year.¹⁸

Table A1: Early development in the patient agenda:

18 January 2002	The first patients travelled overseas for treatment On 18 January 2002, nine patients travelled to France for cataract and joint operations at La Louvière Hospital in Lille. ¹²⁶
July 2002	The Coronary Heart Disease Choice pilot was launched The pilot allowed patients who had been waiting for more than six months for heart surgery to choose to have their treatment elsewhere. During the pilot phase (July 2002 – November 2003), 51% of those eligible for choice (N=3,000) opted for treatment elsewhere. ¹²⁷
September 2002	The London Patient Choice Project (LPCP) started to offer choice for cataract patients The LPCP started to offer choice for cataract patients from 23 September 2002 with the first operation on 1 October 2002. In the week commencing 10 February 2003, the LPCP was extended to cover a range of procedures in general surgery, orthopaedics, and ear, nose and throat surgery. ¹²⁸
Summer 2003	Further expansion of choice pilots From the summer of 2003, all patients waiting more than six months for any form of elective surgery in London were offered the choice of an alternative hospital. From July 2003, patients in West Yorkshire needing eye operations were offered choice by their referring GP. In Greater Manchester, those waiting longer than six months for orthopaedic, ear, nose and throat and general surgery were offered choice and from July 2003, choice was extended to patients needing cataract operations in the south of England who would be able to choose from two and then four hospitals. ¹²⁹
2004	Further expansion of patient choice for those waiting six months for elective surgery Patient choice was extended across the country for those waiting more than six months for elective surgery from 2004. ¹³⁰
2004	Choose and Book first went live in July Choose and Book allowed patients to book appointments electronically and to select a choice of place, time and date for a first appointment. The scope of providers available expanded over time but take-up was initially slower than had been expected.
2006	Choice at referral From 1 January 2006, patients were offered a choice of treatment from at least four providers within their local area when they were referred for elective hospital care. From May 2006, the list of available providers was widened to include a national list of providers including NHS foundation trusts (FTs) and independent sector treatment centres (ISTCs). From August 2006, 11 independent sector providers were approved to add their services to the national menu of options. ¹³²
2007	NHS trusts were able to offer services through Choose and Book All NHS trusts in England were able to add their orthopaedic services to the national menu of provider options available to patients, giving them the same rights as FT providers who had been able to offer services on Choose and Book from May 2006. Additional specialties were opened up over the course of 2007/08. ¹³²
2008	Free choice for routine elective hospital services From April 2008, patients registered with an English GP were given the right to choose from any NHS-funded provider following a referral for routine elective hospital services. ¹²⁴

In August 2003, the Department of Health launched a consultation to explore what patients and the public wanted in terms of choice.¹³³ The response was that people wanted to see wider choice in real and practical terms. The Department also started to consider the link between choice and quality by suggesting that giving the power of choice to patients would ‘provide a powerful incentive to providers to raise their standards and by doing so improve healthcare for all.’¹³¹ While patient choice started as a mechanism to reduce waiting times, it became a driver of competition, with the aim that providers would improve their services to attract more patients and therefore increase their income.¹³⁴

The changing role of the private sector

In 2000, the *NHS Plan* committed to more constructive engagement with the public sector in a bid to end the ‘stand-off between the NHS and private sector providers of healthcare’. The government suggested that the private and voluntary sectors would have a role to play in ensuring patients received the full benefit of the increased investment in the NHS.¹⁵ In a speech to the Social Market Foundation in 2003, the then Chancellor of the Exchequer Gordon Brown emphasised the need to move away from ‘discredited dogmas’ about how the public sector should operate. He stated that the private sector could play a valuable role in supporting the NHS but that the sector shouldn’t be able to ‘exploit private power to the detriment of efficiency and equity’.¹³⁵

However, the evaluation of the Labour government’s market reforms concluded that there had not been a large expansion in quantity of for-profit or third-sector activity by the time of the general election in 2010.¹⁷

Independent sector treatment centres

Treatment centres were developed to provide fast, pre-booked surgery and diagnostic tests for patients by separating scheduled treatment from emergency care. Treatment centres were run both by the NHS and by the independent sector. In 2003, the first independent sector treatment centre (ISTC) was opened in Daventry – the Birkdale Clinic. Independent sector involvement was intended to provide additional capacity to deliver high quality care to NHS patients.¹⁶

In its 2006 report on ISTCs, the Health Select Committee concluded that separating elective and emergency care in treatment centres where there was local agreement and need had been beneficial. However, the committee was not convinced that ISTCs provided better value for money over alternatives such as NHS treatment centres, partnership arrangements or greater use of NHS facilities out of hours. It was suggested that ISTC providers were paid on average 11.2% more than the NHS equivalent cost. However, ISTCs did play a role in reducing the price paid for ‘spot purchases’ with private providers.¹³⁶

Diversity of community and primary care providers

The Department of Health introduced a number of initiatives in an attempt to improve the diversity of the provider landscape. For example, the 2006 white paper *Our health, our care, our say: a new direction for community services* outlined the important role that the ‘third sector’ played in the NHS but noted that the barriers for market entry were often too high. There was also a strong focus on supporting the development of social enterprises

(organisations using business disciplines for social objectives with a reinvestment of profits). The white paper outlined plans to establish a Third Sector Commissioning Task Force to address the key barriers to a sound commercial relationship between the public and the third sector. The Department also committed to establishing a Social Enterprise Unit which would provide funding (from April 2007) to support the development of new models of care provided by the voluntary sector.¹³⁷

In primary care, the Department developed a new contract model – the Alternative Provider Medical Services (APMS) contract – which was designed to encourage private and voluntary sector providers to enter the primary care market.¹³⁸ The Department introduced two procurement programmes in primary care alongside the contract development. In April 2007, the Department of Health issued a call for expressions of interest to provide a range of services as part of the Fairness in Primary Care Procurement (FPCP) programme in four primary care trust (PCT) areas¹³⁹ and in 2009, the Department of Health launched the Equitable Access to Primary Medical Care (EAPMC) programme which provided investment of £250m to support the establishment of new GP practices and GP-led health centres.¹⁴⁰ Ten PCTs participated in FPCP with most procuring a single new practice. A total of 112 new practices in 50 PCTs were procured under EAPMC. Successful bidders under the contracts included private companies, social enterprises, other mutual organisations, groups of existing GPs and other NHS providers.¹⁴¹

The evolution of NHS trusts: the road to foundation trust status

The *NHS Plan* outlined proposals to give clinicians and managers greater freedom to run local services and described the over-centralisation of the NHS. The Department intended to build a ‘new model’ where intervention would be in inverse proportion to success.¹⁵ The Labour government built on the 1989 reforms of the Conservatives by further extending the powers and independence of the self-governing NHS trusts. The new model of trust, (NHS foundation trusts) was established under the Health and Social Care (Community Health and Standards) Act 2003.

The concept of foundation trusts (FTs) was first introduced in 2002 by the then Secretary of State Alan Milburn, who described the concept of ‘foundation hospitals’ in a speech to the New Health Network. This new status was intended to give top-performing hospital trusts the opportunity for more independence. Foundation hospitals were intended to ‘*reflect the spirit of public sector enterprise that our [the Labour government’s] plans are designed to unleash*’.¹²⁵

Unlike NHS trusts, FTs were independent organisations which were not subject to direction from the Secretary of State for Health. FTs were established as public benefit corporation whose primary purpose was to provide goods and services for the purposes of the health service in England. FTs were given greater financial freedoms: they could retain surpluses, were able to borrow funding for capital investment from more sources and had greater flexibility with regard to remuneration. The legislation provided for an independent regulator (later known as Monitor) to monitor the performance of FTs.¹⁹ The first 10 FTs were established on 1 April 2004. The changing status of FTs was to have significant implications for the application of competition legislation to the NHS.

Competition under the Coalition government: 2010 onwards

Early days of the coalition

On 6 May 2010, the general election resulted in a hung parliament where none of the individual parties were able to command a parliamentary majority (326 seats are needed for an overall majority). The Conservative Party gained the largest number of seats (307 after the delayed election in Thirsk and Malton) with Labour following on 258, leaving the Liberal Democrats as potential ‘kingmakers’ on 57 seats.¹⁴² Both Liberal Democrat/Conservative and Liberal Democrat/Labour coalitions were considered but after five days of negotiations between the Liberal Democrats and the Conservatives, agreement was reached on a range of issues on 11 May 2010. The initial agreement majored on economic policy and references to the NHS were limited to a commitment that funding should increase in real terms in each year of the parliament. There was not a single mention of social care.²⁰

A senior source, interviewed by Nick Timmins for his work *Never again?*, suggested the NHS was not a priority during the negotiation exercise as there had been an assumption that there would be only incremental changes to it.¹⁴³ The more comprehensive *Programme for government* published later in May 2010 gave more clues as to the Coalition government’s plans for health. For example, with regard to choice and competition, the government committed to increasing the involvement of independent and voluntary sector providers and to giving every patient the power to choose any provider as long as they could meet NHS standards within NHS pricing.²¹ However, there was little to indicate the government would pursue a reform programme which was to become one of the most controversial sets of reforms in the history of the NHS. Just eight weeks later, in July, the publication of the white paper *Equity and excellence: Liberating the NHS*²² made it clear that major reorganisation was indeed on its way.

While some commentators had expressed surprise at the scale and pace of the reform programme, the Secretary of State for Health Andrew Lansley had expressed strong views on the role of competition while in opposition, outlining a vision of the NHS where competition was maximised and Monitor played the role of promoting competition.¹⁴⁴

Annex B:

Selected extracts from board minutes between October 2011 and July 2012

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This annex outlines extracts from board meetings from the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust and shows how the understanding of the merger process to be followed developed over time.

Table B1: Selected extracts from board minutes from both trusts between October 2011 and July 2012

Date of meeting	Which trust	Discussion points
14 October 2011	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	The minutes explained that a meeting had been held with Monitor to discuss closer collaboration and merger and that once McKinsey had completed their initial scoping, Monitor had suggested that the trusts would need to develop a business case and a detailed case for the Co-operation and Competition Panel (CCP). ¹⁴⁵
9 December 2011	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	The minutes explained that information had been sent to the CCP which had responded that it was considering the proposal. Frontier Economics had been engaged to assist with the preparation of information to be provided to the panel. The minutes reported that the joint programme board was considering sending the information to the Office of Fair Trading (OFT) as it would be taking over the responsibilities of the CCP under the Health and Social Care Bill. ¹⁴⁶ <i>[While this is an accurate reflection of the minutes, the OFT had the powers before the Health and Social Care Act 2012. The Act confirmed those powers rather than establishing them.]</i>
21 December 2012	Poole Hospital NHS Foundation Trust	The minutes outlined a need to liaise with the CCP and recognised that as the first FT-to-FT merger, there would be a learning process for both the trusts and Monitor. ¹⁴⁷
13 January 2012	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	The minutes reported that Monitor had suggested the trust should seek its own legal advice as to whether competition law applied to FTs. It was also suggested that 'Monitor was reluctant to give advice and so Poole and RBCH must shape this themselves and keep in contact with Monitor'. ¹⁴⁸
25 January 2012	Poole Hospital NHS Foundation Trust	The minutes reported that discussions had commenced with the OFT on their part in the proposed merger. ¹⁴⁹
29 February 2012	Poole Hospital NHS Foundation Trust	The minutes outlined that discussions had taken place with lawyers regarding the process the trusts were required to undertake with the OFT to progress merger work and the impact this would have on the timescale. ¹⁵⁰

9 March 2012	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	The minutes noted that the OFT review was likely to lead to an assessment by the Competition Commission (CC). ¹⁵¹
28 March 2012	Poole Hospital NHS Foundation Trust	The minutes highlighted the fact that the Health and Social Care Bill would be likely to impact on the merger. ¹⁵²
13 April 2012	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	The discussion recognised that the OFT submission would be one of the most difficult hurdles to negotiate. ¹⁵³
25 April 2012	Poole Hospital NHS Foundation Trust	The minutes noted that working across the old rules and the new Health and Social Care Act was a major challenge and that the trusts were in regular contact with Monitor. ¹⁵⁴
11 May 2012	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	The minutes suggested the OFT process was likely to take two months and following a possible referral to the CC, the trusts were unlikely to complete the process before February 2013. One board member expressed disappointment that the trust was not 'getting the support from its advisers that it had expected'. There was also discussion about the OFT's knowledge of the sector. ¹⁵⁵
27 June 2012	Poole Hospital NHS Foundation Trust	The minutes reported that the draft submission to the OFT had been made on 29 May 2012 and the OFT had responded with 61 questions on 14 June which the trusts were working through. The OFT had also requested a full business case earlier than had been anticipated. ¹⁵⁶
13 July 2012	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	The minutes outlined that the OFT had asked for a benefits case, which was not its usual practice, but the OFT was still likely to refer the trust to the CC which would impact on the timetable. Monitor had confirmed that it would run its process concurrent with the end of the CC process and the minutes reported that a very constructive relationship was developing with Monitor. ⁸⁵
25 July 2012	Poole Hospital NHS Foundation Trust	The chief executive's report for the PHFT's board noted that the business case requested by the OFT would provide the OFT with a clear summary of the clinical benefits and would be the basis upon which Monitor could comment. The paper suggested that 'clarity is needed in relation to the Monitor process and timescales for assessing mergers following the Health and Social Care Act 2012'. ¹⁵⁷

References

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1. Gaynor M, Laudicella M and Propper C. *Can Governments do it better? Merger mania and hospital outcomes in the English NHS*. The Centre for Market and Public Organisation; 2012.
2. Public Accounts Committee. Oral evidence: Regulating NHS Foundation Trusts, HC 1119. House of Commons. 31 March 2014.
3. Health Select Committee. *Health Committee – Seventh Report Public expenditure on health and social care*. House of Commons. 2014.
4. Competition and Markets Authority. *Anticipated acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust by Frimley Park Hospital NHS Foundation Trust*. Competition and Markets Authority; 2014.
5. Office of Fair Trading. *Acquisition by University College London Hospitals NHS Foundation Trust of Royal Free London NHS Foundation Trust’s neurosurgery services*. Office of Fair Trading; 2013. Accessed via: http://webarchive.nationalarchives.gov.uk/20140402142426/http://www.of.gov.uk/shared_of/mergers_ea02/2013/UCLH.pdf
6. Office of Fair Trading. *Anticipated pathology joint venture between University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and the Doctors Laboratory Limited*. Office of Fair Trading; 2013. Accessed via: http://webarchive.nationalarchives.gov.uk/20140402141250/http://www.of.gov.uk/shared_of/mergers_ea02/2013/UCLH-RF-TDL.pdf
7. Competition and Markets Authority. *Anticipated acquisition by Chelsea and Westminster Hospital NHS Foundation Trust of West Middlesex University Hospital NHS Trust*. Competition and Markets Authority; 2014. Accessed via: https://assets.digital.cabinet-office.gov.uk/media/5452416140f0b6131200000f/Notice_of_commencement_Chelsea_hospitals.pdf
8. Office of Health Economics. *Report of the Office of Health Economics Commission on Competition in the NHS*. Office of Health Economics. 2012
9. Hansard HC Deb Column 626. 31 January 2011.
10. Hansard HC Deb Column 698. 31 January 2011.
11. Bevan G, Karanikolou M, Exley J, Nolte E, Connolly S and Mays N. *The four health systems of the United Kingdom: how do they compare?* Nuffield Trust and Health Foundation; 2014
12. Department of Health. *Working for Patients*. The Stationery Office; 1989
13. Labour Party. *New Labour: Because Britain deserves better*. Labour Party Sales; 1997.
14. Department of Health. *The new NHS: modern, dependable*. The Stationery Office; 1997.
15. Department of Health. *The NHS Plan: a plan for investment, a plan for reform*. The Stationery Office; 2000.
16. Department of Health. *Departmental Report 2005*. The Stationery Office; 2005
17. Allen P and Jones L. Diversity of health care providers. In: Dixon A, Mays N, Jones L (eds) *Understanding New Labour’s market reforms of the English NHS*. The King’s Fund; 2011.
18. Department of Health. *Delivering the NHS Plan: next steps on investment, next steps on reform*. The Stationery Office; 2002.
19. Health and Social Care (Community Health and Standards) Act 2003. Explanatory Notes.
20. Conservative Party. Conservative Liberal Democrat coalition negotiations. Agreements reached 11 May 2010. http://www.conservatives.com/News/News_stories/2010/05/Coalition_Agreement_published.aspx [Accessed 13 September 2014]
21. HM Government. *The Coalition: our programme for government*. Cabinet Office; 2010.
22. Department of Health. *Equity and Excellence: Liberating the NHS*. The Stationery Office; 2010
23. Department of Health. *Liberating the NHS: Greater choice and control – A consultation on proposals*. Department of Health; 2010
24. The Department of Health. *Legislative framework and next steps*. The Stationery Office; 2010. Cm 7993.
25. Health and Social Care Bill as introduced to the House of Commons on 19 January 2011.
26. Liberal Democrats. *Motion carried with amendments: Updating the NHS: Personal and Local*. 12 Mar 2011.
27. Hansard HC PBC C484-5. 2 March 2011.
28. Speech by the Rt. Hon Andrew Lansley, Secretary of State for Health, to NHS staff at Frimley Park Hospital in Surrey with the Prime Minister and Deputy Prime Minister on 6 April 2011.
29. NHS Future Forum. *Choice and competition: report from the NHS Future Forum*. Department of Health; 2011
30. Department of Health. *Government response to the NHS Future Forum report*. The Stationery Office; 2011. Cm 8113.
31. Department of Health. *Briefing notes on Government amendments to the Health and Social Care Bill: Lords Report Stage*. Department of Health; February 2012.
32. Hansard HL Deb Column 1735. 6 March 2012.
33. Hansard HL Deb Column 1741. 6 March 2012.
34. Lansley A. Letter to NHS foundation trust chief executives. Department of Health; 2012. Accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/215074/dh_133421.pdf
35. Department of Health. *Principles and Rules for Cooperation and Competition (PRCC)*. Department of Health; 2007.
36. Department of Health. *Principles and Rules for Cooperation and Competition (PRCC)*. Department of Health; 2010

37. Ross T and Adams S. Norman Lamb: NHS competition rules must be reviewed. *Daily Telegraph*. 26 Feb 2013. www.telegraph.co.uk/news/politics/9896186/Norman-Lamb-NHS-competition-rules-must-be-reviewed.html [Accessed 12 March 2014].
38. The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013.
39. House of Lords Secondary Legislation Committee. *30th Report of Session 2012–13*. HL Paper 136. The Stationery Office; 2013.
40. Department of Health. *Changes to the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013*. Department of Health; 2013
41. HC Deb 24 April 2013. Vol 744 Columns 1479–80.
42. HC Deb 24 April 2013. Vol 744 Column 1508.
43. HC Deb 24 April 2013. Vol 744 Columns 1479–1517.
44. Hansard HL Deb Vol 735 Columns 1733–1735. 6 March 2012.
45. CCP (2009) Co-operation and competition panel begins work today. Accessed via: <http://webarchive.nationalarchives.gov.uk/20140106173514/http://www.monitor-nhsft.gov.uk/regulating-health-care-providers-commissioners/cooperation-and-competition/archive-co-operation-and-0>
46. Co-operation and Competition Panel. *Merger guidelines*. Co-operation and Competition Panel; 2010.
47. Health and Social Care Act 2012: Explanatory Notes.
48. Competition and Markets Authority. *Mergers: Guidance on the CMA's jurisdiction and procedure*. Competition and Markets Authority; 2014.
49. HM Treasury. Enterprise for all – the challenge for the next Parliament. 2001. Accessed via: http://webarchive.nationalarchives.gov.uk/20021017190443/http://www.hm-treasury.gov.uk/Newsroom_and_Speeches/Press/2001/press_67_01.cfm
50. Department of Trade and Industry. *A World Class Competition Regime*. The Stationery Office; 2001.
51. Fair Trade Act 1973. Accessed via <http://www.legislation.gov.uk/ukpga/1973/41/contents>
52. Competition Commission and Office of Fair Trading. *Merger Assessment Guidelines*. Competition Commission and Office of Fair Trading; 2010.
53. Office of Fair Trading. *The OFT's role in reviewing NHS mergers: Frequently Asked Questions*. Office of Fair Trading; 2013.
54. Monitor. *Supporting NHS providers: guidance on merger benefits*. Monitor; 2014.
55. Competition and Markets Authority. *CMA guidance on the review of NHS mergers*. Competition and Markets Authority; 2014. Accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/339767/Healthcare_Long_Guidance.pdf
56. OECD. *Policy roundtables: The failing firm defence 2009*. OECD; 2010.
57. Office of Fair Trading. *Anticipated acquisition by HMV of 15 Zavvi stores ME/4036/09*. Office of Fair Trading; 2009.
58. Competition Commission. *Merger References: Competition Commission Guidelines* (rev. ed). Competition Commission; 2007.
59. Office of Fair Trading, Competition Commission and Monitor. *Ensuring that patients' interests are at the heart of assessing public hospital mergers*. Office of Fair Trading, Competition Commission and Monitor; 2013.
60. Competition and Markets Authority and Monitor. *Competition review of NHS mergers: A short guide for managers of NHS providers*. Competition and Markets Authority and Monitor; 2014
61. Monitor, *Supporting NHS providers: guidance on transactions for NHS foundation trusts*; Monitor; 2014
62. www.poole.nhs.uk/about-us/what-we-do.aspx
63. www.rbch.nhs.uk/about_the_trust/who_we_are.php
64. Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. *Initial Submission to the Competition Commission*. The Competition Commission; 2013.
65. Competition Commission. *Summary of hearing with West Hampshire Clinical Commissioning Group held on 15 February 2013*. Competition Commission; 2013.
66. Competition Commission. *Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust: A report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust*. Competition Commission; 2013.
67. Dixon A, Appleby J, Robertson R, Burge P, Devlin N and Magee H. *Patient Choice: How patients choose and how providers respond*. The King's Fund; 2010.
68. Beckert W, Christensen M, Collyer K. (2012) Choice of NHS-funded hospital services in England. *The Economic Journal*. Special Issue: Foundations of revealed preference. Volume 122, issue 560, pages 400-417, May 2012.
69. Competition and Markets Authority. *CMA reviews proposed merger of Frimley Park and Heatherwood and Wexham NHS Hospitals*. Competition and Markets Authority; 2014
70. Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. *Relevant Customer Benefits Submission*. The Competition Commission; 2013.
71. Competition Commission. *Summary of hearing with Wessex Area NHS Commissioning Board held on 15 February 2013*. Competition Commission; 2013.
72. Monitor. *Authorisation of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*. Monitor; 2005. www.gov.uk/government/groups/the-royal-bournemouth-and-christchurch-hospitals-nhs-foundation-trust
73. The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, *Annual Report and Accounts 2012/13*; 2013. www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/our_publications/annual_report/annualreport_2013.pdf
74. Monitor. *NHS Foundation Trusts removed from significant breach of their authorisation*. Accessed via: <http://webarchive.nationalarchives.gov.uk/20140311012443/http://monitor-nhsft.gov.uk/about-your-local-nhs-foundation-trust/regulatory-action/nhs-foundation-trusts-removed-significant-br>
75. Correspondence from David Bennett (Monitor) to Peter Harvey, Chairman Poole Hospital NHS FT dated 29 July 2010. Accessed via: www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3504
76. Poole Hospital NHS Foundation Trust. *Annual reports and accounts 2012/13*. Poole Hospital NHS FT; 2013. Accessed via: www.gov.uk/government/uploads/system/uploads/attachment_data/file/293836/POOLE_Annual_Report_and_Accounts_2012-13.pdf
77. Correspondence between Paul Streat (Monitor) and Angela Schofield (Chair Poole Hospital NHS Foundation Trust) on 4 June 2013. Accessed via: <http://webarchive.nationalarchives.gov.uk/20140106173514/http://www.monitor.gov.uk/sites/default/files/Letter%20to%20Poole%20040613.pdf>
78. Bolton NHS Foundation Trust. *Annual Report and Accounts 2012/13*. Bolton NHS Foundation Trust; 2013.
79. Monitor and NHS England. *Monitor and NHS England's review of the marginal rate rule*. Monitor and NHS England; 2013.
80. NHS England and Monitor. *2015/16 National Tariff Payment System: Tariff Engagement Documents Overview*. NHS England and Monitor; 2014.
81. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. *Core Brief: Joint working between the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust*. 2011. Accessed via: www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/meetings/2011/july.pdf

82. Poole Hospital NHS Foundation Trust. *Chief Executive's Report. Part One: Board of Directors*. 26 October 2011. Accessed via: www.poole.nhs.uk/pdf/BoD%20Oct%2011%20C%20CEO%20Part%201%20Report%20October%202011.pdf
83. Poole Hospital NHS Foundation Trust. Part 1 Minutes of the meeting of the Board of Directors of Poole Hospital NHS Foundation Trust held at 9.00 am on Wednesday 27 June 2012 in the Board Room, Poole Hospital. Accessed via: www.poole.nhs.uk/PDF/BoDMinutesPart127June2012R.pdf
84. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. Minutes of a Meeting of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Board of Directors held on Friday 8 June 2012 in the Committee Room, Royal Bournemouth Hospital. Accessed via: www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/meetings/2012/july_bod1.pdf
85. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. Minutes of a Meeting of the Royal Bournemouth and Christchurch Hospitals NHS FT Board of Directors held on Friday 13 July 2012 in the Committee Room, Royal Bournemouth Hospital. Accessed via: www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/meetings/2012/sept_bod1.pdf
86. Poole Hospital NHS Foundation Trust. Part 1 Minutes of the meeting of the Board of Directors of Poole Hospital NHS Foundation Trust held at 9.00 am on Wednesday 25 July 2012 in the Board Room, Poole Hospital. Accessed via: www.poole.nhs.uk/pdf/BoDMinutesPart1-25July2012R.pdf
87. Monitor. *Anticipated merger of Poole Hospital NHS Foundation Trust and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*. Monitor; 2013.
88. Office of Fair Trading. *Anticipated merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust ME/5351/12*. Office of Fair Trading; 2013. Accessed via: http://80.86.35.165/shared_of/mergers_ea02/2013/NHS-foundation-trusts.pdf
89. Poole Hospital NHS Foundation Trust. Part 1 Minutes of the meeting of the Board of Directors of Poole Hospital NHS Foundation Trust held at 9.00 am on Wednesday 24 July 2013 in the Board Room, Poole Hospital. Accessed via: www.poole.nhs.uk/pdf/BoD%20Minutes%20Part%201%20-%2024%20Jul%202013%20R.pdf
90. Information obtained by Incisive Health in December 2013 through Freedom of Information requests to Poole Hospital NHS Foundation Trust and the Royal Bournemouth and Christchurch NHS Foundation Trusts.
91. Monitor. *Monitor closes investigation into Poole Hospital NHS Foundation Trust*. Monitor; 2014. Accessed via: www.gov.uk/government/news/monitor-closes-investigation-into-poole-hospital-nhs-foundation-trust
92. Department of Health. *Payment by Results Guidance for 2012–13*. Department of Health; 2013.
93. Competition Commission. *Provisional findings report*. The Competition Commission; 2013.
94. Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. *Response to the Competition Commission's provisional findings on the competitive effects of the RBCH-PH merger*. Competition Commission; 2013.
95. Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. *Benefits of the merger*. Competition Commission; 2013.
96. Poole Hospital NHS Foundation Trust. Correspondence to Mr R Witcomb re the proposed merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust dated 24 July 2013. Accessed via: http://webarchive.nationalarchives.gov.uk/20140402141250/http://www.competition-commission.org.uk/assets/competitioncommission/docs/2013/royal-bournemouth-and-christchurch-polee/130805_rbch_ph_ph_clinicians_response_to_pfs.pdf
97. Competition Commission. Notice of acceptance of final undertakings pursuant to section 82 and schedule 10 of the Enterprise Act 2002. 2013. Accessed via: http://webarchive.nationalarchives.gov.uk/20140402141250/http://www.competition-commission.org.uk/assets/competitioncommission/docs/2013/royal-bournemouth-and-christchurch-polee/notice_of_acceptance_final_undertakings.pdf
98. NHS Dorset Clinical Commissioning Group, NHS Dorset Clinical Commissioning Group Governing Body Meeting. Services Review Specification; 2014 Accessed via: www.dorsetccg.nhs.uk/Downloads/aboutus/CCG%20Board/21%20May%202014/19%20CSR%20Specification.pdf
99. Dorset Clinical Commissioning Group. *NHS to review healthcare in Dorset*. 14 October 2014.
100. Department of Health. *A mandate from the Government to NHS England: April 2014 to March 2015*. Department of Health; 2013.
101. Independent Reconfiguration Panel. Terms of Reference. www.irpanel.org.uk/view.asp?id=58 [Accessed 6 October 2014].
102. Fleming D. Letter to Barbora Zbynovska, 25 January 2013. Published by the Competition Commission.
103. Young A. Letter to Barbora Zbynovska, 1 February 2013. Published by the Competition Commission.
104. Watson F and Goodson T. Letter to Barbora Zbynovska 29 March 2013. Published by the Competition Commission.
105. NHS England. *Planning and delivering service changes for patients: A good practice guide for commissioners on the development of proposals for major service changes and reconfigurations*. NHS England; 2013.
106. Monitor. *Our new approach to transactions: consultation responses and next steps*. Monitor; 2014.
107. Monitor. *Supporting NHS providers: guidance on transactions for NHS Foundation Trusts*. Monitor; 2014.
108. Monitor. *Competition review of NHS mergers: A short guide for managers of NHS providers*. Monitor; 2014.
109. Office of Fair Trading. *Competing on Quality – Literature Review*. Office of Fair Trading; 2014.
110. Competition Commission. Notice of acceptance of interim undertakings pursuant to section 80 of the Enterprise Act 2002. Competition Commission; 2013. Accessed via: http://webarchive.nationalarchives.gov.uk/20140402141250/http://www.competition-commission.org.uk/assets/competitioncommission/docs/2013/royal-bournemouth-and-christchurch-polee/notice_of_acceptance_final_undertakings.pdf
111. Dorsett J. *Quarterly report on the performance of the NHS foundation trust sector: 3 months ended 30 Jun 2014*. Monitor; 2014. Accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/356383/BM1492_NHSFT_quarterly_performance.pdf
112. Monitor. *Closing the NHS Funding Gap: how to get better value healthcare for patients*. Monitor; October 2013.
113. Dalton, D. *Examining new options and opportunities for providers of NHS care: the Dalton Review*. Department of Health; 2014.
114. Greve B. *The Times They Are Changing: Crisis and the Welfare State*. Wiley; 2012.
115. Hawe E, Yuen P, Baillie L. *OHE guide to UK health and health care statistics*. Office of Health Economics; 2011.
116. Thatcher, M. Speech to Conservative Party Conference; Margaret Thatcher Foundation; 1982. Accessed via www.margaretthatcher.org/document/105032on 24 January 2014.
117. Key T. Contracting out of ancillary services. In: Robert Maxwell (ed) *Reshaping the National Health Service*. Policy Journals; 1988.
118. Marks J. *The NHS: Beginning, Middle and End?: The Autobiography of Dr John Marks*. Radcliffe Publishing; 2008.
119. Edwards B and Fall M. *The executive years of the NHS: The England account 1985–2000*. Nuffield Trust; 2005.
120. Timmin N. *The Five Giants: A Biography of the Welfare State*. Harper Collins; 1995.
121. National Health Service and Community Care Act 1990.
122. Blair T. Speech by Prime Minister Tony Blair to the Labour Party conference. BBC; 1999. Accessed via: http://news.bbc.co.uk/1/hi/uk_politics/460009.stm

123. Department of Health. *More resources for the NHS: More choices for patients*. Department of Health; 2001.
124. Department of Health. *Responsibilities and operational requirements for the correct use of Choose and Book*. Department of Health; 2008.
125. Milburn A. Speech by Rt Hon Alan Milburn MP Secretary of State for Health to the New Health Network. NHS History.Net. Accessed via: www.nhshistory.net/milburnspeech.htm
126. BBC. *NHS patients travel abroad for surgery*. BBC. 2002.
127. Department of Health. CHD Choice. Department of Health; 2010. Accessed via: http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Healthcare/Longtermconditions/Vascular/Coronaryheartdisease/CHDchoice/DH_096629
128. Hansard: HC, 26 February 2003, C634W.
129. Milburn A. Speech by Rt Hon Alan Milburn MP, 11 February 2003: Choices for All. Department of Health; 2003.
130. Reid J. Speech by Rt Hon John Reid MP, Secretary of State for Health, 16 July 2003: Choice Speech to the New Health Network. Department of Health; 2003.
131. Department of Health. *Building on the Best: Choice, Responsiveness and Equity in the NHS*. The Stationery Office; 2003.
132. Department of Health. *Choice matters: 2007–8 Putting patients in control*. Department of Health; 2007.
133. Donnelly L. *Radical consultation: what do patients want?* Health Service Journal 2003;II3(5867).
134. Dixon A and Robertson R. Patient choice of hospital. In: Dixon A, Mays N, Jones L (ed) *Understanding New Labour's market reforms of the English NHS*. The King's Fund; 2011.
135. Brown G. *A modern agenda for prosperity and social reform*. The Social Market Foundation; 2003.
136. House of Commons Health Committee. *Independent Sector Treatment Centres. Fourth report of session 2005–06 volume 1*. House of Commons.
137. Department of Health. *Our health, our care, our say: a new direction for community services*. The Stationery Office; 2006.
138. HM Government. *The NHS Improvement Plan: Putting People at the Heart of Public Services*. The Stationery Office; 2004.
139. Department of Health. *Calls for Expressions of Interest for the provision of NHS Primary Medical Care and related services*. Department of Health; 2007.
140. Department of Health. *Equitable Access to Primary Medical Care Commercial Strategy, Framework and Provisions: Guidance for PCTs*. Department of Health; 2008.
141. Coleman A, McDermott I, Checkland K, Harrison S. *Alternative Providers of Primary Care in the English National Health Service: A study of commissioning, organisation and operation*. National Primary Care Research and Development Centre; 2011.
142. BBC. General Election 2010 National Results after 650 of 650. BBC. <http://news.bbc.co.uk/1/shared/election2010/results>
143. Timmins N. *Never Again? The Story of the Health and Social Care Act 2012: A study in Coalition Policy Making*. The King's Fund and the Institute for Government; 2012.
144. Lansley A. Extract from: The Future of Health and Public Service Regulation speech 09 July 2005. Accessed via: www.andrewlansley.co.uk/newsevent.php?newseventid=21
145. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals National Health Service Foundation Trust Board of Directors held on Friday 14 October 2011 in the Committee Room, Royal Bournemouth Hospital. Accessed via: www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/meetings/2011/october.pdf
146. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (2011) Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals National Health Service Foundation Trust Board of Directors held on Friday 9 December 2011. Accessed via: www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/meetings/2012/janbod.pdf
147. Poole Hospital NHS Foundation Trust. Part 1 Minutes of the extraordinary meeting of the Board of Directors of Poole Hospital NHS Foundation Trust held at 11.00 am on Wednesday 21 December 2011 in the Postgraduate Centre, Poole Hospital. Accessed via: www.poole.nhs.uk/PDF/BoDMinutesPart1December2011.pdf
148. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals National Health Service Foundation Trust Board of Directors held on Friday 13 January 2012 in the Committee Room, Royal Bournemouth Hospital. Accessed via: http://www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/meetings/2012/feb_bod1.pdf
149. Poole Hospital NHS Foundation Trust. Part 1 Minutes of the meeting of the Board of Directors of Poole Hospital NHS Foundation Trust held at 9.00 am on Wednesday 25 January 2012 in the Board Room, Poole Hospital. www.poole.nhs.uk/PDF/BoDFeb12AMinutesPart1-25January2012R.pdf
150. Poole Hospital NHS Foundation Trust. Part 1 Minutes of the meeting of the Board of Directors of Poole Hospital NHS Foundation Trust held at 9.00 am on Wednesday 29 February 2012 in the Board Room, Poole Hospital. Accessed via: www.poole.nhs.uk/PDF/BoDAMinutesPart129February2012R.pdf
151. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals National Health Service Foundation Trust Board of Directors held on Friday 9 March 2012 in the Committee Room, Royal Bournemouth Hospital. Accessed via: www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/meetings/2012/april_bod1.pdf
152. Poole Hospital NHS Foundation Trust. Part 1 Minutes of the meeting of the Board of Directors of Poole Hospital NHS Foundation Trust held at 9.00 am on Wednesday 28 March 2012 in the Board Room, Poole Hospital. Accessed via: www.poole.nhs.uk/pdf/BoDMinutesPart1-28March12R.pdf
153. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals National Health Service FT Board of Directors held on Friday 13 April 2012 in the Committee Room, Royal Bournemouth Hospital. Accessed via: www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/meetings/2012/may_bod1.pdf
154. Poole Hospital NHS Foundation Trust. Part 1 Minutes of the meeting of the Board of Directors of Poole Hospital NHS Foundation Trust held at 9.00 am on Wednesday 25 April 2012 in the Board Room, Poole Hospital. www.poole.nhs.uk/pdf/BoDMinutesPart1-25April12R.pdf
155. Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. Minutes of a Meeting of The Royal Bournemouth and Christchurch Hospitals National Health Service Foundation Trust Board of Directors held on Friday 11 May 2012 in the Committee Room, Royal Bournemouth Hospital. Accessed via: www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/meetings/2012/june_bod1.pdf
156. Poole Hospital NHS Foundation Trust. Part 1 Minutes of the meeting of the Board of Directors of Poole Hospital NHS Foundation Trust held at 9.00 am on Wednesday 27 June 2012 in the Board Room, Poole Hospital. Accessed via: www.poole.nhs.uk/PDF/BoDMinutesPart127June2012R.pdf
157. Poole Hospital NHS Foundation Trust. Chief Executive's Report to the Board of Directors: Part One. 25 July 2012. Accessed via: www.poole.nhs.uk/pdf/BoDJul12CChiefExecutiveJULYreportpartone.pdf

CC	Competition Commission
CCG	Clinical Commissioning Group
CCP	Co-operation and Competition Panel
CMA	Competition and Markets Authority
CQC	Care Quality Commission
DGH	District general hospital
FT	NHS foundation trust
NHS TDA	NHS Trust Development Authority
OECD	Organisation for Economic Co-operation and Development
OFT	Office of Fair Trading
PHFT	Poole Hospital NHS Foundation Trust
RBCHFT	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
RCB	Relevant customer benefit
RTT	referral to treatment time
SLC	Substantial lessening of competition
TSA	Trust special administration/administrator
UHSFT	University Hospital Southampton NHS Foundation Trust

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