There are currently two types of NHS hospitals (i.e. public healthcare hospitals) in England: NHS Foundation Trusts ("FTs") and NHS Trusts. The UK Government expects most NHS hospitals to have achieved FT status by April 2014. NHS hospitals may merge either with other NHS hospitals or with private healthcare operators. Depending on the nature of the merging hospitals, the applicable UK merger control regime and procedure may differ (although technically speaking the UK authorities’ powers are said to be concurrent):

- mergers between private healthcare operators are reviewed by the Office of Fair Trading (and Competition Commission if referred) under the general UK merger control regime. Note—Private patient units ("PPUs") of NHS hospitals are considered to be ‘enterprises’ for the purposes of merger control and are also reviewed under the general UK merger control regime.
- mergers between a private healthcare operator and an NHS hospital (i.e. either an FT or an NHS Trust) are reviewed by the OFT (and Competition Commission if referred) under the general UK merger control regime, taking account of an opinion from Monitor in respect of patient benefits as regards the NHS healthcare aspects of the merger.
- mergers between FTs or between an FT and an NHS Trust are reviewed by the OFT (and Competition Commission if referred) under the general UK merger control regime, taking account of an opinion from Monitor in respect of patient benefits, and
- mergers between NHS Trusts only are reviewed by Monitor under a healthcare-specific merger control regime.

The focus below is on mergers between NHS hospitals (NHS Trusts and/or FTs).

See further practice note: Healthcare

Key points in relation to the OFT process when applied to FTs and NHS trusts

Section 79 of the Health and Social Care Act 2012 (HSCA 2012) which came into force on 1 July 2012, provides that the merger provisions of the Enterprise Act 2002 apply to mergers involving FTs (see below for mergers between NHS trusts only). As a result, the OFT and, following an OFT reference, the Competition Commission (CC) have jurisdiction to assess the competition aspects of mergers between FTs, as well as mergers between an FT and another business, provided the proposed merger satisfies certain thresholds. Under the HSCA 2012, as part of its review, the OFT must obtain non-binding advice on patient benefits from Monitor (see below).

References: Health and Social Care Act 2012, s 79
On 22 March 2013, the OFT published a paper setting out answers to frequently asked questions on its role in reviewing NHS mergers, describing the types of mergers involving NHS providers that it considers will be caught by the provisions of the UK merger control regime under the Enterprise Act 2002. In the paper, the OFT states that it also has jurisdiction to review mergers between an FT and an NHS Trust, as well as mergers between an NHS Trust and another business, but not mergers between NHS Trusts only.

References: OFT guidance-role in reviewing NHS mergers

The OFT believes that NHS Trusts are capable of being considered ‘enterprises’ (ie businesses) for the purposes of the merger provisions of the Enterprise Act 2002 (see below). Nevertheless, the OFT has stated that it will not review mergers involving only NHS Trusts because these will not give rise to a change of control, as all NHS Trusts are under the common control of the Secretary of State for Health. Monitor will continue to review such mergers, although this role will gradually disappear in light of the requirement that all NHS Trusts become FTs (or become part of one) under HSCA 2012.

Accordingly, the OFT and CC (as well as their successor, the Competition and Markets Authority (CMA)) will review mergers between FTs, mergers between an FT and an NHS Trust, as well as mergers between either an FT or an NHS Trust and another business. Whether a particular merger qualifies for an investigation by the OFT will depend on the specific circumstances of the case in question.

When does a merger arise? Meaning of ‘enterprise’ in the context of NHS mergers

The term ‘enterprise’ includes the whole or part of a business, whose activities are carried on for gain or reward.

References: EnA 2002, s129(1); OFT guidance-role in reviewing NHS mergers, para 20

The OFT has specified that commercial arrangements and NHS reconfigurations such as an outsourcing or supply agreement where they involve a transfer of assets, rights and/or employees, or where parties transfer or swap, assets may create a notifiable relevant merger situation under the EnA 2012.

References: OFT guidance-role in reviewing NHS mergers, para 22

In addition, the OFT has stated that it considers that NHS Trusts (which may include, for example, community and ambulance services) fall within the definition of an ‘enterprise’ and as such may be considered enterprises for the purpose of UK merger review. The OFT explained that ‘[while] NHS services are ‘free for the patient at the point of delivery’, the primary care trusts (and/or commissioning organisations) procure and pay a consideration for the provision of such services’.

References: OFT guidance-role in reviewing NHS mergers, para 24

Monitor has published a briefing note providing guidance as to when transactions involving the transfer of pathology services may amount to a relevant merger situation. This includes: ‘the transfer of a combination of customer contracts, assets, records, the application of TUPE to the transfer of staff and the introduction of a joint or single management structure’. By contrast, some pathology reconfigurations might not amount to a relevant merger situation, where they ‘take the form of agreements to cooperate or to coordinate business strategy, without the transfers of contracts, assets and staff that often indicate a change of control/businesses ceasing to be distinct’. In such cases, although the transaction might not be subject to UK merger control rules, parties should still ensure that the transaction does not reduce the choice and competition in a way that adversely affects the interests of patients, and more generally that it complies with the competition rules under the Competition Act 1998.

References: Monitor—Briefing note, June 2013; OFT guidance-role in reviewing NHS mergers, paras 9, 17-20

In the HCA/Guy’s and St Thomas’ involving an FT and a private healthcare operator, the OFT considered that the transaction did not result in the transfer of an ‘enterprise’ and accordingly did not give rise to a relevant merger situation, based on the following factors.

References: OFT decision—HCA/Guy’s and St Thomas’ merger
• the transaction concerned the lease of space by St Thomas’ FT to HCA for use as a PPU, and HCA would be investing its own funds to establish its private patient services facilities
• no staff, customer assets or liabilities would be transferred from St Thomas’ FT to HCA. Consultant practising privileges would not be transferred to HCA and consultants practising at St Thomas’ FT would have to apply for privileges to practise at HCA’s facilities
• St Thomas’ FT did not provide dedicated private patient cancer services prior to the transaction, except for a very limited amount of services, and
• no services or patients would transfer to HCA and St Thomas’ FT was contractually permitted to continue to provide the level of services post-transaction up to a specified amount.

Voluntary notification regime

There is no obligation under the general UK merger control regime (under the Enterprise Act 2002) to seek prior clearance of a qualifying merger from the authorities either before or after the merger takes place. The commercial decision whether to do so usually depends on an analysis of the risk of a reference to the CC. Moreover, especially in relation to mergers involving NHS hospitals, the merging parties may want to take into account the fees payable in respect of a merger assessment by the OFT, although no fees will be payable where the parties seek informal advice from Monitor and/or the OFT, or at the stage of pre-notification discussions.

See practice note: UK merger process.

On 17 October 2013, the OFT, CC and Monitor published a joint statement on ‘ensuring that patients’ interests are at the heart of assessing public hospital mergers’.

References: Joint OFT, CC and Monitor statement

Even though NHS hospitals are not obliged to notify mergers to the OFT, the authorities encourage NHS hospitals considering a merger to engage with Monitor and, where appropriate, the OFT at the earliest opportunity in order to obtain guidance on the process of merger control and on the evidence that will be required in order to carry out a merger investigation. In particular, Monitor will offer informal advice to NHS hospitals on how they might assess any prospective patient benefits and any possible competition implications arising out of a proposed merger.

References: OFT guidance-role in reviewing NHS mergers, para 30; Monitor’s Briefing note on the application of merger control rules to pathology service reconfigurations, para 16

Monitor’s opinion

Pursuant to section 79 of the HSCA 2012, the OFT must notify Monitor where it decides to carry out an investigation of an NHS merger. Once notified, Monitor is under a duty to provide (non-binding) advice to the OFT on:

References: Health and Social Care Act 2012, s 79

• relevant customer benefits (RCBs) arising from the merger for people who use healthcare services provided for the purposes of the NHS, that is, any patient benefits, and
• any other matters relating to the proposed merger as Monitor considers appropriate.

In the joint statement by the OFT, CC and Monitor of 17 October 2013, the regulators noted that, given Monitor’s expertise as the healthcare sector regulator, the OFT and CC will place significant weight on Monitor’s advice on the patient benefits of a proposed merger involving NHS hospitals. All three authorities share a common general framework for analysing hospital mergers and each assessment will be carried out on a case by case basis.

References: OFT, CC and Monitor joint statement
Mergers between NHS trusts

Monitor

Until 1 April 2013 the Co-operation and Competition Panel (CCP) reviewed mergers involving NHS hospitals under the ‘Principles and Rules of Cooperation and Competition (PRCCs)’ and the CCP’s Merger Guidelines. Under the changes introduced by HSCA 2012 as of 1 April 2013, the CCP has become the Competition Directorate of Monitor, the concurrent sector regulator for all providers of NHS-funded healthcare in England.

Monitor has exclusive jurisdiction to review mergers between NHS Trusts only. Monitor is responsible for providing (non-binding) advice to the NHS Trust Development Authority on the effect of a merger on patient choice and competition, while ultimate decision-taking power rests with the Secretary of State for Health. This role will gradually disappear as NHS Trusts become (part of) FTs.

Framework for merger assessment

Monitor’s approach to the review of transactions between NHS Trusts ‘is likely’ to be similar to the CCP’s remit under the PRCCs and the CCP’s Merger Guidelines, including in relation to the applicable jurisdictional thresholds.

References: PRCCs; CCP merger guidelines

The review of two proposed NHS mergers (in both instances involving an FT and an NHS Trust) was submitted to the CCP shortly before the CCP became part of Monitor and the OFT took over responsibility for the review of mergers between FTs and NHS Trusts: Royal Free London FT/Barnet and Chase Farm Hospitals NHS Trust (20 August 2013) and University Hospitals Bristol FT/North Bristol NHS Trust (20 September 2013). It was decided that, in the interests of continuity and to minimise the risk of duplication of effort, the CCP would complete its review of the proposed mergers. The CCP conducted its review under the PRCCs, which have been superseded following the coming into force of the HSCA, in view of the fact that Monitor stated that it would review mergers in a similar way as it did under the CCP’s PRCCs.

References: Monitor—Briefing note on application of merger rules to pathology services, para 7

Meaning of ‘merger’ and applicable thresholds

For the purposes of the PRCCs, the term ‘merger’ includes ‘mergers, acquisitions, joint ventures and other transactions between NHS service providers that result in two previously independent organisations (or parts of organisations) coming under common management or control’, including vertical integration.

Merging NHS Trusts should submit a merger notification to Monitor where the turnover of the combined entity exceeds:

- £70m in the case of acute and mental health trusts
- £35m in the case of community service providers; or
- £15m in the case of primary care providers. In the case of mergers between NHS Trusts which are active in different sectors, the lowest applicable threshold will apply

Review timetable

The CCP Merger Guidelines set out the following merger review timeline:

- Monitor will start its review within ten working days of satisfying itself that the proposed merger falls within its remit and that the parties have provided sufficient information for Monitor to start its review (at which point Monitor will publish details of the merger and a Notice of Acceptance on its website)
- the timetable for Monitor’s merger review starts from the date of publication of the Notice of Acceptance (‘Day 1’)
- depending on the relevant procedure adopted, Monitor will aim to issue its advice within the following periods:
  - within ten working days of Day 1 for ‘fast-track’ reviews
  - within 40 working days of Day 1 for an initial assessment of whether the merger is consistent with the PRCCs (Phase I reviews)
• within an additional 80 working days if Monitor considers at the end of the Phase I review that there is a realistic prospect that the merger results in material adverse effects on patients and taxpayers (Phase II reviews) (ie 120 working days of Day 1 in total). Note—monitor has the power to extend the timetable and/or ‘stop the clock’, including where there is a delay in the receipt of requested information.

A merger may be deemed suitable for the fast-track track procedure where it falls within one of four categories: (i) temporary mergers with a duration of up to two years; (ii) mergers between non-competitors; (iii) transactions resulting in a change in the degree of control exercised by one party over the other (where Monitor or the CCP have previously advised that the merger is consistent with the PRCCs); and (iv) other mergers that are very likely to be consistent with the PRCCs, for example certain mergers involving providers of community health services that pass the screening tests devised by Monitor.

References: PRCCs and CCPs merger guidelines, appendix 2

Relevant market

In order to define the relevant market(s), Monitor will rely on the same methodology as other UK competition authorities, albeit ‘with adjustments for the specific circumstances of the health sector’. This will involve reliance on the ‘hypothetical monopolist test’ as the relevant framework for market definition. Adjustments to this test will tend to take into account issues including the following:

References: PRCCs and CCPs merger guidelines

• the nature of NHS patients and commissioners as the merging parties’ customers: patients are typically less sensitive to price changes given that the NHS is a free service, whilst commissioners might not have the ability to seek alternative service providers to react to a loss of service quality (eg in the context of competitive tendering); and
• the motivations of NHS service providers, given that generally they might not be purely motivated to increase profits.

Monitor’s approach will also be influenced by whether the services provided by the merging parties are in a market in which there is ‘competition in the market’ or ‘competition for the market’ (see below):

• where there is competition in the market (that is, patient-choice based competition for the services in question), Monitor will (i) identify the services that compete with those provided by the merging parties and define the relevant market(s), and (ii) identify the providers that offer the competing services and assess the effect of the merger on patient choice and competition as a result of the loss of the merging parties as independent competitors in each affected market
• where there is competition for the market (that is, competitive tendering for the services provided by the merging parties), Monitor will directly assess the effect of the merger on competition without formally defining the relevant market(s) affected by the merger. This is because market definition is unlikely to contribute to the identification of credible bidders in future competitive tendering opportunities

Merger analysis

Principle 10 of the PRCCs provides that:

‘Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients’ and taxpayers’ interests, for example because they will deliver significant improvements in the quality of care.’

Monitor will assess whether the proposed merger is likely to give rise to adverse effects (the costs/detriment) on patients and/or taxpayers (including both financial and non-financial impacts) arising from a loss of patient choice or competition (eg the merger may reduce the pressure on the merged entity to ensure patients do not switch to other service providers and/or limit the ability of commissioners to turn elsewhere for services). If Monitor identifies such costs, it will assess the benefits of the merger to patients (through, for example, improved clinical outcomes, increased patient safety, better services, greater efficiency, or more integrated care) and/or taxpayers (eg lower costs, value for money), and weigh these against the costs.

If the costs outweigh the benefits, Monitor is likely to find that there is an adverse effect on patients and taxpayers and that the merger is inconsistent with the PRCCs. In such a case, it may recommend that changes be made to the transaction (by way of assurances or remedies) or, where this is not possible, that a transaction should not be permitted. Note—that Monitor may also accept assurances or remedies in order to maximise the net benefit of the merger even in those cases where the merger, without intervention, would still result in a net benefit to patients and taxpayers.

In assessing mergers under Principle 10, Monitor will carry out a cost-benefit assessment. The cost-benefit framework is set out in the CCP’s Merger Guidelines.
Substantive assessment of NHS mergers—the Poole/Bournemouth proposed merger

The CC’s findings

The anticipated merger of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (‘RBCH’) and Poole Hospital NHS Foundation Trust (‘PH’) (see Royal Bournemouth and Christchurch Hospitals/Poole Hospital), was the first merger between two FTs to be reviewed by the OFT and referred to the CC under Enterprise Act 2002, and provides a blueprint for the assessment of similar mergers in the future.

References: Royal Bournemouth and Christchurch Hospitals/Poole Hospital

On 17 October 2013, the CC announced that it decided to prohibit the anticipated merger. The parties were required to sign an undertaking that they would not attempt to merge again for the next 10 years.

In order to carry out its analysis, the CC first identified the relevant markets:

- as regards market definition, the CC concluded that each specialty constitutes a separate product market. Within each specialty, in-patient treatment (including day care) and out-patient treatment are considered to be separate markets. Finally, private healthcare services are separate markets from NHS services
- the geographical scope of each relevant product market is local in nature, with the geographic market definition turning upon a drive-time catchment area analysis

Within each relevant market, the CC found that RBCH and PH are each other’s closest geographical competitor, and the parties overlap in the provision of 76 specialties. The CC concluded that the proposed merger may be expected to result in a substantial lessening of competition (‘SLC’) in the supply of 55 services, together accounting for approximately 20 to 30% of the total clinical income of both RBCH and PH.

The CC examined whether there were any relevant patient and commissioner benefits resulting from the merger, in the form of lower prices, higher quality, greater choice or greater innovation, and whether such benefits would accrue within a reasonable time and would be unlikely to accrue without the merger. Even though the parties made a number of submissions as regards customer benefits, the CC concluded that the merger would not give rise to any customer benefits and that the only effective remedy to the SLC identified would be to prohibit the merger.

See further practice notes: Efficiencies and customer benefits in merger control and Efficiency claims fail to revive hospital merger.

For more detail on the CC’s investigation, see practice note: Royal Bournemouth and Christchurch Hospitals/Poole Hospital.

Industry background and competition in health services

The CC noted that patient choice is an important aim of health policy, and the fact that hospitals stand to gain or lose revenues from patients exercising choice has an important role in incentivising hospitals to maintain and increase quality.

The CC also noted that while FTs are required to provide certain NHS services, they have a degree of operational autonomy which gives them an incentive to maximize their income by taking steps to attract patients for profitable specialties, for example by maintaining and improving service quality.

There are two models for competition in the provision of NHS healthcare services:

- ‘competition in the market’: this is competition between hospitals for patients where patients exercise choice between healthcare providers. Competition in the market occurs mainly in respect of routine elective (planned) services as well as maternity services. Patient choice and payment by results (‘PbR’) regimes incentivise service providers to compete for patients. The PbR regime sets tariffs for procedures and providers are paid according to the number of procedures which they carry out. As a result competition is almost always on quality rather than on price. Hospitals are motivated to compete on quality in order to attract patient referrals and hence income
- ‘competition for the market’: this occurs where the commissioning entity uses a competitive process to choose between different providers in order to provide healthcare services to patients

Accordingly, FTs compete to provide healthcare services to commissioners, GPs and patients. Although the remuneration system set out under the PbR regime incentivises providers of acute elective services to win additional patients, tariffs do not always accurately reflect costs of provision and this may affect these incentives. As a result, the CC examined the way in which incentives work in the wider Dorset area in its competitive effects assessment.
Relevant market

The CC defined the relevant product markets as follows:

- each specialty was found to constitute a separate product market (on the basis that there is typically only one treatment for a specific healthcare problem so that there is no demand-side substitution). Each specialty can be further divided into sub-specialties
- within each specialty, inpatient treatment (including day cases) and outpatient treatment were considered to be separate markets. There is an asymmetric constraint between inpatient and outpatient treatment, as inpatient providers can provide outpatient services but not vice versa
- outpatient (and, to a lesser extent, inpatient) services should not be further separated according to whether or not the services can be provided in community settings. However, certain services are provided only in the community and should be viewed as separate markets
- non-elective and elective activities are separate markets, although the provision of elective activities may be constrained to some extent by non-elective providers; and
- private healthcare services were separate markets from NHS services, with each market again split by specialty

In terms of the geographical scope of each relevant product market, the CC concluded that it was local in nature, with the geographic market definition turning upon a catchment area analysis. This was broadly defined as being the drive-time within which each hospital attracted the majority of its patients.

The evidence suggested that the merging parties attracted most of their patients from within a drive-time (or ‘isochrone’) of 17 minutes for RBCH and of 22 minutes for PH. The CC used this catchment area as the starting point for the competitive assessment. However, the CC also considered the constraints posed on the parties by rivals located further away.

Counterfactual

The CC considered the situation that would have prevailed in the Dorset area absent the merger (the counterfactual). Even though the parties submitted that the appropriate counterfactual was one in which PH exited the market, the CC concluded that (in the absence of the merger) neither party would have exited the market.

Competition assessment

RBCH and PH are each other’s closest geographical competitor. The CC found that the parties overlap in the provision of:

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

The CC also took into account constraints at sub-specialty level.

Elective services

The NHS policy framework (including the PbR framework, the introduction of FTs with their ability to retain surplus and the changes to the regime for competition enforcement) is designed to incentivise FTs to compete for patients in order to earn income. Given that there is a fixed income for each treatment under the PbR regime, the CC concluded that competition in elective services is largely based on quality. Patients and GPs assess quality in a number of different ways, while GPs, due to their experience, act as advisers to patients when they are choosing a hospital. Patients have a right of provider choice for their first consultant-led outpatient appointment for routine elective services, and survey evidence indicated that a significant proportion of patients exercise choice and, if quality were to decline, would consider switching. Proximity is a key parameter of choice for patients. The greater the number and quality of alternative hospitals in the local area, the stronger the FTs’ incentives are in delivering those aspects of quality that are important to patients and their GPs.

On the basis of analysis of catchment areas, patient survey results and GP referral patterns, the CC concluded that the parties are each other’s closest alternatives for patients and GPs in the local area, and that they are likely to face limited constraints from other providers for a large proportion of their services. The CC also found that the parties competed with each other prior to the decision to merge, in so far as they engaged in marketing and strategic behaviour. The CC concluded that the merger would be likely to give rise to unilateral effects in markets for 19 overlapping elective inpatient specialties and 33 overlapping outpatient specialties that relate to elective inpatient activity.
The loss of actual competition between the parties would result in:

- a reduction (or lack of improvement) in quality in the overlap specialties in which competition would be removed; and
- reduction in quality at the hospital level

**Non-elective services**

The CC found that there are areas of substantial overlap between the parties in the provision of non-elective services. However, many patients do not have a choice of hospitals for non-elective services (for example, because they are transported by emergency services according to ambulance protocols). Accordingly, given the nature of emergency treatment, the link between quality and choice is less clear than in the case of elective services. Moreover, the parties, especially RBCH, were not strongly incentivised to attract additional patients. For these reasons, the CC concluded that the proposed merger was unlikely to result in a substantial lessening of competition in relation to non-elective services.

The CC considered maternity services separately because, even though they are non-elective services, they are not emergency services, and they have many aspects that make them similar to elective services. The CC found that RBCH attracts a significantly smaller number of mothers compared with PH, but nevertheless it appeared to be the only provider other than PH with a substantial number of births in the parties’ catchment areas and was likely to be the strongest constraint on PH. In addition, PH has incentives to try to attract more expectant mothers. Accordingly, the CC concluded that the merger could be expected to lead to unilateral effects in maternity services (both inpatient and outpatient services).

**Community services**

With the exception of certain maternity services and a general dermatology outpatient service, there is no overlap between the parties’ activities in the supply of community services. Moreover, the relative ease of entry in this market would be likely to offset any unilateral effects.

**Competition ‘for the market’ in elective, non-elective, community and specialised services**

The CC identified two concerns in a merger where competition is ‘for the market’:

Based on the information provided by the relevant commissioners, the CC did not find that the merger would be likely to give rise to a substantial lessening of competition in relation to competition for the market for elective, non-elective, community or specialised services.

**Private services**

Even though the parties overlap in the provision of a number of private services, they are likely to be constrained by competing providers for most of these. However, the CC concluded that there are no major alternative competing providers of inpatient private cardiology services and the merger would be likely to give rise to unilateral effects in relation to this.

**No countervailing factors**

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

- in the event of a competitive tender, the merger could lead to worse outcomes because there would be fewer bidders; and
- suppliers on existing contracts might provide lower-quality services

**Conclusion on competition assessment**

The CC concluded that the proposed merger may be expected to result in a substantial lessening of competition in the supply of 19 elective inpatient services, 34 outpatient services, non-elective inpatient maternity services, and cardiology private services. These specialties together accounted for approximately 20 to 30% of the total clinical income of both RCBH and PH.
Patient surveys and an analysis of GP referral patterns confirmed that the two hospitals represented each other’s principal alternative provider across a wide range of services. This is unsurprising given that the two FTs are next to each other and both are, broadly, full range large NHS hospitals.

The CC found that the two FTs had incentives to actually compete against each other and that these would fall away with the merger.

**Patient benefits**

The CC examined whether there were any relevant patient and commissioner benefits resulting from the merger, in the form of lower prices, higher quality, greater choice or greater innovation, and whether such benefits would accrue within a reasonable time and would be unlikely to accrue without the merger.

The parties submitted that the merger would result in relevant customer benefits in the following clinical areas:

- **maternity:** the main benefit claimed by the parties was that the merger would enable them to build a new maternity unit. Although the CC accepted this would benefit patients, it did not consider that such benefit would accrue within a reasonable time. Moreover, there were no clear plans for the new unit, no concrete location for the new unit had been identified, only limited detail of the revenue effects had been demonstrated by the parties owing to a nascent business plan, and many planning issues had not been resolved.

- **cardiology:** the parties argued that they could combine cardiology rotas which would mean that patients at PH will have access to a cardiologist 24/7, which they did not currently have. The CC found that although a single rota could benefit patients, this could accrue without the merger and had, in part, already occurred.

- **haematology:** although the parties argued that the merger would provide them with the opportunity to consolidate certain haematology services at PH, the commissioner of these services told the CC that there were no plans to reconfigure the services (because the merger parties both met the relevant standards for level 3 haematology services). Accordingly, the CC did not have sufficient confidence that the reconfiguration would take place.

- **A&E and emergency surgery:** the parties argued that services could be reconfigured to provide better A&E and emergency services. The CC noted that whilst such a reconfiguration could have benefits, it could also create adverse effects which had not been analysed in detail by the merger parties. Without such an assessment, the CC could not conclude that the A&E reconfiguration proposed by the parties was an RCB.

The CC also noted that due to insufficient evidence provided by the merging parties in this regard, financial savings, merger avoided costs, merger-enabled investments, a balanced portfolio of services, and cost savings to commissioners would not be likely to result in relevant customer benefits.

**Consideration of appropriate remedies**

**Proposed behavioural remedy**

As a means of monitoring the quality of the merged trust, the parties proposed a behavioural remedy based on the friends and family test ("FFT"). Under the FFT, patients would be asked, based on their experience, how likely they would be to recommend the relevant ward/day case unit/clinic/service to friends and family if they needed similar care or treatment.

If, on the basis of the FFT, the quality decreased post-merger, the merging parties proposed to offer a number of behavioural remedies in order to address this. This was the only remedy proposed by the parties.

The CC rejected the proposed remedy, noting that, even if fully effective, it would only remedy the adverse effects of the SLC, rather than addressing the SLC at source by restoring competition; the remedy is reactive and poses the danger that by the time the fall in quality is addressed, harm has already occurred; and competition drives continuous improvements in quality in ways that minimum quality standards like the FFT standards do not.

**Structural remedies**

SLC was found in 55 different clinical areas. Since all of these areas would need to be addressed by a remedy, the CC considered it impractical to impose divestiture because the services affected by the SLC would not be easily divisible from the rest of the merging parties’ operations.

The CC found that prohibition would be a comprehensive, timely and durable solution to the SLC. Prohibition is practical to implement, monitor and enforce and has a low risk profile. In reaching this conclusion, the CC noted that it did not receive
any responses from the parties that suggested that prohibition would not be effective or any proposals from the parties that other structural remedies could be an effective solution to identified SLC.

**Outcome**

In the absence of any relevant customer benefits to take into account, the CC concluded that the only effective remedy to the substantial lessening of competition identified would be to prohibit the merger. Although the parties proposed a behavioural remedy based on monitoring the quality of the merged entity’s services, the CC did not consider that this would be effective. Accordingly, the CC decided to prohibit the proposed merger.

**Failing firm defence**

In RBCH/PH, the parties submitted that in the absence of the merger, PH would have exited the market, and that the competition assessment should be carried out with this counterfactual in mind. The CC rejected this argument.

In its guidance note on NHS mergers, the OFT states that in its assessment of NHS mergers, the NHS providers may wish to submit that an alternative counterfactual should be used to assess the impact of the merger. This may include circumstances where one of the merging NHS providers is failing to meet its duty to provide high quality and safe services to patients within the funding that is available as set out under the NHS constitution, and as such may be under pressure to reconfigure or close certain or all the services it provided. The OFT states that in those circumstances, it will consider the evidence available in assessing such submissions and will review (amongst other evidence) internal documents that discuss the options available to the organisation that claims it would have failed or exited absent the merger.

References: OFT guidance-role in reviewing NHS mergers, paras 42-43

In the joint statement published by the OFT, CC and Monitor on 17 October 2013, the regulators noted that some NHS hospitals face clinical and financial difficulties and may seek to merge to address these. The merger review process is designed to take into account the particular circumstances of failing organizations. Where hospitals are demonstrably failing, the authorities may conclude that the proposed merger has no impact on patients because the merger is no worse in terms of choice and competition than if the hospitals did not merge. Where hospitals are in clinical or financial difficulty, Monitor and the Trust Development Authority (where this involves an NHS Trust) will be closely involved with the hospitals concerned and the OFT will place significant weight on Monitor’s advice in these circumstances.

References: OFT, CC and Monitor joint statement

See further practice note: Considering the scope of the failing firm defence.

**After Bournemouth/Poole**

The OFT has since reviewed a number of NHS mergers. For example in its decision in UCLH/Royal Free London on 21 February 2013, the OFT decided not to refer to the CC the acquisition by University College London Hospitals NHS Foundation Trust ("UCLH") of Royal Free London NHS Foundation Trust’s ("RFH") neurosurgery services.

References: OFT report-UCLH/RFL merger

Although the parties’ combined share of supply of NHS neurosurgery services in London post-transaction would have been high and they are close competitors, the OFT found that there would be sufficient competitive constraints, in terms of alternative providers, to mitigate any competition concerns. Accordingly, the OFT concluded that there would be no realistic prospect of an SLC in the provision of neurosurgery services in North London.

Given the OFT’s conclusion on SLC, it did not need to take into account the (non-binding) advice from Monitor with respect to patient benefits. Accordingly, the OFT decided not to refer the acquisition to the CC and cleared the merger.

**When are mergers likely to raise competition concerns?**

The present regulatory framework applies competition analysis (predicated upon ‘market dynamics’) to NHS hospital mergers (predicated upon patient care) and, as a result, mergers between neighbouring NHS hospitals are more likely to raise competition concerns. Such mergers will need to be approached with care and would require a clear story of patient benefits. Although not necessary, the prospects of success will be much stronger where patients will continue to have access to at least one alternative competing facility offering, within a realistic drive-time, any overlapping clinical specialities in relation to which competition concerns might arise.
How can merging parties prove the existence of customer benefits?

Where the merging parties argue that a proposed merger will give rise to customer benefits, the CC would expect the merging parties to:

- provide an assessment of the clinical benefits (and any disbenefits) that the proposed merger will give rise to, as well as a robust assessment of the financial or economic viability of the merging parties’ plans
- determine what the preferred proposal is and provide evidence for the need for change
- establish the groups necessary to evaluate the relevant benefits, including, for example, the relevant clinical advisory group, programme board, commissioner review group and any other commissioner decision making bodies, and
- develop a model of care in consultation with the relevant groups set out above as appropriate.

As described above, in RBCH/PH, the CC examined whether there were any relevant patient and commissioner benefits resulting from the merger in a number of clinical areas, in the form of lower prices, higher quality, greater choice or greater innovation, and whether such benefits would accrue within a reasonable time and would be unlikely to accrue without the merger. Even though the parties submitted that the merger would result in customer benefits in a number of clinical areas, the CC noted that they had provided insufficient evidence to support their submissions and, as a result, reached the conclusion that the proposed merger would not be likely to result in relevant customer benefits.

Merging parties should also keep any relevant third parties (eg commissioners) informed about the facts of the proposed merger, since the CC would seek comments from them on the potential benefits and disbenefits of the proposed merger. In RBCH/PH, the CC noted that although the commissioners largely supported the merger, they had not been provided with details of the patient benefits of the proposed service reconfigurations, and, accordingly, could not provide evidence on whether the proposals put forward by the parties would give rise to such benefits.

Practical impact of the CC’s decision in RBCH/PH and future trends

The CC’s decision does not rule out further mergers involving NHS hospitals or FTs. However, the CC’s decision shows that the OFT and the CC (as well as their successor, the Competition Markets Authority), will not shy away from prohibiting NHS mergers if the case for the merger is not sufficiently made. Going forward, trusts should seek to ensure that, where possible, a strong case in respect of patient benefits is identified at the outset, and they engage with Monitor at the earliest possible opportunity in order to obtain guidance.

As described above, on the same date as the CC’s prohibition decision in RBCH/PH, the OFT, CC and Monitor published a joint statement on “ensuring that patients’ interests are at the heart of assessing public hospital mergers”, encouraging NHS hospitals considering a merger to engage with Monitor and, where appropriate, the OFT at the earliest opportunity in order to obtain guidance on the process of merger control and on the evidence that will be required in order to carry out a merger investigation. In this regard, Monitor may offer informal advice to NHS hospitals on how they might assess any prospective patient benefits and any possible competition implications arising out of a proposed merger. Monitor will also be active in scrutinising and challenging the strategies of FTs, including emerging merger proposals, and this will assist parties to identify at an early stage whether a proposed merger is likely to give rise to patient benefits.

References: OFT, CC and Monitor joint statement; OFT guidance—role in reviewing NHS mergers, para 30; Monitor’s Briefing note on the application of merger control rules to pathology service reconfigurations, para 16
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