

CMA guidance on the review of NHS mergers

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1. Preface

- 1.1 This guidance provides an overview of the approach of the Competition and Markets Authority (CMA) when reviewing mergers involving a National Health Service (NHS) foundation trust and mergers between NHS trusts and other enterprises in England (NHS mergers).
- 1.2 The CMA recognises that there are many drivers for NHS mergers and these include financial savings, sharing of best practices, better delivery of integrated care and service reconfiguration to generate better outcomes for patients or value for money for the taxpayer. The CMA acknowledges that mergers in the NHS may bring benefits and address some of the significant financial challenges that NHS providers face as well as assist with their continual strive to improve clinical quality, service and safety.
- 1.3 The CMA's role in reviewing NHS mergers has arisen due to the gradual introduction of choice and competition in the NHS. The NHS has evolved from centrally organised to a system where providers and commissioners have increased autonomy to drive delivery of high-quality services to patients. The initiatives leading to this started with the purchaser/provider split in 1991 and further initiatives introduced in the 2000s to facilitate more effective competition and increased quality, including: payment-by-results, the establishment of foundation trusts, the provision of some NHS services by independent sector treatment centres and the introduction of patient choice. These developments have facilitated choice for patients and commissioners. They have also led to a greater focus by providers of healthcare services to improve services to attract patients.
- 1.4 Therefore, whilst collaboration and integrated care remain important to delivering effective healthcare services to patients, these developments mean that competition also plays an important role in incentivising providers to improve quality for patients and efficiency.
- 1.5 Many mergers will not affect an NHS provider's incentives to improve services for patients. However, some may impact improving clinical quality and safety and therefore adversely affect patient interests by reducing incentives for the providers to maintain and improve services for patients thereby leading to reduced quality or choice for patients or commissioners. Specifically, the aspects of quality which may be impacted by a reduction in incentives to compete include clinical factors such as infection rates, mortality rates, ratio of nurses or doctors to patients, equipment, best practice and non-clinical factors such as waiting times, patient experience, cleanliness and parking facilities.

- 1.6 The CMA recognises the benefits that the exercise of patient choice and competition can deliver, one of a number of incentives on providers to continually improve care, but also the benefits a merger can bring, such that it may nevertheless be the best way of delivering certain benefits to patients in a timely manner.
- 1.7 In this context, the merger review process is designed to examine the potential (i) adverse effects for patients and/or commissioners arising from a loss of competition and (ii) benefits of a merger for patients and commissioners. The CMA is seeking to ensure that the merger is in the overall interest of patients. To assess the merger, it gathers and considers evidence from various sources including the merging providers, the Department of Health, Monitor (the sector regulator for health services in England), NHS England, the Care Quality Commission, commissioners, local patient representatives, third party providers and others. In its assessment, the CMA takes into account the structure and the regulatory regime that providers are subject to.
- 1.8 UK merger control applies to any transactions leading to a change of control over the activities (or a part of the activities) of one or more providers. In the NHS context, the term 'merger' includes, among other types of transactions, those as set out in section 56 of the NHS Act 2006 as amended, 'acquisitions' regardless of whether any financial consideration is payable; joint ventures; the transfer of individual services or activities to another provider; and asset swaps.
- 1.9 Many NHS mergers will not raise competition concerns and therefore may not require review by the CMA. As explained in this guidance, the CMA and Monitor are willing to aid and advise the providers contemplating a merger. However, it is up to providers to decide whether or not to notify. This guidance explains how the CMA will approach its assessment of NHS mergers both procedurally and substantively in order to assist merging providers seeking to analyse whether their NHS merger may raise competition concerns.

2. Scope of the guidance

- 2.1 This guidance is concerned with those mergers involving at least one foundation trust or NHS trust (or a part of it, if related to specific services) of NHS services in England, such as NHS hospitals (acute, community and mental health), ambulance trusts or other trusts (collectively referred to throughout as providers) or part of their organisation, which are covered by the provisions of the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013 (ERRA13) (the Act).¹ Mergers between NHS trusts only are not covered by the Act. However, mergers involving NHS trusts and other organisations will be covered by the Act. Chapter 5 provides more detail on the types of transactions that are covered by the Act. This guidance does not concern transactions between clinical commissioning groups (CCGs), general practitioners (GPs), dentists and pharmacies, between other providers of healthcare services to the NHS or commercial suppliers in the healthcare sector, for example suppliers of pharmaceuticals or medical equipment.
- 2.2 This guidance forms part of the advice and information published by the CMA under section 106 of the Act. This guidance should be read alongside the other detailed guidance that the CMA has published or adopted in relation to merger review and the CMA's procedures (see Chapter 9 on further information). Readers may also find it helpful to read Monitor's guidance on relevant customer benefits.²
- 2.3 This guidance reflects the views of the CMA at the time of publication and may be revised from time to time to reflect changes in best practice, legislation and the results of experience, legal judgments and research. It may in due course be supplemented, revised or replaced. The CMA's webpages will always display the latest version of the guidance. Where there is any difference in emphasis or detail between this guidance and other guidance produced or adopted by the CMA, the most recently published guidance takes precedence. While the CMA is not bound to follow the approach taken by the Office of Fair Trading (OFT) or Competition Commission (CC) in merger investigations under the Act prior to the coming into force of the ERRA13, this guidance cites previous relevant OFT and CC decisions to illustrate how it will apply the provisions of the Act. Similarly, whilst not bound by their advice, the

¹ The guidance does not apply to Scotland, Wales and Northern Ireland. The healthcare sector is somewhat different in Scotland, Wales and Northern Ireland. For example, they do not have foundation trusts and Monitor does not have a role. However, if there were to be a merger of a public provider within those countries that fell within the CMA's jurisdiction (the same provisions of the Act apply throughout the UK), merging providers in those jurisdictions may find this guidance helpful.

² see www.monitor.gov.uk/ for Monitor Guidance on Merger Benefits.

CMA has referred to advice by the Cooperation and Competition Panel, in relation to relevant customer benefits in particular, where it has felt this would be useful despite the different legal test they applied.³

- 2.4 This guidance is not intended to be comprehensive. It cannot, therefore, be seen as a substitute for the Act or the Health and Social Care Act 2012 (HSCA), the ERRA13 and the regulations and orders made under these statutes, nor can it be cited as a definitive interpretation of the law. Anyone in any doubt about whether they may be affected by the legislation should consider seeking legal advice.
- 2.5 Furthermore, although the CMA will have regard to this guidance in handling NHS mergers under the Act, the CMA will apply this guidance flexibly and may depart from the approach described in the guidance where there is an appropriate and reasonable justification for doing so.
- 2.6 In addition, the merger control regime in England provides that, in cases referred for an in-depth 'Phase 2' investigation, the final decision-making authority is an independent group of experts selected from a panel appointed by the Secretary of State (the Inquiry Group). Where this guidance is expressed to apply to the CMA's policy when making decisions whether to refer a merger for an in-depth Phase 2 investigation, this does not bind the independent Phase 2 Inquiry Group when undertaking its assessment.

³ The Cooperation and Competition Panel previously considered mergers against the Principles and Rules for Cooperation and Competition and provided advice to the Department of Health and Monitor.

3. NHS merger review in England

Introduction

- 3.1 Merger review in England is primarily the responsibility of the CMA, which is an independent non-ministerial government department.
- 3.2 The merger control regime applies to all sectors of the economy. While the competition test is the same for nearly all mergers reviewed by the CMA, the CMA's assessment takes into account all of the particular characteristics and specificities of the sector. In relation to NHS mergers, for example:
- NHS providers may compete on quality in addition to or instead of price (as discussed in detail in Chapter 6 below)
 - Monitor has a statutory role as part of the merger regime to provide advice to the CMA on the relevant customer benefits of the merger
 - the CMA will consider how any regulation that providers are subject to may affect the competitive assessment of the merger

Role of the CMA

- 3.3 The CMA is the UK's competition authority responsible for ensuring that competition and markets work well for consumers.⁴ In the healthcare context, this means that the CMA is working for the benefit of patients and taxpayers.
- 3.4 The CMA has a function to obtain and review information relating to merger situations.
- 3.5 The UK has a two-phase merger control regime. The Act imposes a duty on the CMA to refer completed and anticipated mergers for an in-depth 'Phase 2' investigation if it believes that it is or may be the case that:
- a relevant merger situation has been created or arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation
 - the creation of that situation has resulted, or may be expected to result, in a substantial lessening of competition (SLC)⁵

⁴ In some markets, for example pathology, other customers who may suffer adverse effects from a loss of competition could also include hospitals. However, patients and commissioners are used as proxy for all customers throughout this guidance.

⁵ Sections 22(1) and 33(1) of the Act.

- 3.6 This is subject to the exceptions to the duty to refer, where the CMA may exercise its discretion as to whether to refer to a Phase 2 inquiry, and undertakings that the CMA may accept in lieu of reference (see Chapters 7 and 8).
- 3.7 If a reference to Phase 2 is made, the CMA conducts a more detailed analysis and the Inquiry Group must decide:
- whether a relevant merger situation has been or will be created
 - if so, whether the creation of that situation has resulted, or may be expected to result, in an SLC with worse outcomes for patients and/or commissioners within any market or markets in the UK for goods or services (where both limbs are satisfied, this is referred to as an ‘anti-competitive outcome’)⁶
- 3.8 If the Inquiry Group finds that there is an anticompetitive outcome it must decide:
- whether action should be taken by it, or by others, to remedy, mitigate or prevent the SLC concerned or any adverse effect that has resulted from, or may be expected to result from, that SLC
 - if action is to be taken, what action should be taken and what is to be remedied, mitigated or prevented

Role of Monitor

- 3.9 Monitor is the sector regulator for health services in England. Monitor’s job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, Monitor makes sure that: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anticompetitive behaviour by providers and commissioners.

Monitor arrangements to support NHS foundation trusts

- 3.10 Monitor’s role includes assessing NHS providers’ compliance with the provider licence. As part of this role, Monitor will review certain transactions

⁶ Sections 35 & 36 of the Act.

(such as mergers) to ensure that foundation trusts comply with the governance and continuity of service conditions of their provider licence. This is separate from the CMA merger control review process; Monitor does not have the power to prohibit mergers to which the Act applies on the basis that they are expected to give rise to an SLC.

- 3.11 NHS foundation trusts engage with Monitor in most transactions in connection with Monitor's other regulatory obligations. In addition to conducting a risk assessment of mergers, Monitor, as sector regulator, will also be active in engaging with those NHS foundation trusts considering a merger, for example by reviewing the strategic rationale for the transaction to help the NHS foundation trust ensure it is robust. Such discussions may assist merging providers to identify at an early stage if the merger raises competition issues and so help the merging providers when considering whether to notify the merger to the CMA. They might also assist merging providers to identify at an early stage whether a merger will lead to benefits for patients. The CMA expects this to benefit providers as they will take into account any competition issues at the outset of their proposals. Further information on how NHS foundation trusts can engage with Monitor is set out in Monitor's Transactions Guide.
- 3.12 Ultimately, the CMA is responsible for deciding whether an NHS merger falls within its jurisdiction.⁷ The CMA is also responsible for deciding whether an NHS merger may lessen competition leading to worse outcomes for patients/commissioners and Monitor's role is an advisory one to the merging providers. Therefore, if in doubt as to whether the NHS merger may fall within CMA jurisdiction or raise competition concerns, merging providers may wish to approach the CMA directly for informal advice.⁸ Where they have decided to notify the CMA, it is particularly helpful to the merging providers to engage with the CMA early in pre-notification discussions to help identify the information that should be included in the Merger Notice (see Chapter 4).

The role of Monitor within the CMA merger review process

- 3.13 The CMA must notify Monitor as soon as reasonably practicable where it decides to carry out an investigation of a merger involving an NHS foundation trust. The CMA will do so as soon as possible after it has sent notice to the relevant merging provider(s):

⁷ See Chapter 5 below.

⁸ See paragraph 4.4ff.

- either informing them that it is satisfied that the Merger Notice is satisfactory or
- informing them that it has sufficient information for it to begin an investigation

3.14 Once notified, Monitor is under a duty to provide advice to the CMA on:⁹

- benefits¹⁰ arising from the merger (for people who use healthcare services provided for the purposes of the NHS)
- such other matters relating to the matter under investigation, as Monitor considers appropriate

3.15 Monitor's advice is not binding on the CMA. However, the CMA will place significant weight, given Monitor's role and expertise as sectoral regulator, on its views and opinion on relevant customer benefits of a merger. A flow chart setting out the various steps and interrelationship between the CMA merger control review and Monitor processes is set out in Annex A.

Role of the NHS Trust Development Authority

3.16 The NHS Trust Development Authority (TDA) is responsible for providing leadership and support to the non-foundation-trust sector of NHS providers. The TDA will oversee the performance management of these NHS trusts, ensuring they provide high-quality sustainable services, and will provide guidance and support on their journey to achieving foundation trust status.

3.17 The TDA has a role in agreeing mergers involving NHS trusts and will act as the seller in mergers involving NHS trusts. The CMA will therefore engage with and seek views from the TDA where relevant.

⁹ Section 79 of the HSCA.

¹⁰ See section 30(1)(a) of the EA02.

4. Procedure and contacting the CMA

The voluntary regime

- 4.1 Under the Act there is no requirement to notify¹¹ mergers to the CMA, regardless of whether or not the CMA would have jurisdiction to review the merger. In the UK, merging providers decide whether or not to notify the CMA. The merger control regime is therefore described as ‘voluntary’.¹²
- 4.2 The CMA has a responsibility to keep merger activity under review and may investigate, on its own initiative, mergers that have not been notified.¹³ The CMA has four months from the merger being made public or it being completed (whichever is the later) to decide whether or not to make a Phase 2 reference.
- 4.3 Merging providers should determine for themselves whether to notify the CMA. If providers are unsure as to whether the CMA has jurisdiction to review their NHS merger or as to whether it may raise competition concerns, providers can contact the CMA for informal advice (see paragraphs 4.4 to 4.10 below). Providers are encouraged to notify the CMA about their merger before completing where the merger could give rise to possible competition concerns.¹⁴

Approach to engaging with the CMA

Informal engagement and advice

- 4.4 In planning mergers, it is for merging providers to assess whether transactions might give rise to competition concerns and whether to notify the NHS merger to the CMA. As noted in paragraph 3.11, the CMA expects that merging providers which fall within Monitor’s regulatory regime may find it helpful to discuss their plans with Monitor and their independent advisers. Such engagement with Monitor should generally take place before either

¹¹ Notification means submitting a Merger Notice to the CMA.

¹² The merging providers may, however, be asked to provide sufficient information for the CMA to be able to review the merger if the CMA chooses to investigate on its own initiative.

¹³ The CMA obtains information about anticipated and completed mergers from a range of sources, including through dedicated Mergers Intelligence staff responsible for monitoring non-notified merger activity, from Monitor and third parties. Where the CMA learns of a merger that it thinks might have adverse effects on patients or commissioners due to a loss of competition, the CMA may open an investigation on its own initiative. The CMA may contact the merging providers in order to establish whether the thresholds which trigger its jurisdiction are met and to obtain information about the merger.

¹⁴ Completing a merger without notifying the CMA can result in additional costs for merging providers: (i) the CMA has powers to impose restrictions (known as interim measures) on merging providers to prevent them taking actions (for example, merging of functions or consolidation of decision making) that might pre-empt the CMA’s exercise of its merger review powers and (ii) costs can arise from having to undo the merger if the merger is prohibited.

advice is sought from the CMA or a notification is made to the CMA. However, merging providers are ultimately free to contact the CMA or to notify a transaction to the CMA at a time of their own choosing. The section below explains how providers may choose to engage with the CMA in addition and the advice the CMA can offer.

CMA's advice on the merger review process

- 4.5 The CMA is willing to assist NHS providers before they have decided whether or not to notify their merger.
- 4.6 Merging providers may wish to contact the CMA either for general advice on how it assesses jurisdiction or undertakes its competitive assessment.

CMA's advice on specific proposed transactions

- 4.7 The CMA also offers Informal Advice on specific proposed transactions in line with its *Mergers: Guidance on the CMA's approach to jurisdiction and procedure (CMA2)*.
- 4.8 The content of the Informal Advice will differ depending on the case and information received. However, the CMA will not be in a position to provide a definitive view on whether or not a merger raises competition concerns, given that it will not have undertaken any market testing, for example. Therefore the CMA will generally explain how it conducts its assessment, what considerations may be relevant and what type of evidence it would be looking for.
- 4.9 Where merging providers have obtained Informal Advice on a particular transaction (rather than obtained generic advice), they will be requested to inform the CMA Mergers Unit if and when the proposed transaction goes ahead (where key steps are taken for the proposed transaction to go ahead). Informing the case officer is different from submitting a Merger Notice and does not mean that the CMA will necessarily investigate the transaction. Nevertheless, where the CMA considers that it is a case it would want to review, it may encourage the merging providers to engage in pre-notification discussions.
- 4.10 Any advice (including Informal Advice) provided is not a decision of the CMA and cannot bind the CMA. Therefore, both the content of the advice and the fact that a merging provider has contacted the CMA is strictly confidential to the provider(s) seeking that advice and their advisers, even after the transaction becomes public. The CMA would be concerned by any intentional or accidental breach of confidence in this respect – either by the providers concerned or by their advisers – and might take the view that it could not offer

those responsible any such advice in the future. This restriction applies even where only one provider to a transaction seeks advice, as the advice should not be revealed by the recipient to the other provider. The CMA will, however, normally be willing on request to inform orally the other provider of the terms of the advice given. In all cases, the guidance given by the CMA is confidential and is only for the board members, senior executive officers and the general counsel of the provider making the request and any advisers that are privy to the request.¹⁵

Pre-notification

- 4.11 As soon as merging providers have decided to notify the CMA (following initial discussions with Monitor and/or based on their and their adviser(s)' assessment) and before submitting a Merger Notice, providers are strongly encouraged to approach the CMA to discuss their merger (and any drafts of the providers' Merger Notice).
- 4.12 At the pre-notification stage the CMA is able to discuss mergers on a confidential basis, which means the CMA will not disclose that it is in pre-notification without the providers' consent. Pre-notification of an NHS merger may happen before or after the merger proposal has been announced. The benefits of pre-notification, especially in the context of NHS mergers, are as follows:
- (a) help to reduce the amount of information that is provided to the CMA by clarifying what information the CMA needs. The CMA can assist the merging providers to understand how to complete the Merger Notice and what specific evidence will assist it to assess the merging providers' claims
 - (b) allow more time for the CMA to develop its understanding of the relevant local health economy (such as services provided by the merging providers and their competitors in the area) and consider in more depth submissions from the merging providers
 - (c) allow merging providers to engage in early discussions with the CMA on areas that may raise competition concerns (such as particular services where the merging providers are particularly close competitors)
 - (d) where the merging providers consent, allow the CMA to contact certain third parties, such as commissioners, for their views. This may allow

¹⁵ In case of doubt, providers should confirm with the CMA the identity of the persons with whom they are permitted to share the advice received.

merging providers to address some issues raised by others upfront in the Merger Notice

- (e) facilitate early engagement with the CMA and Monitor on any relevant customer benefits of the merger from an early stage
- (f) lessen pressures on the statutory timelines and reduce information requests during the CMA's assessment process

Notification

- 4.13 Where merging providers decide to notify formally an NHS merger to the CMA, they must do so by completing a Merger Notice. A template Merger Notice, available at www.gov.uk/government/publications/mergers-forms-and-fee-information, sets out the categories of information required by the CMA, together with guidance notes to assist merging providers in identifying the specific nature and extent of information required in their case. The CMA webpage also sets out how to submit the Merger Notice. Merging providers cannot formally submit a Merger Notice until the merger (whether anticipated or completed) has been made public.

Information exchange between the CMA and Monitor

- 4.14 Sharing of information (including data) between the CMA and Monitor is crucial for the effective fulfilment of their respective duties and should reduce the burden on merging providers which could otherwise arise, for example from duplicative information requests. The CMA may, where appropriate, wish to discuss with Monitor mergers that merging providers bring to its attention; informal advice it will be providing or has provided; pre-notification drafts; and information it obtains throughout its investigation.
- 4.15 The information and data sharing from the CMA to Monitor will include any confidential information which the CMA considers will facilitate the effective fulfilment of its merger control statutory functions. If either or both of the merging providers request that the CMA should not share with Monitor some or all of the information or data submitted to it, they should submit a non-confidential version of such submission and state clearly what information should remain confidential to the CMA, together with the reasons for this. However, in certain circumstances, whilst having regard to the confidentiality requests, the CMA may nonetheless decide to disclose information to Monitor without the consent of the merging providers. This may occur, for example, where it considers that disclosure is necessary to enable the CMA to exercise its statutory functions, including the need to have regard to Monitor's advice on relevant customer benefits.

- 4.16 Monitor's advice may contain information that is confidential (either as regards the merging providers or other confidential information known to Monitor). Monitor may share such information with the CMA. To the extent that the merging providers consider that information they provide to Monitor should not be included in the published version of Monitor's advice, they should submit a non-confidential version of such submission to Monitor and state clearly what information should remain confidential to Monitor, together with the reasons for this.
- 4.17 For further information on the treatment of confidential information by the CMA, see *Transparency and disclosure: Statement of the CMA's policy and approach (CMA6)*, which also explains how the CMA will deal with a request under the Freedom of Information Act 2000.

Timescales for the merger review process

- 4.18 A flow chart setting out an overview of the process is set out in Annex B. The CMA has a statutory deadline of 40 working days in which to complete the initial merger review process (Phase 1). That statutory period starts on the first working day after the CMA confirms (a) that it has received a satisfactory Merger Notice, containing the information it requires for its review, or (b) in the case of an investigation started on the CMA's initiative, that it has received sufficient information to enable it to begin its investigation. The CMA may 'stop the clock' where information the CMA has formally requested from the merging parties remains outstanding. The CMA will notify Monitor that it has started its investigation into a merger involving a foundation trust as soon as possible once the statutory period begins.
- 4.19 There is also a statutory deadline, of 24 weeks for Phase 2 investigations. This may be extended by up to eight weeks if the CMA considers there are special reasons why a report cannot be prepared and published within the statutory deadline¹⁶ and the CMA is also able to stop the clock where information requested from the merging providers, using its statutory powers, is outstanding (see below). If it determines in its final report that a merger is expected to result in an SLC, the CMA has a statutory period of 12 weeks (extendable by up to six weeks for special reasons) in which to implement remedies by either making an order or accepting undertakings.

¹⁶ Section 39(3) of the Act.

Information-gathering powers

- 4.20 The CMA's decisions are evidence-based. The information provided with the initial Merger Notice will enable the CMA to commence its investigation and request information and views from third parties. Sometimes the CMA may need additional, or more comprehensive, information from merging providers than is provided in the Merger Notice to allow it to make a decision on whether or not to make a reference or, if at Phase 2, for the purposes of the Phase 2 investigation. The CMA asks for any such additional data, information or documents as soon as it is clear it will be necessary. For the timetables to be met, requests for such information normally identify a short deadline for a full response. However, in all cases the CMA ensures that its requests are tailored to the case at hand and appropriate for its investigation.
- 4.21 The CMA has the power under section 109 of the Act to issue a notice requiring a person to provide information or documents, or to give evidence at a specified time and place (a section 109 notice). While the CMA may issue requests for information informally,¹⁷ it is likely to use the section 109 power where (i) it considers there to be a risk that it will not receive the information sufficiently in advance of its statutory deadline for the information to be analysed and taken into account in its decision(s), (ii) it has doubts that the recipient will comply with an informal request and/or the recipient has previously failed to respond to such an informal request, or (iii) the CMA believes that there is a risk that relevant evidence may be destroyed.¹⁸
- 4.22 If a merging provider fails to comply with a section 109 notice, this permits the CMA to extend the relevant statutory timetable (including, where relevant, the four-month statutory deadline for referring completed mergers – see paragraph 4.2) for as long as the response to the information requested is overdue. If the merging providers have notified the merger to the CMA using a Merger Notice, the CMA may also reject the Merger Notice.
- 4.23 In addition to causing delay to the review timetable, failure to comply without reasonable excuse with a notice under section 109 of the Act can have more serious consequences, including in some circumstances the imposition of a fine.

¹⁷ Where the CMA requests information from third parties, it will typically request that information informally in the first instance.

¹⁸ Such notices may also be issued before the CMA's investigation formally opens, for example the CMA may issue enquiry letters under its formal section 109 powers.

- 4.24 The CMA will also contact other governmental departments, regulators (including Monitor), NHS England, commissioners, industry associations and patient groups for their views on merger cases where appropriate.

Publication

- 4.25 At Phase 1, the CMA will be mindful of the need to respect the confidentiality of commercially sensitive information provided to it (by the merging providers and third parties). At the same time, it is required by section 107 of the Act to publish its decisions and in respect of SLC decisions it will try to ensure that evidence that is key to the reasoning and outcome of its decision is included within the public version of the decision.¹⁹
- 4.26 At Phase 2 the CMA will publish various documents including key submissions of the merging providers and third parties, and key documents (that is issues statement, provisional findings, notice of possible remedies).²⁰ Parties should provide non-confidential versions of all submissions for publication at the same time as their full submissions. If this is not possible, parties should discuss timing of submission of the non-confidential version with the case team. Parties should accompany the non-confidential version with a detailed explanation of why they consider that particular parts of their submissions should not be disclosed, including explaining the nature of the information, the harm that could be caused, and the likelihood and magnitude of that harm.
- 4.27 In the event of a disagreement concerning a proposal by the CMA to publish information, parties may make representations to the CMA's Procedural Officer.

Interim orders

- 4.28 The CMA will normally make interim orders in Phase 1 where it has reasonable grounds for suspecting that two or more enterprises have ceased to be distinct (for example, the transaction is completed). An interim order is intended to prevent any pre-emptive action (for example, implementation of the NHS merger including the merging of functions or consolidation of decision-making of the merging providers) that might prejudice the reference and/or impede the taking of any remedial action by the CMA.²¹

¹⁹ For guidance on the CMA's wider approach to such issues of confidentiality, see [Transparency and disclosure: Statement of the CMA's policy and approach \(CMA6\)](#).

²⁰ For further information about disclosure during Phase 2, see [Chairman's guidance on disclosure of information in merger and market inquiries \(CC7\)](#).

²¹ Section 72 of the Act.

4.29 The risk of pre-emptive action in an anticipated merger is generally lower than in a completed merger. However, in anticipated mergers at Phase 1 the CMA would expect to make an interim order in those cases that it considers raise concerns about pre-emptive action that is difficult or costly to reverse. This could occur, for example, where merging providers are coordinating commercial strategies for the next few years, for example regarding recruitment, bed closures and targeted marketing of service. In anticipated cases, the CMA would normally expect to use tailored interim orders which have greater focus on specific concerns rather than the template interim order.²² In anticipated mergers, interim orders would not typically prohibit collaboration between the merging providers that pre-date discussions on the merger.²³

Merger fees

4.30 A fee is payable for the CMA's review by the provider who gives the Merger Notice or, in the event of a CMA own initiative case, by the acquiring provider, subject to some limited exceptions (including where the merger is found to be outside the CMA's jurisdiction). The amount of the fee and exemptions are set out in the Enterprise Act 2002 (Merger Fees and Determination of turnover) Order 2003 (SI 2003/1370), as amended. The amount of the fees can also be found in [Merger Fee Information](#). There is no specific exemption for NHS providers.

Further information

4.31 Further information is available in [Mergers: Guidance on the CMA's approach to jurisdiction and procedure \(CMA2\)](#).

²² See the CC [Notice of Acceptance of Interim Undertakings](#) pursuant to section 80 of the Act in the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust.

²³ The CMA notes that it is the merging providers' responsibility to consider how the competition law rules apply to information exchanges. For assistance, see Monitor [Guidance on the application of the Competition Act 1998 in the healthcare sector](#).

5. What is a relevant merger situation?

The CMA's jurisdiction

5.1 The CMA has jurisdiction to examine a merger where:

- two or more enterprises cease to be distinct
- and
 - either the UK turnover of the acquired enterprise exceeds £70 million
 - or the enterprises which cease to be distinct supply or acquire goods or services of any description and, after the merger, together supply or acquire at least 25% of all those particular goods or services of that kind supplied in the UK or in a substantial part of it. The NHS merger must also result in an increment to the share of supply or acquisition.²⁴

5.2 UK merger control applies to any transactions leading to a change of control over the activities (or a part of the activities) of one or more providers. In the NHS context, the term 'merger' includes, among other types of transactions, those as set out in section 56 of the NHS Act 2006 as amended,²⁵ 'acquisitions' regardless of whether any financial consideration is payable; joint ventures; the transfer of individual services or activities to another provider;²⁶ and asset swaps. The terms 'acquirer' and/or acquired assets or target are interpreted widely and refer to the acquisition of control in all of these scenarios.

Enterprise

5.3 'Enterprise'²⁷ in the context of UK merger control may refer to an entire organisation or a part of it, whether or not it operates for profit. An 'enterprise' may comprise any number of components, most commonly including the employees working in the service and the assets and records needed to carry on that activity, together with the benefit of existing contracts and/or goodwill. In healthcare, entire organisations such as NHS foundation trusts and NHS

²⁴ Transactions which do not give rise to a relevant merger situation are still subject to general competition provisions contained in the Act and the Competition Act 1998.

²⁵ See the [report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust](#), 17 October 2013, paragraph 3.3.

²⁶ See the OFT's decision in the acquisition by [University College London Hospitals NHS Foundation Trust of Royal Free London NHS Foundation Trust's neurosurgery services](#), ME/5574/12, dated 21 February 2013, and the OFT's decision on anticipated pathology joint venture between [University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and The Doctors Laboratory Limited](#), ME/6094/13, dated 8 November 2013.

²⁷ The term enterprise is defined in section 129 of the Act.

trusts controlling hospitals, ambulance services, mental health services, community services and individual services or specialities may be enterprises for the purpose of UK merger control.

- 5.4 The CMA assesses, on a case by case basis, whether the combination of staff, assets (for example, equipment, patient records), rights and liabilities (for example, NHS contracts) each provider contributes to a transaction is sufficient to form an 'enterprise'. In this assessment, the CMA takes account of the substance of the transaction and the features of the sector. In the case of NHS mergers, it considers what is necessary to operate the relevant service or clinical specialty (considered against the background of the acquiring provider's pre-existing activities). It is not always necessary for the transaction to include the transfer of an NHS contract.²⁸ An enterprise may be acquired even without the transfer of a contract if, for example, the acquiring provider is already able to supply the services without requiring the NHS contract to transfer and acquires staff and assets.
- 5.5 See [Mergers: Guidance on the CMA's approach to jurisdiction and procedure \(CMA2\)](#) for further information on the CMA's approach to enterprise.

Change of control

- 5.6 Two enterprises cease to be distinct if they are brought under common ownership or control.²⁹ There must be a change in the level of control over the activities of one or more enterprises for UK merger control to apply.³⁰
- 5.7 A merger between two NHS trusts is not deemed to create a relevant merger situation because, under the existing legislation, both merging providers are already under the common control of the Secretary of State for Health. Monitor continues to assess mergers between NHS trusts only and will advise the TDA on the competition aspects of such transactions.
- 5.8 The changes in the level of control are assessed on a case-by-case basis taking into account the features of the sector and the substance of the NHS merger. Ownership or control include situations falling short of full control,

²⁸ NHS contracts refer to the supply of goods and services to the NHS.

²⁹ Section 26 of the Act.

³⁰ See OFT decision on the anticipated pathology joint venture between [University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and The Doctors Laboratory Limited](#), ME/6094/13, dated 8 November 2013. For an example of a case in which none of the assets contributed to the joint venture came under common control of any of the other joint venture partners, see the OFT's decision on the anticipated Pathology Joint Venture between [Cambridge University Hospitals NHS Foundation Trust, Colchester Hospital University NHS Foundation Trust, East and North Hertfordshire NHS Trust, Hinchingsbrooke Health Care NHS Trust, The Ipswich Hospital NHS Trust and West Suffolk NHS Foundation Trust](#), ME/6427/14, dated 27 March 2014.

such as where one enterprise has material influence over the policy of the other.³¹

- 5.9 The ability to exercise ‘material influence’ is the lowest level of control that may give rise to a relevant merger situation. In assessing material influence, the CMA focuses on the acquiring provider’s ability materially to influence policy relevant to the behaviour of the target entity in its provision of NHS healthcare services. The policy of the target in this context means the management of the provider, in particular in relation to its competitive conduct, and thus includes the strategic direction of an organisation and its ability to achieve its strategic and commercial objectives. In the case of a full merger or joint ventures, it relates to the ability of each member of the joint venture to gain the ability materially to influence policy relevant to the behaviour of the other providers’ activities in the provision of relevant NHS services.
- 5.10 Other levels of control set out in the Act are ‘de facto control’ and holding a ‘controlling interest’ in the organisation. A ‘controlling interest’ would occur, for example, where an NHS foundation trust acquires all of the rights over all or part of the activities of another NHS provider.
- 5.11 The Act will apply to situations of ‘shared’ control by several providers over another. Only one party can have a controlling interest over an organisation but other entities might have lower levels of control over the same organisation. For example, while an NHS foundation trust may have a controlling interest over the activities of all its services, another provider (such as another NHS foundation trust) may gain material influence over one or more services of the first NHS foundation trust by way of entering into a management contract transferring a material amount of control over the running of those services.
- 5.12 Any increase in the level of control over the target (or in the case of a merger of equals or joint ventures over the other merging providers’ activities) may give rise to a relevant merger situation.
- 5.13 See [Mergers: Guidance on the CMA’s approach to jurisdiction and procedure \(CMA2\)](#) for further information on the CMA’s approach to jurisdiction to change of control.

³¹ Section 26 of the Act.

Turnover test

- 5.14 The relevant turnover is calculated by adding the UK turnover of all the enterprises involved in the transaction and either deducting the UK turnover of those enterprises which remain under the same ownership and control after the merger or, where no enterprises remain under the same ownership after the merger, by deducting the lower of them.³² In practice, in an acquisition where only two merging providers are involved, the target's UK turnover (either in its entirety or of the relevant service being acquired) will be the relevant turnover.
- 5.15 See [Mergers: Guidance on the CMA's approach to jurisdiction and procedure \(CMA2\)](#) for further information on the CMA's approach to jurisdiction on turnover.

Share of supply

- 5.16 The merging providers' share of supply or acquisition must be 25% or more in the UK or a substantial part of the UK for the share of supply test to be met. For the test to be satisfied, the share of supply must lead to an increment. In other words, the merging providers must supply or acquire the same category of services or goods (of any description). The test cannot capture mergers where the merging providers are solely active at different levels of the supply/procurement chain.
- 5.17 The Act expressly provides the CMA with a wide discretion in describing the relevant services or goods, requiring only that, in relation to that description, the merging providers' share of supply or acquisition is 25% or more.³³ The share of supply may differ from the market share, which is determined through an economic analysis of market definition. The share of supply can relate to any reasonable description of services or goods. It can include a wide variety of specialties (such as the provision of outpatient consultations) or a narrow description of a specialty or sub-specialty measured by a reasonable criteria. Also, the CMA has a wide discretion when determining what criteria can be relevant to quantify the estimated share of supply of the merger parties.³⁴ For example, two pathology providers may have a small market share when considering the routine tests they provide within a 1-hour drive. However, they may still meet the share of supply test if they both provide routine pathology

³² See paragraph 4.47ff and Annex B of the [CMA Mergers Guidance](#) on how to calculate the relevant turnover for the jurisdictional test. In the context of NHS mergers, an enterprise may include a service (part of a service) only. See further paragraph 5.19 below.

³³ Section 23 of the Act.

³⁴ See, for example, the OFT's decision of 21 February 2013 on the acquisition by University College London Hospitals NHS Foundation Trust of Royal Free London NHS Foundation Trust's neurosurgery services.

tests and these account for 25% or more of routine pathology services to the nearest CCGs to them (they need not both supply the same CCGs), if these areas are sufficient to form a substantial part of the UK.

- 5.18 See [Mergers: Guidance on the CMA's approach to jurisdiction and procedure \(CMA2\)](#) for further information on the CMA's approach to what constitutes a substantial part of the UK, including reference to relevant jurisprudence.

Applicability of the UK merger control regime to NHS mergers

- 5.19 In practice, this means that the Act applies to mergers between NHS foundation trusts, between NHS foundation trusts and NHS trusts and between NHS foundation trusts and other 'enterprises'.³⁵ It also applies to mergers between NHS trusts and other 'enterprises'.³⁶ All types of NHS foundation trusts and NHS trusts may be subject to UK merger control, including those managing hospitals, community, mental health or ambulance services. Transactions between individual services, controlled prior to the merger by two different entities, may also trigger a merger review if all jurisdictional criteria explained above are met.^{37,38}

Applicability of the UK merger control regime to NHS service reconfigurations

- 5.20 The merger control regime may apply to NHS service reconfigurations in certain circumstances. Where those with control over providers³⁹ decide to merge two or more enterprises, the transaction may qualify for investigation if it meets the jurisdictional thresholds set out above.
- 5.21 NHS service reconfigurations can take many forms and may involve the transfer of an 'enterprise' depending on the circumstances. In some cases, NHS commissioners and providers enter into multi-party agreements that lead to the transfer of staff and/or assets. Sometimes providers agree between themselves to transfer assets and/or staff and other rights and liabilities. In other cases, providers decide to merge following an NHS commissioner's independent decision to change who provides services. For example, following the award for the provision of a particular service to a sole provider,

³⁵ Section 23 of the Act.

³⁶ The CMA considers that NHS trusts are capable of being enterprises. 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.

³⁷ See, for example, OFT's decision of 21 February 2013 on the acquisition by University College London Hospitals NHS Foundation Trust of Royal Free London NHS Foundation Trust's neurosurgery services. Also the OFT's decision of 8 November 2013 on the creation of a joint venture in relation to pathology services only between University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and the Doctors Laboratory Limited.

³⁸ See paragraphs 5.1–5.17 above.

³⁹ This can be the board of an NHS foundation trust or the Secretary of State for Health in the case of NHS trusts.

other providers might agree to transfer their assets and staff to the new chosen provider or a third party. In all these cases, if the combination of assets, staff, and rights transferred is sufficient to form an enterprise (see paragraphs 5.3 and 5.4 above) and the other jurisdictional criteria are met, these types of transfer can create a relevant merger situation reviewable under UK merger control.

- 5.22 The award of a contract for the provision of a clinical service, that was not previously commissioned, to a provider by any NHS commissioner does not imply any change of control of an existing 'enterprise' leading to a relevant merger situation. In addition, the CMA's jurisdiction to review mergers does not extend to the award of a contract following a competitive process to provide particular services, provided that there is nothing more attached to the contract award (that is, no transfer of assets such as equipment or staff from one provider to the winning provider, for example).
- 5.23 NHS service reconfigurations can also be relevant when deciding on the most appropriate counterfactual against which the impact of an NHS merger must be assessed. This is considered in paragraphs 6.10 to 6.35 below. NHS service reconfigurations can also be relevant to the assessment of relevant customer benefits (for example, where merging providers propose to deliver higher-quality services through service reconfiguration). This is considered in Chapter 7.

6. Merger assessment

- 6.1 While many mergers that take place in the UK do not raise competition issues which lead to worse outcomes for patients and/or commissioners, the merger control process is designed to allow the CMA to identify those where such issues may arise, so that they may be properly investigated and, where necessary, resolved through appropriate remedies.
- 6.2 This section should be read alongside the [Merger assessment guidelines \(CC2 \(revised\)/OFT1254\)](#).

The substantial lessening of competition test

- 6.3 Competition occurs between providers seeking to obtain more commissioner contracts and/or patients by providing them with a better offering. An SLC occurs when competition is substantially less after the merger than would otherwise have been the case, resulting in a worse outcome for patients and/or commissioners (through, for example, higher prices, a reduction in range, quality and/or choice or less innovation).
- 6.4 At Phase 1, the CMA's test for reference (see paragraph 3.5) will be met if the CMA has a reasonable belief, objectively justified by relevant facts, that there is a realistic prospect that the merger will lessen competition substantially.⁴⁰ If the reference test is met, the question as to whether there is a relevant merger situation and SLC is one for resolution by the Inquiry Group on the basis of a detailed Phase 2 investigation.⁴¹ At Phase 2, the Inquiry Group decides whether in its view an SLC is likely to arise.⁴²

Competition in the NHS in England

- 6.5 There are, broadly speaking, two different models of competition in the provision of NHS healthcare services. These are competition to attract patients (that is, competition in the market) and competition to attract contracts to provide services (that is, competition for the market).
- 6.6 Competition to attract patients occurs where patients have a choice between providers of the same service. Payments for these services are commonly made according to the payment-by-results rules, at nationally mandated

⁴⁰ At Phase 1, the decision on reference is taken by a senior staff member of the CMA.

⁴¹ Subject to the CMA exercising the exceptions to the duty to refer or accepting undertakings in lieu of a reference (see Chapters 7 and 8).

⁴² The statutory questions the CMA must decide at Phase 2 are summarised in Chapter 3.

prices across England. Providers are motivated to compete on quality in order to attract patient referrals and hence income.

- 6.7 The effect of competition to attract patients is to focus provider decisions on factors that matter to patients and GPs. The number and quality of alternative providers in a local area has an impact on the strength of the providers' incentives to focus on delivering those aspects of quality that are important to the providers' patients and their GPs. Examples of benefits of competition include focusing on waiting times, implementing best practice guidance, delivering innovative models of care, extending expertise and enhanced service provision and improving facilities to attract patients.⁴³
- 6.8 Competition to attract contracts to provide services occurs because commissioners have to select which provider or providers are best placed to provide services to patients. Providers therefore have incentives to maintain their reputations for quality and value and perform well under existing contracts, as well as to demonstrate that they can deliver high quality and excellent value for money when commissioners select which provider or providers are best placed to provide services to patients.
- 6.9 The loss of actual competition between providers may manifest itself in a reduction (or lack of improvement) in quality in services in which competition would be removed, or in a reduction in quality at the provider level. For services where the price is not fixed, commissioners may also benefit from competition in the form of lower prices and greater choice.

Identifying the appropriate counterfactual

- 6.10 The application of the SLC test involves a comparison of the merger scenario against the competitive situation without the merger. The competitive situation that would likely exist if the merger did not take place is referred to as 'the counterfactual'. The counterfactual may be either more or less competitive than the prevailing conditions of competition.⁴⁴ As such, selection of the appropriate counterfactual is an important step in determining whether or not there is an SLC.

⁴³ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, paragraph 6.122.

⁴⁴ For a discussion of whether or not to apply a more competitive counterfactual than the prevailing conditions of competition, see OFT decision on the anticipated pathology joint venture between University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and The Doctors Laboratory Limited, ME/6094/13, dated 8 November 2013.

- 6.11 The CMA will consider the merging providers' submissions on the counterfactual together with any relevant views of third parties (including commissioners, the TDA and Monitor). With regard to documentation from the merging providers, the CMA will be particularly interested in evidence that has not been prepared in contemplation of the merger.
- 6.12 At Phase 1, the CMA considers the effects of the merger compared with the most competitive counterfactual providing always that it considers that situation to be a realistic prospect. In practice, the CMA generally adopts the pre-merger situation as the counterfactual. An alternative counterfactual to the prevailing (pre-merger) conditions may be used at Phase 1, where there is compelling evidence that the prospect of prevailing conditions continuing is not realistic.
- 6.13 At Phase 2, the CMA may examine several possible scenarios but only the most likely scenario will be selected as the counterfactual. Typically only developments that appear likely on the basis of the facts available to it and the extent of its ability to foresee future developments will be incorporated in the counterfactual.
- 6.14 Examples of possible counterfactuals are:
- the prevailing conditions of competition (or the pre-merger situation in the case of completed mergers)
 - a provider ceasing to provide services (this could be either ceasing to provide certain services (we refer to this as exiting services) or ceasing to provide all services (we refer to this as exiting provider)) (see paragraphs 6.16 to 6.33 below)⁴⁵
 - loss of a potential entrant
 - parallel transactions⁴⁶
 - another merger than the one under review (involving one of the merging providers)

⁴⁵ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, for a discussion of exiting provider and the OFT decision on acquisition by University College London Hospitals NHS Foundation Trust of Royal Free London NHS Foundation Trust's neurosurgery services, ME/5574/12, dated 21 February 2013, for a discussion of exiting services.

⁴⁶ For a discussion of parallel transactions, see the OFT decision on anticipated pathology joint venture between University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and The Doctors Laboratory Limited, ME/6094/13, dated 8 November 2013.

- it is also possible that new legislation or policy developments will affect the way that merging providers would have competed absent the merger

This section addresses some of these possible counterfactuals in more detail.

Providers ceasing to provide all or certain services

6.15 Future events significant for the assessment of the most appropriate counterfactual can relate to certain or all services of one or more of the merging and/or other providers. Due to financial and clinical difficulties faced, providers may submit that they are not viable in their current form. The counterfactual whereby providers cease to provide all services (exiting provider) is discussed below. However, previous cases have also required the CMA to consider changes to (including the possible closure of) certain services. These possible counterfactuals are considered separately below. In both cases, where the evidence is not sufficient for the CMA to adopt an exiting provider/service counterfactual, it will take into account any evidence from the merging parties on financial and/or clinical difficulties in its competitive assessment.

Exiting provider scenario

- 6.16 Where merging providers consider that either of them would have exited the market (that is, been dissolved) absent the merger, they should submit evidence (including internal documents) as to why such exit would occur. They should also explain, in the event of such exit, what would happen to the assets used to provide the services, for example whether the services would be provided in the same location by another provider, or if patients/commissioners would use services of another provider elsewhere.
- 6.17 When assessing whether the appropriate counterfactual is that either of the merging providers would exit the market, the CMA will consider such factors as the providers' current and forecast financial positions, internal documents, reports and/or the view of the Care Quality Commission (CQC), Monitor's views, its risk ratings and any action taken by Monitor.
- 6.18 In forming a view on an exiting provider scenario, the CMA will consider the following three limbs:
- (a) whether the provider would exit (through failure or otherwise) and, if so
 - (b) whether there would be an alternative acquirer for the provider's assets to the acquirer under consideration; and
 - (c) where the patients and the commissioner contracts of the provider would go in the event of the provider's exit

- 6.19 For the CMA to accept at Phase 1 an exiting provider argument, it would need compelling evidence to believe that it was inevitable that the provider would exit and be confident that there was no substantially less anticompetitive acquirer for the provider or its assets. The CMA would then consider whether the result of the exit of the provider and its assets would be a substantially less anticompetitive outcome than the merger. Where the CMA finds that all three limbs of the exiting provider test are met (see paragraph 6.18 above), the merger will not lead to an SLC.
- 6.20 At Phase 2 the three limbs described in paragraph 6.18 above are also relevant to the CMA's consideration. If the CMA considers that there were alternative acquirers, it will try to identify who the alternative acquirer(s) might have been and take this into account when determining the counterfactual. Having identified the most appropriate counterfactual, the CMA at Phase 2 will generally consider the implications of that counterfactual as part of the SLC analysis.

Would the provider exit?

- 6.21 When considering whether or not the provider would exit, the CMA will consider the inevitability (at Phase 1) or likelihood (at Phase 2) of the relevant entity being dissolved.
- 6.22 When considering this limb, the CMA would have regard to the regulatory regime that is in place to ensure that NHS hospitals and other providers meet certain regulatory obligations including those in provider licences relating to, among other things, financial and clinical measures. If an NHS provider is found not to meet certain obligations, it may be placed in 'special measures'. If, following further investigation and analysis undertaken by Monitor and the CQC, it is found to be significantly failing against its obligations, it may be placed into the Trust Special Administration (TSA) process by Monitor or the Secretary of State, which is a statutory process triggered by an NHS provider being unable to pay its debts when they fall due.⁴⁷ The TSA process may lead to dissolution of a provider. This regulatory context and the treatment of an NHS provider plays a role in the assessment of the counterfactual.

⁴⁷ The Care Act 2014 allows the TSA process to be triggered if there is a serious failure by an NHS foundation trust to provide services that are of sufficient quality. Whilst a number of NHS providers have been placed into 'special measures' and in some cases have been successfully turned around such that they have come out of 'special measures', there have to date been only two instances of NHS providers going through the TSA process, which was established in 2009.

Would there be an alternative acquirer for the provider's assets?

- 6.23 The CMA will consider whether the provider would go through the TSA process and be dissolved absent the merger. In so doing, it will consider the relevant provider's financial position, reports and/or the views of the CQC and action taken by Monitor or the TDA, as relevant. In the vast majority of instances where NHS providers face financial difficulties, there is little or no risk that these providers would go through the TSA process and exit the market in the short to medium term. The TSA process is only expected to arise in exceptional circumstances and the CMA envisages that the cases where exit is inevitable or likely in the short or medium term may be small in number. However, the CMA will take into account any evidence of the strength of a provider in its competitive assessment where relevant.
- 6.24 Dissolution of a provider is only one outcome of a TSA process. If the TSA process is significantly advanced (that is, at draft report stage) and dissolution is the likely recommendation, this will be relevant evidence of dissolution. If the likely recommendation involves changes to specific services rather than dissolution, this will be assessed in accordance with the CMA's approach to exiting services outlined below.
- 6.25 In the event that dissolution of the relevant entity appears inevitable (Phase 1) or the most likely outcome (Phase 2), the CMA would then consider the alternative options that were available to the trust special administrator. When considering the prospects for an alternative acquirer of the provider's assets, the CMA will look at available evidence supporting any claims that the merger under consideration was the only possible merger, including evidence from the TSA process, the merging providers, Monitor or the TDA, as relevant. The CMA will take into account any submissions as to why another provider would not have delivered safe clinical services or not done so on a financially viable basis.

Where would the patient and commissioner contracts of the provider go?

- 6.26 If there was no alternative or less anticompetitive acquirer, the CMA will consider what would happen to the commissioner contracts and patients of that provider in the event that the entity was dissolved and in the absence of any merger. It will consider whether these would be redistributed among a number of remaining providers and, if so, how. If patients and commissioner contracts are likely to have been dispersed across several providers, the merger, by transferring most or all of the commissioner contracts and patients to the acquiring provider, may have a significant impact on competition. If, on the other hand, the majority of the commissioner contracts and patients were

expected to switch to the acquiring provider, the merger may have little effect on competition.

Exiting services

- 6.27 Where the merging providers consider that either of them would, absent the merger, cease to provide specific services⁴⁸ or if their service offering would change in other ways (for example, due to financial or other constraints or commissioners' plans), they should submit detailed evidence (including internal documents) as to why this would happen. The CMA will then consider the service offering that the provider could be expected to provide in the absence of the merger.
- 6.28 Changes to services can be:
- (a) led by commissioners
 - (b) led by the provider⁴⁹
 - (c) required by the CQC⁵⁰
 - (d) recommended by the Trust Special Administrator
- 6.29 In each case the CMA would consider the reasons for the proposed service variation or exit, whether exit is dependent on other factors (for example, where the service exit is provider led but requires commissioner approval, the CMA would take into account whether this being granted will be inevitable – at Phase 1 – or likely – at Phase 2), what other options were considered and what would happen to the commissioner contracts and patients in the absence of the service exit.
- 6.30 The CMA will examine evidence provided by the merging providers and/or third parties relating to why the provider would have exited the service.
- 6.31 Any proposals for substantial development or variation of the healthcare service (whether led by commissioners or providers) will be subject to public

⁴⁸ There are some limitations to a provider's ability to make changes to its services. Where a provider is an NHS foundation trust, under its licence conditions, it is required to deliver Commissioner Requested Services, unless agreement is obtained from the commissioner. For all providers (both NHS foundation trusts and NHS trusts), even where commissioners support a proposed change, clinical interdependencies between services may restrict the service reconfiguration options available to it.

⁴⁹ See the OFT decision on acquisition by University College London Hospitals NHS Foundation Trust of Royal Free London NHS Foundation Trust's neurosurgery services, ME/5574/12, dated 21 February 2013.

⁵⁰ The CQC has the power to suspend or cancel registration for some or all services, thereby preventing a provider from providing these services.

consultation.⁵¹ The fact that consultation has not yet taken place would not in itself preclude the CMA from concluding that a service change was inevitable at Phase 1 or likely at Phase 2. However, the CMA would require a robust evidence base in support of the proposed change being likely to go ahead absent the merger.

- 6.32 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 clinical or financial difficulties and therefore less likely to exercise a strong competitive constraint on the other merging provider. This would be taken into account in the overall substantive assessment of the case (see paragraph 6.58 below).

Loss of potential entrant

- 6.33 Absent the merger, one or more of the merger providers may be most likely to increase capacity to provide existing services or begin providing new services in an area served by the other merger provider. This counterfactual suggests that without the merger competition between the merging providers will be stronger than in the prevailing situation without the merger.

Parallel transactions

- 6.34 The CMA may be required to assess an NHS merger at a time when there is the realistic prospect of another NHS merger proceeding in the same market.⁵² The CMA will assess whether an SLC arises both independently of the parallel transaction proceeding and on the assumption that the parallel transaction proceeds (unless the parallel transaction can clearly be ruled out as too speculative).

Identifying the relevant markets

- 6.35 In examining whether an SLC is likely to occur, the CMA needs to identify the market that is relevant to the merger. Identifying the relevant market involves an element of judgement.

⁵¹ There is no definition of what constitutes a substantial development/variation; this is something on which the commissioner and local authority are encouraged to reach agreement. See: Department of Health, Local Authority Health Scrutiny, Proposals for consultation, 12 July 2012, paragraph 42.

⁵² A parallel transaction is considered as part of the counterfactual on the basis that it would occur whether or not the merger happens. In this context, a parallel transaction is one which is either anticipated or which has been completed but remains subject to merger review by the CMA under the Act.

6.36 The purpose of market definition is to provide a framework for the CMA's analysis of the competitive effects of the merger. The relevant market contains the most significant competitive alternatives available to the patients and/or commissioners of the merging providers. We note that market definition is a useful tool, but not an end in itself, and that the boundaries of the market do not determine the outcome of our competitive assessment in any mechanistic way.

Product market definition

6.37 The CMA generally considers the narrowest market (where the merging providers overlap) and then whether this can be widened through substitution on the demand side or supply side.⁵³

6.38 Product market definition is specific to each case. However, in relation to mergers of NHS hospital and clinical services, the CMA may adopt the following product market definitions:

- Markets no wider than an individual specialty.⁵⁴ Where there are limits to supply-side substitution within specialties, the CMA may take into account constraints at sub-specialty level in its competitive effects assessment.
- Within each specialty:
 - The CMA may treat outpatient and inpatient⁵⁵ activities as separate markets. There is an asymmetric constraint between inpatient and outpatient services, with inpatient providers readily capable of providing outpatient services but not vice versa.
 - Outpatient (and to a lesser extent inpatient) services are not generally likely to be further separated according to whether or not the services can be provided in community settings.⁵⁶ However, where certain

⁵³ See the OFT decision on the anticipated pathology joint venture between University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and The Doctors Laboratory Limited, ME/6094/13, dated 8 November 2013.

⁵⁴ The CMA will endeavour to ensure that specialties are defined consistently across providers and, where appropriate, may combine individual specialties which are substitutes. See, for example, the report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013 (paragraph 6.297), where the CC noted that certain activities common to the merging providers (including births) were classified as obstetrics by one provider and as midwifery by the other, and the CC therefore combined these two specialties to give a total figure for maternity.

⁵⁵ The CMA is likely to treat day cases as part of inpatient activity.

⁵⁶ The CMA may further segment services where the community setting does not constrain the outpatient services. The CMA is more likely to segment between outpatient services and services provided in a community setting in the case of a merger involving one or a few services rather than a full hospital merger.

services are provided only in the community, these community services may be viewed as separate markets.

— Non-elective and elective activities may be separate markets,⁵⁷ although the provision of elective activities may be constrained to some extent by non-elective providers.

- Privately-funded healthcare services are likely to be separate markets from NHS services. Within private services, each specialty likely constitutes a separate market and within each specialty, markets may be defined along inpatient and outpatient lines (as with NHS services).⁵⁸

6.39 There are other services where it may be appropriate to consider different markets according to patient characteristics or type. For example, mental health services could be segmented according to whether they are for adults, elderly people, children or adolescents.⁵⁹

Geographic market definition

6.40 In publicly funded healthcare services the relevant geographic market may be based on the location of providers and will be informed by an assessment of the willingness of patients to travel for consultation or treatment (the 'catchment area').⁶⁰ The geographic market may not necessarily be the same for all services or for all competition concerns ('theories of harm') under investigation.

6.41 In particular, the CMA may find it appropriate to define different geographic markets when considering competition in the market and for the market. The CMA will be guided by the needs and behaviour of those who make choices

⁵⁷ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, paragraphs 5.44–5.47, in which the CC found that non-elective and elective activities are separate markets. Elective providers are unlikely to be able to expand quickly to provide non-elective services in the same specialties, and it is unlikely that a provider will be supplying non-elective services without also providing elective services in the same specialty. Therefore in practice the two types of service are unlikely to constrain each other.

⁵⁸ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, paragraphs 5.7–5.53.

⁵⁹ See, for example, the decision of the Cooperation and Competition Panel (which previously considered mergers against the Principles and Rules for Cooperation and Competition and provided advice to the Department of Health and Monitor) in the [Merger of Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership NHS Trust](#).

⁶⁰ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, where the CC looked at the distances travelled by patients to reach the providers, and the geographic areas where the merging providers attracted a large share of patients. See also OFT decision on the anticipated pathology joint venture between University College London Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and The Doctors Laboratory Limited, ME/6094/13, dated 8 November 2013, where the OFT defined geographic markets on the basis of drive-times from each customer's location, while noting that the conditions of competition are similar across the particular customers in question in that case.

about the service. Patients and GPs may in practice tend to choose from a smaller set of providers than those considered by a commissioner seeking to establish a limited number of providers in an area.

- 6.42 As part of the assessment the CMA will consider whether the merging providers are constrained by providers located outside the relevant geographic market.

Measures of concentration: market shares

- 6.43 Market shares of providers can give an indication of the potential extent of market power. The combined market shares of the merging providers, when compared with their respective pre-merger market shares, may provide an indication of the change in market power resulting from the merger.
- 6.44 As part of its assessment of the merger, the CMA may consider market shares of the merging providers and other providers. If so, the CMA will seek to define what the relevant market is on which these shares are calculated (as discussed above).⁶¹
- 6.45 The CMA will generally look at shares at the specialty level across the relevant geographic area, consistent with its general approach to defining markets. However, on the basis that there may be some differences within specialties, the CMA may also take constraints at sub-specialty level into account by analysing the level of activity of relevant providers within specialties at treatment level. The CMA may also look at shares across a wider or narrower geographic area (for example, GP surgeries or sets of surgeries), if these are informative for the competitive assessment. The CMA may consider shares of volume and/or shares of revenue.

Examining the effects on competition

Unilateral effects

- 6.46 One way a horizontal merger⁶² can harm competition is if it removes an important current or potential⁶³ competitor, resulting in a reduced incentive for the merged provider to maintain and provide better-quality services to patients

⁶¹ This relevant market will represent a technical market and may differ from what providers refer to as the market that they operate in.

⁶² That is, a merger between providers of the same (or similar) services.

⁶³ See paragraphs 5.4.13–5.4.18 of [Merger assessment guidelines \(CC2 \(revised\)/OFT1254\)](#) for further information on the treatment of potential competition in the review of mergers generally.

and value for money for commissioners. This effect is known as a ‘unilateral effect’ and is the effect that the CMA considers most frequently.

- 6.47 The depth and breadth of analysis undertaken is different between Phase 1 and Phase 2. However, the framework within which that assessment takes place is broadly similar.

Competition to attract patients

- 6.48 In relation to competition to attract patients of NHS services, competition is almost always on quality,⁶⁴ rather than on price,⁶⁵ as the majority of services are covered by national prices and the payment-by-results rules. The same basic framework applies to elective, non-elective, specialised and community services.⁶⁶ Specifically, the aspects of quality which may be impacted by a reduction in competition include clinical factors, such as infection rates, mortality rates, ratio of nurses or doctors to patients, equipment, best practice, and non-clinical factors such as waiting times, access cleanliness and parking facilities.
- 6.49 The CMA will assess the extent and nature of current (or pre-merger) competition. The CMA’s approach will generally be to identify which services are provided by both merging providers (the overlap services), then ask whether, in respect of each of the overlap services:
- (a) patients and/or GPs have and exercise choice of provider
 - (b) quality and/or price influences that choice
 - (c) the merging providers would have an incentive to compete to attract patients absent the merger
 - (d) the merging providers are close competitors
- 6.50 The CMA will assess the merging providers’ incentives to compete and how they have responded to them. In this respect, the CMA will consider submissions from the merging providers and internal documents together with third party views on the market.

⁶⁴ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, paragraphs 6.72–6.77.

⁶⁵ However, it is possible for there to be variations from the national tariff.

⁶⁶ Different types of tariffs apply to different services. For example, national prices do not apply to some community services.

6.51 The CMA may take into account the extent to which the merging providers' incentives to compete might have been affected by factors including, but not limited to:

- (a) the profitability of increasing activity given the tariff and cost structures
- (b) capacity constraints
- (c) the relationships the merging providers have with CCGs

6.52 In previous merger inquiries, providers have submitted that:

- (a) the contracts the merging providers had with each other for sharing clinical staff meant that they had reduced incentives to compete with each other and limited ability to differentiate themselves from each other
- (b) there was no scope for the merger to reduce quality due to the regulation around quality which existed in relation to the merging providers' services

Whilst the CMA will consider each case and arguments on their merits, the CMA's predecessor found on the first point that (i) where the provider supplying treatment, rather than the provider lending the doctor, would be paid for the treatment, each provider still had an incentive to attract patients and (ii) the consultant is one factor among many in patient choice or in quality. On the second point, although regulation plays an important role in ensuring minimum standards of quality in the provision of elective services, it does not lead to all providers providing the same levels of quality and does not remove the incentive for providers to compete on quality.⁶⁷ That is, providers can strive to exceed minimum regulation standards, which is in the interest of patients.

6.53 When assessing closeness of competition, the CMA's starting point will be to consider referral patterns and the overlaps between the catchment areas of the merging providers together with those of any other local providers,⁶⁸ given that location is usually important in patients' choice of hospitals. The CMA may also survey patients⁶⁹ or use existing evidence on diversion ratios (for example, evidence of where patients went in the event of a temporary

⁶⁷ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, paragraphs 6.133–6.142 & 6.179–6.184.

⁶⁸ When undertaking the competitive assessment, the CMA will look primarily at providers offering a similar or broader service than the merging providers. This means that if some specialties or major treatments are only provided by a subset of providers, including the merging providers, the CMA will consider whether there is a different competitive constraint on the merging providers in those specialties/treatments.

⁶⁹ This is more likely to take place in a Phase 2 investigation.

closure).⁷⁰ This may provide evidence of how patients and GPs are choosing between providers in the local area.

- 6.54 Ultimately the CMA is 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.⁷¹ The larger this geographical area and the greater the number of services relative to the merging providers' overall activity, the greater the likely effect of the merger on the merging providers' incentives to compete.

Competition to attract contracts to provide services

- 6.55 Providers compete for the market when they are (or may be) competing to be one of a limited number of providers of a service. This is often the case for specialised services, where there is an expectation of a small number of providers of services that are often costly to provide, and pathology services, where routine tests are commissioned for GPs by clinical commissioning groups, for example. Providers may compete on quality and, in some cases, price.⁷²

- 6.56 There are generally two concerns in a merger when competition is 'for the market':

- (a) in the event of a competitive tender the merger could lead to worse outcomes because there would be fewer bidders (which may be reflected in commissioners receiving reduced value for money, including lower-quality services or higher prices where services are not subject to a national price)
- (b) providers on existing contracts might provide lower-quality services, knowing that commissioners have fewer alternative possible providers of those services, and therefore commissioners would be less likely to switch away from the existing provider

- 6.57 Where there is competition to attract contracts to provide services, the CMA's assessment will consider whether the merging providers would be close

⁷⁰ A diversion ratio between Service A and Service B represents the proportion of revenues that would divert to Service B (as opposed to Services C, D, E) as patients' second choice in the event of a price increase for Service A (or the temporary unavailability of Service A).

⁷¹ This is because providers may be able to flex certain aspects of quality at a local level (such as through services provided at outpatient clinics), depending on the conditions of competition. For example, see paragraphs 72–80 of the [report on the anticipated merger between Heatherwood and Wexham Park Hospitals NHS Foundation Trust and Frimley Park Hospital NHS Foundation Trust](#).

⁷² Any Qualified Provider services do not typically restrict the number of providers, so these will not generally feature in an assessment of the effect of the merger on competition to attract contracts to provide services.

competitors to supply these services and what other providers would constrain them.

Weakened competitive constraint

6.58 When considering the competitive constraint that the merging providers exercise on each other, the CMA may take into account whether one or both of the merging providers faces clinical or financial challenges (and whether this is expected to continue to be the case absent the merger). The CMA is likely to take into account, among other evidence, CQC reports on quality over time, Monitor governance ratings over time and any turnaround plan(s).⁷³

Coordinated effects

6.59 A horizontal merger may also lessen competition by enabling or encouraging post-merger coordinated interaction among providers in the market that has adverse effects on patients and/or commissioners by diminishing the incentive to provide high-quality services or value for money.

6.60 Coordination may arise when providers operating in the same market recognise that they can provide less value for money without the threat of losing revenue or patients if they limit the extent to which they compete against each other.

6.61 Such coordination need not be explicit (that is, no anticompetitive agreement is required) but might emerge through implicit understandings and can take a number of forms. Providers may be able to keep quality lower or provide less value for money than they would otherwise, if there is an implicit understanding between those providers that they will not compete strongly against each other, for example by dividing up the services they provide or the geographic areas they provide services in between them or allocating contracts among themselves in bidding competitions. For anticompetitive coordination to be effective, the following conditions need to be met:

- providers need to be able to reach a common understanding and monitor compliance with such an understanding
- providers must have the incentive to stick to the coordinated outcome

⁷³ See the OFT's decision in the acquisition by University College London Hospitals NHS Foundation Trust of Royal Free London NHS Foundation Trust's neurosurgery services, ME/5574/12, dated 21 February 2013, paragraphs 80–81.

- there must be little chance of such an understanding being disrupted by other factors, such as entry or expansion by other providers or action by the commissioners
- 6.62 See [Merger assessment guidelines \(CC2 \(revised\)/OFT1254](#))⁷⁴ for further information on coordinated effects.
- 6.63 The CMA is aware that NHS providers have a duty to cooperate to improve services and deliver care to patients. There are many ways in which providers can do so (for example, by ensuring the patient experiences seamless care along a care pathway) whilst complying with competition law. However, they should not reach agreements which restrict choice and competition if they operate against patients' and commissioners' interests.⁷⁵

Vertical and conglomerate mergers

- 6.64 Mergers are not always between providers of the same set of services.⁷⁶ In general, vertical and conglomerate mergers are less likely than horizontal mergers to give rise to an SLC. In a vertical merger, the merging providers may benefit from efficiencies that give them a greater incentive to compete (and therefore, for example, to offer better quality or lower prices).
- 6.65 Nevertheless, vertical mergers may occasionally damage competition if the merged provider restricts downstream competitors' access to a key input or restricts upstream competitors from a key 'route to market'. For example, a merger may distort the pattern of onward referrals from one merger provider to the other at the expense of other providers of the same set of services who might compete on quality for referrals absent the merger.
- 6.66 Conglomerate mergers may occasionally damage competition and thereby adversely affect patients and/or commissioners if the merged provider can link the services or products in the separate markets.
- 6.67 These harmful effects of vertical or conglomerate mergers on competition and therefore patients and/or commissioners will only arise if the merged provider would have the ability and incentive to act this way. Such a strategy results in harm to competition and therefore adversely affects patients and/or

⁷⁴ Adopted by the CMA.

⁷⁵ See Monitor [Guidance on the application of the Competition Act 1998 in the healthcare sector](#).

⁷⁶ Vertical and conglomerate mergers bring services or products together that do not themselves compete but may be related. For example, a vertical merger in the NHS would include a merger of provider services at different stages of a patient pathway.

commissioners, and such harm outweighs any beneficial effects on competition through efficiencies achieved by the merger.

- 6.68 See [Merger assessment guidelines \(CC2 \(revised\)/OFT1254\)](#) for further information on vertical and conglomerate effects.

Assessing countervailing factors

- 6.69 The CMA will also consider any factors that might prevent or significantly reduce any harmful impact of the merger. There are three main factors – efficiencies, entry and expansion in the market, and countervailing buyer power.

Efficiencies

- 6.70 While mergers can harm competition and thereby adversely affect patients, they can also give rise to efficiencies that make the merged provider a more effective competitor (for example, if the merger itself gives the merging providers incentives to increase quality of services or reduce prices). If these merger-specific efficiencies are large and timely enough, they can enhance rivalry and prevent a merger giving rise to an SLC. Efficiencies that do not enhance rivalry can also be taken into account as relevant customer benefits, provided that they are likely to arise within a reasonable period (see Chapter 7).
- 6.71 However, claimed efficiencies can be hard for the CMA to verify because most of the information is held by the merging providers. As a result, for the CMA to give weight to efficiency arguments, it must have compelling evidence that such efficiencies not only result directly from the merger itself, but also that they will be timely, likely and sufficient to prevent an SLC from arising.
- 6.72 Further information on types of efficiencies are set out in the [Merger assessment guidelines \(CC2 \(revised\)/OFT1254\)](#).

Entry and expansion

- 6.73 In some cases, entry by new providers or expansion by providers already in the market may be timely enough and sufficient in scope and likelihood to prevent any harmful impact of the merger.
- 6.74 In order for entry or expansion to be a constraint post-merger, it is necessary that (i) other providers can profitably begin or expand activity in response to a reduction in quality or increase in price by the merging providers, and (ii) patients or commissioners would be willing to switch to those providers in

sufficient numbers to make the quality reduction or price increase by the merged provider unprofitable.

- 6.75 However, there may be barriers to entry or expansion in the market. These barriers may be absolute, for example a patent; structural, for example economies of scale; or strategic, for example the advantage of being the first mover or pioneer in a market.
- 6.76 To determine whether entry or expansion is most likely, the CMA will consider factors such as how the investment in new services or service expansion will be financed; the profitability of entry and expansion; and the likely demand for the services from patients and commissioners.
- 6.77 The CMA considers that barriers to entry for inpatient services are high and generally entry into inpatient services by anyone other than an existing acute hospital is unlikely.⁷⁷ Barriers to entry into outpatient services are generally lower, especially for services which are not capital intensive and do not require specific equipment (for example, many consultations would fall into this category); however, the availability of consultants may still make entry difficult.
- 6.78 The CMA will consider the likelihood and effectiveness of new entry and expansion on a case-by-case basis. The CMA will seek evidence from merging providers and/or third parties of planned entry and expansion by a specific provider.

Countervailing buyer power

- 6.79 A customer has countervailing buyer power when it has the negotiating strength to limit a provider's ability to raise prices or lower quality. An SLC is less likely to occur where all customers have countervailing buyer power post-merger than where only some customers do. A customer's negotiating strength is greater if it can easily switch its demand away from the merged provider.
- 6.80 NHS services are free at the point of use. Therefore, in the provision of NHS services there is a split between those exercising choice and using services (the patients), and those who pay for the services (the commissioners). In relation to the users of NHS services, individual GPs and patients are unlikely in the majority of cases to have negotiating strength sufficient to require the merged provider to maintain and improve quality levels. This is because no

⁷⁷ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, paragraphs 7.12–7.17.

GP/practice or patient is likely to account for a substantial proportion on an ongoing basis of either provider's income in relation to any specific service (even at the level of inpatient elective services provided in a particular specialty, it is unlikely that a GP or practice would persistently account for a significant proportion of those services). Therefore in relation to competition in the market, individual GPs and patients are unlikely to have negotiating strength.

- 6.81 When looking at whether the commissioners would be likely to have the ability to prevent the merged provider from reducing quality or increasing price in respect of those specialties where it was less constrained by a competitor, the CMA will consider whether in these circumstances the commissioner would be able easily to switch (or threaten to switch) its demand to another provider or otherwise constrain the merged provider. The CMA would be looking at whether the commissioners could act to prevent a decrease in quality or increase in price at the margins, in particular in an area where, for example, the merging providers both provided services of a high quality, at levels over and above key regulatory requirements or in areas where the merged provider would not consider a decrease in quality such that it lost Commissioning for Quality and Innovation (CQUIN) payments or fell below a quality regulatory threshold to be a significant issue.

7. Exceptions to the duty to refer at Phase 1

- 7.1 Where the CMA believes at the end of a Phase 1 assessment that it is or may be the case that the merger results or may be expected to result in an SLC, the CMA has a discretion to clear the merger where:
- any relevant customer benefits in relation to the creation of the relevant merger situation concerned outweigh the SLC concerned and any adverse effects of the SLC
 - the market concerned is not, or the markets concerned are not, of sufficient importance to justify the making of a reference to Phase 2
 - for anticipated mergers, the arrangements concerned are not sufficiently far advanced, or are not sufficiently likely to proceed, to justify the making of a reference to Phase 2⁷⁸
- 7.2 The sections below explain how the CMA applies its discretionary exceptions to the duty to refer at Phase 1.

Relevant customer benefits

- 7.3 Where the CMA believes that it is or may be the case that the merger results or may be expected to result in an SLC which would result in worse outcomes for patients and/or commissioners,⁷⁹ the CMA may take relevant customer benefits arising from a merger into account when deciding whether to refer a merger for a Phase 2 investigation. In the context of NHS mergers, this means benefits to patients and/or commissioners.
- 7.4 The CMA takes account of relevant customer benefits in different ways at Phase 1 and Phase 2 (see paragraphs 8.4 to 8.6 for a discussion of how these are taken into account at Phase 2). At Phase 1, relevant customer benefits provide a potential exception to the duty to refer a merger where they outweigh adverse effects on patients and/or commissioners of the SLC. This is discussed in more detail below.

Process and Monitor involvement

- 7.5 Where a foundation trust is involved, Monitor must provide the CMA in Phase 1 with advice on relevant customer benefits of the merger (see below what

⁷⁸ Sections 22(2) & 33((2) of the Act.

⁷⁹ The CMA will not take relevant customer benefits into account where it does not identify an SLC. In such cases, the merger is cleared without the need to assess relevant customer benefits.

constitutes a relevant customer benefit) for people who use health services provided for the purposes of the NHS, as soon as reasonably practicable after receiving notice that the CMA has decided to investigate the merger.⁸⁰ In practice, this will be done as soon as possible after the CMA informs the merging providers that it is starting the statutory timetable for Phase 1 merger review.

- 7.6 Monitor's advice is not binding on the CMA. However, the CMA will place significant weight on Monitor's expert advice on the relevant customer benefits of a merger.
- 7.7 It is open to merging providers to decide not to claim relevant customer benefits.⁸¹ As explained in Chapter 4, where merging providers intend to claim that the merger gives rise to relevant customer benefits, they are encouraged to engage in pre-notification discussions with Monitor and the CMA on these at the earliest opportunity. This can be done in parallel to discussing the substantive assessment and evidence for inclusion in the Merger Notice with the CMA during the pre-notification period. If merging providers do not make claims on relevant customer benefits until after filing the Merger Notice, it is unlikely that the CMA will have time to consider fully the claims made by the merging providers within the 40 working day statutory time frame for merger review.
- 7.8 Monitor is likely to be the primary point of contact in relation to relevant customer benefits, and merging providers should expect to engage extensively with Monitor on the evidence required in this respect.⁸² Merging providers are encouraged to provide the CMA with copies of draft submissions provided to Monitor in relation to relevant customer benefits (once they have decided to notify the CMA). The CMA will not commence an investigation until it considers that the merging providers have provided sufficient information on relevant customer benefits or indicated in the Merger Notice that they will not be submitting any in Phase 1. Therefore, if the CMA is not provided with drafts of the relevant customer benefits submission, this may delay the start of the CMA review. The CMA will liaise closely with Monitor as to whether the information received with respect to relevant

⁸⁰ Section 79(5) of the HSCA.

⁸¹ If merging providers decide not to make reasoned submissions in relation to relevant customer benefits, this should be noted in the Merger Notice and the decision indicated in writing to Monitor. There is no requirement on the merging providers to explain their decision in this respect. In order to comply with its statutory duty, Monitor will then inform the CMA of the providers' decision as soon as reasonably practicable.

⁸² It is envisaged that Monitor and the CMA will liaise closely in relation to the information provided in relation to relevant customer benefits. Wherever possible the CMA and Monitor will consolidate questions on relevant customer benefits for the merging providers to avoid two information requests on these.

customer benefits will allow Monitor to start its assessment of relevant customer benefits.

- 7.9 Monitor will share its thinking (written or oral) with the CMA in order for the CMA to be able to refer to it on the 'state of play' call with the merging providers as well as reflect it in the issues letter.⁸³
- 7.10 Monitor and the CMA will discuss Monitor's views in relation to relevant customer benefits on an ongoing basis and in any event prior to the issues meeting and case review meeting.⁸⁴ The CMA may ask Monitor to provide further advice in relation to additional evidence provided by the merging providers in response to the issues letter. Monitor will provide written advice on relevant customer benefits to the CMA, which it will have shared with the merging providers, and which will be published alongside the full text of the decision.
- 7.11 See *Monitor Guidance on Merger Benefits* for further information on the process for Monitor providing advice to the CMA.⁸⁵

What constitutes a relevant customer benefit?

- 7.12 First, relevant customer benefits are limited to be benefits in the form of:⁸⁶
- (a) lower prices, higher quality or greater choice of services or goods in any market in the UK, or
 - (b) greater innovation in relation to such services or goods
- 7.13 The types of benefits providers have previously submitted, either to the Cooperation and Competition Panel, Monitor or the OFT/CC, include:
- (a) Higher-quality services through implementing a particular model of care. The Cooperation and Competition Panel found that implementing a particular model of care across a merged provider would improve the

⁸³ In all cases, the CMA commits that, generally in the period between working days 15 and 20, it will have a 'state of play' discussion with the merging providers, typically by conference call. The purpose of this discussion is to give the merging providers information on any competition concerns, including feedback from the CMA's market test, whether or not the CMA is to send the merging providers an issues letter, and the theories of harm that the CMA proposes to include in the issues letter. The case team will also provide an update on the likely timetable for the case going forward.

⁸⁴ The case review meeting is an internal meeting following the issues meeting held with the merging providers.

⁸⁵ The draft guidance which was consulted on can be found at www.monitor.gov.uk/. The CMA understands that Monitor will shortly be publishing the final version of that guidance.

⁸⁶ Section 30(1) of the Act.

quality of services, for example by reducing the length of stay,⁸⁷ providing round-the-clock access to a dedicated treatment room,⁸⁸ reducing mortality rates and delivering higher-quality stroke services.⁸⁹ The CMA will take into account such factors as any previous experience the merging providers or other providers may have of successfully implementing a particular model of care and whether the specific model of care will improve quality for patients and what issues it is looking to address.

- (b) Higher-quality services through service reconfiguration.⁹⁰ The CMA will consider, for example, how the quality of those services will improve and any effect on interdependent services and whether the reconfigurations lead to any disadvantages for some patients and/or commissioners. In particular, where quality is expected to improve due to volume, the CMA will consider the evidence between minimum volumes and quality outcomes in the relevant services.
- (c) Higher-quality services through increased consultant or staff cover.⁹¹ The CMA will consider, for example, the extent to which existing services suffer from staffing problems and how staff increases will result in clinical improvements to patients.
- (d) Higher-quality services through access to equipment. The CMA will consider how the equipment leads to better outcomes for patients.
- (e) Greater innovation through research and development and greater ability to attract funding for research and development.⁹² The CMA will consider what improvements in research and development will arise as a result of the merger.

⁸⁷ See the [Cooperation and Competition Panel advice on the merger of Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust](#).

⁸⁸ See the [Cooperation and Competition Panel advice on the merger of acute services between University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust](#).

⁸⁹ See the [Cooperation and Competition Panel advice on the merger of Northumbria Healthcare NHS Foundation Trust with North Cumbria University Hospitals NHS Trust](#).

⁹⁰ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, Section 9 & Appendix M, and the [Cooperation and Competition Panel advice on the merger of Nuffield Orthopaedic Centre NHS Trust and Oxford Radcliffe Hospitals NHS Trust](#).

⁹¹ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, Section 9 & Appendix M.

⁹² See the [Cooperation and Competition Panel advice on the merger of Nuffield Orthopaedic Centre NHS Trust and Oxford Radcliffe Hospitals NHS Trust](#).

(f) Financial savings.⁹³ Benefits could arise from efficiencies from having a large-scale operation (through, for example, making more efficient use of clinical staff or equipment or sharing back-office functions), supplying a broader scope of service (for example, by making the care pathway more efficient or making the treatment of patients with multiple healthcare needs more efficient) and from using the more efficient processes or working methods of one of the merging providers. Merging providers may also avoid costs that would otherwise have been incurred.

- Financial savings could be retained by the health service providers in which case the CMA would typically expect the monies to be reinvested in healthcare services and so give benefits to patients and/or they could be passed on to commissioners and in either case they could qualify as relevant customer benefits. Merging providers should explain what savings can be expected and how the savings will benefit patients and/or commissioners (and whether there are any disbenefits, for example if staff savings led to a decrease in the number of nurses as well as the costs of implementation)

7.14 Whether or not any of these benefits constitute relevant customer benefits will need to be assessed on a case-by-case basis. In addition to evidence provided by the merging providers and Monitor's advice, the CMA may also take into account relevant evidence such as reports by commissioning entities, clinical studies, Royal College guidance, academic papers and/or patient surveys.

7.15 Secondly, a benefit is only a relevant customer benefit if it has accrued or is expected to accrue to relevant patients (and/or commissioners) within the UK within a reasonable period from the merger and would be unlikely to accrue without the merger or a similar lessening of competition.⁹⁴

7.16 What is a reasonable period will vary on a case-by-case basis, depending, for example, on the nature of the proposed benefit and the circumstances of its implementation. For example, a large-scale building project or merger of a maternity⁹⁵ or A&E service may reasonably require a longer implementation period – with benefits possibly not accruing to patients for a number of years – than a small project. In addition to the timeliness consideration, the CMA

⁹³ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, Section 9 & Appendix M, and the Cooperation and Competition panel advice on the merger of Nuffield Orthopaedic Centre NHS Trust and Oxford Radcliffe Hospitals NHS Trust.

⁹⁴ Section 30(2) & (3) of the Act. Where a benefit may have occurred absent the merger but taken longer than a reasonable period, the CMA may take into account the time gained as a relevant customer benefit.

⁹⁵ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, paragraph 9.84.

needs sufficient evidence to form a belief that the benefits will accrue (see paragraph 7.18).

- 7.17 In determining whether the benefit is merger specific, the CMA will consider whether it was likely to occur in any event (for example, if the benefit was in any event likely to arise through a commissioner-led reconfiguration) and whether the merging providers would have the ability and incentive to achieve the benefits independently or through arrangements (such as another merger) that do not give rise to competition issues.
- 7.18 The CMA will consider whether it believes the benefits are likely to be realised. The CMA will review implementation plans, and the more detailed and advanced these are, the more persuasive they are likely to be. The merging providers' incentives to implement the benefits will also be relevant to the likelihood of implementation. When considering incentives, the CMA will take into account the competitive constraints post-merger.
- 7.19 The CMA recognises that providers going through an NHS merger are required to go through a number of regulatory approvals. The CMA appreciates that the timing and sequencing may mean that certain reconfiguration plans which are relevant for the merging providers to put forward a benefits case may not have been fully developed. While this may be the case when assessing benefits, the CMA must reach a degree of confidence that the planned action gives rise to a benefit.
- 7.20 In this context, the level of information required to demonstrate a benefit will vary on a case-by-case basis. When submitting benefits, the evidence required to prove the planned action will give rise to a benefit will vary depending on the nature of the action put forward. The CMA understands that in order to effect reconfigurations, providers need to go through a number of steps. Not all of them need to have been completed for the CMA to accept a benefit. The absence of the merging providers having completed the following steps may not prevent the CMA from concluding that the benefit is expected to arise:
- (a) undertaken or started a public consultation on the benefits (in respect of changes where consultation would be required for reconfiguration)
 - (b) taken a firm decision to proceed with them
 - (c) implemented or started to implement them
- 7.21 However, for the more extensive benefit proposals (for example, accident and emergency reconfiguration), the CMA expects that for each benefit the merging providers put forward, the merging providers will have satisfied

themselves that the proposed customer benefits are likely to occur and have taken the first in a series of steps, namely:

- (a) determined what the preferred proposal is (the CMA would look at, among other evidence, the merging providers' internal documents) and, where relevant, provided evidence for the need for change (for example, if the current service does not comply with relevant quality and safety standards or recommendations)
- (b) discussed plans with clinicians of the merging providers and relevant commissioners
- (c) developed a model of care (a plan for the way in which services will be delivered following reconfiguration) by engaging with clinicians of the merging providers, relevant commissioners, as well as any clinical experts and any relevant advisory group as appropriate
- (d) produced an assessment of the clinical advantages (and any disadvantages) as well as a robust assessment of the financial or economic viability of the plans⁹⁶

7.22 The CMA will also contact relevant third parties such as commissioners for their views on the benefits. Third parties will be contacted at the beginning of the Phase 1 inquiry (likely within the first week) for their views on the merger with the potential for more detailed follow-up questions throughout the inquiry.

7.23 See [Monitor Guidance on Merger Benefits](#) for further information on what might constitute a benefit and the evidence required.

Weighing up the benefits against the SLC at Phase 1

7.24 In order for the CMA to decide not to refer a merger to Phase 2 on the basis of the relevant customer benefits, it must believe that any such relevant customer benefits concerned outweigh the SLC and any adverse effects of the SLC in all affected markets.⁹⁷ The relevant customer benefits need not necessarily arise in the market(s) where the SLC has arisen. It is therefore open to the merging providers to show that sufficient relevant customer benefits might accrue in one market as a result of the merger that would outweigh the finding of an SLC in another market(s).

⁹⁶ See the CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, Section 9.

⁹⁷ Sections 22(2) & 33(2) of the Act. It is not possible to apply an exception to the duty to refer on the basis of relevant customer benefits in relation to certain affected markets, whilst accepting an undertaking in lieu in respect of other markets.

- 7.25 The CMA will examine the evidence put forward by the merging parties, together with Monitor's advice on the benefits accruing to patients as a result of the merger. If the evidence received is sufficient for the CMA to establish that there are relevant customer benefits, it will then consider if these outweigh the likely adverse effects of the merger on patients and/or commissioners.
- 7.26 Weighing up the benefits against the adverse effects on patients involves consideration of the facts and circumstances of an individual case. In exercising its discretion to decide whether the claimed relevant customer benefits are such as to outweigh the SLC concerned and any adverse effects of the SLC, the CMA has regard both to the magnitude of the benefits and the probability of them occurring, and sets this against the scale of the identified anticompetitive effects and the probability of them occurring.
- 7.27 The more powerful and more likely the anticompetitive effects of the merger, the greater and more likely the relevant customer benefits must be to meet and overcome such concerns.⁹⁸
- 7.28 Whilst the framework differs, the analysis set out above from paragraph 7.12 to 7.22 is also relevant to Phase 2 merger decisions (see Chapter 8).

Markets of insufficient importance ('de minimis')

- 7.29 The CMA may decide not to refer a merger if it believes that the market(s) to which the duty to refer applies is/are not of sufficient importance to justify a reference.
- 7.30 The CMA considers that the market(s) concerned (as opposed to the merging providers' turnover in the relevant market(s) concerned) will generally be of sufficient importance to justify a reference (such that the exception will not be applied) where its/their annual value in the UK, in aggregate, is more than £10 million. By contrast, where the annual value in the UK of the market(s) concerned is, in aggregate, less than £3 million, the CMA will generally not consider a reference justified provided that there is in principle not a clear-cut undertaking in lieu of reference available.
- 7.31 Where the annual value in the UK, in aggregate, of the market(s) concerned is between £3 million and £10 million, the CMA will consider whether the expected adverse effect on patients and/or commissioners resulting from the merger is materially greater than the average public cost of a reference. The

⁹⁸ Paragraph 4.10 of [Mergers: Exceptions to the duty to refer and undertakings in lieu of reference guidance \(OFT1122\)](#).

CMA will base its assessment of expected harm on: the size of the market concerned; its view of the likelihood that an SLC will occur; its assessment of the magnitude of any competition that would be lost and therefore adverse effects on patients; and its expectation of the duration of that SLC.

- 7.32 The CMA will also take account of the wider implications of its decisions in this area, and will be less likely to exercise its discretion, and therefore more likely to refer, where the merger is potentially replicable across a number of similar markets in a particular sector.
- 7.33 The CMA may also have regard to the rationale behind an individual merger. In so doing, the CMA may take into account the clinical and financial position of the providers as well as any benefits expected from the merger, even where the CMA did not find that these constituted relevant customer benefits.

Arrangements insufficiently far advanced/insufficiently likely to proceed

- 7.34 The CMA may decide not to refer a merger if it believes that the arrangements concerned are not sufficiently far advanced or are not sufficiently likely to proceed to justify a reference. This exception therefore only applies to anticipated mergers.
- 7.35 The intention of this exception to the duty to refer under section 33(2)(b) of the Act is to avoid the unnecessary expense of a reference where it is still uncertain whether the merging providers will proceed with the merger.
- 7.36 This provision also ensures that the duty to refer is not triggered when the CMA is informed of potential transactions on a confidential basis in order for the merging providers to seek informal advice.
- 7.37 The CMA would usually expect a merger to be sufficiently advanced to justify a reference where the providers to a merger have publicly announced an agreed merger or their intention to merge (in whole or in part).⁹⁹
- 7.38 This exception may be appropriate for use in situations where commercial discussions between the merging providers are still ongoing at the time of the CMA's investigation, for example in anticipated joint venture situations where there remains material ambiguity about how the joint venture will be structured.

⁹⁹ The CMA requires the merger or merger proposal to be in the public domain before it starts its investigation. In practice, the CMA will also ask for evidence of heads of agreement or similar for the agreed merger or evidence of board-level approval in principle.

- 7.39 In practice, the CMA would take a view soon after notification as to whether this exception applies.
- 7.40 The fact that further approval is required, for example from Monitor, for the merger to proceed would not be sufficient to justify the use of this exception.

8. Remedies

Procedure and framework

Undertakings in lieu at Phase 1

- 8.1 If the CMA finds that its duty to refer the merger for a Phase 2 investigation applies, the merging providers may be able to avoid that outcome by offering binding undertakings in lieu of reference (UILs) for the CMA to accept. See [Mergers: Guidance on the CMA's approach to jurisdiction and procedure \(CMA2\)](#) for further information on the UIL process.
- 8.2 In order to accept UILs under section 73 of the Act, the CMA must be confident that the competition concerns identified will be resolved by means of the UILs offered without the need for further investigation. UILs are therefore appropriate only where the competition concerns raised by the merger and the remedies proposed to address them are clear-cut, and those remedies are effective and capable of ready implementation. Any UILs accepted by the CMA must be for the purpose of remedying, mitigating or preventing the SLC concerned or any adverse effects identified.
- 8.3 Given the complexity of remedies in healthcare cases, where merging providers are looking to obtain a Phase 1 clearance by offering UILs, the CMA is particularly ready to engage in early dialogue with merging providers on the availability and design of remedies with the case team throughout the case, including in pre-notification. Such discussion will not be disclosed to the CMA decision-maker in advance of their decision on competition issues.

Remedies and relevant customer benefits at Phase 2

- 8.4 If, following a Phase 2 assessment, the CMA decides that a merger gives rise to an SLC, it must consider whether action should be taken by it, or by others, to remedy, mitigate or prevent the SLC concerned or any adverse effect that has resulted from, or may be expected to result from, that SLC. If action is to be taken, the CMA then considers what action should be taken and what is to be remedied, mitigated or prevented.
- 8.5 The CMA at Phase 2 will normally take relevant customer benefits into account, as permitted by the Act, by considering the extent to which effective alternative remedies may preserve such benefits.¹⁰⁰ The CMA may modify a remedy to ensure retention of a relevant customer benefit or it may change its remedy selection, for instance it may decide to implement a remedy other

¹⁰⁰ Sections 35(5) & 36(6) of the Act.

than prohibition or it may decide that no remedy is appropriate. See paragraphs 7.12 to 7.22 for a discussion of what constitutes a relevant customer benefit, which also applies to Phase 2.

- 8.6 Merging providers may either submit further evidence on relevant customer benefits at Phase 2 to the CMA or, in the event that they did not submit any relevant customer benefits during the Phase 1 inquiry, make such submissions for the first time in Phase 2. The CMA will seek Monitor's views regarding the Phase 2 relevant customer benefits proposal recognising its expertise as a sectoral regulator. Where the CMA has been provided with advice in Phase 1, the CMA will attach such weight to that advice in Phase 2 as it considers appropriate in the light of any changes to the proposed customer benefits and/or relevant evidence gathered and analysis undertaken during the course of its investigation.

Categories of remedies

- 8.7 Remedies fall into two categories:

- (a) structural remedies, which are generally one-off measures that seek to restore or maintain the competitive structure of the market (such as divestment of all or part of the acquired assets to a suitable purchaser who can provide effective competition for a completed merger, or prohibition for an anticipated merger)
- (b) behavioural remedies, which are normally ongoing measures that are designed to regulate or constrain the behaviour of merger parties. Behavioural undertakings may be accepted or imposed in addition to, or instead of, divestiture

- 8.8 At Phase 1 the CMA is more likely to accept structural undertakings as UILs than behavioural undertakings because they address the change to the market structure that gives rise to the competition concerns.

- 8.9 Behavioural undertakings and remedies may bring a number of risks which can reduce their effectiveness or create competition concerns elsewhere. In terms of monitoring and enforceability, behavioural remedies can raise significant concerns: it is difficult to design them so that there are no loopholes and, even if this is achieved, requires monitoring and may be liable to circumvention.

- 8.10 As such, the CMA will therefore typically expect UILs offered by merging providers to be structural, rather than behavioural, in nature.¹⁰¹ As discussed above, where merging parties wish to obtain clearance for the merger at Phase 1 by offering UILs, they are encouraged to engage early with the case team in their design.
- 8.11 See [Mergers: Exceptions to the duty to refer and undertakings in lieu of reference guidance \(OFT1122\)](#) for more information on how the CMA will assess UILs in Phase 1.
- 8.12 Similarly, at Phase 2, the CMA will generally prefer structural remedies to behavioural remedies because:
- (a) structural remedies are likely to deal with an SLC and its resulting adverse effects directly and comprehensively at source by restoring rivalry (they address the change to the market structure that gives rise to competition concerns);
 - (b) behavioural remedies may not have an effective impact on the SLC and its resulting adverse effects, and may create significant costly distortions in market outcomes; and
 - (c) structural remedies do not normally require monitoring and enforcement once implemented.

See [Merger remedies \(CC8\)](#) for more detail on the assessment of remedies in Phase 2.¹⁰²

¹⁰¹ See further [Mergers: Exceptions to the duty to refer and undertakings in lieu of reference guidance \(OFT1122\)](#). Experience has indicated that UILs are accepted most frequently in cases where, first, the problematic overlaps represent a small proportion of the merger and, second, those overlaps involve asset packages – such as stand-alone operations in separate local markets – that are severable from the remainder of the transaction without materially affecting the overall rationale for the merger.

¹⁰² The CC report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013, paragraph 9.162ff, discusses behavioural remedies, including those previously accepted by the Cooperation and Competition Panel.

9. Further information

CMA publications

Mergers: Guidance on the CMA's approach to jurisdiction and procedure (CMA2)

Administrative penalties: Statement of Policy on the CMA's approach (CMA4)

Merger Notice for use by business for notifying an anticipated or completed merger to the CMA under Section 96 of the Enterprise Act 2002 (as amended)

Transparency and disclosure: Statement of the CMA's policy and approach (CMA6)

OFT/CC publications adopted by the CMA¹⁰³

Merger assessment guidelines (CC2 (revised)/OFT1254)

Mergers: Exceptions to the duty to refer and undertakings in lieu of reference guidance (OFT1122)

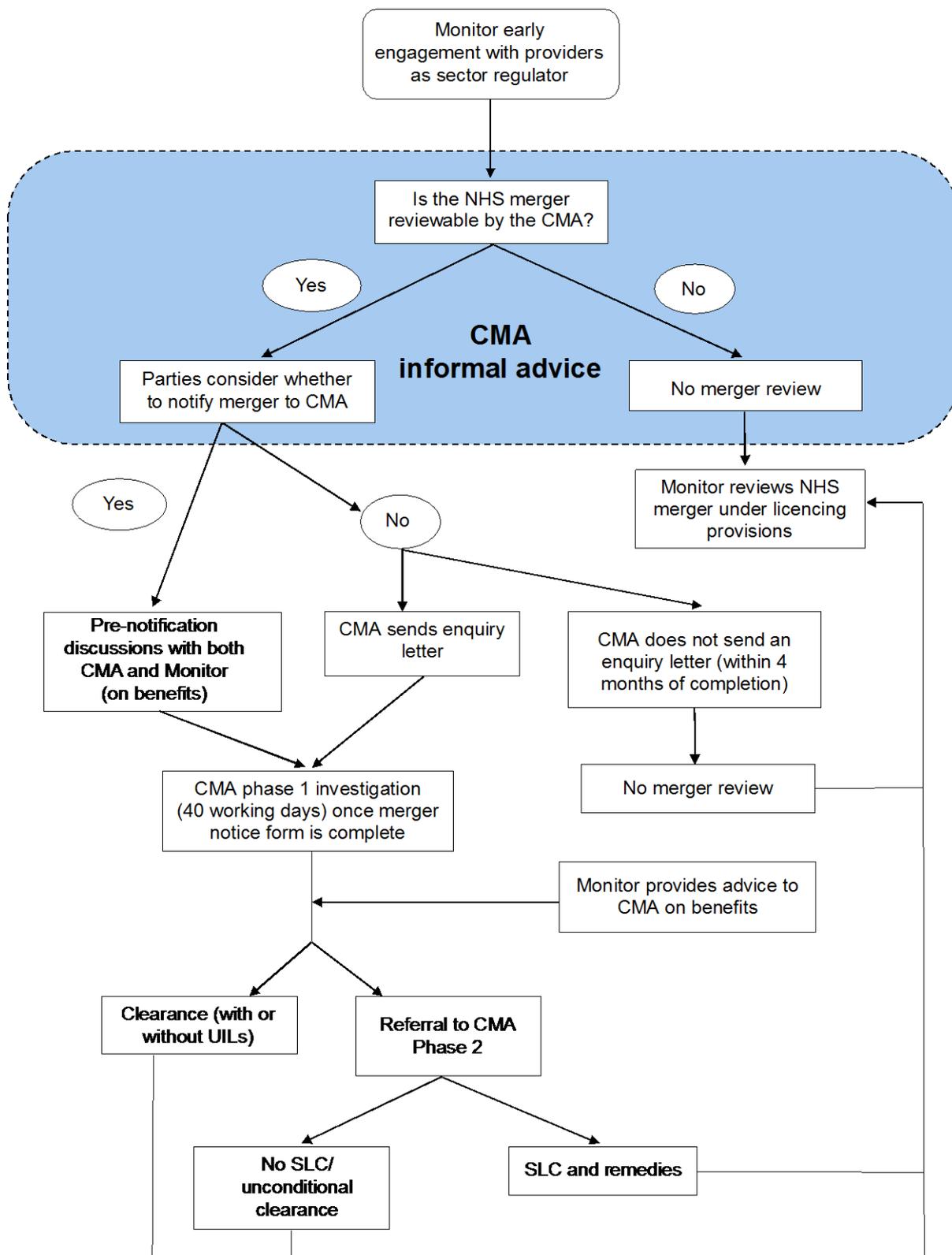
Merger Remedies: Competition Commission Guidelines (CC8)

Chairman's Guidance on Disclosure of Information in Merger and Market Inquiries (CC7)

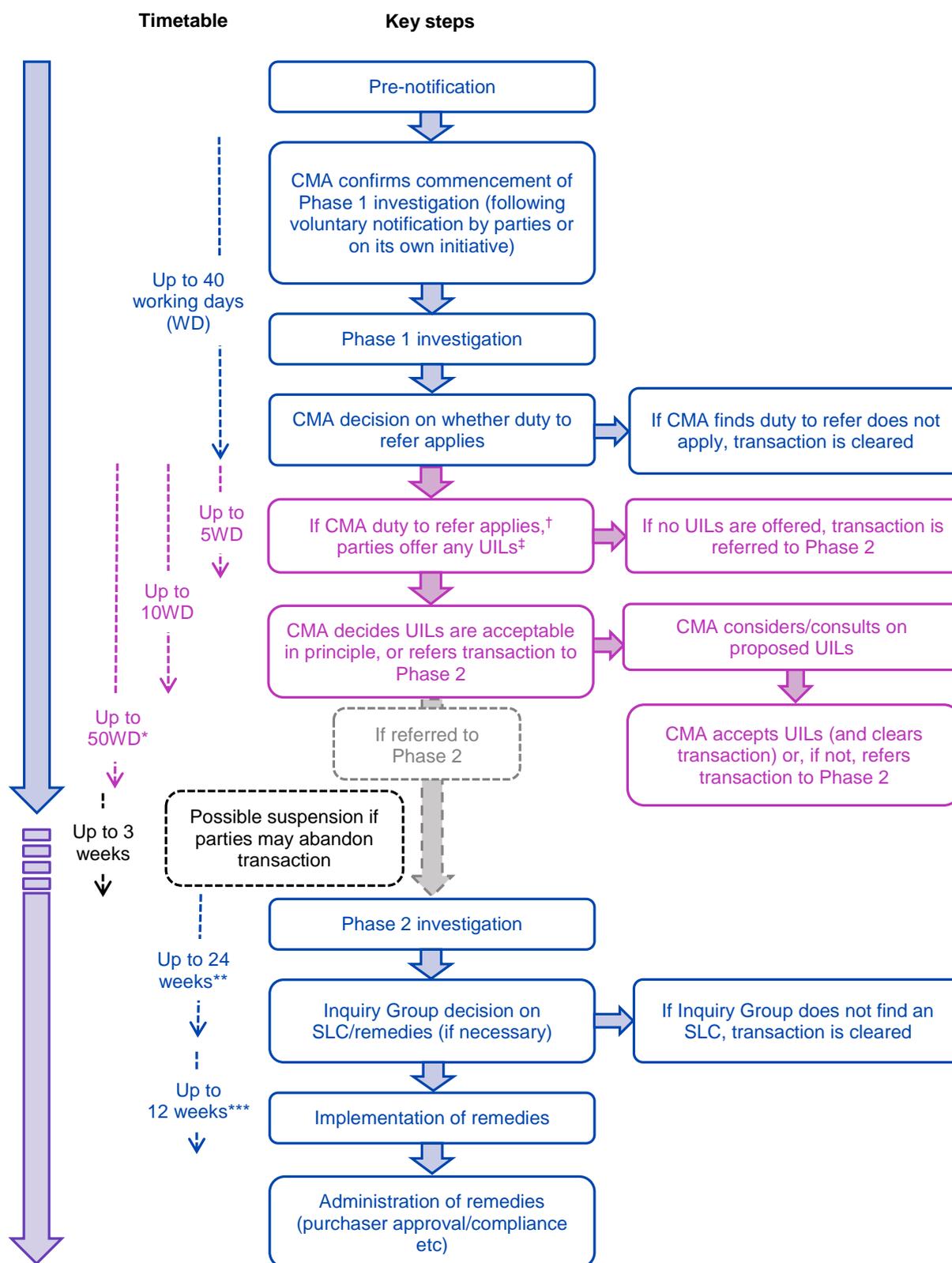
CMA publications and OFT/CC publications adopted by the CMA are available at www.gov.uk/cma.

¹⁰³ As the documents were published prior to the amendments introduced to the Act by the ERRA13, they should be read subject to guidance CMA2 and to the notes in Annex D of that guidance.

Principal stages and interaction of CMA and Monitor processes



Principal stages of a CMA merger investigation



*Extendable by up to 40 working days. **Extendable by up to eight weeks. ***Extendable by up to six weeks.

[†]Exceptions to the duty to refer considered including relevant customer benefits.

[‡]Undertakings in lieu of reference to Phase 2.

Glossary

Act	Enterprise Act 2002, as amended, which sets out the legislation governing the CMA's review of mergers.
Buyer power	This can arise where commissioners enjoy significant negotiating power, for example because they account for a significant proportion of revenues of the provider and have good alternatives.
Conglomerate merger	Merger between two providers which are not active in the same market but which are nevertheless related in some way.
Counterfactual	CMA examines the likely effects of the merger against what would happen without the merger (this is known as the counterfactual).
Enterprise	The activities or part of the activities of a business.
Entry/expansion	Where other providers are able and have incentives to begin supplying or expanding their service offering such that it limits the risk of harm from the merger.
ERRA13	The Enterprise and Regulatory Reform Act 2013, which amended the Enterprise Act 2002 and created the CMA.
HSCA	Health and Social Care Act 2012, which confirmed the CMA's jurisdiction over mergers involving a foundation trust and set out Monitor's role.
Integrated care	Mergers arising from integrated care initiatives can be subject to merger control. Typically, mergers between providers that supply different parts of the patient care pathway (for example, GPs and acute hospitals) are less likely to give rise to competition concerns. However, they may do so if they distort patient choice (for example, by enabling the merged provider to direct referrals to itself to the detriment of competitors).
Market definition	The purpose of market definition is to provide a framework for the CMA's analysis of the competitive effects of the merger. The relevant market contains the most significant competitive alternatives available to the customers of the merging providers.
Relevant customer benefits	Benefits to patients and/or commissioners arising as a result of the merger within a reasonable period.
Service reconfigurations	Mergers arising from service reconfigurations can be subject to merger control. The CMA will have regard to the context of the service reconfiguration in its assessment (for example, it

may be relevant to the counterfactual or benefits of the merger). The CMA's jurisdiction to review mergers does not extend to the award of a contract by a commissioner, provided that there is nothing more attached to the contract award (that is, no transfer of assets such as equipment or staff from one provider to another).

Share of supply

Share of supply of any particular goods or services.

UILs

Undertakings in lieu. Undertakings offered by the merging providers, which the CMA may accept instead of referring the merger for a Phase 2 investigation.

Vertical merger

Merger between two providers supplying services at a different point in time of a patient's pathway.