RESPONSE TO THE CONSULTATION ON

THE CMA GUIDANCE ON THE REVIEW OF NHS MERGERS

1. Clifford Chance LLP welcomes the opportunity to comment on the Consultation on the CMA Guidance on the review of NHS mergers (the **Consultation Document**).

2. Our comments below are based on the substantial experience of lawyers in our Antitrust Practice of advising clients on competition law across a diverse range of sectors, including healthcare. However, the comments in this response do not necessarily represent the views of every Clifford Chance lawyer, nor do they purport to represent the views of our clients.

3. Terms defined in the Consultation Document have the same meaning in this response.

4. Overall, we find the Consultation Document to be helpful and concise, largely replicating the merger review guidance that the CMA has given elsewhere while providing a specific healthcare perspective where possible. We do, however, believe that there are some areas which could benefit from further clarification and/or development.

5. We appreciate that a relatively small number of NHS mergers have been reviewed by the CMA (and its predecessor organisations) since the introduction of the Health and Social Care Act 2012. As a result, the CMA has a relatively limited body of experience on which to compile this guidance. We therefore welcome the statement (at paragraph 2.3) that the guidance may be revised from time to time to reflect changes in best practice, legislation and the results of experience, legal judgments and research. We would hope that the guidance will be updated on a regular basis as the CMA acquires more experience with NHS mergers, in particular to include more practical guidance of both a procedural and substantive nature.

The Role of Monitor

6. The Consultation Document sets out a number of different roles for Monitor, including the risk assessment of mergers from a governance/continuity of services perspective (paragraph 3.10), the review of the strategic rationale for a proposed merger as sector regulator (paragraph 3.11), its statutory duty to advise the CMA on benefits arising from a merger (paragraph 3.13) and providing early consultation to merging parties to identify the types of competition issues that might arise (paragraph 4.5).

7. The Consultation Document has helpfully noted that the CMA will place significant weight on the advice that Monitor is required to provide to it at phase 1 on the patient benefits of a merger. It would be helpful if the document provided further information on the role of Monitor at phase 2. Given its sectoral expertise, we assume that there is no

reason why the CMA should not continue to place significant weight on Monitor's views at phase 2 in relation to patient benefits notwithstanding the absence of a formal role at that stage of the process. In practice, this should mean continuing to seek Monitor's views on patient benefits throughout the course of the phase 2 review, in particular in the event that the merging providers provide additional evidence on the expec.ted patient benefits of their merger during phase 2.

Informal advice and pre-notification

8. We welcome the CMA's willingness to engage in informal advice with merging providers, in particular in circumstances where the providers are seeking advice on jurisdictional issues only (e.g. where providers are unsure as to whether the CMA has jurisdiction to review their NHS merger). We also welcome the clarification by the CMA that informing the CMA case officer if and when the proposed transaction goes ahead does not mean that the CMA will necessarily investigate the transaction.

9. In relation to the pre-notification phase, it would be helpful if the guidance were to give an indication / time range that can be expected for this phase based on cases to date. Given Monitor's formal role in relation to patient benefits and the need to engage in pre-notification with Monitor, we understand that the CMA pre-notification phase is likely to be relatively lengthy and potentially considerably longer than the average time frame for mergers outside of the NHS. It would be helpful for NHS executives to be made aware of this feature of the process so that they can factor this potentially lengthy stage into their transaction planning.

Interim orders

10. It would be helpful if the guidance confirmed that interim orders in the context of anticipated mergers would not typically prohibit pre-existing collaboration between the merging providers – i.e. collaboration which had existed prior to the providers entering into discussions about a possible merger. As the CMA recognises in the Consultation Document, collaboration is an important factor in delivering effective healthcare to patients and it is important that ordinary course collaboration is not prohibited during the merger review process.

The counterfactual

11. We are grateful for the CMA's acknowledgment that new legislation or policy developments could create alternative counterfactuals (paragraph 6.12). It would be helpful if, in addition, the guidance recognised that certain "commissioner-led" scenarios could be taken into account in the context of the counterfactual – e.g. where commissioners have indicated an intention for a certain service reconfiguration to take place regardless of whether or not the planned merger in question takes place.

12. The wording at paragraph 6.14 as currently drafted is a little misleading as it suggests the CMA will only consider exit as an alternative counterfactual to the *status quo ante*

whereas it is clear that the CMA, particularly at phase 2, may accept alternative counterfactuals (as explained in paragraph 6.12).

13. Paragraph 6.32 appears to overlap with paragraph 6.14.

Competitive assessment

14. Paragraph 6.3 states "*The statutory context of the Act means that, in those Phase 1 cases where there is genuine uncertainty as to whether the duty to refer arises, 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*". We would respectfully submit that this is an incorrect interpretation of the reference test. The relevant question is not whether there is genuine uncertainty as to whether the duty to refer arises – indeed, if there is genuine uncertainty then the test cannot be met. Rather, the test is at phase 1 whether there is a realistic prospect of a substantial lessening of competition.

Relevant patient benefits

15. We believe that the Consultation Document's section on relevant patient benefits is a useful summary of current thinking on the issue. Though the examples of previously submitted benefits and indications as to how the CMA would consider such submissions (paragraph 7.11) are helpful, we would be grateful for more guidance as to which types of proposed benefits are likely to be accepted by the CMA. We understand that Monitor is intending to publish further guidance on patient benefits that may be relevant in this respect.

16. In relation to financial savings benefits, we welcome the CMA's statement that it would expect savings to be reinvested in healthcare services (paragraph 7.11), which we interpret to mean that it is not necessary to provide additional evidence of how those savings will actually be reinvested. In this respect, we consider that the guidance should make a clearer distinction between relevant customer benefits which accrue to patients and those which accrue to commissioners. This distinction is hinted at in paragraphs 7.1 and 7.13, but the rest of the guidance conflates the two concepts. While we recognise that benefits for commissioners will indeed equate to benefits for patients in most cases, this may not always be the case. In particular, a merger may result in financial savings for commissioners (as the merging providers are able to provide their services at lower cost), while at the same time being neutral in terms of benefits for patients of the providers (as services will continue to be provided at the same quality). Given that such benefits for commissioners fall within the statutory definition of relevant customer benefits, we consider that it would be neither reasonable nor legally justified to expect merging providers to be able to provide evidence of the use to which commissioners will put their cost savings, and the attendant benefits for patients.

17. On a similar note, it would be helpful if the guidance clarified (in line with paragraph 7.22) that reinvestment of cost savings need not be channelled into the service(s) where the CMA had identified an SLC.

Remedies

18. In relation to structural remedies, it would be helpful if the guidance included examples of the type of structural remedies that might apply in the NHS merger context, such as the transfer of a service to a third party provider and the circumstances in which a type of "access" remedy might be acceptable, e.g. whereby one of the merging providers provides access to its facilities etc to a third party provider to enable it to offer a particular service on the merging provider's site.

19. In addition, we do not believe that the CMA should be so dismissive of the possibility of behavioural remedies at phase 1 (paragraph 8.3). This appears to be a read-across of its general approach to remedies in other merger cases, but could stand to be adapted in regards to NHS mergers, particular considering that the CCP and Monitor (as well as the Competition Commission at phase 2) have accepted behavioural remedies in the past, and that Monitor is well-placed to monitor compliance with such remedies.

20. It would seem that there should be greater logic and suitability for remedies of a behavioural nature in the NHS setting given the pre-existing presence of sectoral regulation. Applying a behavioural remedy in this context effectively amounts to no more than adding an additional layer of soft regulation and should therefore (assuming the behavioural remedy is deemed to be capable of being effective) at the very least merit serious consideration by the CMA. We assume that this explains the reasoning for CCP recommending behavioural-type remedies in relation to a number of its merger assessments in the past. If, in fact, the CMA does not agree with the CCP's past approach in relation to this issue, it would be helpful if the CMA could state explicitly this in the guidance and provide an explanation for the divergence in approach between itself and CCP.

21. Paragraph 8.5 indicates that in anticipated mergers where the CMA has identified an SLC "this will often mean that the merger is prohibited". The CMA may wish to reconsider this wording as it is not clear to us that this is strictly true given that prohibition is the remedy of last resort and the [majority] of anticipated cases have tended to be resolved by a remedy that falls short of a prohibition.

Clifford Chance LLP

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