CMA
Competition & Markets Authority

CMA guidance on the review of NHS mergers

Consultation document

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This publication is also available at: www.gov.uk/cma.

CONSULTATION INFORMATION PAGE

Scope of this consultation	The consultation is intended to give advisers and interested parties the opportunity to provide views and comments on the CMA's approach to the review of NHS mergers within the existing statutory framework. This guidance builds upon experience of the CMA's predecessors (the Office of Fair Trading and the Competition Commission) in assessing NHS mergers together with existing guidance on the review of mergers published or adopted by the CMA.
Duration	9 May 2014 to 20 June 2014
Enquiries	By telephone: 020 3738 6586 By email: healthcare.mergers@cma.gsi.gov.uk By post: Sheldon Mills, Senior Director of Mergers, CMA, Victoria House, Southampton Row, London WC1B 4AD
How to respond	Respondents to this consultation are asked to supply a brief summary of the interest or organisations they represent, where appropriate. We ask that any suggested changes or comments on the documents be submitted in writing by email or letter by 20 June 2014 at the latest.
After the consultation	We will collate responses to the consultation and publish a formal summary of these, along with a final version of the CMA guidance on the review of NHS mergers over the summer.
Compliance with the Cabinet Office Consultation Principles	This consultation is compliant with the latest Cabinet Office Consultation Principles. The Cabinet Office Consultation Principles can be found at www.gov.uk/government/publications/consultation-principles-guidance.
Feedback about this consultation	If you wish to comment on the conduct of this consultation or make a complaint about the way this consultation has been conducted, please write to: Alex Chisholm Chief Executive CMA Victoria House Southampton Row London WC1B 4AD

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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 public providers of National Health Service (NHS) services (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 integration 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 integration 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 the overall goal of the NHS to improve 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 outcomes, 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, in continually striving to 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 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 Instances of mergers, acquisitions, service reconfigurations, integrations, joint ventures, asset transfers between providers may qualify for review under merger control rules. However, the majority of NHS mergers will not raise competition concerns and therefore may not require investigation by the CMA. It is up to providers, with advice and assistance from Monitor and the CMA, to decide whether or not to notify. This guidance sets out how the CMA will approach its assessment of NHS mergers both procedurally for those cases which may raise competition concerns and substantively in order to assist merging providers seeking to analyse whether their NHS merger may do so.

2. Scope of the guidance

2.1 This guidance is concerned with those mergers involving at least one public benefit organisation providing 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] It does not concern transactions between 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).

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 OFT or 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 CMA has referred to advice by the Cooperation and Competition Panel, in relation to patient benefits in particular, where it has felt this would be useful despite the different legal test they applied.[2]

2.4 This guidance is not intended to be comprehensive. It cannot, therefore, be seen as a substitute for the Act and the regulations and orders made under the Act, the ERRA13 or the Health and Social Care Act 2012 (HSCA), nor can it be cited as a definitive interpretation of the law. Anyone in any doubt about

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[1] Mergers between NHS trusts only are not covered by the Act.

[2] 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.

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 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.

3. Merger review in the UK

Introduction

3.1 Merger review in the UK 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. For example, in relation to NHS mergers:

- 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 potential 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. 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, and
- the creation of that situation has resulted, or may be expected to result, in a substantial lessening of competition (SLC)[3]

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[3] 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 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). 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 leading to 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').[4]

3.8 If the Inquiry Group finds that there is an anti-competitive 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 substantial lessening of competition
- 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 protect and promote the interests of patients by ensuring that the sector works for their benefit. As well as making sure public providers are well managed, Monitor makes sure essential services are maintained, the NHS payment system promotes quality and efficiency, and that procurement, choice and competition operate in the best interests of patients.

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[4] Section 35(2) of the Act.

Monitor arrangements to support NHS foundation trusts

3.10 Monitor's role includes monitoring NHS providers' compliance with the licence under which they are allowed to operate. This includes a role in approving (where it is satisfied that NHS foundation trusts have taken the necessary preparatory steps) certain transactions involving NHS foundation trusts.[5] As part of this role, Monitor will conduct a risk assessment of mergers from the perspective of governance as well as the continuity of services. This is separate from the CMA merger control review process; Monitor does not have the power to prohibit mergers on the basis that they are expected to give rise to an SLC.

3.11 In addition to conducting a risk assessment of mergers, Monitor, as sector regulator, will also be active in scrutinising and challenging 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. This will assist merging providers to identify at an early stage if the CMA has jurisdiction to review their transaction and 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.

3.12 Ultimately, however, the CMA is responsible for deciding whether an NHS merger falls within its jurisdiction or may lead to worse outcomes for patients/ commissioners and Monitor's role is an advisory one only. 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. Where they have decided to notify the CMA, it is important that merging providers engage with the CMA early in pre-notification discussions to determine what information the CMA will require.

The role of Monitor within the merger review process

3.13 The CMA must notify Monitor where it decides to carry out an investigation of a merger involving an NHS foundation trust. Once notified, Monitor is under a duty to provide advice to the CMA on:[6]

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[5] Under the National Health Service Act 2006, Monitor has a statutory role in approving mergers between NHS foundation trusts or NHS foundation trusts and NHS trusts; acquisitions by an NHS foundation trust of an NHS trust or another NHS foundation trust; separations of NHS foundation trusts into two or more NHS foundation trusts; and dissolutions of NHS foundation trusts. For further information, see www.monitor.gov.uk/.

[6] Section 79 of the HSCA.

- benefits[7] 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

3.14 Monitor's advice is not binding on the CMA. However, the CMA will place significant weight on Monitor's advice on the patient 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

3.15 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.

3.16 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.

[7] 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 notify[8] 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'.[9]

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.[10] 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 launch an in-depth Phase 2 assessment.

4.3 Merging providers are expected to determine for themselves, possibly with their advisers and/or following a discussion with Monitor, whether they should notify the CMA. Providers are encouraged to notify the CMA about their merger before completing where the merger could give rise to possible competition concerns.[11] However, 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 4.11 below).

Approach to engaging with the CMA

Informal advice

4.4 As noted above, in planning mergers and acquisitions, it is for merging providers, possibly with their advisers, to assess whether transactions might give rise to competition concerns and whether to notify the NHS merger to the CMA.

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[8] Notification means submitting a Merger Notice to the CMA.
[9] 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.
[10] 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.
[11] 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.

4.5 Monitor expects NHS foundation trusts to engage with it early when they are considering strategic options such as a merger, acquisition, joint venture or reconfiguration. This is in order to ensure that the underlying strategy (for example, financial synergies, overall patient benefits) is well developed and, where the transaction if reviewable by the CMA, to identify the type of competition issues that might arise.

4.6 To assist their merger planning, NHS providers and their advisers may choose to contact the CMA's mergers unit for advice on an informal basis, whether or not they have also been in contact with Monitor regarding the merger. However, CMA informal advice cannot be obtained for mergers that are purely speculative.

4.7 The mergers unit will give advice on an informal basis on competition issues[12] (and/or, where relevant, jurisdictional issues) arising out of a prospective merger situation. We refer to this as informal advice (IA).

4.8 Providers seeking IA should submit relevant details on the NHS merger and relevant information on the jurisdictional and/or substantive issue they are seeking IA on. The CMA will give IA as soon as possible after receiving the information described above.

4.9 IA is not a decision from the CMA but advice. Therefore, both the content of IA and the fact that a merging provider has applied for it is strictly confidential to the provider(s) seeking that advice and their legal advisers, even after the transaction becomes public. The CMA would be concerned by any intentional or accidental breach of trust 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 IA in the future. This restriction applies even where only one provider to a transaction seeks IA, 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 IA 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 the legal/financial advisers that are privy to the request.[13]

4.10 Receipt of IA is conditional upon the merging providers agreeing to inform the CMA case officer if and when the proposed transaction goes ahead. Informing

[12] Including how the CMA might approach the counterfactual in the particular case, for example as to whether one of the merging providers could be regarded as an 'exiting provider'.
[13] 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.

the case officer is different from a formal notification and does not mean that the CMA will necessarily investigate the transaction.

4.11 See *Mergers: Guidance on the CMA's approach to jurisdiction and procedure* (CMA2) for further information on the procedure for IA (including how to apply for IA) and what to expect from the process (in particular, caveats to the IA).

Pre-notification

4.12 As soon as merging providers have decided to notify the CMA (either following initial discussions with Monitor 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' completed Merger Notice).

4.13 Pre-notification of an NHS merger may happen after the merger proposal has been announced. However, 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 and that providers could approach the CMA in pre-notification before the NHS merger is announced. The benefits of pre-notification, especially in the context of NHS mergers, are as follows:

- help to reduce the amount of information that the CMA needs from the merging providers
- 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
- allow the CMA to identify specific evidence which will assist it to assess the merging providers' claims
- 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)
- encourage the merging providers to engage with the CMA and Monitor on any relevant benefits of the merger from an early stage
- lessen pressures on the statutory timelines and reduce information requests during the CMA's assessment process

Notification

4.14 Where merging providers have decided 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

4.15 Regular sharing of information and 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.

4.16 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 benefits.

4.17 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.

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 stage of its 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' in certain circumstances, in particular where information the CMA has formally requested remains outstanding.

4.19 At Phase 1, the CMA determines whether it believes that the merger results in a realistic prospect of an SLC. If so, it has a duty to refer the merger for a Phase 2 assessment unless the CMA exercises its discretion to apply any of the exceptions to the duty to refer. These exceptions include the benefits of the merger outweighing the SLC and any adverse effects from it on patients and/or commissioners (see Chapter 7).[14] The parties may also offer and the CMA accept undertakings in lieu of a reference (see Chapter 8).

4.20 At Phase 2, generally limited to 24 weeks, a CMA Inquiry Group conducts an in-depth investigation to assess if a merger is expected to result in an SLC. It issues a provisional decision for consultation during this time frame and, if an SLC is expected, the CMA Inquiry Group then consults upon relevant customer benefits of the merger and possible remedies. It will issue its decision on whether there is an SLC, whether there are relevant customer benefits, and appropriate remedies in its final report. If it determines in its final report that a merger may result in an SLC, the CMA has a statutory deadline of 12 weeks (extendable by up to six weeks for special reasons) to make an order or accept undertakings to give effect to the Phase 2 remedies it determined were appropriate.

Information-gathering powers

4.21 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 initial Merger Notice to allow it to make a decision on

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[14] 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.

reference.[15] 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.

4.22 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,[16] 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.[17]

4.23 If a relevant merger party 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) 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.

4.24 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.

4.25 However, in all cases the CMA ensures that its requests are tailored to the case at hand and necessary for its investigation.

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

[15] This is the case even though the information it has received is sufficient for the CMA to be satisfied that the Merger Notice is complete for the purposes of commencing the CMA's review and its 40 working day timetable.
[16] Where the CMA requests information from third parties, it will typically request that information informally in the first instance.
[17] 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.

Publication

4.27 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.[18]

4.28 In addition to the above, the CMA generally discloses publicly initial Phase 2 submissions and responses made by merging providers to the Phase 2 issues statement. 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.

4.29 In the event of a disagreement on the matter with the case team at Phase 1 or the Inquiry Group at Phase 2, parties may make representations to the CMA's Procedural Officer.

Orders and information sharing between providers

4.30 The CMA will normally make interim orders in investigations where it has reasonable grounds for suspecting that two or more enterprises have ceased to be distinct. An interim order is intended to prevent any 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.

4.31 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

[18] 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).

may focus on a number of specific concerns rather than the template interim order.[19]

Merger fees

4.32 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).[20]

Further information

4.33 Further information is available in *Mergers: Guidance on the CMA's approach to jurisdiction and procedure* (CMA2).

[19] 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.
[20] 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. There is no specific exemption for NHS providers.

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.[21]

5.2 UK merger control applies to different types of transactions. In the NHS context, the term 'merger' includes those as set out in section 56 of the NHS Act 2006 as amended,[22] 'acquisitions' regardless of whether any financial consideration is payable; joint ventures (where different joint venture partners acquire different levels of control over the 'enterprises' being contributed by the other joint venture partners); the transfer of individual services or activities to another enterprise;[23] asset swaps; and any other transactions leading to a change of control over the activities of one or more enterprises. The terms 'acquirer' and/or acquired assets or target are interpreted widely and refer to the acquisition of control in all of these scenarios.

5.3 Arrangements between private patient units (PPUs) and private hospital operators to operate or manage a PPU are subject to the possibility of CMA review.[24]

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[21] 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.
[22] 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.
[23] 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.
[24] See the CMA's final report on the private healthcare market investigation dated 2 April 2014, section 11.

Enterprise

5.4 'Enterprise'[25] 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 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.

5.5 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 merger 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). Therefore, an enterprise may be acquired even without the transfer of a contract if, for example, the acquiring provider is already entitled to supply the services without requiring the NHS contract to transfer and acquires staff and assets.

Change of control

5.6 Two enterprises cease to be distinct if they are brought under common ownership or control. There must be a change in the level of control over the activities of one or more enterprises for UK merger control to apply.[26]

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.

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[25] The term enterprise is defined in section 129 of the Act.

[26] 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, Hinchingbrooke Health Care NHS Trust, The Ipswich Hospital NHS Trust and West Suffolk NHS Foundation Trust, ME/6427/14, dated 27 March 2014.

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

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 mergers of equals 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.

Turnover test

5.13 The relevant turnover is calculated by adding the turnover of all the enterprises involved in the transaction and either deducting the 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.[27]

Share of supply

5.14 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.

5.15 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.[28] 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. For example, two pathology providers may have a small market share when considering the routine tests they provide within a 1-hour drive.[29] However, they may still meet the share of supply test if they both provide routine pathology tests and these account for 25% or more of routine pathology services to the three nearest clinical commissioning groups (CCGs) to them (they need not both supply the same CCGs), if these areas are sufficient to form a substantial part of the UK.

Applicability of the UK merger control regime to NHS mergers

5.16 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'. It also applies to mergers between NHS trusts and other 'enterprises'.[30] 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.

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[27] See paragraphs 4.47ff and Annex B of the CMA Mergers Guidance on how to calculate the relevant turnover for the jurisdictional test.
[28] Section 23 of the Act.
[29] 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.
[30] Section 23 of the Act. Section 79 of the HSCA confirmed the role of the CMA in examining mergers between NHS foundation trusts as well as between NHS foundation trusts and other enterprises.

Applicability of the UK merger control regime to NHS service reconfigurations

5.17 The merger control regime may apply to NHS service reconfigurations in certain circumstances. Where those with control over providers[31] decide to merge two or more enterprises, the transaction may qualify for investigation if it meets the jurisdictional thresholds set out above.

5.18 NHS service reconfigurations can take many forms, which may involve the transfer of an 'enterprise' depending on the circumstances. In some cases, NHS commissioners and providers enter into multi-party agreements. Sometimes providers agree between themselves to transfer assets and then ask the commissioner to transfer a contract. 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, 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 and staff is sufficient to form an enterprise (see paragraphs 5.4 and 5.5 above) and the other jurisdictional criteria are met, these types of transfer can create a relevant merger situation reviewable under UK merger control.

5.19 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 to an NHS 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 the winning provider, for example).

[31] This can be the board of an NHS foundation trust or the Secretary of State for health in the case of NHS trusts.

6. Merger assessment

6.1 While most mergers that take place in the UK will 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.

The substantial lessening of competition test

6.2 Competition occurs between providers seeking to obtain more commissioner contracts and/or patients by providing them 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).

6.3 At Phase 1, the CMA's test for reference 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.[32] 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.[33] At Phase 2, the Inquiry Group decides whether in its view an SLC is likely to arise.

Competition in the NHS in England

6.4 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).

6.5 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 tariffs that are set centrally. Providers are motivated to compete on quality in order to attract patient referrals and hence income.

[32] At Phase 1, the decision on reference is taken by a senior staff member of the CMA.
[33] 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).

6.6 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.[34]

6.7 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 run competitive processes.

6.8 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

6.9 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.[35] As such, selection of the appropriate counterfactual is an important step in determining whether or not there is an SLC.

6.10 At Phase 1, 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.

[34] 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.
[35] 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 At Phase 2, the CMA may examine several possible scenarios but only the most likely scenario will be selected as the counterfactual. 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.

6.12 Examples of alternative counterfactuals are:

- another merger than the one under review
- 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 6.15 to 6.32 below)[36]
- loss of a potential entrant
- parallel transactions[37]
- it is also possible that new legislation or policy developments will affect the way that merging providers would have competed absent the merger

6.13 Where relevant, the CMA will consider the merging providers' submissions on the counterfactual together with views of third parties (including commissioners and Monitor).

6.14 In the absence of sufficient evidence relating to exit, the CMA is unlikely to accept that the appropriate counterfactual is anything other than the pre-merger situation. However, where there is insufficient evidence on exit, the CMA will take into account any evidence of the strength (or lack of due to clinical or financial difficulties) of a provider in its competitive assessment.

Exiting provider

6.15 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

[36] 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.

[37] 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.

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.

6.16 Where the CMA receives such submissions, it will assess whether the appropriate counterfactual is that either of the merging providers would exit the market. In such cases, in addition to the merging providers' submission and the views of third parties, the CMA may consider 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.

6.17 In forming a view on an exiting provider scenario, the CMA will consider the following three limbs:

- whether the provider would exit (through failure or otherwise) and, if so
- whether there would be an alternative acquirer for the provider's assets to the acquirer under consideration; and
- where the patients and the commissioner contracts of the provider would go in the event of the provider's exit

6.18 The CMA has different thresholds for reaching an SLC finding in Phase 1 and Phase 2. The impact of this on the counterfactual is explained below. This guidance then explains the three limbs in more detail highlighting the differences between Phase 1 and Phase 2 where relevant.

At Phase 1

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 6.17 above), the merger will not lead to an SLC.

At Phase 2

6.20 At Phase 2 the three limbs are also relevant to the CMA's identification of an appropriate counterfactual. 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.

The three limbs

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 There is a regulatory regime 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 process (TSA) 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.[38] 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.

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. 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. 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.

6.24 Dissolution of a provider is only one outcome of a TSA process. The CMA is, however, likely to accept that dissolution of the relevant entity is inevitable (Phase 1) or the most likely outcome (Phase 2) such that it is the appropriate starting point for the counterfactual if the TSA process is significantly

[38] The Care Bill also allows the TSA process to be triggered by clinical failure. 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 only been two instances of NHS providers going through the TSA process, which was established in 2009.

advanced (at draft report stage) and dissolution is the likely recommendation. 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 outlines 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 to the merger under review. 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.

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 services[39] or if their service offering would change in other ways (for example, due to financial or other constraints), 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.

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[39] 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.

6.28 Changes to services can be:

- led by commissioners
- led by the provider[40]
- required by the CQC[41]

6.29 In each case the CMA would consider 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 consultation.[42] 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, the CMA is unlikely to accept that the appropriate counterfactual is anything other than the pre-merger situation. However, where there is insufficient evidence on exit, the CMA will take into account evidence on clinical or financial difficulties in its competitive assessment. Merging providers may therefore 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 (see paragraph 6.56 below).

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[40] 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.
[41] The CQC has the power to suspend or cancel registration for some or all services, thereby preventing a provider from providing these services.
[42] 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.

Identifying the relevant markets

6.33 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.

6.34 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

6.35 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.[43]

6.36 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.[44] 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 inpatient[45] 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.

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[43] 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.

[44] The CMA will 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.

[45] The CMA is likely to treat day cases as part of inpatient activity.

– 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.[46] However, where certain 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,[47] 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).[48]

6.37 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.[49]

Geographic market definition

6.38 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'). [50] The geographic market may not necessarily be the same

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[46] 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.
[47] 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.
[48] 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.
[49] 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.
[50] 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.

for all services or for all competition concerns (‘theories of harm’) under investigation.

6.39 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 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.

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

Examining the effects on competition

Market shares

6.41 Market shares may give an indication of the extent of a provider’s 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.

6.42 As part of its assessment of the merger, the CMA may consider market shares. If so, the CMA will seek to define what the relevant market is on which these shares are calculated (as discussed above).[51]

6.43 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.

Unilateral effects

6.44 One way a horizontal merger[52] can harm competition is if it removes an important competitor, resulting in a reduced incentive for the merged provider

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[51] This relevant market will represent a technical market and may differ from what providers refer to as the market that they operate in.
[52] That is a merger between providers of the same (or similar) services.

to maintain and provide better-quality services to patients and value for money for commissioners. This is known as a 'unilateral effect' and is the effect that the CMA considers most frequently.

6.45 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

6.46 In relation to competition to attract patients of NHS services, competition is almost always on quality,[53] rather than on price,[54] as the majority of services are covered by national prices and the payment by results regime. The same basic framework applies to elective, non-elective, specialised and community services.[55] Specifically, the aspects of quality which may be impacted by a reduction in competition include clinical factors such as outcomes, infection rates, mortality rates, ratio of nurses or doctors to patients, equipment, best practice and non-clinical factors such as waiting times, cleanliness and parking facilities.

6.47 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:

- patients and/or GPs have and exercise choice of provider
- quality and/or price influences that choice
- the merging providers would have an incentive to compete to attract patients absent the merger
- the merging providers are close competitors

6.48 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.

[53] 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.
[54] However, it is possible for there to be variations from the national tariff.
[55] Different types of tariffs apply to different services. For example, national prices do not apply to some community services.

6.49 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:

- the profitability of increasing activity given the tariff and cost structures
- capacity constraints
- the relationships the merging providers have with CCGs

6.50 In previous merger inquiries, providers have submitted that:

- 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
- 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.[56] That is, providers can strive to exceed minimum regulation standards, which is in the interest of patients.

6.51 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,[57] given that location is usually important in patients' choice of hospitals. The CMA may also survey patients[58] or use existing evidence on diversion ratios (for example, evidence of where patients went in the event of a temporary

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[56] 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 and 6.179–6.184.

[57] 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.

[58] This is more likely to take place in a Phase 2 investigation.

closure).[59] This may provide evidence of how patients and GPs are choosing between providers in the local area.

6.52 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. 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

6.53 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.[60]

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

- 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)
- providers on existing contracts might provide lower-quality services, knowing that commissioners have fewer options to replace them post-merger than in the counterfactual

6.55 Where there is competition to attract contracts to provide services, the CMA's assessment will consider whether the merging providers would be close competitors to supply these services and what other providers would constrain them.

[59] A diversion ratio between Service A and Service B represents the proportion of sales 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).
[60] 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.

Weakened competitive constraint

6.56 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).[61]

Coordinated effects

6.57 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.

6.58 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.

6.59 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
- 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

[61] 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.

6.60 See *Merger assessment guidelines* (CC2 (revised)/OFT1254) for further information on coordinated effects.

6.61 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.[62]

Vertical and conglomerate mergers

6.62 Mergers are not always between providers of the same set of services.[63] 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).

6.63 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.

6.64 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.

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

6.66 See *Merger assessment guidelines* (CC2 (revised)/OFT1254) for further information on vertical and conglomerate effects.

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[62] See www.monitor.gov.uk/.

[63] 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.

Assessing countervailing factors

6.67 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

6.68 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 benefits, provided that they are likely to arise within a reasonable period (see Chapter 7 below).

6.69 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.

6.70 Further information on types of efficiencies are set out in the *Merger assessment guidelines* (CC2 (revised)/OFT1254).

Entry and expansion

6.71 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.

6.72 In order for entry to be a constraint post-merger, it is necessary that *(a)* other providers can profitably begin or expand activity in response to a reduction in quality or increase in price by the merging providers, and *(b)* 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.

6.73 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.

6.74 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.[64] 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.

6.75 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

6.76 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.

6.77 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 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).

6.78 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 to easily switch (or threaten to switch) its demand to another provider or otherwise constrain the merged provider. The CMA would be looking at

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[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 7.12–7.17.

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

Relevant customer benefits

7.1 The CMA can take relevant customer benefits arising from a merger into account when deciding whether to refer a merger for a Phase 2 investigation and, at Phase 2, when making its decision as to remedies. In the context of NHS mergers, this means benefits to patients and/or commissioners. This chapter therefore refers to relevant customer benefits as relevant patient benefits.

7.2 The CMA takes account of relevant patient benefits in different ways at Phase 1 and Phase 2. At Phase 1, relevant patient 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.

7.3 At Phase 2, where the CMA has found adverse effects on patients and/or commissioners to be likely to arise from a loss of competition, it will consider what action should be taken to remedy the SLC. When considering remedies, the CMA will normally take relevant patient benefits into account and have regard to the impact of any remedial action on patient benefits expected to arise from the merger (see Chapter 8). It will consider the extent to which alternative remedies (that is, remedies other than prohibition or divestiture of the acquired provider) may preserve such benefits.

Process and Monitor involvement

7.4 Monitor must provide the CMA in Phase 1 with advice on benefits of the merger (in the form of those within section 30(1)(a) of the Act) 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.[65]

7.5 Monitor's advice is not binding on the CMA. However, the CMA will place significant weight on Monitor's advice on the patient benefits of a merger.

7.6 Where merging providers wish to submit that the merger gives rise to relevant patient benefits, they are encouraged to engage in pre-notification discussions

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[65] Section 79(5) of the HSCA.

with the CMA and Monitor on these at the earliest opportunity.[66] This is because, in such circumstances, the CMA will not notify the merging providers that it has a complete Merger Notice, such that its timetable starts, until it considers that the merging providers have provided sufficient information on relevant patient benefits. The CMA will liaise closely with Monitor as to whether the information received with respect to relevant patient benefits will allow Monitor to start its assessment.

7.7 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 paper.[67]

7.8 Monitor and the CMA will discuss Monitor's views in relation to relevant patient benefits on an ongoing basis and in any event prior to the issues meeting and case review meeting.[68] 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.

7.9 See *Monitor Guidance on Merger Benefits* for further information on the process for Monitor providing advice to the CMA.[69]

What constitutes a relevant patient benefit?

7.10 Relevant patient benefits are limited to be benefits in the form of:[70]

- lower prices, higher quality or greater choice of services or goods in any market in the UK, or
- greater innovation in relation to such services or goods

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[66] If merging providers decide not to make reasoned submissions in relation to RCBs, this should be noted in the Merger Notice and the decision indicated in writing to Monitor. In order to comply with its statutory duty, Monitor will then inform the CMA of the providers' decision as soon as reasonably practicable. If merging providers submit information in relation to RCBs after the CMA has given notice of a satisfactory notification, the CMA considers that it is unlikely to have time to fully verify the claims made by the merging providers within the 40 working day statutory time frame.
[67] 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 as much information as possible about 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.
[68] The case review meeting is an internal meeting following the issues meeting held with the merging providers.
[69] 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.
[70] Section 30(1) of the Act.

7.11 The types of benefits providers have previously submitted, either to the Cooperation and Competition Panel or the OFT/CC, include:

- Higher-quality services through implementing a particular model of care. The CMA will take into account any previous experience the merging providers or other providers may have of successfully 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 quality of services, for example by reducing the length of stay,[71] providing round-the-clock access to a dedicated treatment room,[72] reducing mortality rates and delivering higher-quality stroke services.[73] The CMA will consider whether the specific model of care will improve quality for patients and what issues it is looking to address.

- Higher-quality services through consolidating services to a single site.[74] The CMA will be looking to understand how the quality of those services will improve and any effect on interdependent services. 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.

- Higher-quality services through increased consultant or staff cover. The CMA will be considering the extent to which existing services suffer from staffing problems and how staff increases will result in clinical improvements to patients.[75]

- Higher-quality services through access to equipment. The CMA will consider how the equipment leads to better outcomes for patients.

- Greater innovation through research and development and greater ability to attract funding for research and development.[76] The CMA will consider

[71] 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.
[72] 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.
[73] See the Cooperation and Competition Panel advice on the merger of Northumbria Healthcare NHS Foundation Trust with North Cumbria University Hospitals NHS Trust.
[74] 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 and Appendix M, and the Cooperation and Competition Panel advice on the merger of Nuffield Orthopaedic Centre NHS Trust and Oxford Radcliffe Hospitals NHS Trust.
[75] 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 and Appendix M.
[76] See the Cooperation and Competition Panel advice on the merger of Nuffield Orthopaedic Centre NHS Trust and Oxford Radcliffe Hospitals NHS Trust.

what improvements in research and development will arise as a result of the merger.

- Financial savings.[77] 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) and 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). The CMA will generally expect any saving made to be reinvested in healthcare services, such that they benefit patients due to higher quality, greater choice or innovation of services and/or commissioners in the form of lower prices.

7.12 Whether or not any of these benefits constitute relevant patient benefits will need to be assessed on a case by case basis. In addition to evidence provided by the merging providers, 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.

7.13 A benefit is only a relevant patient 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.[78]

7.14 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 maternity 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.

7.15 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 other than the specific merger.

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[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, Section 9 and Appendix M, and the Cooperation and Competition panel advice on the merger of Nuffield Orthopaedic Centre NHS Trust and Oxford Radcliffe Hospitals NHS Trust.
[78] Section 30(2) and (3) of the Act.

7.16 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.

7.17 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.

7.18 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 CMA does not expect merging providers to have:

- already publicly consulted on the benefits (in respect of changes where consultation would be required for reconfiguration)
- taken a firm decision to proceed with them
- implemented them

7.19 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, they have taken the first in a series of steps, namely:

- determined what the preferred proposal is (the CMA would look at, among other evidence, the merging providers' internal documents) and provided evidence for the need for change
- discussed plans with clinicians of the merging providers and relevant commissioners
- developed a model of care in consultation with clinicians of the merging providers, relevant commissioners, as well as any national clinical experts as appropriate and any relevant advisory group

- produced an assessment of the clinical advantages (and any disadvantages) as well as a robust assessment of the financial or economic viability of the plans[79]

7.20 The CMA will also contact relevant third parties such as commissioners for their views on the benefits.

7.21 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

7.22 In order for the CMA to decide not to refer a merger to Phase 2, any relevant patient benefits must outweigh the SLC and any adverse effects of the SLC in all affected markets.[80] The relevant patient 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 patient benefits might accrue in one market as a result of the merger that would outweigh the finding of an SLC in another market(s).

7.23 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 patient benefits, it will then consider if these outweigh the adverse effects of the merger on patients and/or commissioners.

7.24 Weighing up the benefits against the adverse effects on patients is a complex issue, which turns on the facts and circumstances of an individual case. However, the factors that the CMA may take into account when undertaking the assessment include:

- magnitude of the benefits it believes may be expected to occur. In this respect, the CMA will consider whether the benefit is one which will impact on nearly all or a large number of services and therefore patients and/or commissioners (for example, implementation a model of care across all or a number of services, maternity reconfiguration)

[79] 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.

[80] It is not possible to apply an exception to the duty to refer in relation to certain affected markets, whilst accepting an undertaking in lieu in respect of other markets. Sections 22(2) and 33(2) allow the CMA not to make a reference because of the application of an exception to the duty to refer. Section 73(1) allows the CMA to accept an undertaking in lieu where it is under a duty to make a reference, taking account of the power of the CMA under sections 22(2) and 33(2) to decide not to make such a reference.

- the strength of its belief the benefits will occur
- set against these the magnitude of the adverse effects on patients and/or commissioners that the CMA has identified. In this respect, the CMA will consider in how many specialties it has found adverse effects arising to patient and/or commissioner interests as a result of a loss of competition
- the strength of the CMA's belief that a loss of competition which will adversely affect patients and/or commissioners will occur as a result of the NHS merger

7.25 The more powerful and more likely the adverse effect to patients and/or commissioner interests are due to a loss of competition from the merger, the greater and more likely the relevant patient benefits must be to meet and overcome such concerns.

Markets of insufficient importance ('de minimis')

7.26 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.

7.27 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.

7.28 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 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.

7.29 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.

7.30 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 patient benefits.

Arrangements insufficiently far advanced/insufficiently likely to proceed

7.31 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.

7.32 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.[81]

7.33 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).[82]

7.34 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.

7.35 In practice, and where this is justified, the CMA would take a view soon after notification as to whether a full competition analysis is not required because of the early stage of proceedings.

7.36 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.

[81] The CMA is not obliged under section 107(1)(a) of the Act to publish a decision not to refer on the basis of this exception.

[82] 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.

8. Remedies

Undertakings in lieu

8.1 If the CMA finds that its duty to refer the merger for a Phase 2 investigation applies, the merging providers may have an opportunity 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 The CMA is highly unlikely to accept behavioural remedies at Phase 1. The CMA will therefore typically expect UILs offered by merging providers to be structural, rather than behavioural in nature.[83]

8.4 More guidance on structural and behavioural UILs and their substantive consideration can be found in *Mergers: Exceptions to the duty to refer and undertakings in lieu of reference guidance* (OFT1122) and *Merger remedies* (CC8).

Remedies at Phase 2

8.5 If, following a Phase 2 assessment, the CMA decides that a merger gives rise to an SLC, it will take steps to remedy the effects. For an anticipated merger, this will often mean that the merger is prohibited,[84] although it could be allowed to proceed subject to suitable conditions, for example a divestiture (sale) of part of the assets to be acquired.

8.6 For a completed merger, the CMA will normally seek to divest all or part of the acquired assets to a suitable purchaser who can provide effective

[83] 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 businesses in separate local markets – that are severable from the remainder of the transaction without materially affecting the overall rationale for the merger.

[84] 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 9.158ff.

competition. Undertakings as to future behaviour may be accepted in addition to, or occasionally instead of, divestiture.

8.7 The CMA at Phase 2 will normally take relevant patient benefits into account, as permitted by the Act, once it has decided on the existence of an SLC by considering the extent to which alternative remedies may preserve such benefits.[85] In essence, relevant patient benefits that will be forgone due to the implementation of a particular remedy may be considered as costs of that remedy by the CMA. The CMA may modify a remedy to ensure retention of a relevant patient benefit or it may change its remedy selection, for instance it may decide to implement a remedy other than prohibition or, in rare cases, it may decide that no remedy is appropriate. See Chapter 7 for a discussion of what constitutes a relevant patient benefit, which is the same at both Phase 1 and 2.

8.8 Further information is available in *Merger Remedies: Competition Commission Guidelines* (CC8).

[85] Sections 35(5) and 36(6) of the Act.

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 CMA

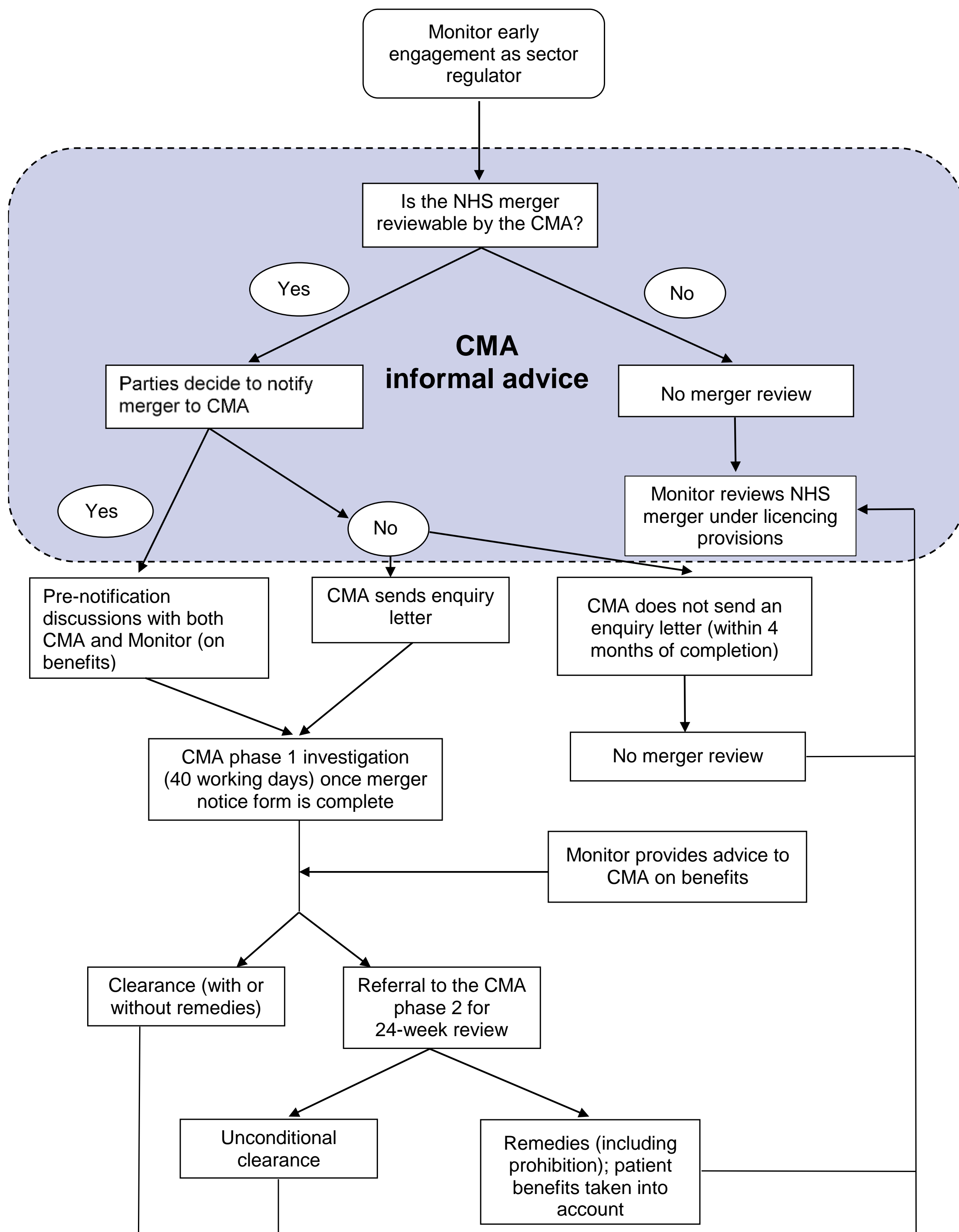
Merger assessment guidelines (CC2 (revised)/OFT1254)

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

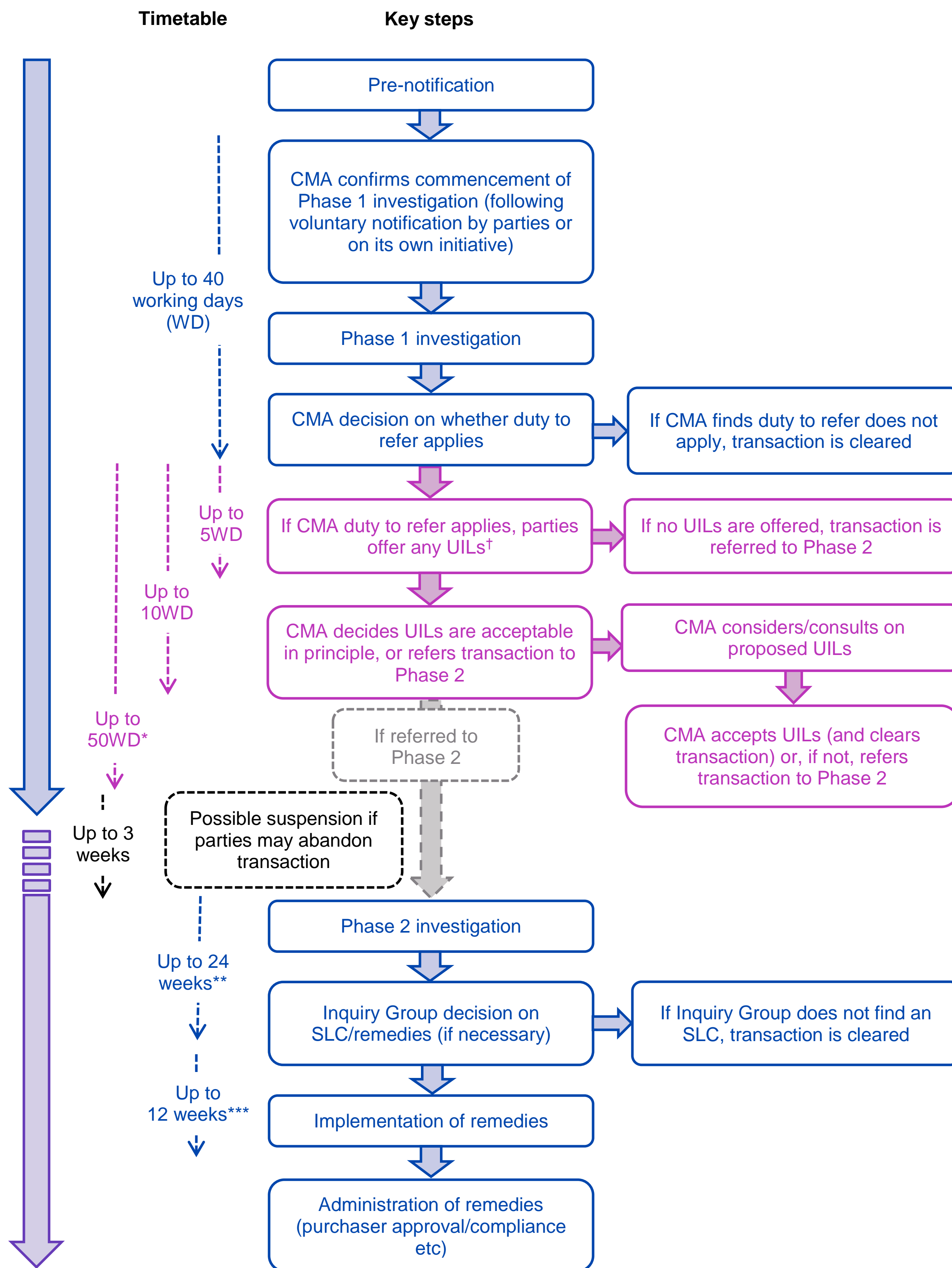
Merger Remedies: Competition Commission Guidelines (CC8)

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

Principal stages and interaction of CMA and Monitor processes



Principal stages of a CMA merger investigation



*Extendable by up to 40 WD. **Extendable by up to 8 weeks. ***Extendable by up to 6 weeks.
†Undertakings in lieu of reference to Phase 2.