

Anticipated merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust

Decision on relevant merger situation and substantial lessening of competition

ME/6875-19

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SUMMARY

1. The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (**RBCH**) and Poole Hospital NHS Foundation Trust (**PH**) (together, the **Parties**) are acute hospital trusts, each of which operates a district general hospital in the Bournemouth-Poole conurbation. These two district general hospitals offer a wide range of services principally commissioned by Dorset CCG; specialised services are commissioned by NHS England (**NHSE**).
2. The Parties are located near to each other and overlap in the provision of NHS elective services, NHS specialised and community services, NHS non-elective services, and private patient services. PH has not had a dedicated private patient service offering since August 2018 and currently provides only a limited set of private patient services.
3. The Parties have sought to merge before. One of the CMA's predecessor bodies, the Competition Commission (**CC**), prohibited the Parties from merging in October 2013, on the basis of considerations relating to the Government policy framework in place at that time, including the way the Parties were remunerated, in which competition between trusts was encouraged to drive better outcomes for patients.
4. RCBH and PH approached the CMA on 31 October 2019 requesting consent to merge to form a single NHS Foundation Trust (the **Merger**).
5. The Competition and Markets Authority (**CMA**) has decided to clear the proposed Merger between the Parties.

Competitive Assessment

6. In any merger control investigation, the CMA will assess the extent and nature of current (or pre-merger) competition. The current status of public policy choices about the role of competition within the provision of healthcare services is therefore a particularly relevant factor in the review of national health service (**NHS**) mergers.
7. As in its recent merger investigations between NHS hospitals in Birmingham, Manchester, Derby/Burton and Liverpool, the CMA found in this case that NHS providers have been facing a number of challenges including significant growth in demand for services, financial pressures and capacity constraints, and are subject to significant levels of regulatory oversight.

8. The CMA has found that the NHS across England is taking a collaborative approach in response to these constraints and, as a result, competition between providers is typically limited. The CMA has found that the implementation of key national policies contained in the NHS Long Term Plan (**LTP**), the *Five Year Forward View*, local Sustainability and Transformation Partnerships (**STPs**), and control totals and their emphasis on collaboration and integration across providers within the Local Health Economy (**LHE**), whereby systems of care, not just organisations, should be managed and regulated, have collectively shaped how healthcare services are delivered and how operational decisions are made.
9. In addition to these national policy and regulatory factors, the CMA has identified certain local factors that limit any competition between the Parties. Most notably, the use of block contracts by their primary commissioner, the move to an integrated care system (**ICS**) and the introduction of financial risk sharing mechanisms within the ICS.
10. The evidence in this case shows that the combination of these national policies and local factors has substantially reduced the role of competition in organising the provision of NHS services in the east Dorset area.
11. In assessing the potential impact of the Merger on competition in the provision of healthcare services, the CMA treated elective and non-elective services as separate frames of reference. The CMA distinguished between the provision of community services and services which are provided in hospital settings. The CMA also distinguished between private services and NHS services, and assessed the Merger on the basis of its impact on competition both 'in' and 'for' the market. Within each of elective services and non-elective services and for private patient services, the CMA has previously considered that the provision of outpatient services is a separate frame of reference from the provision of inpatient services (the latter including day-cases). However, it was not necessary to do so in this case because no competition concerns arise on any plausible basis. For the same reason, it has not found it necessary to assess the effects of the Merger at specialty level.
12. The CMA did not find any competition concerns in relation to elective services, principally because the evidence shows that the Parties do not have a strong incentive to compete against each other for patient volumes. More specifically:
 - (a) The Parties are paid to provide elective services by Dorset CCG under a block contract system and not under the Payment by Results (**PbR**) system. In 2018/19, income from block contracts accounted for nearly all

of the Parties' revenues associated with the provision of elective and non-elective services: 99% of RBCH's revenues and 93% of PH's revenues. This means that the Parties have a weak financial incentive to compete and attract additional patients;

- (b) The Parties are members of an ICS in Dorset, together with one other acute trust and two non-acute trusts (one providing community and mental health services and the other ambulance services), Borough Councils and Public Health Dorset. The CMA has found that the ICS reduces the Parties' incentives, and to some degree their ability, to compete for additional patients. While each trust within the ICS is responsible for its own finances, they collaborate to maximise access to national funding for the ICS partners as a whole.
- (c) A series of national policies and regulations, of which ICSs are one part, have collectively shaped how clinical services are delivered and how operational decisions are made based on collaboration between providers within LHEs and not competition between providers.

- 13. The CMA therefore believes that the Merger will not give rise to a realistic prospect of an SLC in elective services.
- 14. The CMA did not find any competition concerns with regard to the supply of non-elective services, specialised services, community services, and private patient services. In each case there was either no overlap, limited scope for patients to choose which hospital to attend, or, for specialised and community services, no recent or planned tender involving competition between the Parties.

Conclusion

- 15. The Merger will therefore **not be referred** under section 33(1) of the Enterprise Act 2020 (the **Act**).

ASSESSMENT

Parties

- 16. RBCH operates across two sites in Bournemouth:¹
 - (a) The Royal Bournemouth Hospital, to the east of the city centre, which provides urgent and emergency care, surgery, critical care, outpatient

¹ Accompanying Merger Submission, paragraphs 19 and 20.

and diagnostic services and a midwife-led birthing unit providing several services for the wider east Dorset population; and

(b) Christchurch Hospital, which offers specialist palliative care, outpatient clinics and diagnostic imaging services in Dorset (around two miles from Royal Bournemouth Hospital).

17. The income of RBCH in FY2018/19 was £337 million, generated entirely in the UK.²
18. PH provides trauma, maternity care, paediatrics and ENT services in Poole, to the west of the Bournemouth city centre. It is also the NHS cancer centre, including radiotherapy services, for Dorset. The income of PH in FY2018/19 was £260 million, generated entirely in the UK.³ In FY2018/19, PHT incurred a deficit of £11.7 million after receiving £8.6 million in Provider Sustainability Funding.⁴
19. The Parties' hospitals are approximately eight miles from each other.⁵

Transaction

20. RCBH and PH approached the CMA on 31 October 2019 requesting consent to merge to form a single NHS Foundation Trust.⁶
21. The Merger will be structured as a merger under section 56 of the NHS Act. Upon completion of the Merger both Parties will be dissolved, and a new NHS foundation trust will be established with a single statutory board and executive team once the necessary regulatory approvals have been obtained pursuant to an agreement dated September 2017.⁷
22. All assets, workforce and liabilities of each Party will transfer to the new NHS Foundation Trust.

² Merger Notice paragraph 6 and RBCH Annual Report and Accounts page 194.

³ Merger Notice paragraph 6 and PH Annual Report and Accounts page 192.

⁴ In the financial year 2019/2020, the Parties' control total is a deficit of £17.7 million. See Accompanying Merger Submission, paragraph 27.

⁵ The Royal Bournemouth Hospital and PH are approximately 8 miles or 20 minutes drive from each other. Paragraph 17 of the Accompanying Merger Submission.

⁶ In the previous merger proposal, for the purpose of remedying the SLCs identified in the CC Final Report and the adverse effects which flow from them, on 19 December 2013, the CC accepted the undertakings given by RBCH and PH under section 82 of the Enterprise Act 2002 (the Act) (the Undertakings). The acceptance of these Undertakings has the effect that RBCH and PH may not merge (or otherwise cease to be distinct) without the prior written consent of the CMA. The CMA's decision on the Undertakings is available on the CMA's case page: <https://www.gov.uk/cma-cases/royal-bournemouth-and-christchurch-hospitals-nhs-foundation-trust-poole-hospital-nhs-foundation-trust-merger-inquiry>.

⁷ RBCH, Extract from Part 2 Minutes of meeting of the Board of Directors of RBCH at Appendix 022, and PH, Board of Directors Paper Part 2 – One Acute network Competition & Markets Authority Update at Appendix 023.

23. As with other NHS mergers, there is no consideration associated with this Merger.

Jurisdiction

24. Each of RBCH and PH is an enterprise and these enterprises will cease to be distinct as a result of the Merger.⁸
25. Both Parties have a turnover in excess of £70 million, so the turnover test in section 23(1)(b) of the Act is satisfied.
26. The CMA therefore believes that it is or may be the case that arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation,
27. The initial period for consideration of the Merger under section 34ZA(3) of the Act started on 28 February 2020 and the statutory 40 working day deadline for a decision is therefore 27 April 2020.

Background

28. This section provides, first, an overview of the policy and regulatory background relevant to the Merger, and to the role of competition in the NHS generally; and second, an overview of the LHE in which the Parties are active. The factors discussed below are relevant to how the CMA assesses the services provided by the Parties, in particular elective services. The implications of these factors for the Merger are considered in the competitive assessment section.

Regulation and competition in the NHS sector

Regulation

29. This section provides a brief overview of the policy and regulatory bodies related to the Merger.
30. The Department of Health and Social Care (**DHSC**) is responsible for the NHS, public health and social care in England. It develops policy, introduces legislation, and allocates funding from HM Treasury to the NHS.

⁸ Section 79 (1) and (3) of the Health and Social Care Act (HSCA) 2012 state that where the activities of one or more NHS foundation trusts and the activities of one or more businesses cease to be distinct, this is to be treated as being a case in which two or more enterprises cease to be distinct enterprises for the purposes of Part 3 of the Act. Both RBCH and PH are NHS foundation trusts.

31. Clinical Commission Groups (**CCGs**) are clinically-led bodies responsible for the planning and commissioning of healthcare services for their local area. CCGs commission most secondary care services (ie medical services provided by specialists or consultants in a field of medicine, whether in a hospital or community setting).
32. NHSE is responsible for setting the direction of the NHS and improving care. It is also the commissioner of primary healthcare services (ie medical services provided by general practitioners (**GPs**) and community pharmacies) and specialised tertiary healthcare services (ie services provided in more specialised medical centres) and is responsible for overseeing the operation of CCGs.
33. NHS Improvement (**NHSI**) authorises and regulates NHS foundation trusts, sets prices for NHS services (the National Tariff) and supports providers.⁹ NHSI also oversees NHS trusts in England and assists and supports NHS trusts to ensure continuous improvement in quality and the financial sustainability of NHS services.¹⁰
34. On 1 April 2019 NHSE and NHSI came together to act as a single organisation.
35. The Care Quality Commission (**CQC**) is an independent regulator of standards in health and adult care. It monitors services to make sure that they are safe, effective, caring, responsive to patient needs and that providers are well led. It carries out unannounced inspections and gives ratings of acute hospitals.
36. The Health and Social Care Act 2012 (**HSCA**) strengthened the incentives for NHS providers to compete for patient referrals by maintaining and improving the quality of patient care, with a view to making the NHS more responsive, efficient and accountable.¹¹

⁹ Monitor was the economic regulator for NHS foundation trusts whereas the Trust Development Authority (**TDA**) regulated NHS trusts. The TDA and Monitor came together to act as a single organisation in June 2015, forming NHSI.

¹⁰ 'Policy changes in the NHS since 2012 and their effect on the competition assessment of the Dorset merger', dated 14 February 2020 (**NHSI's Submission**), paragraph 88 and 90.

¹¹ The HSCA also confirmed that mergers involving NHS foundation trusts were caught by the Enterprise Act 2002 (and therefore fell within the CMA's jurisdiction). It also included duties for Monitor regarding providing advice to the CMA, in particular on relevant patient benefits, under section 79 of the HSCA.

How competition works between NHS trusts

37. There have been two models of competition in the provision of NHS healthcare services:¹²
- (a) Competition *for* the market to attract contracts to provide services to patients, and
 - (b) Competition *in* the market to attract patients.
38. Competition for the market usually involves a competitive tender. It is the commissioning body (eg NHSE or a CCG) that determines the level of activity the winning bidder is able to perform. Therefore, although providers are generally free to decide which clinical services they will offer (including how much of their capacity to devote to each clinical area and the degree of specialisation that they offer), competition for the market occurs for some services as commissioners often use tenders to select providers¹³ that are best placed to offer certain services to patients. Providers therefore have an incentive to maintain their reputation for quality and value in order to demonstrate their credibility and to maximise their chance of winning a contract. These are often services with no or little patient choice and are usually associated with the provision of specialised and community services.
39. Competition in the market occurs when NHS providers in England receive income by attracting patients for elective treatments and maternity and paediatric services. Historically, providers were paid at uniform nationally mandated prices (the National Tariff) for every consultation or treatment made (in most services), based on PbR rules.¹⁴ The PbR payment model, coupled with the right of patients in England to choose at which NHS hospital they can receive their elective treatment, gave providers incentives to improve quality to attract patient referrals from GPs.¹⁵
40. The CMA's role in reviewing NHS mergers arose because of the gradual introduction of patient choice and competition in the NHS (including the PbR payment model giving incentives for NHS providers to compete for patients).¹⁶

¹² CMA guidance on the review of NHS mergers ([CMA29](#)), paragraph 6.5.

¹³ In this document, the terms 'provider' and 'trust' are used interchangeably.

¹⁴ The CMA's role in reviewing NHS mergers arose due to the gradual introduction of patient choice and competition in the NHS (including the PbR payment model giving incentives for NHS providers to compete for patients), CMA guidance on the review of NHS mergers ([CMA29](#)), paragraph 1.3.

¹⁵ [Derby Teaching Hospitals/Burton Hospitals](#), paragraph 38.

41. However, as discussed in more detail below, current market conditions and recent policy developments have significantly limited the incentive of NHS trusts, including the Parties, to compete for elective patients. These policy developments are expected to further decrease the role of competition in the NHS going forward.

Current policies in the NHS

42. In a submission to the CMA, NHSI described policy changes in the NHS since 2012 and their effect on competition between NHS trusts and, more specifically, between the Parties.¹⁷ NHSI stated that the changes in policy and payments regime (including, the *Five Year Forward View*, STPs and LTP) increasingly promote collaboration and diminish the role of competition to such an extent that it is unlikely that NHS mergers could result in an SLC.¹⁸ An overview of NHSI's views and the relevant policy changes is provided below.
43. NHSI stated that since the implementation of the HSCA in 2012, the challenges faced by the NHS have increased significantly. The increase in demand for NHS services – most notably resulting from an ageing population and increases in long term health conditions – have put financial and operational pressure on the healthcare system.¹⁹ One consequence of this has been that competition has not evolved to be a primary driver for how NHS trusts have organised themselves to attract particular patients, (as had been envisaged in the HSCA). In response to these challenges, NHSI and NHSE have introduced new policies, which have shifted the focus towards encouraging performance improvements by promoting greater collaboration and away from competition.²⁰
44. In October 2014, NHSE published the *Five Year Forward View*.²¹ It set out a vision for greater integration of services and cooperation between providers, and suggested steps to support new ways of working.²² NHSI noted that the *Five Year Forward View* 'shifted the focus of improving NHS services from incentives which facilitated competition to a future of

¹⁷See footnote 10.

¹⁸ NHSI's Submission, paragraph 121.

¹⁹ NHSI's Submission, paragraph 48.

²⁰ [Aintree University Hospital NHS Foundation Trust/Liverpool and Broadgreen University Hospitals NHS Trust](#). See also NHSI's Submission, paragraphs 28-32.

²¹ [NHS Five Year Forward View \(2014\)](#). NHSI stated that the Five Year Forward View received widespread support from the healthcare sector and the government, suggesting that the system designed by the HSCA was not working and not suited to meeting the NHS's challenges. NHSI's Submission, paragraph 41.

²² For example, by allowing CCGs to move away from the activity-based payments envisaged by the PbR reimbursement regime.

increased collaboration and integration'.²³ STPs were announced in December 2015 as the next step for implementing the *Five Year Forward View*.²⁴

45. In January 2019, NHSE and NHSI published the LTP, which sets out a vision for moving the NHS to a new model of service delivery based on even greater collaboration and integration between healthcare providers than is set out in the *Five Year Forward View*. This includes developing STPs into new local health system partnerships called ICSs, by April 2021, as well as changes to payment mechanism and, potentially, licencing.²⁵
46. Like STPs, the intention is for ICSs to combine providers and commissioners into a LHE with shared goals and shared decision making.²⁶ According to NHSI, these changes have removed the expectation that the trusts should operate by focusing on their own interests only and created an expectation that the trust should make decisions in a local system through collaboration and partnership with commissioners and providers, balancing the needs of different organisations to benefit patients.²⁷
47. NHSI submitted that this means that providers and purchasers are no longer expected to contract with each other through a simply transactional relationship, in accordance with the HSCA.²⁸ Rather, these reforms require them to develop strategies for the LHE and to create payment mechanisms to support their strategies. NHSI submitted that this may reduce the scope for competition between the trusts, in particular because:
 - (a) 'if providers internalise the budgetary impact of any revenue increases on care purchasers, [NHSI] would expect [this] to dampen the providers' incentives to generate additional patient activity via performance improvement'²⁹ (although they may continue to do so via other mechanisms); and
 - (b) 'the future contractual mechanism (ICS) in which neighbouring providers are expected to work together to develop strategy and achieve improvements in care quality may reduce the scope and incentive for

²³ NHSI's Submission, paragraph 42.

²⁴ STPs are made up of local commissioners, GPs and NHS providers and present an opportunity for the commissioners and providers to make decisions about local care together. NHSI's Submission, paragraph 52.

²⁵ NHSI's Submission, paragraphs 44 and 56.

²⁶ ICSs will be supported by more regulatory and contractual mechanisms – they will be codified through contracts between partner organisations which should redefine their relationships and incentives.

²⁷ NHSI's Submission, paragraph 58.

²⁸ NHSI's Submission, paragraph 64.

²⁹ NHSI's Submission, paragraph 64.

providers to increase their market share at the expense of their neighbours.’³⁰

Other impacts on NHS trusts’ decision-making

48. NHSI submitted that the changes in the institutional environment explained above have been accompanied by a series of other changes to policy and incentives, which have changed the decision-making process of NHS providers and, in turn, reduced their ability to respond to market incentives.³¹ This has had the greatest effect on NHS foundation trusts,³² such as the Parties.
49. Since the previous merger proposal in 2013, a series of measures have been implemented that have changed the landscape in which NHS foundation trusts operate and weakened their incentives to compete for market share. In particular:
- (a) **Single Oversight Framework:** The merger between the TDA and Monitor in June 2015 (creating NHSI) reduced the difference in the regulatory environment facing ordinary NHS trusts and NHS foundation trusts, which has led to the establishment of the Single Oversight Framework (**SOF**) in 2016 for measuring and managing the performance of NHS providers, making a more limited distinction between trusts and foundation trusts, meaning that both types of trust were being assessed in the same way.³³ The SOF is part of a regulatory shift towards more active performance management and improvement support, rather than encouraging providers to respond individually to economic incentives. In 2019, this was replaced by the overall NHS Oversight Framework for FY2019/20.³⁴
 - (b) **System control totals/financial improvement trajectories:** Since FY2017/18, as NHS provider deficits have become common, the NHS providers and NHSI have agreed ‘control totals’ (ie annual financial targets that must be met in order to receive additional funding). NHSI

³⁰ NHSI’s Submission, paragraph 65.

³¹ NHSI’s Submission, paragraph 67.

³² This is because foundation trusts were previously given some level of autonomy, including regarding investments. ‘Foundation trusts are public benefit corporations which are required to provide NHS services but are afforded a degree of operational autonomy. Their principal purpose is the provision of goods and services for the purposes of the health service in England. They can retain their surpluses and borrow to invest in new and improved services for patients and service users.’ *Heatherwood and Wexham Park Hospitals NHS Foundation Trust / Frimley Park Hospital NHS Foundation Trust*, paragraph 16.

³³ NHSI Submission, paragraph 69.

³⁴ It brings together oversight of providers and commissioners under the same framework and replaces both the CCG Improvement and Assessment Framework and the SOF. <https://improvement.nhs.uk/resources/nhs-oversight-framework-201920/>

submitted that, 'In late 2018, it was announced that the NHS would move from simply imposing control totals at the provider level to also imposing them at the local health system (ie STP/ICS) level'.³⁵ NHSI stated that this change signals a shift that moves the NHS further away from the approach of viewing NHS providers as individual market actors, towards a future in which financial planning and decision making is undertaken at local health system level.³⁶

- (c) **Incentive payments at system level:** In previous years, NHS providers were eligible for financial incentive payments for meeting their individual control totals, known as the Provider Sustainability Fund. In FY2020/21, these incentive payments will be transferred into the Financial Recovery Fund (**FRF**), which will be made available to both providers and CCGs in deficit. For each organisation, 50% of its FRF allocation will be paid based on its performance and, to encourage the system working effectively, the other 50% will be linked to the achievement of the 'system trajectory' (the sum of the financial improvement trajectories of the organisations within the system).³⁷
- (d) **Capital limits:** the legislative changes proposed as part of the LTP also include a reserve power for NHSI to set annual capital spending limits for NHS foundation trusts in certain circumstances. The intention is to rectify an anomaly under which foundation trusts are free to make their own borrowing decisions, yet any such borrowing counts against the DHSC's capital Departmental Expenditure Limit.³⁸

50. In addition, NHSI submitted that to support the implementation of the LTP, a number of changes to primary legislation which aim to accelerate the move away from a competitive market dynamic towards a more collaborative dynamic have been proposed.³⁹ In September 2019, after a public consultation, the NHS published its recommendations, which are currently being developed into a draft Bill.⁴⁰ These include removing the CMA's jurisdiction to review NHS foundation trust mergers.⁴¹ This legislation has, however, not yet been introduced and these proposed changes have therefore not yet come into force. The CMA therefore

³⁵ NHSI Submission, paragraph 69.

³⁶ NHSI Submission, paragraph 69.

³⁷ NHSI Submission, paragraph 69.

³⁸ NHSI Submission, paragraph 69.

³⁹ NHSI Submission, paragraph 45.

⁴⁰ While detailed plans have not yet been announced, the government has indicated its broad support for these proposals, see NHSI's Submission, paragraph 46.

⁴¹ <https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1917-NHS-recommendations-Government-Parliament-for-an-NHS-Bill.pdf>

continues to have jurisdiction to review qualifying mergers involving NHS foundation trusts.

Use of block contracts by local commissioners

51. NHSI submitted that the changes in the payment regime have further reduced incentives for competition between trusts.⁴² This has been effected primarily through policies in the *Five Year Forward View*, STPs and the LTP, which have reduced the link between activity and payments, focusing instead on payments to develop integrated care and more suitable care for patients. In this context, NHSI explained that:
- (a) The shift away from activity-based funding began with the Five Year Forward View,⁴³ which called for greater flexibility in payment mechanisms, including the use of non-activity-based contracts, such as block contracts.⁴⁴ By breaking the link between activity and revenue, these changes have substantially decreased the incentives for NHS trusts to compete for patients.⁴⁵⁴⁶
 - (b) The size of the block payments is sometimes determined by historical activity levels, leaving some incentives for performance improvement,⁴⁷ and a system of block contracts could also accommodate some incentives to compete, if selective contracting were present. [X].⁴⁸ These fiscal constraints have led to a situation in which the ability to retain and reinvest surpluses no longer gives rise to meaningful competitive incentives, as for most providers there is no surplus to reinvest.
 - (c) The LTP signals that the move away from activity-based reimbursement is likely to accelerate over the coming years. It does not refer to mechanisms to incentivise competition, but rather proposes to ‘move funding away from activity-based payments’⁴⁹ to a blended payment

⁴² On the significance of the use of block contracts vs PbR, see paragraphs 37-41 above.

⁴³ Which is the basis of the PbR system and which has provided much of the rationale for the CMA's involvement in NHS mergers.

⁴⁴ Block contracts are types of contracts where payments do not vary with fluctuations in the level of activity, but instead pay a fixed sum of money. This is unlike the PbR reimbursement regime which paid a fixed price per treatment that exceeded the costs of production for most providers.

⁴⁵ NHSI's Submission, paragraphs 76 – 78. Consistently, the use of activity-based payments has reduced over the last three financial years from 71% to 58%, while the use of block contracts and risk sharing arrangements (such as cost and volume contracts) has increased from 29% to 42%.

⁴⁶ NHSI Submission, paragraph 76 to 77.

⁴⁷ For example, in this case, competition can still provide some incentive for performance improvement, as there is a monetary return on increased market share in the subsequent financial year.

⁴⁸ NHSI's Submission, paragraph 86.

⁴⁹ NHSI's Submission, paragraph 79.

model.⁵⁰ The proposals aim to create shared incentives for providers and commissioners to work together to reduce avoidable admissions and to ‘minimise transactional burdens and friction and provide space to transform services’.⁵¹

- (d) While many services are still paid on an activity basis, NHSI expects that blended payments will become more widespread going forward. This will further reduce trusts’ ability to unilaterally expand their market capacity, as strategic decisions, such as capacity changes, are likely to be made through ICSs.⁵²

Capacity constraints

52. NHSI submitted that, in addition to the policy changes which encourage cooperation between trusts, severe capacity constraints currently faced by NHS trusts (including foundation trusts) throughout England place further limitations on the ability of NHS trusts, including the Parties, to respond to competitive incentives.⁵³
53. NHSI submitted that, for competition to provide effective incentives for the NHS trusts to compete on performance quality, trusts must have an incentive to increase their market share (by attracting patient activity) and have the capacity to accommodate the additional patients.⁵⁴ NHSI stated that capacity constraints have long been a characteristic of the NHS elective care, reducing the trusts’ ability to compete for additional patients.⁵⁵
54. NHSI noted that, in the past, the CMA considered that, in general, capacity constraints do not necessarily preclude increase in activity volumes.⁵⁶ However, NHSI submitted that the capacity constraints experienced by the NHS trusts in recent years make it increasingly difficult for trusts to identify additional efficiency improvements that can be undertaken in order to accommodate increases in activity. Capacity utilisation has increased, and operational performance has deteriorated on many operational metrics

⁵⁰ *NHS Long Term Plan*, page 101, paragraph 6.7 and 6.8. January 2019. The FY2019/20 national tariff included a blended payment model for emergency care. Blended payments currently apply to the provision of non-elective services and, from April 2020, blended payments are also planned for outpatient attendances.

⁵¹ NHSI’s Submission, paragraph 79. Guidance on blended payment for emergency care, NHS England and NHS Improvement. January 2019, Available at: https://improvement.nhs.uk/documents/476/Guidance_on_blended_payment_for_emergency_care.pdf

⁵² NHSI’s Submission, paragraph 83.

⁵³ NHSI’s Submission, paragraph 71.

⁵⁴ NHSI’s Submission, paragraph 71.

⁵⁵ Capacity constraints are typically measured by waiting times or by bed occupancy rates.

⁵⁶ For example, activity volumes may be increased even where capacity constraints exist where providers are able to undertake efficiency improvements. NHSI’s Submission, paragraph 72.

since 2015.⁵⁷ NHSI submitted that the increased utilisation of non-elective services by an ageing population is likely to be a contributing factor for this trend.⁵⁸

55. In addition, NHSI stated that the sector has seen substantial staffing shortages, particularly in relation to the supply of doctors and nurses.⁵⁹ According to NHSI, these shortages constitute another constraint on the trusts' capacity to accommodate any additional patients that may result from quality improvements, thus further limiting the scope for competition between trusts.⁶⁰

Competition in the east Dorset area

56. Both Parties are NHS foundation trusts that provide hospital services to the Bournemouth-Poole conurbation and the east Dorset area. Dorset CCG is the main commissioner for acute care provided at RBCH and PH. The trusts both receive a relatively small amount of their elective services income from West Hampshire CCG and Wiltshire CCG.⁶¹ Specialised services are commissioned by NHS England & NHSI Specialised Commissioning South West (**NHSE South West**).
57. In addition to the submissions relating to the decreasing role for competition between NHS trusts set out above (paragraphs 37 to 40), NHSI and the Parties also made further submissions reflecting the effect of these changes on the local competitive conditions in the east Dorset area and the Parties' incentives to compete for patients, which are considered below.

Dorset ICS and the Dorset System Collaborative Agreement

58. NHSI submitted that the Dorset area is widely viewed as one of the most developed collaborative systems in the NHS and was one of the first ten areas to be recognised as an ICS.⁶² The Dorset ICS covers the whole of Dorset and includes, among others, Dorset CCG and a number of NHS providers (RBCH, PH, Dorset County Hospital NHS Foundation Trust, Dorset Healthcare University Foundation Trust and South Western

⁵⁷ NHSI's Submission, paragraph 73.

⁵⁸ NHSI's Submission, paragraph 72.

⁵⁹ For example, the biggest shortage is in nursing with around 40,000 reported vacancies in substantive nursing posts, see NHSI's Submission, paragraph 74.

⁶⁰ NHSI's Submission, paragraph 74.

⁶¹ Call note with West Hampshire CCG party of 4 March 2020: RBCH and PGH are in close proximity to WHCCG borders. Patients that are on the border may choose to go to RBCH and PGH and that is why it is important for WHCCG to have a working relationship with both the providers and Dorset CCG. This happens formally and informally.

⁶² NHSI's Submission, paragraph 103.

Ambulance Services NHS Foundation Trust), as well as Bournemouth, Poole and Dorset County Councils and Public Health Dorset.⁶³

59. In addition, the Parties submitted that Dorset CCG and other members of the ICS (including the Parties)⁶⁴ have entered into a Dorset Health System Collaborative Agreement (the **Agreement**), which sets out how the ICS members will co-operate to ensure that care is provided in an integrated manner.⁶⁵ The Parties stated that the Agreement introduces the use of block contracts (including for elective treatments), setting out the fixed amounts paid by Dorset CCG to the NHS trusts, including the Parties.
60. The Parties stated that since FY2017/18, both RBCH and PH have primarily been remunerated through block contracts from Dorset CCG for their elective and non-elective activity.⁶⁶ This was confirmed by Dorset CCG.⁶⁷ The only PbR income received by RBCH and PH relates to patients referred from Wiltshire CCG and West Hampshire CCG,⁶⁸ respectively, and accounts for only a small number of elective and non-elective patients.⁶⁹
61. NHSI submitted that while the initial value for block contracts under the Agreement was based on each Party's historic FY2014/15 activity, annual contract values have since been changed to reflect changes in Dorset CCG's funding allocation, rather than activity.⁷⁰ NHSI added that this has removed the link between the value and activity for both Parties, thus limiting their incentives to compete for additional patients.⁷¹
62. The Agreement also sets out a number of arrangements relating to collaborative working and financial risk sharing,⁷² which NHSI and the

⁶³ NHSI's Submission, paragraph 103 and Accompanying Merger Submission, paragraph 127.

⁶⁴ The Agreement sets out the fixed amount to be paid by Dorset CCG to each of the four main NHS providers in Dorset: RBCH, PH, Dorset County Hospital and Dorset Healthcare University NHS Foundation Trust.

⁶⁵ NHSI's Submission, paragraph 104 and Accompanying Merger Submission, paragraph 132.

⁶⁶ This is consistent with the information provided by the Parties. Annex 109 to RFI 1 shows that the Parties are remunerated through block contracts from Dorset CCG.

⁶⁷ Call Note with Dorset CCG dated 17 February 2020.

⁶⁸ West Hampshire CCG confirmed that it now remunerates RBCH under a block contract. West Hampshire CCG explained that the reason for the Trusts being remunerated using PbR model was the fact that both Trusts were outside the CCG's geographical boundaries and did not regularly serve patients falling within its territory, other than those which due to proximity chose to use the either RBCH or PH. See call note with West Hampshire CCG dated 4 March 2020.

⁶⁹ NHSI's Submission, paragraph 115 and Accompanying Merger Submission, paragraph 133 - 135.

⁷⁰ NHSI's Submission, paragraph 113. This was confirmed by Dorset CCG: Dorset CCG did a reset about 3 years ago where they effectively set everyone's allocation based on last year's funding (i.e. base line) and added a 0% increase on top of that for the first year. In Year 2 there was a 1% increase, and in Year 3 Dorset CCG went with the inflationary amount (around 2-2.3%). Everyone is working from the base line. Unless the CCG is actually awarding new services or commissioning something new, then effectively it's a block contract that is rolled over (with the increase). Call note with Dorset CCG dated 17 February 2020.

⁷¹ NHSI's Submission, paragraph 113.

⁷² See paragraph 52.

Parties stated remove the incentives for individual trusts to compete for elective activity with other ICS members.^{73,74} In particular:

- (a) **Collaborative working:** under the Agreement, capacity is managed according to ICS needs, with the goal of reducing inappropriate demand. The parties to the Agreement undertake not to make unilateral decisions which will affect system capacity; and
- (b) **Financial risk sharing:** the parties to the Agreement work with a combined budget, within a system control total agreed by the local partners with financial risk sharing provisions in place, in order to achieve the best outcomes for the relevant population. The Agreement provides that if the parties (either individually or in aggregate) are failing to deliver, they will collaboratively agree how the financial burden should fall. This impacts how operational decisions are made by the Parties since it may be the case that they do not each retain the revenue received by attracting and treating additional patients. Some of the decisions are made collectively rather than individual by the trusts.⁷⁵ For example, NHSI told the CMA that ‘three years ago when a local trust had its control total at risk and this in turn was putting the system control total at risk, there was direct financial support provided by Bournemouth and Dorset CCG to Dorset County Hospital in order that the individual and system control totals could be met.’⁷⁶ Conversely, if the system or providers within the ICS over-deliver, the surplus will be shared according to how it would best benefit the ICS.⁷⁷ For example, Dorset CCG told the CMA that in 2019, the ICS moved some money around the organisations at the end of the year to get everybody over the line to meet their control targets.⁷⁸

63. The Agreement initially covered FY2017/18 and 2018/19 but a new version of the agreement has been agreed for FY2019/20 and a new agreement for FY2020/21 is currently being progressed on the same basis.⁷⁹ NHSI submitted that ‘[i]n practical terms, PbR has been effectively suspended,

⁷³ NHSI’s Submission, paragraphs 104 – 107, Accompanying Merger Submission, paragraph 132 – 134 and response to question 3 of RF11.

⁷⁴ Dorset CCG told the CMA that in Dorset 100% of financial incentives will be linked to system performance, as opposed to the performance of individual hospitals. See Call Note with Dorset CCG dated 17 February 2020.

⁷⁵ The ICS committees do not have statutory decision powers and decisions therefore rely on consensus between the ICS partners. See call note with Dorset CCG dated 17 February 2020.

⁷⁶ NHSI Submission, paragraph 110.

⁷⁷ NHSI also provided a number of examples where this has been implemented, see NHSI’s Submission, paragraphs 109 – 110 and response to question 3 of RF11 and question 3 of RF12. See also call note with Dorset CCG dated 17 February 2020.

⁷⁸ See also call note with Dorset CCG dated 17 February 2020.

⁷⁹ Accompanying Merger Submission, paragraph 97.

removing the incentive for providers to try and use elective activity to address financial difficulties'⁸⁰ and also noted that 'financial arrangements in the Dorset ICS continue to develop in a way that supports overall system balance and sustainability.'⁸¹ Dorset CCG confirmed this position, stating that 'they have fully moved away from the PbR mechanism within the Dorset system'.⁸²

64. The CMA notes that the evidence provided by the Parties, including the internal documents they submitted, is consistent with that provided by NHSI and Dorset CCG.⁸³ The CMA believes that the available evidence clearly shows that the use of block contracts and cooperation within the Dorset ICS has significantly reduced, and indeed largely removed, the Parties' incentives to compete with each other.

Capacity constraints

65. The Parties and NHSI submitted that, like many other NHS providers, both Parties face capacity constraints. They stated that the east Dorset area, in particular, is characterised by an ageing population, which has led to changes in that part of the population's health needs⁸⁴ and, combined with financial and capacity constraints, resulted in a number of challenges for the NHS.⁸⁵ They submitted that unsustainable levels of growing demand for non-elective services has negatively impacted capacity for elective services.⁸⁶ In addition, the Parties also submitted that they face workforce pressures in certain

⁸⁰ NHSI's Submission, paragraph 112.

⁸¹ For example the planning guidance issued to the NHS for financial year 2020/21 links 50% of the funds available to individual organisations through the Financial Recovery Fund, to system performance, see NHSI's Submission, paragraph 115.

⁸² As to whether the way the Parties are remunerated could change in the future, Dorset ICS does not see that changing. Call note with Dorset CCG dated 17 February 2020.

⁸³ See, for example, Capsticks, *Developing One NHS in Dorset: Briefing paper for the Boards of RBCH, PHT and Dorset County Hospital NHS FT*, February 2016, Appendix 020 to the Accompanying Submission, refers to the three NHS foundation trusts looking at options that are available to them to deliver the vision for an acute care collaboration accountable clinical network. See Annex 018 to the Accompanying Submission, *NHS England guidance on transforming urgent and emergency care*: 'A commissioning strategy for urgent and emergency care should be developed using a collaborative approach with health and social care partners across the whole system'. Annex 005 to the Accompanying Submission, *PHT Annual Report 18-19*: 'The Trust has faced considerable financial pressures during the course of the year, mainly associated with challenges associated with the increase in expenditure on high cost agency staff. Nevertheless, at the end of the year, we were pleased to achieve the revised financial position agreed with our regulator and with our partners across the Dorset system – recognising that as an Integrated Care System, all partners are working together to make the best use of our collective resources.'

⁸⁴ NHSI's submission, paragraph 117: 'We note [...] that a contributing factor to capacity constraints is the increased utilisation of non-elective services by an ageing population. This factor may be particularly pronounced in relation to the Dorset trusts, which serve a catchment with a high proportion of older people and a lower proportion of young people than the national average'.

⁸⁵ For example, both Parties have had average general and acute bed occupancy rates above the recommended level in every quarter since Q3 2017/18, see NHSI's submission, paragraph 118.

⁸⁶ NHSI submitted this 'has resulted in cancellations of elective surgery and the system wide plan to assist in clearing the elective backlog involves outsourcing some work to independent providers as well as trying to support additional internal capacity', see NHSI's Submission, paragraph 120.

specialities such as cardiology, which further limit the extent to which the Parties could take on additional activity.

66. NHSI argued that the combination of these constraints has limited the Parties' incentives to compete with each other for additional patients.⁸⁷ The challenges faced by the Parties have been cited by both NHSI and the Parties as one of the key drivers for the Clinical Services Review (**CSR**)⁸⁸ commissioned by Dorset CCG and subsequent plans for reconfiguration of Trusts' activities to establish separate emergency and planned care hospitals to make it easier for the Parties to make the best use of capacity.⁸⁹
67. The CSR commenced in 2014, went through a public consultation from December 2016 and, in September 2017, on completion of the CSR Dorset CCG decided that RBCH will become an emergency hospital and PH will become a planned care hospital.⁹⁰ The review considered that moving emergency services to RBCH was more cost-effective and would offer faster access to services for the local population.⁹¹ The Parties told the CMA that after the Merger they will reconfigure their services in line with the CSR decision of Dorset CCG. Indeed, the Parties submitted that a merger is the most straightforward method of implementing the outcome of the CSR.

Counterfactual

68. The CMA assesses a merger's impact relative to the situation that would prevail absent the merger (ie the counterfactual).
69. For anticipated mergers the CMA generally adopts the prevailing conditions of competition as the counterfactual against which to assess the impact of the merger.⁹²
70. The Parties submitted that there are two possible counterfactual scenarios:⁹³
 - (a) RBCH and PH would remain separate NHS foundation trusts, with RBCH operating the emergency hospital and PH operating the planned care hospital; or

⁸⁷ NHSI's Submission, paragraph 119.

⁸⁸ <https://www.dorsetsvision.nhs.uk/about/csr/>

⁸⁹ Accompanying Merger submission, paragraphs 32-37 and NHSI's Submission, paragraphs 116-120.

⁹⁰ Accompanying Merger Submission, paragraph 33.

⁹¹ Accompanying Merger Submission, paragraph 58.

⁹² *Merger Assessment Guidelines*, section 4.3.

⁹³ Accompanying Merger Submission, paragraph 104.

(b) RBCH and PH would remain separate NHS foundation trusts and would continue to operate in the current format as district general hospitals operating the same range of services as is currently the case (ie the pre-Merger conditions of competition).

71. The Parties viewed the first scenario as highly dependent on the Merger, as neither RBCH or PH could be expected to proceed to the new service configuration given the operational and financial challenges this would entail. In particular, the Parties submitted that each would face considerable risks to its operational performance and sustainability if they remained separate with individual responsibility for the emergency or planned care hospital. Therefore, the Parties said that they viewed the second scenario as the most likely outcome absent the Merger.⁹⁴
72. The CMA considers that the pre-Merger conditions of competition is the most competitive realistic counterfactual. Therefore, for the purposes of its assessment of the Merger, the CMA has adopted the prevailing conditions of competition as the relevant counterfactual for the assessment of the Merger between RBCH and PH.

Frame of reference

73. Market definition provides a framework for assessing the competitive effects of a merger and involves an element of judgement. The boundaries of the market do not determine the outcome of the analysis of the competitive effects of the merger, as it is recognised that there can be constraints on merging parties from outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others. The CMA will take these factors into account in its competitive assessment.⁹⁵

Product Scope

74. In line with previous cases, the CMA has assessed the effects of the Merger by reference to the following product frames of reference:⁹⁶

⁹⁴ Accompanying Merger Submission, paragraphs 107-108.

⁹⁵ [Merger Assessment Guidelines](#), from paragraph 5.2.2.

⁹⁶ The Parties agreed with the approach the CMA took in [University Hospitals Birmingham/Heart of England](#) and [Central Manchester University Hospitals/University Hospital of South Manchester](#), see Annex '051 Competitive Analysis FINAL'.

- (a) the supply of acute elective services (including maternity and paediatric services)⁹⁷ provided in hospital settings;
- (b) the supply of non-elective services⁹⁸ provided in hospital settings;
- (c) the supply of specialised services⁹⁹ provided in hospital settings;
- (d) the supply of community services;¹⁰⁰ and
- (e) the supply of private patient services.¹⁰¹

75. Within each of elective services and non-elective services and for private patient services, the CMA has previously considered that the provision of outpatient services is a separate frame of reference from the provision of inpatient services (the latter including day-cases).¹⁰² However, it was not necessary to do so in this case because no competition concerns arise on any plausible basis (for the reasons set out in detail in the competitive assessment below). For the same reason, it has not found it necessary to assess the effects of the Merger at specialty level.

76. It has not been necessary for the CMA to conclude on the exact product frame of reference for any services provided by the Parties, since no competition concerns would arise from the Merger with regard to these services on any plausible basis.

Geographic scope

77. In line with previous cases, the CMA has adopted the following approach:¹⁰³

⁹⁷ Planned specialist medical care usually following referral from a primary or community health professional such as a GP. Maternity care and some paediatric services are also typically included in this category. See [Derby Teaching Hospitals/Burton Hospitals](#) (15 March 2018), paragraph 8 and explanation of the referral analysis in paragraphs 87 to 95.

⁹⁸ Services that are not scheduled, arising when admission is unpredictable because of clinical need (eg following an A&E attendance).

⁹⁹ Specialised services refer to services in respect of rare, cost-intensive, or complex conditions as specified in NHS England's 'Manual of Prescribed Specialised Services'.

¹⁰⁰ Services provided by care professionals in the community such as health visiting, district nursing, health promotion drop-in sessions, residential care home visits, school nursing activities and community dentistry.

¹⁰¹ Care not funded by the NHS and instead paid for by patients or their insurers.

¹⁰² Some previous cases have treated day cases as a separate frame of reference, but based on discussions with NHSI/E, the CMA decided to combine them in this case. The same approach was followed in [Aintree University Hospital NHS Foundation Trust/Liverpool and Broadgreen University Hospitals NHS Trust](#).

¹⁰³ The Parties agreed that the approach the CMA took in [University Hospitals Birmingham/Heart of England](#) and [Central Manchester University Hospitals/University Hospital of South Manchester](#) was appropriate for the assessment of this Merger, see Annex '051 Competitive Analysis FINAL'.

- (a) **For elective services:** the CMA considers that the geographic frame of reference is informed by GP patient referral information;¹⁰⁴
- (b) **For non-elective services:** the CMA considers that the geographic frame of reference is informed by the willingness of patients to travel for consultation or treatment, taking into account travel distance and travel time;
- (c) **For specialised and community services:** the CMA considers that the geographic frame of reference is informed by the geographic scope of relevant contracts and previous bidding contracts; and
- (d) **For private healthcare services:** the CMA considers that the geographic frame of reference is likely to be at least as large as for elective services. In the Private Healthcare Market Investigation, the CMA found that the average travel time for private hospital patients was just over 30 minutes.

78. However, it has not been necessary for the CMA to conclude on the exact geographic frame of reference for any services provided by the Parties, since no competition concerns would arise from the Merger with regard to these services on any plausible basis.

Conclusion on frame of reference

79. For the reasons set out above, the CMA has considered the impact of the Merger in each frame of reference in the east Dorset area, including the Bournemouth-Poole conurbation.

80. It has not been necessary for the CMA to conclude on the exact frame of reference for any services provided by the Parties, since no competition concerns would arise from the Merger with regard to these services on any plausible basis.

Competitive assessment

Horizontal unilateral effects

81. Horizontal unilateral effects may arise when one firm merges with a competitor that previously provided a competitive constraint, allowing the

¹⁰⁴ In line with previous cases, the CMA did not find necessary to set out the exact boundaries of the geographic scope, since this is all GP referrals and would be captured by the referral analysis.

merged firm profitably to degrade quality (or raise prices if they compete on price) on its own and without needing to coordinate with its rivals.¹⁰⁵ Horizontal unilateral effects are more likely when the merging parties are close competitors. In this case, the CMA has considered whether, after the Merger, the Parties will have the incentive to worsen outcomes or the quality of service to patients. Regarding elective services, this could be, for example, longer waiting times, reduced levels of cleanliness or worsened clinical quality (reduced ratio of clinical staff to patients or slower adoption of clinical best practice). Regarding specialised and community services, this could be, for example, reduced clinical quality or reduced choice for the tendering body, resulting in worse value for money.

82. Historically, competition in the NHS has taken place where patients have a choice between NHS service providers, incentivising providers to improve quality.¹⁰⁶ Mergers between providers of NHS acute services may dampen this incentive if they remove a significant alternative for patients, resulting in lower quality.¹⁰⁷

The existing competitive landscape in the sector

83. In any merger investigation, the CMA will assess the extent and nature of current (or pre-merger) competition. The current status of public policy choices about the role of competition within the provision of healthcare services is therefore a particularly relevant factor in the review of NHS mergers.
84. The CMA recognises that the Parties are public service providers that operate in a heavily regulated environment, with numerous safeguards overseen by the CQC and NHSI, as well as the local CCGs. This regulation limits the extent to which competition can affect the quality and range of healthcare services offered. Nevertheless, competition between providers can take place within the constraints of a heavily regulated environment, and has taken place in the past.
85. However, in recent decisions on NHS mergers, the CMA has found that current policies, such as the introduction of the *Five Year Forward View*

¹⁰⁵ [Merger Assessment Guidelines](#), from paragraph 5.4.1.

¹⁰⁶ CMA guidance on the review of NHS mergers (CMA29), paragraph 6.6 at [Review of NHS mergers: CMA29 - GOV.UK](#): 'Competition to attract patients occurs where patients have a choice between providers of the same service. Payments for these services are commonly made according to the payment-by-results rules, at nationally mandated prices across England. Providers are motivated to compete on quality in order to attract patient referrals and hence income'.

¹⁰⁷ CMA guidance on the review of NHS mergers (CMA29), paragraphs 1.5 and 6.48 at [Review of NHS mergers: CMA29 - GOV.UK](#). Examples of clinical factors include infection rates, mortality rates, ratio of nurses or doctors to patients, equipment, best practice. Examples of non-clinical factors include cleanliness and parking facilities.

and the STPs, had encouraged greater levels of collaboration and collective responsibility in the provision of NHS services within LHEs. In these decisions (including the most recent *Aintree/Liverpool* decision), the CMA found that these policy developments, combined with increased financial and capacity constraints, had led to a reduced emphasis on competition and concluded that regulation and available capacity might determine behaviour more than competition, particularly in the delivery of NHS elective services (although the delivery of other services will also be affected).¹⁰⁸

86. The evidence in this case¹⁰⁹ is consistent with those findings and shows that the continued progression of national policies in this direction, combined with local factors (such as the use of block contracts, the collaboration via the ICS, including financial risk sharing), has substantially reduced the effectiveness of competition as a means of organising the provision of NHS services in the east Dorset area.¹¹⁰
87. In light of the facts described above, the CMA believes that the role for competition between NHS providers (including the Parties) is significantly diminished. The consequences for the effects of the Merger are discussed below.

Competitive assessment by service type

88. The CMA assessed the impact of the Merger in each frame of reference, taking into account the policy changes in the NHS (explained in paragraphs 73 to 80 above) which have materially reduced the role of competition.

¹⁰⁸ See paragraph 7 above.

¹⁰⁹ See, for example the following documents submitted by the Parties. RBCH NHS Standard Contract West Hampshire 19-20 (draft). PHT Annual Report and Accounts 18-19: 'as an Integrated Care System, all partners are working together to make the best use of our collective resources', Annex 005 of the Accompanying Merger Submission. PHT 19-20 Operational Plan: 'All five NHS bodies in Dorset are working within a financial framework for 2019/20 which was agreed within the context of the wider Dorset ICS planning assumptions', Annex 006.1 of the Accompanying Merger Submission. CSR Decision Making Business Case Vol 2. Wessex Clinical Senate Report (April 2016): 'The vision for acute services is for Dorset hospitals to work much more closely together in an efficient way. This would allow patients rapid access to high-quality services that are sustainable on workforce, quality and financial grounds into the future. All the hospitals in Dorset will continue to provide services, but the services each one provides will be different in future to those they provide today and will be part of a Dorset wide network', Annex 016 of the Accompanying Merger Submission. NHS England transforming urgent and emergency care guidance (August 2015): 'A commissioning strategy for urgent and emergency care should be developed using a collaborative approach with health and social care partners across the whole system. Involvement from the voluntary and community sector, patients and carers is important', Annex 018 of the Accompanying Merger Submission. Full Business Case for Merger (draft). Dorset System Agreement 19-20.

¹¹⁰ The Parties signed up to the Finance Collaboration Agreement, as part of which they agreed to block contracts at 0%, 1% and 2% increases. They have also agreed to be transparent about the financial positions of the Parties. See call note with Dorset CCG dated 17 February 2020.

89. The CMA has taken into account the impact of the Merger on competition in both ‘in’ and ‘for’ the market. For elective and non-elective services, NHS trusts would compete ‘in’ the market, while for specialised and community services, they would compete ‘for’ the market.

Elective (including paediatric and maternity services)

90. As noted above, the Parties submitted that Government policy (discussed in the section on ‘Current policies in the NHS’, at paragraphs 42 to 47) has changed significantly since the CC’s review of the Parties’ previous merger proposal, signifying a shift towards collaborative agreements and away from competition.¹¹¹ In addition, the Parties submitted that the operational environment has also changed, further diminishing the Trusts’ incentives to compete for patients (see section on ‘Competition in the east Dorset area’, from paragraph 56).¹¹²
91. In its final report, the CC found that RBCH and PH had incentives to compete for additional patients, in particular because they were remunerated via PbR.¹¹³ The CC found SLCs in 19 elective inpatient specialties and 33 outpatient specialties that related to elective inpatient activity,¹¹⁴ as well as for maternity services.
92. In assessing the impact of the Merger in elective (including paediatric and maternity) services,¹¹⁵ the CMA has taken into account: the evidence on the diminished role of competition in the wider NHS as a result of the policy changes; factors specific to the east Dorset area, such as the Agreement entered into as part of the ICS and financial risk sharing arrangements; the fact that most of the Parties’ revenue for NHS elective services is from block contracts and capacity constraints faced by the Parties in the east Dorset area.
93. In the current case, the CMA found, in line with other recent cases, that competition is no longer as influential an organising principle of the NHS as

¹¹¹ Accompanying Merger Submission, paragraphs 110 and 177 - 123

¹¹² Accompanying Merger submission, paragraphs 35 – 37 and 110.

¹¹³ CC Final Report 2013, paragraphs 45 to 48. [The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Final Report](#), 17 October 2013, paragraph 2.31.

¹¹⁴ Paragraph 53 of CC Summary of report 17 October 2013.

¹¹⁵ In the previous merger proposal, the CC considered that patients have a right of choice of provider for their first consultant-led outpatient appointment for routine elective services, which is enshrined in the NHS Constitution. Even where patients do not exercise this choice themselves (either with or without the advice of their GP), their GP will take the decision as to where the patient should be referred, and similar factors may be relevant to the GP’s choice. Whereas for non-elective services many patients do not have a choice of hospitals, because they are transported by emergency services according to ambulance protocols. For those that are not, the CC noted that there is no guarantee of choice (unlike in relation to elective services). CC Final Report 2013, paragraphs 42 and 55.

it was under the 2012 reforms and the HSCA and that other policies (described above) are far more significant in determining how the Parties make operational decisions.¹¹⁶ In addition, the mechanisms established through Dorset ICS and the Agreement have substantially reduced each Party's ability or incentive to unilaterally increase or decrease capacity to compete for elective activity (as set out at paragraphs 58 to 64).

94. Further, both Parties earn the majority of their revenues from block contracts. In FY2018/19, block contracts accounted for nearly all (99% for RBCH and 93% for PH) of the Parties' revenues associated with the provision of elective and non-elective services. This represented (more than a half (55%) of RBCH's, and nearly three quarters (71%), of PH's total revenues.¹¹⁷ The CMA considers that moving away from PbR to block contracts has substantially reduced the Parties' incentives to compete for additional patients.¹¹⁸
95. The views expressed by the Dorset CCG, the main commissioner of elective services from the Parties, confirmed the role of collaboration and the challenges faced by NHS trusts, including the Parties, in the east Dorset area. Dorset CCG considered that this would remain the case for the foreseeable future. Dorset CCG stated that there has not been competition between the Parties 'for a few years now'¹¹⁹ and it did not expect the Merger to have any effect on competition between the Parties. West Hampshire CCG and NHSE also did not raise competition concerns about the Merger, with NHSE also stating that it does not consider that any competition takes place between the Parties.¹²⁰
96. Likewise, the Parties' internal documents support the position that collaboration, rather than competition, is the primary driver of the Parties' activities and did not suggest that their decision-making has been influenced by each other's activities.¹²¹

¹¹⁶ Aintree/Liverpool: [Aintree University Hospital Foundation Trust/Royal Liverpool and Broadgreen University Hospitals NHS Trust](#) (22 August 2019). University Hospitals Birmingham/Heart of England: [University Hospitals Birmingham/Heart of England](#) (30 August 2017). Derby/Burton: [Derby Teaching Hospitals/Burton Hospitals](#) (15 March 2018). Bournemouth/Poole: [Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust](#) (21 October 2013). See [Central Manchester University Hospitals NHS Foundation/University Hospital of South of Manchester NHS Foundation Trust](#), 91 August 2017, paragraphs 8 and 9.

¹¹⁷ Response to question 17 of RF11.

¹¹⁸ The Parties were unable to separate income received from elective and non-elective activity from Dorset CCG.

¹¹⁹ Call note with Dorset CCG dated 17 February 2020.

¹²⁰ Call note with West Hampshire CCG, dated 4 March 2020. Call note with NHSE dated 17 February 2020. NHSE told the CMA that: 'There is an expectation that the merger will lead to significant improvements for the local area.'

¹²¹ See, documents referred to at footnotes 83 and 109.

97. Finally, as described above (at paragraphs 52 to 55), the NHS as a whole is facing capacity constraints,¹²² which are particularly acute in the east Dorset area. The CMA considers that these constraints – in particular where increased demand for non-elective activity may displace elective activity as a result of insufficient workforce or theatre/bed capacity – are consistent with a situation where the Parties have limited ability to treat additional patients overall, which would reduce any incentives to attract additional patient referrals.¹²³
98. Based on the evidence set out above, the CMA considers that competition is not a key driver for making operational decisions between RBCH and PH and, consistent with both national policy and CCG planning, is unlikely to play a significant role in setting standards for the Parties' elective services in the foreseeable future.
99. Therefore, the CMA believes that the Merger will not affect the Parties' incentives or behaviour in the provision of elective services and will not give rise to a realistic prospect of an SLC as a result of horizontal unilateral effects in the provision of elective services.

Non-elective services

100. In previous cases, including in the CC's review of the previous merger proposal between the Parties,¹²⁴ the CMA found that there was no material competition between providers in non-elective services.¹²⁵ This is because most patients either attend via ambulance or attend their nearest A&E department, meaning there is limited active patient choice.
101. The CMA did not find evidence that the quality of non-elective services is a significant driver of any residual choice.¹²⁶ In addition, the CMA found that payments to trusts for non-elective services are subject to a 'marginal rate emergency tariff', under which providers that go beyond a baseline level are paid at a marginal rate for each additional patient treated. This funding formula dampens trusts' incentives to go beyond their baseline level,

¹²² NHSI Submission, paragraph 72: 'However, in recent years the NHS provider sector has experienced capacity constraints (as measured, for instance, by waiting times or by bed occupancy) that make it increasingly difficult for trusts to identify additional efficiency improvements that can be undertaken in order to accommodate increases in activity'.

¹²³ See paragraphs 45 to 48 above.

¹²⁴ *University Hospitals Birmingham/Heart of England, Derby Teaching Hospitals/Burton Hospitals, Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust and Central Manchester University Hospitals/University Hospital of South Manchester.*

¹²⁵ This was not disputed by the Parties.

¹²⁶ *University Hospitals Birmingham/Heart of England, paragraph 89* and *Derby Teaching Hospitals/Burton Hospitals*, paragraph 95.

meaning that the trusts would have even less incentive to attract patients for non-elective services than they would for elective services.¹²⁷

102. The CC found that the previous merger proposal was unlikely to result in an SLC in relation to non-elective services.¹²⁸ The Parties submitted that there has been no change in the provision of non-elective services since CC's previous review.¹²⁹
103. In addition, the Parties submitted that their financial incentives to compete for non-elective patients are even lower than those observed in previous cases, such as *Derby/Burton*, as the majority of such payments were based on fixed value block contracts,¹³⁰ preventing the Parties from increasing revenue by treating additional patients.¹³¹
104. Dorset CCG confirmed that the services for non-elective patients are primarily remunerated by fixed value block contracts.¹³²
105. The CMA has therefore not received any evidence indicating that there have been any changes to market conditions for non-elective patients which would undermine its previous findings. Therefore, the CMA considers that the Merger will not give rise to a realistic prospect of an SLC with respect to the provision of non-elective services.

Specialised and community services

106. With respect to specialised and community services, providers compete for the market (via tenders to obtain contracts with commissioners to provide such services to patients). The CMA therefore examined whether the Merger was likely to remove an important alternative for commissioners.
107. In 2013, the CC considered whether the previous merger proposal would be likely to lead to reduced competition in relation to services which commissioners may change or reconfigure because the merger would reduce the number of potential suppliers. The CC did not find that the

¹²⁷ *Derby Teaching Hospitals/Burton Hospitals*, paragraph 85, and *Central Manchester University Hospitals/University Hospital of South Manchester*, paragraph 12.21.

¹²⁸ Paragraph 55 of CC Summary of report 17 October 2013,

¹²⁹ Accompanying Merger Submission, paragraphs 149 – 150.

¹³⁰ Only the services associated with providing treatment of a small number of patients outside Dorset are not caught by the block contracts, see response to question 5 of RF11.

¹³¹ Accompanying Merger Submission, paragraph 152 and response to question 5 of RF11.

¹³² See call note with Dorset CCG dated 17 February 2020.

merger would be likely to give rise to SLCs in relation to competition for the market in community or specialised services.¹³³¹³⁴

Specialised services

108. Both Parties provide specialised and public services: RBCH provides 20 specialised services and eight public health services; PH provides 28 specialised services and 12 public health services.¹³⁵
109. The Parties submitted that while they overlap in the provision of certain specialised and public health services, these reflect historical commissioning decisions before the current specialised commissioning arrangements were established.¹³⁶ They stated that they have not participated in any competitive tenders against each other in the last two years.¹³⁷ The Parties were also not aware of any plans on the part of NHSE to hold a competitive tender, or otherwise engage in a selection process, in which NHSE would be choosing between RBCH and PH.¹³⁸
110. NHSE South West, the commissioner of specialised services for east Dorset, confirmed that neither Party bid against each other, and that contracts for specialised services are generally based on historical practice.¹³⁹ More generally, NHSE confirmed that in the last two contract rounds it has not seen any acute NHS trust express an interest in delivering services provided by another acute NHS provider in the South West, where the Parties are present.¹⁴⁰

¹³³ CC Summary of report 17 October 2013, paragraphs 60-62. ¹³⁴ In the previous merger proposal, the CC found SLCs in the following services: (a) 19 elective services; (b) 34 outpatient services; (c) one non elective inpatient service: maternity; (d) one private service: cardiology. CC Summary of report 17 October 2013, paragraphs 60-62 and 66.

¹³⁴ In the previous merger proposal, the CC found SLCs in the following services: (a) 19 elective services; (b) 34 outpatient services; (c) one non elective inpatient service: maternity; (d) one private service: cardiology. CC Summary of report 17 October 2013, paragraphs 60-62 and 66.

¹³⁵ Accompanying Merger Submission, paragraph 146 and Table 5.2.1.

¹³⁶ Response to question 11 of RF11.

¹³⁷ Accompanying Merger Submission, paragraph 148 and response to question 5 of RF12.

¹³⁸ This was also the reason for CC's findings in the previous merger proposal that that the merger was likely to give rise to SLC in the provision of specialised services, see Accompanying Merger Submission, paragraph 148. This has also been confirmed by NHSE. Call note with NHSE dated 17 February 2020.

¹³⁹ Call note with NHSE dated 17 February: NHSE told the CMA that the procurement for specialised services is very much based on a historic and custom practice. NHSE run a process nationally to satisfy the requirements of the public contract regulations (expression of interest process). The process is: (i) publish a list of all the services and high-level figures of the values in the OJEU; (ii) every provider that is interested in providing the services can register an expression of interest; (iii) national selection process where there are multiple bids for the same service. Incumbent providers must express an interest in their own services in order to satisfy the process. There are generally only multiple expressions of interest with small providers that provide easily transferable niche services (for example, neuro-rehabilitation or some mental health provision which can be delivered on a "stand alone" basis in a dedicated facility).

¹⁴⁰ NHSE told the CMA that "[a] lot of activity that NHSE commissions is paid for at the standard national tariff prices, so [...] pricing negotiations are limited. Contracting for specialised services does not focus on going to the

111. Accordingly, the CMA considers that the Merger will not give rise to a realistic prospect of an SLC with respect to the provision of specialised services.

Community services

112. The Parties submitted that they do not compete for the provision of community services. They stated that neither RBCH nor PH provides community services separate from their core acute services and the community services they provide are ‘incidental to their main role as providers of acute hospital-based services’.¹⁴¹
113. Further, the Parties stated that PH has not participated in any tenders for community services since the CC’s review of the Trusts’ previous merger application.¹⁴² While PH does provide certain community services, such as maternity and paediatric services, these services are being provided on a historic basis and there has never been a competitive selection process for PH as the provider of these services.¹⁴³
114. This is consistent with the view from Dorset CCG, commissioner for community services, which stated that there has not been competition between the Parties ‘for a few years now.’¹⁴⁴
115. Accordingly, the CMA considers that the Merger will not give rise to a realistic prospect of an SLC with respect to the provision of community services.

Conclusion on specialised and community services

116. For the reasons set out above, the CMA considers that the Merger will not give rise to a realistic prospect of an SLC in relation to the provision of specialised and community services.

market for a cheaper price – it is around setting up a contract that allows [...] to provide the best services possible within the resource allocation’ See note of call with NHSE dated 17 February 2020.

¹⁴¹ Accompanying Merger Submission, paragraph 154.

¹⁴² In the previous merger proposal, the CC found that the merger between RBCHT and PHT was not likely to give rise to an SLC in relation to the provision of community services. Accompanying Merger Submission, paragraphs 153 and 156.

¹⁴³ Response to question 12 of RFI1.

¹⁴⁴ Call note with Dorset CCG dated 17 February 2020. Although not specific to community services, the CMA’s view is that this suggests there has not been competition between the parties in relation to community services.

Private patient services

117. The CMA has also examined whether the Merger is likely to remove an important alternative for private patients, leading to an SLC.¹⁴⁵
118. RBCH provides private patient (both inpatient and outpatient) services in a range of specialties.¹⁴⁶ PH closed its PPU in August 2018¹⁴⁷ and currently offers a limited number of services to private patients (ie diagnostic and pathology services, support services to patients of BMI Harbour Hospital, and limited maternity services to a small number of patients). However, the available evidence indicates that the services provided by PH do not compete with the services provided by RBCH. In particular:
- (a) PH's decision to cease providing private patient services, ie close the PPU was not Merger-specific.¹⁴⁸ The diagnostic and pathology services offered by PH cannot be accessed by patients separately and independently from the NHS services they are related to¹⁴⁹ and, as a result, the Parties do not compete for the provision of these services for private patients;¹⁵⁰
 - (b) The support private patient services provided by PH to patients of BMI Harbour Hospital are provided under a contract between PH and BMI Harbour Hospital, which means that there is no direct competition between RBCH and PH for private patients;¹⁵¹ and

¹⁴⁵ In the previous merger proposal, the CC found an SLC in one private service: cardiology. Paragraph 64 of the CC Summary of report 17 October 2013.

¹⁴⁶ RBCH offers private patient services in a range of specialties, including Haematology, Orthopaedics and Urology, through the Bournemouth Private Clinic. Private patient services in cardiology at RBCH are offered through the Bournemouth Heart Clinic. This is a privately-owned facility at Royal Bournemouth Hospital that rents space at the Hospital, purchases support services from RBCH and has a profit share agreement with RBCH. Paragraph 158 of the Accompanying Merger Submission.

¹⁴⁷ PH quoted the demand for beds arising from emergency admissions (ie non-elective services) at PHT limiting the number of beds and theatre capacity available for private patient services as the main reason for the closure of its private patient suite. PHT submitted that the Merger did not play any part in this decision and that it has no plans to start providing private patient services in future. Accompanying Merger Submission, paragraphs 158-159 and response to question 7 of RF11.

¹⁴⁸ PH submitted that the Merger did not play any role in the decision to close the private patient ward: 'The commercial strategy that was adopted for Poole in March 2018 indicates that Poole could continue to develop its private patient services'. See RF11 response and Annex 056 (*PHT Commercial Strategy Update March 2018*) of the Accompanying Merger Submission. See also Annex 57 to the Accompanying Merger Submission, *Reconfiguration of Cornelia Suite Private Inpatient Ward Briefing Paper for Staff Partnership Forum*, dated 11 July 2018: 'Taking into account the cost to deliver services provided by the Cornelia Suite the private inpatient ward makes a loss of £358,649 per annum. It is therefore not economical to operate a private patient ward of the size that is currently in place at the trust, where it is being subsidised by NHS funded care and contributing further to our underlying expenditure over income deficit'. See also Annex 101 to the Parties' response to RF11, *Private Patient Income Tracker 2017-2019*.

¹⁴⁹ It merely allows NHS patients to receive their test results earlier.

¹⁵⁰ Response to question 2 of RF12.

¹⁵¹ Response to question 2 of RF12.

- (c) PH receives some private income from mothers who elect to use an overnight private room following delivery but does not offer other private maternity services. In the last two years PH treated one private maternity patient, who was most likely was an overseas patient not eligible for NHS services, which indicates that RBCH and PH do not compete with each other.¹⁵²

119. Accordingly, the CMA believes that the Merger will not give rise to a realistic prospect of an SLC in relation to the provision of private patient services and has not examined this overlap further.

Conclusion on horizontal unilateral effects

120. For the reasons set out above, the CMA believes that it is the case that the Merger may not be expected to result in a realistic prospect of an SLC as a result of horizontal unilateral effects in relation to the provision of elective, non-elective, private, specialised or community services. Accordingly, the CMA considers that the Merger will not give rise to a realistic prospect of an SLC in any candidate market identified.

Third party views

121. NHSI's views on the Merger are set out above.
122. In addition, the CMA contacted the main commissioners for the Parties' activities: West Hampshire CCG, Dorset CCG and NHSE South West. All of these commissioners expressed full support for the Merger. Both Dorset CCG and NHSE South West thought that the Merger will maximise workforce efficiency and service quality and viewed the reconfiguration of the Parties' activities resulting from the CSR as a positive outcome benefiting patients leading to significant improvements in the area.
123. Some other third parties, including patient groups and private individuals, raised concerns about the Merger.¹⁵³ The CMA received submissions from 12 third parties. All of these 12 third parties raised concerns. Ten third parties were concerned about the potential impact on patients of the reconfiguration plans after the Merger. Two other third parties raised concerns that did not specifically relate to the reconfiguration plans.¹⁵⁴

¹⁵² See response to question 6 of RF11 and question 4 to RF12.

¹⁵³ Some of these third parties sent several submissions to the CMA. [REDACTED]

¹⁵⁴ [REDACTED] and [REDACTED].

124. When investigating a merger, the CMA's mandate, by law, relates to assessing the potential impact of that merger on competition. In mergers between NHS providers, the merger review process is designed to examine the potential adverse effects for patients and/or commissioners arising from a loss of competition between hospitals. Assessing the other potential effects of a merger falls outside the CMA's statutory powers. In conducting its assessment, the CMA has therefore only taken into account the submissions relating to the loss of competition that might be brought about by the Merger.
125. One third party [redacted] submitted that there is currently competition between the Parties that will be significantly reduced as a result of the Merger. This third party stated in particular that: 'if the merger goes ahead, there will no longer be competition between Bournemouth and Poole Hospitals across 55 services, and patients will no longer have the choice¹⁵⁵ that the CMA recognises that they had had [in the 2013 CC decision]. Nor will patients have choice about where to attend for outpatients or A&E, stating that more than 50% of A&E attenders self present'.¹⁵⁶ This third party [redacted] added that 'under the merger, no patients would be able to choose to go to Poole Hospital for A&E or maternity. Bournemouth Hospital will be the only option for many patients. For some patients, although Poole Hospital is 20 miles or more away, it is still their nearest hospital. The choice to attend Bournemouth hospital for elective care and outpatients would also be removed from all patients'.¹⁵⁷
126. The same third party [redacted] and eight other third parties raised concerns that following the reconfiguration plans having all emergency care consolidated at RBCH, with the PH site being for planned care only (ie elective and maternity services) may result in some patients facing increased travel times and additional expense in accessing A&E and/or maternity services.¹⁵⁸
127. One other third party stated that the Merger should be blocked, telling the CMA that: 'RBCH is becoming a monopoly provider of medical care and will directly lead to a SLC within the Dorset health market. [...] The PbR system for hospitals is in effect a payment by activity. Hospitals have been paid handsomely for generating more activity and have sucked in all available

¹⁵⁵ [redacted] stated that depending on a range of factors, including recommendation from GP or friends/family, patients can make a choice now. 'To have the choice to attend the hospital closest to where you live, whatever service you are accessing, is important, as being able to access care matters to all, and proximity is a key choice factor for older, poorer & BAME people according to the CMA working paper by Whitehouse and Schiraldi.'

¹⁵⁶ Email from [redacted] to the CMA dated 16 March 2020.

¹⁵⁷ Email from [redacted] to the CMA dated 16 March 2020.

¹⁵⁸ [redacted] For example, one of these third parties told the CMA that: [redacted].

cash since their demands for payment are paramount. [...] RBCH has dominated and in effect taken over the direction of travel of the entire Dorset health economy. All other units are sacrificed, scaled back, downgraded or closed to satisfy RBCH trajectory of empire building and relentless expansion. [...] The Competition and Market Authority will fail in it's core duty if it permits this monolith to prosper at the expense of the other foundation trusts. Competition will cease.¹⁵⁹

128. As noted above, the CMA's statutory role is to assess whether a merger might bring about a SLC. As the CMA has noted in its previous decisions concerning mergers of NHS hospital trusts, choice is relevant, as a driver of competition, where it is inextricably tied to the incentives and ability of providers to attract a higher number of patients by increasing quality of their services.¹⁶⁰
129. The CMA and its predecessors have historically found that patient choice and competition on quality do not play a material role in the provision of non-elective services such as A&E services.
130. For elective services, the CMA has found (as set out at paragraphs 90 to 99) that, in this case, the Parties' incentives and ability to compete for patients have been significantly reduced, including by the use of block contracts (rather than the PbR system noted in one of the third party submissions), the Agreement entered into as part of the ICS and financial risk sharing arrangements. The CMA therefore considers the policy and regulatory environment, as well as the funding model under which the Parties operate, means that they do not today compete for patients to any material extent with respect to elective services (including paediatric and maternity services). On this basis, the CMA considers that the choice that existed between the Parties in 2013 is no longer a material consideration in the assessment of whether the Merger gives rise to competition concerns.
131. One third party referred to above [REDACTED] made a detailed submission on the patients benefits case prepared by the Parties and published on their website.¹⁶¹ This third party [REDACTED] submitted that there are a number of significant disbenefits created by having elective, maternity, emergency and outpatient monopolies on one acute site only. It stated that the Merger

¹⁵⁹ [REDACTED]

¹⁶⁰ Aintree/Liverpool: [Aintree University Hospital Foundation Trust/Royal Liverpool and Broadgreen University Hospitals NHS Trust](#) (22 August 2019). University Hospitals Birmingham/Heart of England: [University Hospitals Birmingham/Heart of England](#) (30 August 2017). Derby/Burton: [Derby Teaching Hospitals/Burton Hospitals](#) (15 March 2018). Bournemouth/Poole: [Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust](#) (21 October 2013).

¹⁶¹ See [Patient benefits resulting from creating a major emergency hospital and a major planned care hospital](#). see email from [REDACTED] of 16 March. [REDACTED] submission: [REDACTED].

means loss of patient (and GP) choice, which is likely to affect service quality; it also means delayed access to distant overcrowded services, reducing outcomes and increasing patient risk in emergency, and deterring take up of care. According to this third party [REDACTED], this will particularly affect rural residents, those on low incomes, who are older, or have mobility problems, and those without access to a car, increasing health inequalities. The third party submitted that there is no clinical evidence base to support centralising services in rural Dorset, no credible risk assessment has been carried out, and plans to take Poole Hospital & beds out of A&E care are likely to cause system collapse.

132. Evidence relating to the potential benefits to patients arising from the Merger would only be considered by the CMA after it had identified an SLC, in which case it would assess whether relevant customer benefits – ie merger-specific benefits to patients – are such that the merger should not be referred for a phase 2 investigation because they outweigh the SLC resulting from the merger.¹⁶² In this case the CMA has not identified an SLC (for the reasons set out in detail above) and therefore it has not been necessary for the CMA to assess relevant customer benefits.
133. One of the third parties referred to above also raised a concern about RBCH's ability to deal with an increase in the number of patients.¹⁶³ Another third party stated that the merger of the hospital services and in particular that of A&E seemed likely to be financially and medically incoherent.¹⁶⁴ Another third party made submissions in relation to compliance with 'Equality legislation' and the NHS being free at the point of delivery.¹⁶⁵
134. As these concerns do not relate to the loss of competition brought about by the Merger, they have not been taken into account in the CMA's assessment.

Decision

135. Consequently, the CMA does not believe that it is or may be the case that the Merger may be expected to result in an SLC within a market or markets in the United Kingdom.
136. The Merger will therefore **not be referred** under section 33(1) of the Act.

¹⁶² [Mergers: Exceptions to the duty to refer, paragraphs 76-86.](#)

¹⁶³ [REDACTED]

¹⁶⁴ [REDACTED]

¹⁶⁵ [REDACTED]

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27 April 2020