Decision to give consent to The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust to merge

The CMA's decision to give consent to The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust to merge given on 27 April 2020. Full text of the decision published at a later date.

Summary

1. The CMA has decided to give The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (**RBCH**) and Poole Hospital NHS Foundation Trust (**PH**) (together referred to as the **Parties**) consent to merge (**the Merger**). As set out in detail below, this consent is required as a result of undertakings given to the Competition Commission (**CC**)[1] on 20 November 2013 by the Parties under section 82 of and Schedule 10 to the Enterprise Act 2020 (the **Act**) (the **Undertakings**),[2] following its decision on the merger.[3]

2. This consent decision is separate from the decision on whether the Merger creates a relevant merger situation that has resulted, or may be expected to result, in a substantial lessening of competition (**SLC**) in any market or markets in the UK under section 33(1) of the Act (the **SLC decision**) [4] However, the outcome and substantive consideration of the SLC decision have contributed to the consent decision.

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[1] The CC is one of the CMA's predecessor bodies. On 1 April 2014 the Competition and Markets Authority (**CMA**) took over the functions of the Competition Commission and the competition and certain consumer functions of the Office of Fair Trading (**OFT**).
[2] See Undertakings.
[3] *The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Final Report*, 17 October 2013,
[4] The CMA has investigated the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust. For more details please visit the case page: https://www.gov.uk/cma-cases/royal-bournemouth-and-christchurch-hospitals-nhs-foundation-trust-poole-hospital-nhs-foundation-trust-merger-inquiry

Background

3. On 17 October 2013, the CC published a report on the anticipated merger of RBCH and PH.[5] The CC found that the proposed merger may be expected to result in a SLC in several markets.[6]

4. For the purpose of remedying the SLCs identified in the Report and the adverse effects which flow from them, on 19 December 2013, the CC accepted the Undertakings.

5. Except with the prior consent of the CMA the Hospital Trusts undertook not to: (i) apply for or implement a merger within the meaning of section 56 (Mergers) of the National Health Service Act 2006, as amended by section 168 of the Health and Social Care Act 2012, of their respective organizations; or (ii) apply for or implement an acquisition by RBCH of PH, or by PH of RBCH, within the meaning of section 56A (Acquisitions) of the National Health Service Act 2006, as inserted by section 169 of the Health and Social Care Act 2012.[7]

6. 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 Undertakings may be varied, superseded or released by the CMA under section 82(2) of the Act.

RBCH and PH's request for consent to the merger

7. The Parties approached the CMA on 31 October 2019 requesting consent to merge. RBCH and PH explained that they no longer have the same incentives to compete that were identified by the CC in 2013 in its review of the Parties' previous merger proposal.

8. RBCH and PH stated that at a national level, the *NHS Long Term Plan* (**LTP**), the *Five Year Forward View*, local Sustainability and Transformation Partnerships (**STPs**) and financial control totals implemented in recent years, have all dampened the role of competition for patients and that much greater emphasis has been placed on collaboration and integration across providers, which has already been recognised by the CMA in its recent decisions on NHS mergers.

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[5] *The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Final Report*, 17 October 2013,
[6] *The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Final Report*, 17 October 2013, paragraph 8.1.
[7] The main provision regarding the prohibition of the merger is at paragraph 2.1 of the Undertakings.

9. In Dorset, the Parties submitted that, together with Dorset CCG and other NHS providers in Dorset, they are working collaboratively on day-to-day service planning, quality monitoring and improvement and demand management. A common strategic approach has been adopted aimed at reducing growth in the demand for hospital-based services by providing more care in patients' homes and other community-based settings. Neither RCBH or PH has a strategic goal of competing to attract more patients.

10. The Parties submitted that the remuneration of RBCH and PH has shifted from activity-based tariffs to block contracts so neither RBCH nor PH has an incentive to compete for additional patients' referrals. They also submitted that financial risk-sharing agreements have been adopted, meaning that neither RBCH nor PH fully retains any surpluses, which further dampens competitive incentives.

11. In light of these changes in circumstances, the Parties consider that the concerns previously identified by the CC in its report regarding the merger between RBCH and PH in relation to incentives to compete for patient volumes no longer arise, and that therefore the CMA should give consent to the Merger.

Considering RBCH and PH's request

12. The CMA's approach to granting consent under a remedy will depend on the individual circumstances affecting a particular undertaking or order and its terms.

13. In determining whether to give consent under the Undertakings in this case, the CMA is considering whether the circumstances prevailing at the time of the Undertakings have changed, such as to make it appropriate for the CMA to grant consent to RBCH and PH to merge. In doing so, the CMA will have regard to the substantive considerations set out in its guidance on merger remedies,[8] guidance on merger review,[9] and the Chairman's Guidance on Disclosure.[10]

14. The scope of the CMA's consent decision is limited to determining whether to grant consent for RBCH and PH to apply for or implement a merger, or

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[8] Merger remedies, CMA87 (December 2018).
[9] Remedies: Guidance on the CMA's approach to the variation and termination of merger, monopoly and market undertakings and orders (CMA11). In paragraph 2.6 of this guidance the CMA considers that changes in market conditions are among the change of circumstances that may lead to a variation or termination of undertakings.
[10] Disclosure of information in CMA work (CC7). This guidance was originally published by the CC and has been adopted by the CMA board. The original text has been retained unamended, therefore it does not reflect or take account of developments in case law, legislation or practice since its original publication.

apply for or implement an acquisition by RBCH of PH, or by PH of RBCH (see paragraph 4, above).

NHS policy and local market conditions at the time of the CC's decision

15. In the report on the anticipated merger of RBCH and PH, the CC found that the patient choice and payment by results (**PbR**) regimes incentivised acute service providers to compete for patients. The PbR regime sets tariffs for procedures and providers are paid according to the number of procedures which they carry out. National PbR tariffs cover the majority of acute healthcare (elective and non-elective) in hospitals. Through the regulatory framework that has been set up, including the PbR regime and the commissioning of services by Clinical Commissioning Groups (CCGs), foundation trusts may compete to provide healthcare services to commissioners, GPs and patients. The remuneration system set out under the PbR regime incentivizes providers of acute elective services to win additional patients.[11]

16. The CC found that NHS policy at the time of its decision implied that the parties should have incentives to compete. It also considered a number of factors that could remove these incentives, including the profitability of increasing elective activity given the tariffs and cost structure, capacity constraints, and the relationships between the parties and CCGs.

17. The CC found that expansion of elective services appeared to be profitable at the margin, subject to capacity issues. It found that despite existing capacity constraints there is a level of flexibility around capacity, which meant that the parties could expand to some extent within specialties (particularly if hospitals try to expand more profitable specialties or procedures at the expense of less profitable ones). It found that in general it expected commissioners to pay for genuine increases in activity, and so these relationships did not entirely remove the trusts' incentives to compete (although they may soften them or make the link between activity and income less direct). On this basis, it concluded that the parties had incentives to compete.[12]

18. The CC concluded that the merger may be expected to result in an SLC in the Dorset area as a result of unilateral effects in relation to some elective

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[11] *The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Final Report*, 17 October 2013, paragraph 13 of summary and paragraphs 2.31-2.37.
[12] *The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Final Report*, 17 October 2013, paragraphs 6.56-6.185.

services and some outpatient services and in relation to maternity services (inpatient and outpatient) and to inpatient cardiology services to private patients. In the context of quality competition, the CC noted that unilateral effects included effects not only on clinical quality but other factors which patients and GPs took account of when coming to a decision on choice of provider (eg provider environment, waiting times, location of services). The CC also found that commissioners would be unable to constrain the merged entity from decreasing quality and that entry was unlikely to occur in a timely and sufficient manner to counteract the unilateral effects identified in relation to the various specialties. The CC did not find efficiencies that would be sufficient rivalry-enhancing to counteract any adverse merger impact.[13]

19. The CC concluded that prohibition of the merger was the only remedy that would address the SLCs and adverse effects that were found.[14]

Changes to NHS policy and local market conditions in east Dorset

20. The CMA has examined whether there has been a change in the circumstances prevailing at the time the Undertakings were accepted. The CMA has gathered this information for the purpose of determining whether any changes to NHS policy and local market conditions in east Dorset, might have a bearing on the appropriateness of the CMA granting its consent to the Merger.

21. The CMA considers that there have been a number of changes to NHS policy and local market conditions in the east Dorset area since the CC's prohibition decision in 2013, as described by the Parties and NHS Improvement (**NHSI**) in their submission to the CMA.[15] NHSI submitted that the changes in policy and payments regime 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.[16]

22. NHSI stated that since the implementation of the Health and Social Care Act 2012 (**HSCA**), the increase in demand for NHS services – most notably resulting from an ageing population and increases in long term health

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[13] *The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Final Report*, 17 October 2013, paragraph 7.25.
[14] *The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Final Report*, 17 October 2013, paragraph 10.1.
[15] 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**).
[16] NHSI's Submission paragraph 121.

conditions – has put financial and operational pressure on the healthcare system.[17] 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 NHS England (**NHSE**) have introduced new policies, which have shifted the focus towards encouraging performance improvements by promoting greater collaboration and away from competition.[18]

23. In particular, NHSI submitted that:

(a) In October 2014, NHSE published the *Five Year Forward View*.[19] It set out a vision for greater integration of services and cooperation between providers, and suggested steps to support new ways of working.[20] NHSI noted that the *Five Year Forward View* 'shifted the focus of improving NHS services from incentives which facilitated competition to a future of increased collaboration and integration'.[21] STPs were announced in December 2015 as the next step for implementing the *Five Year Forward View*.[22]

(b) 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 set out in the *Five Year Forward View*. This includes developing STPs into new local health system partnerships called Integrated Care Systems (**ICSs**), by April 2021, as well as changes to payment mechanism and, potentially, licencing.[23]

24. NHSI submitted that these changes have removed the expectation that the Parties should operate focusing on their own interests only and created an expectation that the trust should make decisions in a local system through

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[17] NHSI's Submission, paragraph 48.
[18] CMA Aintree/Liverpool Decision: *Aintree University Hospital Foundation Trust/Royal Liverpool and Broadgreen University Hospitals NHS Trust* (22 August 2019).. See also NHSI's Submission, paragraphs 28-32.
[19] 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.
[20] For example, by allowing CCGs to move away from the activity-based payments envisaged by the PbR reimbursement regime.
[21] NHSI's Submission, paragraph 42.
[22] 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.
[23] NHSI's Submission, paragraphs 44 and 56.

collaboration and partnership with commissioners and providers, balancing the needs of different organisations to benefit patients.[24]

25. In addition, NHSI submitted that since 2013, a series of measures have been implemented changing the landscape in which foundation trusts operate and weakening their incentives to compete for market shares, including:

(a) the establishment of the Single Oversight Framework;

(b) the move from imposing control totals[25] at the service provider level to also imposing them at the local health system level;

(c) the transfer of incentive payments into the Financial Recovery Fund made available to providers and CCGs in deficit;

(d) a reserved power for NHSI to set annual capital spending limits for NHS foundation trusts; and

(e) proposed changes to primary legislation that aim to accelerate the move away from competitive market dynamic towards a more collaborative dynamic.[26]

26. NHSI stated 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.[27] In addition, the Parties, other members of the ICS and Dorset CCG 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. [28] The Agreement introduces the use of block contracts, setting out the fixed amounts paid by Dorset CCG to the NHS trusts.

27. The Agreement also sets out a number of arrangements relating to collaborative working and financial risk sharing, which according to NHSI and the Parties, remove the incentives for individual trusts to compete for elective activity with other ICS members.[29]

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[24] NHSI's Submission, paragraph 54.
[25] Control totals are defined as *'*annual financial targets that must be met in order to receive additional funding*'*. NHSI's Submission, paragraph 69.
[26] NHSI's Submission, paragraph 69.
[27] NHSI's Submission, paragraph 103.
[28] NHSI's Submission, paragraph 104.
[29] NHSI's Submission, paragraph 111.

Third party views

28. Between 1 April 2020 and 21 April 2020, the CMA consulted on whether to give consent to the Merger under paragraph 2.1 of the Undertakings.[30] The CMA received one submission during the consultation period from a third party, **[✂]** (**[✂]**).[31]

29. This third party **[✂]** submitted that none of the NHS policy changes would make the anti-competitive effects identified by the CC in its decision unlikely and that the CMA should only take into account those NHS policy changes which have been implemented, rather than hypothetical possible changes. They also stated that the way in which the Parties organise their payment systems seem largely irrelevant to residents who currently have a choice about where to access maternity, elective, A&E and outpatient care services, who will no longer have that choice post-Merger. Finally, this third party stated that the Merger undermines the Parties' undertaking not to apply for such a merger within 10 years.[32]

30. The same third party **[✂]** also submitted comments on the CMA's SLC decision separately.[33]

31. The CMA has taken this third party's submission into account. However, as set out at paragraph 20 to 27 there have been changes to NHS policy since the previous merger proposal, which have in particular resulted in changes to the way the Parties are remunerated and how they make operational decisions.

32. In its investigation into whether the Merger gives rise to a realistic prospect of an SLC under section 33(1) of the Act, the CMA received submissions from 12 third parties in relation to the proposed merger, who all raised concerns. The majority of 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.[34]

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[30] *Notice of consultation to give consent to The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust to merge under paragraph 2.1 of the undertakings given to the Competition Commission under section 82 of the Enterprise Act 2002.*
[31] Email from **[✂]** to the CMA dated 20 April 2020.
[32] Email from **[✂]** to the CMA dated 20 April 2020.
[33] See paragraph 33 below.
[34] One third party raised a concern that related to the level of competition between RBCH and PH: 'RBCH has dominated and in effect taken over the direction of travel of the entire Dorset health economy. All other units are

33. As referred to at paragraph 30, **[✂]** made a detailed submission on the patients benefits case prepared by the Parties.[35] In particular, they submitted that there are a number of significant dis-benefits created by having elective, maternity, emergency and outpatient monopolies on one acute site only. They stated that the Merger 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 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. They 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.

34. The CMA has reviewed these submissions as part of the SLC decision.

CMA's assessment

35. The CMA has considered whether the Merger would undermine the effectiveness of the Undertakings in meeting their aim to remedy the SLC found by the CC in 2013 such that it would not be appropriate for it to give its consent to merge.

36. As discussed in paragraphs 20 to 27 above, the evidence available indicates that there have been a number of changes to NHS policy and market conditions in the east Dorset area, which have substantially reduced the ability and incentives for the Parties to compete such that the competition concerns identified in the CC's report no longer arise. As reflected in the SLC decision, the Merger will not give rise to horizontal unilateral effects in relation to the supply of elective, non-elective, specialised, community, and private patient services in the east Dorset area. Therefore, the CMA considers that the Merger is unlikely to undermine the effectiveness of the Undertakings in achieving their original aim.

37. In light of the above, the CMA has decided that it would be appropriate to give consent to the Parties under paragraph 2.1 of the Undertakings.

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sacrificed, scaled back, downgraded or closed to satisfy RBCH trajectory of empire building and relentless expansion.' The CMA notes that this complaint is based on understanding that the Parties are still primarily remunerated using the PbR mechanism, which has not been the case for several years.

[35] See *Patient benefits resulting from creating a major emergency hospital and a major planned care hospital.* see email from **[✂]** of 16 March. **[✂]** submission: **[✂]**.

The CMA's decision

38. The CMA gives its consent to the Merger under paragraph 2.1 of the Undertakings.

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