

Response of



to

Provisional Decision on Remedies  
(Non-Confidential)

7 February 2014

Appendix 2

ABU DHABI | BEIJING | BRUSSELS | FRANKFURT | HONG KONG | LONDON | MILAN | NEW YORK | PALO ALTO  
PARIS | ROME | SAN FRANCISCO | SÃO PAULO | SHANGHAI | SINGAPORE | TOKYO | TORONTO | WASHINGTON, DC

WE OPERATE IN THE UK AND ITALY AS SHEARMAN & STERLING (LONDON) LLP, A LIMITED LIABILITY PARTNERSHIP ORGANISED IN THE UNITED STATES UNDER THE LAWS OF THE STATE OF DELAWARE, WHICH LAWS LIMIT THE PERSONAL LIABILITY OF PARTNERS. SHEARMAN & STERLING (LONDON) LLP IS AUTHORISED AND REGULATED BY THE SOLICITORS REGULATION AUTHORITY (FIRM SRA NUMBER 211340). A LIST OF ALL PARTNERS' NAMES, WHICH INCLUDES SOLICITORS AND REGISTERED FOREIGN LAWYERS, IS OPEN FOR INSPECTION AT 9 APPOLD STREET, LONDON EC2A 2AP. EACH PARTNER OF SHEARMAN & STERLING (LONDON) LLP IS ALSO A PARTNER OF SHEARMAN & STERLING LLP WHICH HAS OFFICES IN THE OTHER CITIES NOTED ABOVE.

## APPENDIX 2: KINGS OAK / CAVELL

### 1. Introduction

- 1.1 BMI notes that the CC has at no stage proposed divestment as a remedy for single site hospitals.

*"In areas where hospital operators had high market shares but only owned one facility (i.e. Single or Duopoly areas ), we did not consider that divestiture would be an effective remedy to the AEC identified since the sale of a hospital would simply transfer market power from one operator to another" (para 2.2, PDR).*

*"We did not consider that divestiture in Single or Duopoly areas would be an effective remedy since, in both cases, divestiture would replace one rival with another rather than introduce more rivalry. A divestiture remedy would, therefore, only be appropriate in those areas where we have competition concerns in which Clusters of hospitals are owned by the same operator" (para 25, Remedies Notice).*

- 1.2 Kings Oak/Cavell is, as BMI has previously informed the CC, run as a single site hospital. A proposed divestment is therefore not an effective remedy on the CC's own analysis.

- 1.3 As the CC is aware, BMI bought Cavell on 1 February 2008. [REDACTED]

- 1.4 [REDACTED]

- 1.5 On 8 January 2014, BMI submitted to the CC a paper entitled "Savings of hospitals in close proximity: shared management and shared services", which quantified and explained some of the costs savings and efficiencies arising from BMI's ownership of these sites. These efficiencies are also addressed in Appendix 6 to this response; that Appendix should be read in conjunction with those papers.

### 2. Kings Oak/Cavell is run as a single unit

- 2.1 As planned, Kings Oak and Cavell, which are 0.6 miles apart, have been run as an integrated hospital in the fundamental ways listed below since Cavell was acquired from Nuffield in 2008. [REDACTED]

(a) [REDACTED]

(b) [REDACTED]

(c) [REDACTED]

(d) [REDACTED]

(e) [REDACTED]

(f) [REDACTED]

(g) [REDACTED]

(h) [REDACTED]

(i) [REDACTED]

(j) [REDACTED]

2.2 Since the fact that Kings Oak/Cavell is integrated is fundamental to BMI's defence (and the outcome of the CC's assessment of this 'cluster'), each of these facts (a) to (j) is supported below by illustrative evidence. BMI is willing to provide further evidence to verify each these points should the CC require.

2.3 *First, consolidation of services at one site.* In considering the effectiveness of divestitures, the CC takes into account, *inter alia*, the substitutability of the hospitals by range of medical specialties offered, including availability and type of ICU. In the case of Kings Oak/Cavell, now a single split site hospital where "hospital ingredients" are shared across sites, this exercise is fundamental to understanding the effectiveness of the proposed remedy. The CC has to assume that the two sites would be able to compete against each other as separate hospitals. Each site would therefore require assets and services that are currently located at the other.<sup>1</sup>

2.4 Since its acquisition of Cavell six years ago, BMI has consolidated certain services (and the related specialist staff/expertise) in one or the other site. The hospitals no longer function independently but are truly interdependent. The CC must look beyond specialties to also consider the services and equipment which only one site provides. The table below shows – highlighted in yellow – the number of ingredients which are now provided at one site or the other.

Table 1 : [REDACTED]

[REDACTED]

2.5 The planning behind each of these decisions is detailed and focuses on the needs of the local resident population. It allows better, and more, facilities than would be possible if each hospital had to fully replicate the assets of the other. As examples:

- MRI / CT scanning.<sup>2</sup> Before the installation of these facilities at Cavell in 2012, CT scans were only available for patients two days per week and MRI scans three days per week, on a mobile basis. The MRI service is now available 8am to 8pm five days a week (and sometimes on Saturdays), whilst the CT service is performed Monday to Friday. [REDACTED]. Before the hospitals came under common ownership and this scanning equipment was installed, it was uneconomic for each hospital to invest due to insufficient volumes. Further information on the introduction of scanning facilities at Cavell is included in BMI's submission of 8 January 2014. The implications of divestment of one or other sites on the use of these scanning facilities at either is discussed at length in that paper and also later in this document.

---

<sup>1</sup> The costs of building each hospital up so that it is a viable competitor to the other is addressed later in this Appendix and at detail in Appendix 6.

<sup>2</sup> <http://www.privatehealth.co.uk/news/february-2012/bmi-hospitals-welcome-delivery-of-cutting-edge-mri-scanner-36535/>.

- Endoscopy. BMI is currently investing [X] at Cavell in order to upgrade endoscopy capabilities, [X] patients provided with a superior service as a result of investment supported by [X]. The installation of these enhanced endoscopy facilities is also discussed in the 8 January submission and the implications of divestment are expanded later in this submission.
- [X] Suite. From April/May 2014, the hospital will operate [X]. The suite was installed in the [X].
- [X]

2.6 *Second, patient pathways.* The investment across both sites means that patient care pathways often involve treatment at both.

(a) Example pathway 1 ([X]):

- [X]
  - [X]
- [X]

(b) Example pathway 2 ([X]):

- [X]
  - [X]
- [X]

(c) Example pathway 3 ([X]):

- [X]
- [X]

2.7 Patients on pathways across sites are directed between them via joint (common) directions: an example flyer showing directions to Cavell includes directions to Kings Oak and is provided at Annex 1. If desired, patients can request transport between sites, which is provided via a porter's van.

2.8 The excerpt below, picked at random from a Kings Oak/Cavell Quarterly Clinical Report 1Q 2013 shows (as an illustrative excerpt only) how this integration works in practice.

[X]

2.9 *Third, several services are provided centrally.* One example is [X].

2.10 [X] is also centralised. [X].

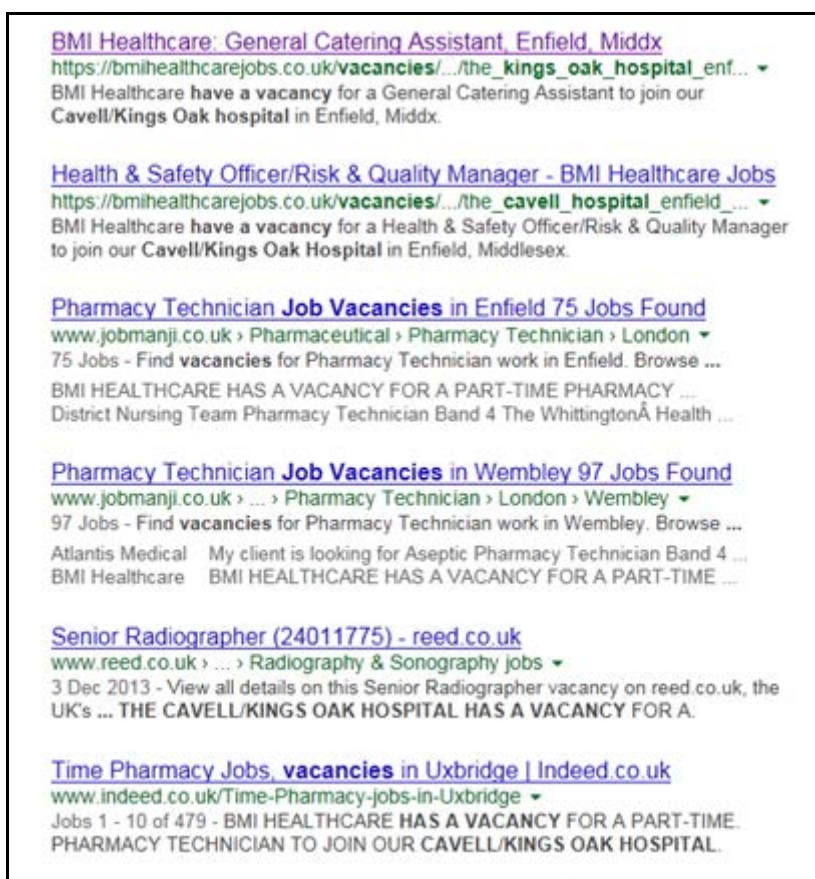
- 2.11 Similarly, [REDACTED].
- 2.12 The management of Kings Oak/Cavell has recently been in talks about [REDACTED]. Conversations, both internal and external, have from the outset been premised on the understanding that this service will be provided at only one site. Not only is it unnecessary to duplicate this service for an integrated hospital, but allowing critical specialist resources to be pooled (rather than watered down at both sites) results in a better patient offering. Relevant to efficiencies (discussed later in this response), the implementation of [REDACTED] at one site will cost BMI [REDACTED]; this cost would be double were the sites considered separate.
- 2.13 *Fourth, investment.* Investment cases for equipment are predicated on volumes from both sites and investment decisions are based on the needs of both hospitals combined.
- [REDACTED]
- 2.14 The location of such investment is based purely on which hospital has the most suitable space. [REDACTED].
- 2.15 As noted, it is envisaged that [REDACTED] will be required by the hospital: it is likely to be installed at [REDACTED].
- 2.16 There are current plans to install [REDACTED] at Cavell for [REDACTED]. The rationale for this – and the consideration to the needs and capacity of each of the Kings Oak and Cavell sites – is illustrated by the slide below, [REDACTED].
- [REDACTED]
- 2.17 Crucially, the Kings Oak/Cavell budget covers both sites. For example, the 2013 review is based upon [REDACTED]. Doing so allows management to make critical business decisions (e.g. investment decision based on the demand and anticipated volumes which are crucial to cover fixed costs).
- [REDACTED]
- 2.18 This allows efficiencies. For example, [REDACTED].
- 2.19 *Fifth, capacity utilisation (in terms of theatre lists etc.) is managed across sites.* [REDACTED]
- 2.20 *Sixth, staff.* Staff within the clinical departments (including consultants) work across both hospital sites [REDACTED].<sup>3</sup>
- 2.21 [REDACTED].
- 2.22 Using staff in this way allows efficiency and flexibility, e.g. cover in the event of sickness, or the balancing of theatre lists safely. [REDACTED].

---

<sup>3</sup> [REDACTED]

2.23 Most consultants in the Kings Oak/Cavell consultant directory are listed at both hospitals.<sup>4</sup> This shows the fluidity in which consultants move between the hospitals depending on the point in a patient's care pathway or availability of equipment, and the way in which this is marketed to the public. Note that this was not always the case: when Cavell was owned by Nuffield, some consultants refused to work there; now most consultants move fluidly between both sites due to increased confidence (resulting from better theatre management, staff and one unified work culture). Of course, where a specialty is located in one site, consultants will be based at that hospital. [REDACTED].

2.24 The snapshot below illustrates that staff are recruited for a single split site hospital:



2.25 *Seventh, administration.* [REDACTED].

[REDACTED]

2.26 [REDACTED]

2.27 The Medical Advisory Committee reviews admitting rights and all clinical outcomes and activity (including the hospital complaints policy) across both sites. Meeting venues alternates between hospitals.

<sup>4</sup> <http://www.bmihealthcare.co.uk/graphics/images/healthcare-professionals/hp-pdfs/BMI-KingsOak-Cavell-consultant-directory.pdf>.

2.28 The evidence all points towards Kings Oak/Cavell being in fact a single split-site hospital.

### **3. Efficiencies generated by the split site**

3.1 On 8 January 2014, BMI submitted to the CC a paper entitled 'Savings of hospitals in close proximity: shared management and shared services' in which it explained, *inter alia*, the benefits accruing to patients at Kings Oak/Cavell. The paper set out the efficiencies generated by the shared management team at Kings Oak/Cavell. This has been developed further in BMI's response on the financial impact of divestment on the business (Appendix 6) and in Compass Lexecon's paper 'the NPV of divestitures' (Appendix 7). BMI responds in this context.

3.2 In relation to efficiencies created by shared management, the current cost of the shared management team is [redacted] p.a. whereas the sites would each cost [redacted] p.a. to operate separately. BMI estimates that the current shared management represents a saving of [redacted] as against requiring separate management teams for each site. After divestment, each site would require an additional Opex cost of [redacted] p.a. rising in line with salary costs. This corresponds to an increase of [redacted] in operating cost. If BMI and the operator of the divested hospital were to recover all of this increase in cost by increasing prices uniformly across episodes, a [redacted] price increase would be required at these two sites.<sup>5</sup>

3.3 In addition, the Kings Oak/Cavell pathways create efficiencies since hospital management can resource staff with the necessary expertise, as well as equipment, efficiently. Breaking these efficiencies would result in longer waiting periods and reduced quality and convenience of service provision. Sharing staff and resources across sites means that BMI can deal with a shortage of skilled staff across all major departments. For example, the ability to move staff between sites prevents cancellation and delays that might otherwise arise as a result of sickness or capacity shortages. [redacted].

3.4 As noted above, a similar flexibility is afforded by the ability to use the operating theatres at both sites. Operating four theatres (as opposed to two) gives the option to transfer entire theatre lists between one site and the other. For example, [redacted]. This ensures continuity of care and minimises the risk of delays and disruptions to care. In a post divestment world this resiliency is lost.

### **4. Patient benefits**

4.1 The current economies of scale and scope have resulted in the management of Kings Oak/Cavell implementing its '6 Cs' clinical strategy (for which it has received national recognition) and it is currently working on introducing [redacted]. These strategies would be much more difficult, if not impossible, to implement were either hospital divested. This clearly reduces the prospect of clinical development and improved patient care.

4.2 The Kings Oak/Cavell patient pathways, as discussed at paragraph 2.6 above, give several benefits. The hospital is able to provide an effective service for patients by

---

<sup>5</sup> That is, a [redacted] price increase would be required to increase net revenues by [redacted] on the assumption of constant volumes.

using staffing and equipment resources optimally. However it also gets the benefit of resources which match those of a larger hospital. If patient pathways were not an option due to divestment, patients would have a disrupted care journey and longer waiting times; the hospital would face reduced efficiency and reduced ability to reduce prices or invest. Similar continuity benefits arise from service departments operated centrally (such as [redacted]) – the integration of one hospital, but with the economies of scale and superior facilities which are achieved through larger patient volumes and budget.

4.3 [redacted]

4.4 [redacted]

## 5. Impact of divestment

5.1 If one or other of the sites were to be divested, each of the following would occur.

5.2 [redacted]. The CC must assume that each of the hospitals will invest to replicate the service capacity offered by the other (to become a standalone competitor to the other across the 16 specialties plus oncology) otherwise the divestment will be ineffective. [redacted].

5.3 [redacted]. Since coming into BMI ownership, ward utilisation has increased from [redacted] to [redacted] at Cavell; and its theatre utilisation rate from [redacted] to [redacted]. The capacity utilisation rates (and hence hospital output) at Cavell pre- and post- acquisition say much about the efficiencies that have been achieved through a period of declining private demand and a recession.

5.4 The ability and incentive of the hospitals to invest to match the other will also be impacted by:

(a) Cost. [redacted].

[redacted]

[redacted]

[redacted]

(b) Logistical considerations. Either hospital (post-divestment) may have difficulty in locating capital equipment due to size constraints.

[redacted]

➤ [redacted]

[redacted]

[redacted]

➤ [redacted]



5.5 [REDACTED]

5.6 [REDACTED]

5.7 Transitional arrangements would be unworkable. An anti-poaching provision for consultants as the CC appears to envisage would obviously not work in a scenario where consultants have practising privileges at Kings Oak/Cavell and treat patients at Kings Oak/Cavell now.

5.8 How does the CC envisage managing transitional arrangements? Plainly hold separate arrangements are unworkable due to the long embedded inter-dependencies. [REDACTED], in view of the time required to build and implement these (as well as replicating the core departments which are operated centrally, such as [REDACTED], it is likely that very significant transitional provisions will need to be put in place to cover [REDACTED]. The CC has no legal power to force BMI and the purchaser to invest to replicate services. These transitional arrangements may persist into the long term. A clean cut structural remedy appears highly unlikely on the facts.

5.9 In summary, divestment of either hospital would result in the loss of efficiencies (both in terms of cost saving and in patient services/pathways) and customer benefits that BMI's ownership of both, and operation as a split-site hospital, currently confers on patients. Given the extent of patient benefits that would be lost, even were both hospitals to remain in existence as private hospitals, the CC must reconsider the proportionality of the remedy. This is particularly the case since the hospitals are already sufficiently constrained (see paragraph 7.2).

## 6. Strategic choices available to operators

6.1 On separation, the respective owners would have two main strategy choices:

(a) [REDACTED]

(b) [REDACTED]

6.2 [REDACTED]

6.3 [REDACTED]

6.4 [REDACTED]

## 7. Kings Oak/Cavell is adequately constrained

7.1 Kings Oak/Cavell is an integrated, split site hospital, not two hospitals prone to divestiture.

7.2 For completeness, and without prejudice to this position, given the extent of the detriment to patient benefit that would ensue were the CC to continue with a divestment, the CC should also revisit BMI's response to the Provisional Findings. BMI does not intend to repeat those arguments here. However, it notes that it has more than adequately demonstrated that each of Kings Oak and Cavell is sufficiently constrained in its local environments, by a large number of competitors including Aspen Holly House, Spire Bushey, Royal National Orthopaedic Hospital PPU (Spire),

Spire Roding, HCA's Wellington Diagnostics and Outpatients Centre, Highgate, Ramsay's The Rivers, North Middlesex PPU, Lister Hospital, Queen Elizabeth II PPU and the central London hospitals. [§]. A selection of new evidence, provided by the management of Kings Oak/Cavell in the course of putting together this response, is provided at Annex 11.

- 7.3 Finally, BMI reiterates that in 2008 the OFT considered the competitive implications for BMI (who already owned Kings Oak and the Garden within a 30 minute drive time) acquiring Cavell (then Enfield). Although this OFT review was several years ago, the CC must realise that the local private healthcare market has if anything become even more competitive. For example, Aspen Holly House has recently undergone a £21 million refurbishment. [§]. In paragraphs 2.92 and 2.93 PDR, the CC dismisses BMI's double jeopardy argument. The better explanation for the divergent OFT and CC outcomes is that the OFT in fact did do a detailed analysis of the dynamics of the local market and the CC has not done so.

## **8. Conclusion**

- 8.1 The CC has mischaracterised the two hospitals and assumed that they are readily capable of being viable, self-standing hospitals competing against each other across the 17 specialisations. Separation of the hospitals will lead to a loss to patients, and no competitive improvement in the medium term.
- 8.2 To be effective, the CC must therefore have a rational, evidenced based expectation that post-divestment Kings Oak and Cavell will operate as separate, fully-functioning private hospitals. The CC has not addressed this at all.
- 8.3 In any event, the CC must modify its cost-benefit analysis to capture the loss to patients of the de-merger; the costs to both operations of re-equipping and reorganising provision. In addition, the CC needs to properly assess what demand there will be from potential purchasers in these circumstances.