Anticipated merger between University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust

ME/6666-17

The CMA's decision on reference under section 33(1) of the Enterprise Act 2002 given on 30 August 2017. Full text of the decision published on 14 September 2017.

Please note that [✂] indicates figures or text which have been deleted or replaced in ranges at the request of the parties for reasons of commercial confidentiality.

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SUMMARY

Background

1. University Hospitals Birmingham (**UHB**) and Heart of England (**HEFT**) plan to merge to form a single NHS Foundation Trust (the **Merger**). UHB and HEFT are together referred to as the **Parties**. The Competition and Markets Authority (**CMA**) believes that these arrangements, if carried into effect, will result in the creation of a relevant merger situation.[1]

2. UHB operates from a single hospital site (Queen Elizabeth Hospital) in Birmingham. HEFT operates from three main hospitals and one smaller site (Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and the Birmingham Chest Clinic). The Parties are located near to one another and overlap across a number of healthcare services provided to NHS patients, overseen by local commissioners and NHS England.

3. In Birmingham and Solihull, in addition to the Parties, there is one other acute provider, Sandwell and West Birmingham NHS Trust (**SWBH**), and two other hospitals providing specialist services, Birmingham Women's and Children's Foundation Trust (offering specialist paediatric and women care) and Royal Orthopaedic Hospital NHS Foundation Trust (a specialist orthopaedic centre).

4. Since 2012, HEFT has had sustained difficulties in governance, quality of care and finances.[2] In 2013, the Care Quality Commission (**CQC**) rated the trust as requiring improvement overall. In October 2015, Monitor, now NHS Improvement (**NHSI**) ,[3] directed that the leadership of UHB take over the running of HEFT on an interim basis (the **Intervention**). NHSI deemed UHB a high performing trust in leadership and safety, with clear lines of responsibility and accountability, and significant capabilities and transactional experience.[4]

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[1] The CMA believes that it is or may be the case that the Parties will cease to be distinct as a result of the Merger, that the turnover test is met and that accordingly arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation. Section 79(1) of the HSCA states that where the activities of two or more NHS FTs cease to be distinct activities, this is to be treated as a case in which two or more enterprises cease to be distinct enterprises for the purpose of Part 3 of the Act.
[2] For a more detailed description of the history of problems at HEFT and the subsequent steps taken to improve the situation, see section 2.1 of the advice that NHS Improvement provided to the CMA on 28 July 2017 (**NHSI Advice**). A link to this is available on the case page. Under section 79(5) of the HSCA 2012, NHSI is required to provide the CMA with advice on (a) the effect of the merger on benefits (relevant customer benefits) for people who use healthcare services provided for the purposes of the NHS; and (b) such other matters relating to the merger as NHSI considers appropriate.
[3] Since 1 April 2016, Monitor and the NHS Trust Development Authority have been operating as a single integrated organisation known as NHS Improvement. NHSI, through Monitor, authorises and regulates NHS foundation trusts, sets prices for NHS acute services (through the National Tariff) and supports commissioners to maintain service continuity.
[4] See section 2.2. of the NHSI Advice.

5. Since the Intervention, several key stakeholders, including NHSI, the CQC and key commissioners[5] have said that HEFT has significantly improved in terms of governance, financial leadership, stability and quality of patient care.

6. However, the Parties submitted to the CMA that the current situation is not sustainable and only a full merger between UHB and HEFT will embed and sustain the performance improvements achieved. The Parties said that, absent the Merger, UHB management would withdraw, nullifying the improvements made so far and that any alternative management that HEFT could find would not be as effective as UHB.

Competitive assessment

7. In its recent in-depth investigation of a merger between NHS hospitals in Manchester,[6] the CMA found that NHS providers are facing significant growth in demand for services, while working under certain budgetary, capacity and regulatory constraints. The CMA also found that competition between NHS service providers continues to be possible but may be more limited than has previously been found to be the case. The CMA has taken account of these findings in its investigation of the Merger.

8. In assessing the Merger, the CMA adopted a counterfactual in which HEFT would operate independently from UHB (with or without further regulatory intervention).

9. In assessing the potential impact of the Merger on competition in the provision of healthcare services, the CMA treated each specialty as a separate product frame of reference and, within each specialty, treated outpatient, inpatient and day case activities (as well as non-elective and elective services) as separate frames of reference. The CMA distinguished private services from NHS services[7] and assessed the Merger on the basis of its impact on competition both 'in' and 'for' the market.

10. The CMA assessed a range of evidence on closeness of competition, including GP referral analysis, internal documents, the Parties' submissions and third party comments, including those of commissioners.

11. The CMA analysed GP referral patterns, which focus directly on the actual choices made by patients and GPs at each individual GP practice, and

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[5] Birmingham CrossCity Clinical Commissioning Group (**CCG**), Birmingham South Central CCG and Solihull CCG.

[6] See Report on the anticipated merger between Central Manchester University Hospitals and University Hospital of South Manchester of 1 August 2017 (hereafter **CMFT/UHSM**).

[7] Within private services, each specialty constitutes a separate market and within each specialty, markets can be defined along inpatient, outpatient and day case lines (as with NHS services).

applied the filters adopted in *CMFT/UHSM* to this data. This allowed the CMA to focus its assessment on those elective specialties (either inpatient, outpatient or daycare) where one of the Parties would be expected to capture over 40% of patients diverted from the other Party. The CMA also investigated the extent of differentiation between the Parties, for example, with regard to sub-specialisation, the effects of pre-Merger collaboration and the extent to which patients in a given specialty were exercising meaningful choice.

12. As a result of its investigation, the CMA did not identify competition concerns with regard to community services, a number of elective and non-elective acute services, specialised services, or private services. In each case there was either no overlap, limited scope for patients to actively choose which hospitals to attend, or a sufficient number of alternative healthcare providers around Birmingham and Solihull. The CMA also did not identify potential competition concerns with regard to hospital-wide effects.

13. However, with regard to a number of NHS elective services,[8] the CMA found the Parties to be close alternatives for patients, with only one other district general hospital (SWBH) in the local vicinity remaining post-Merger.

14. Therefore, while the Parties' internal documents indicate that competition does not play a major role in the Parties' decision-making process, and they face some capacity constraints, the CMA could not rule out that there is scope to treat additional patients in some specialties and so an incentive may remain to respond to local healthcare market conditions, for example by improving patient care. However, given the difficulties HEFT has had in the past (see paragraph 4 above), the CMA believes that the competitive constraint from HEFT may have been limited.

15. In light of the above, the CMA believes that the Merger gives rise to a realistic prospect of a substantial lessening of competition (**SLC**) as a result of horizontal unilateral effects in the supply of 25 elective specialties.[9]

Exceptions to the duty to refer – Relevant Customer Benefits

16. Under section 33(2)(c) of the Act, the CMA may decide not to refer a case in which it has found a realistic prospect of an SLC if it believes that any relevant

[8] Such services are typically planned or scheduled in advance and usually require a referral from a GP or other primary care provider.
[9] Endocrinology, Urology, Gastroenterology, Clinical haematology, Breast surgery, Colorectal surgery, Nephrology, Geriatric medicine, Diabetic Medicine, I/V Radiology, Rheumatology, Upper Gastrointestinal surgery, Neurology, Medical oncology, Pain management, ENT (Ear, Nose, Throat),Cardiology, Vascular surgery, Respiratory medicine, Respiratory physiology, Plastic surgery, TIA (Transient Ischaemic Attack), General Surgery, Chemical pathology, Speech and Language therapy. See for a detailed overview Annex 1

customer benefits (**RCBs**) related to the merger outweigh the effects of the SLC. The Parties submitted that the Merger has led, and will lead, to RCBs outweighing any adverse competitive effects.

17. For a merger involving one or more NHS Foundation Trusts, NHSI is required to provide the CMA with advice on any benefits which may accrue from that merger for people who use health services provided by the NHS.[10] NHSI advised the CMA that UHB was delivering significant benefits for a large number of patients of HEFT and the Merger was likely to deliver further improvements and higher quality care for patients of both UHB and HEFT.

18. Specifically, NHSI advised the CMA that the Merger would deliver the following RCBs:

    (a) **Hospital-wide 'cross-cutting' improvements** including to waiting times for diagnosis and treatment, in the monitoring of and response to clinical quality issues, governance, stabilisation of clinical services in urgent need,[11] workforce, use of clinical IT and culture and staff morale.

    (b) **Speciality-specific improvements** to neurology, interventional radiology, plastic surgery, gastroenterology and liver medicine and vascular surgery.

19. NHSI advised the CMA that these improvements were merger-specific because the sustainability and durability of these improvements required leadership that only UHB could provide. NHSI told the CMA that it was highly likely that the benefits yet to be implemented or embedded would be realised within a reasonable period following the Merger. The CMA has placed significant weight on this advice, given NHSI's role and expertise as sector regulator for the NHS. The CMA also had regard to the evidence and submissions from key stakeholders (see paragraph 5 above), supporting the findings in the NHSI advice.

20. In light of the Parties' submissions and NHSI's advice, the CMA believes that the benefits identified by NHSI qualify as RCBs for the purposes of its competitive assessment. In line with the relevant legal test, the CMA then considered whether these RCBs would outweigh the competition concerns identified. In making its decision the CMA had regard, on the one hand, to the magnitude of the benefits and the probability of them occurring and, on the other hand, to the scale of the SLCs and the probability of them occurring.[12]

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[10] See NHS Mergers Guidance (CMA29), paragraph 7.5. NHSI is not required to provide such advice where the merger involves only NHS Trusts and not NHS Foundation Trusts.
[11] Namely, neurology, interventional radiology and plastic surgery.
[12] NHS Mergers Guidance, paragraph 7.26.

21. The CMA believes that the RCBs (in particular, those of a cross-cutting nature) are substantial and will have a positive impact on many if not all HEFT patients and also some UHB patients. The CMA believes there is a high probability of the RCBs occurring, given the expertise of the UHB management, UHB's track record of realising a number of benefits since the Intervention and NHSI's advice in this regard.

22. In contrast, whilst the CMA identified a number of potential competition concerns (on a 'may be the case' basis in line with the legal threshold at Phase 1), the CMA believes that the potential for HEFT to exert a strong competitive constraint on UHB in the counterfactual is limited. In particular, the CMA has had regard to the significant challenges experienced by HEFT since 2012 until the Intervention and the risk of those difficulties recurring absent the Merger. Further, the potential competition concerns identified relate to a small percentage of services provided by the Parties (representing 8-14% of total turnover).

23. In light of the above and on the specific facts of this case, the CMA believes that the RCBs arising from the Merger outweigh the potential adverse effects of the SLCs identified. The CMA has therefored exercised its discretion not to refer the Merger for an in-depth Phase 2 assessment.

24. The Merger will therefore **not be referred** under section 33(1) of the Act.

ASSESSMENT

Parties

25. UHB is an acute general hospital trust operating from a single hospital site (Queen Elizabeth Hospital) in the Birmingham local authority area. The turnover of UHB in 2015-2016 was approximately £762m in the UK and it has around 1200 inpatient beds.

26. HEFT is an acute general hospital trust operating from three main hospitals and a smaller site in the Birmingham, Solihull and South Staffordshire local authority areas (Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and the Birmingham Chest Clinic). The turnover of HEFT in 2015-2016 was approximately £683m in the UK and it has around 1380 beds.

Transaction

27. The Parties envisage that the new FT will be formed following completion of CMA, NHSI and CQC regulatory processes (and subject to the outcomes of these processes).

Jurisdiction

28. The Parties engage in activities which constitute 'enterprises' for the purposes of section 23 of the Act[13] and these enterprises will cease to be distinct as a result of the Merger. The parties submitted that the proposed arrangements between their Foundation Trusts (FTs) create a qualifying merger reviewable by the CMA under the merger control provisions of the Act.

29. The UK turnover of HEFT exceeds £70 million, so the turnover test in section 23(1)(b) of the Act is satisfied.

30. 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.

31. The initial period for consideration of the Merger under section 34ZA(3) of the Act started on 5 July 2017 and the statutory 40 working day deadline for a decision is therefore 30 August 2017. The Merger was considered at a Case Review Meeting.[14]

Background

32. The CMA has examined the role of competition in the NHS in general and with regard to the Parties' activities in the local health economy (**LHE**).[15]

The role of patient choice and competition in the NHS

33. Competition between NHS providers may arise where providers can raise income by attracting additional patients. Providers are commonly paid at nationally mandated prices for every consultation or treatment made, based on 'payment-by-results' (**PbR**) rules. Providers therefore have an incentive to improve quality[16] to attract patient referrals, and hence raise income. PbR

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[13] Section 79(1) of the HSCA states that where the activities of two or more NHS foundation trusts cease to be distinct activities, this is to be treated as a case in which two or more enterprises cease to be distinct enterprises for the purpose of Part 3 of the Act. The HSCA confirmed the CMA's role in assessing the competition aspects of mergers involving foundation trusts.
[14] See Mergers: Guidance on the CMA's jurisdiction and procedure (CMA2), January 2014, from paragraph 7.34.
[15] Local health economy refers to NHS organisations including GP practices, and voluntary and independent sector bodies involved in the commissioning, development and provision of health services for particular population groups.
[16] For NHS services, competition does not occur on price as the people who receive care do not pay for their treatment at the point of delivery and therefore providers cannot use price as a way to ration demand. Unlike price or quantity, many aspects of quality cannot be set directly. The quality of a product or service is the outcome of many different decisions which will involve trading off different factors. For example, the decision not to fill a nursing vacancy is made by trading off the possible effect on quality of care and the impact on the cost of providing care. The priorities that determine how these decisions are made will affect individual aspects of the

rules generally apply to elective and non-elective services. In addition, NHS providers may compete for contracts to provide services (ie competition for the market), when commissioners such as clinical commissioning groups (**CCG**s) and NHSE select providers best placed to offer services to patients.[17]

34. The incentive for hospitals to compete exists where patients can exercise some choice. Patients have the right to choose any provider in England that has been commissioned by a CCG or NHSE for their first outpatient appointment for NHS elective services, which is enshrined in the NHS Constitution (2009). Patients generally choose a provider with their GP based on information and recommendations given by their GP.[18] Moreover, patients are entitled to ask to change hospital if they must wait longer than the target waiting times.[19]

35. The CMA recognises that NHS FTs, such as the Parties, are public service providers that operate in a heavily regulated environment, with numerous safeguards[20] overseen by the CQC[21] and NHSI,[22] as well as NHS England[23] and local CCGs.[24] This regulation limits the parameters within which competition can affect the quality and range of healthcare services offered.

36. In this regard, the CMA found in *CMFT/UHSM* that current policies, such as the Five Year Forward View (**FYFE**) and the Sustainability and Transformation Plans (**STP**),[25] had encouraged greater levels of collaboration and collective responsibility in the provision of NHS services within local health economies. The CMA found that these policy developments, combined with increased financial and capacity constraints, had led to a reduced emphasis on

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hospital's quality, such as the ratio of nurses to patients, as well as feeding into the hospital's overall reputation. See paragraph 4.7 of the CMFT/UHSM Report.

[17] NHS Mergers Guidance, paragraphs 6.5-6.9.

[18] For a more detailed discussion of patient choice, see paragraphs 4.2 to 4.5 of the CMFT/UHSM Report.

[19] For example, the 18 weeks from referral to treatment (**RTT**) target or the target of 2 weeks for a patient to be seen by a cancer specialist. However, the right to choose does not normally extend to inpatient or day case treatments or non-elective services.

[20] Appendix B of the CMFT/UHSM Report provides a detailed industry background and regulation in the NHS.

[21] The CQC is an independent regulator of standards in health and adult care in England and monitors, inspects and regulates services to make sure that they are safe, effective, caring, responsive to patient needs and that providers are well led.

[22] NHSI, through Monitor, authorises and regulates NHS foundation trusts, sets prices for NHS services (the National Tariff) and supports commissioners to maintain service continuity.

[23] NHS England is also the commissioner of primary healthcare services (ie medical services provided by general practitioners (GPs), dental practices, community pharmacies and high street optometrists) and specialised tertiary healthcare services (ie services provided in more specialised medical centres).

[24] CCGs are clinically led statutory NHS 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 particular field of medicine, whether in a hospital or community setting).

[25] See, for example, paragraphs 4.17-4.26 of the CMFT/UHSM Report.

competition in that LHE. The CMA concluded in that case that regulation and capacity might determine behaviour more than competition.[26]

37. Therefore, while regulation and capacity constraints may not necessarily exclude the role of competition, they will limit its impact for certain services. The CMA has taken this and policy initiatives around collaboration between providers into account where relevant in its competitive assessment.[27]

Competition in the Birmingham and Solihull LHE

38. UHB, HEFT, and SWBH are the three major NHS acute hospital trusts in Birmingham and Solihull. There are two other NHS trusts in Birmingham providing specialist services.[28] Furthermore, there are eight NHS acute trusts located in other parts of the West Midlands. These competitors are discussed in more detail in the competitive assessment.

39. Birmingham CrossCity CCG, Birmingham South Central CCG and Solihull CCG are the main commissioners in the LHE.[29] In FY2017/18, they accounted for over 80% of the Parties' income from CCGs.[30]

40. The CMA has examined the context of the LHE, including the history of challenges faced by HEFT in recent years, the approach taken by commissioners and other NHS acute providers, as well as the state of public health around Birmingham and Solihull. These considerations provide important background for understanding the role of competition and the CMA's assessment of the potential impact of the Merger.

41. The proposed Merger arises against a backdrop of several unsuccessful regulatory interventions at HEFT. Since 27 October 2015, HEFT has been under UHB's intervention as part of Monitor's third attempt to recover HEFT. Prior to UHB's intervention, HEFT faced serious challenges in the delivery of care and its operational and financial performance. In particular:

    (a) in November 2013, the CQC gave HEFT an overall rating of "Requires Improvement" following an inspection;

[26] See, for example, paragraphs 9.7 and further of the CMFT/UHSM Report.
[27] See paragraph 10.17 of the CMFT/UHSM Report.
[28] They are Birmingham Women's and Children's Foundation Trust, offering specialist paediatric and women care, and Royal Orthopaedic Hospital NHS Foundation Trust, which is a specialist orthopaedic centre.
[29] The CCGs are working together to implement a transition plan which, subject to public consultation and NHSE approval, may ultimately lead to their merger into a single CCG in 2018.
[30] Excluding specialised services which are commissioned nationally by NHSE.

(b) in December 2013, following HEFT's failure to achieve the 4-hour A&E target for six quarters, Monitor placed conditions requiring HEFT to improve performance for urgent and emergency care;

(c) in October 2014, Monitor imposed additional conditions requiring HEFT to improve board capability and governance systems;

(d) in November 2014, an independent review by Deloitte found that HEFT did not meet the standards required to govern an NHS Foundation Trust. This review led to the resignation of the then Chief Executive;

(e) in December 2014, the CQC found that insufficient progress had been made at HEFT since its November 2013 inspection. An interim Chief Executive was appointed;

(f) in January 2015, following reviews of governance and mortality at HEFT and concerns relating to its management capacity, Monitor required an improvement programme at HEFT and appointed an Improvement Director. Monitor removed the first interim Chief Executive and a second Interim Chief Executive was appointed. HEFT sought unsuccessfully to recruit a substantive chief executive; and

(g) on 27 October 2015, Monitor appointed the UHB Chair Executive, Dame Julie Moore, as Interim Chief Executive of HEFT to stabilise the operational and financial decline as well as the governance failures at HEFT.

42. UHB submitted that it was well placed to support HEFT due to its reputation and experience in assisting other organisations. It submitted that "*[UHB] is amongst the best performing FTs in the country for clinical quality and financial and operational performance*", and that it has "*experience in 'buddying' other Trusts in difficulty to improve their performance.*"[31]

43. NHSI told the CMA that the unsuccessful interventions between 2012 and 2015 "*demonstrates that HEFT was unable to respond to its regulator, let alone competition*".[32]

44. The Parties have faced general capacity pressure similar to other NHS trusts in recent years. The CMA recognises that the Parties (and in particular HEFT) have failed some key national targets,[33] and that their bed occupancy rates

[31] Paragraph 6.2.8, Merger Notice.
[32] NHSI letter to the CMA, 10 August 2017.
[33] For example, both Parties failed the 18-week referral to treatment target in some specialties and the 4-hour A&E waiting time.

were consistently above the recommended operational standard (see paragraphs 78-79 below for a further discussion on capacity constraints).

45. The CMA believes that capacity pressure is likely to sustain in Birmingham and Solihull at least in the short term. The Parties submitted that Birmingham's population growth forecast is 14% by 2031,[34] and that the extent of local demographic diversity means that certain chronic and acute diseases are likely to be more prevalent in the LHE compared to other parts of the country. The CMA notes that the expected demand growth may create additional capacity pressure on the Parties.

46. The CMA has taken the above into account where relevant in the competitive assessment and also when considering whether the claimed RCBs outweigh the potential anti-competitive effects.

Counterfactual

47. The CMA assesses a merger's impact relative to the situation that would prevail absent the merger (ie the counterfactual).

48. The counterfactual is an analytical tool used in answering the question of whether the merger gives rise to a realistic prospect of an SLC.[35] Since the counterfactual may be either more or less competitive than the prevailing conditions of competition, the selection of the appropriate counterfactual may increase or reduce the prospects of an SLC finding by the CMA. For anticipated mergers, the CMA generally adopts the prevailing conditions of competition as the counterfactual. However, the CMA will assess the merger against an alternative counterfactual where, based on the evidence available to it, it believes that, in the absence of the merger, the prospect of the prevailing conditions continuing is not realistic, or there is a realistic prospect of a counterfactual that is more competitive than these conditions.[36]

49. The Parties submitted that the correct counterfactual is the conditions that existed prior to the start of the Monitor-mandated Intervention in HEFT in October 2015. The Parties submitted that a counterfactual in which the UHB management of HEFT continues is not appropriate as the Intervention is not sustainable. The Parties submitted that this is because of the risk of confusion of accountabilities and because the duplication of roles poses a strain on the executive team, with significant time spent preparing for and attending

[34] Based on Office for National Statistics. See paragraph 5.3.2, Merger Notice.
[35] See Merger Assessment Guidelines, paragraphs 4.3.1.
[36] Merger Assessment Guidelines (OFT1254/CC2), September 2010, from paragraph 4.3.5. The Merger Assessment Guidelines have been adopted by the CMA (see Mergers: Guidance on the CMA's jurisdiction and procedure (CMA2), January 2014, Annex D).

separate meetings for each trust. The Parties also said that all of the improvements made at HEFT under UHB management would fall away if the Intervention were to end.

50. The Parties submitted that a counterfactual situation in which HEFT would be considered as a healthy, independent (ie after UHB management exit) and strong competitor would also be inappropriate. This is because HEFT continues to face challenges, as evidenced by a recent CQC report from October 2016. HEFT would therefore struggle to find suitable management with a level of experience and knowledge of the local healthcare market comparable to the current interim management.

51. At Phase 1, the CMA must assess the merger against the most competitive counterfactual (as between the Parties) of which there is a realistic prospect.[37] In this regard, it is difficult to gauge whether the prevailing conditions of competition constitute the most competitive conditions between the Parties. The CMA acknowledges that HEFT's ability to impose a competitive constraint on UHB prior to the Intervention might have been limited due to the problems HEFT encountered in 2012-2015, which are described above in the Background section. On the one hand, joint management of UHB and HEFT post-Intervention may have softened competition between them further. On the other hand, improvements made at HEFT may have enhanced HEFT's ability to compete, making HEFT a more credible alternative to UHB. If the Intervention has led to improvements that would endure absent the Merger, then the use of evidence from the pre-Intervention period may understate the degree of competition in the counterfactual. In any case, the CMA believes that HEFT was able to exert a competitive constraint on UHB prior to and during the Intervention.

52. The CMA therefore adopted a counterfactual in which HEFT would operate independently from UHB (with or without further regulatory intervention) and therefore continue to exert some competitive constraint on UHB. In gauging the extent of this constraint, given the uncertainties outlined above, the CMA analysed data and evidence both from the period preceding the Intervention and following the Intervention. This is taken into account in the competitive assessment and the assessment of RCBs below.

Frame of reference

53. Market definition provides a framework for assessing the competitive effects of a merger and involves an element of judgement. The boundaries of the

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[37] Merger Assessment Guidelines (OFT1254/CC2), September 2010, from paragraph 4.3.5.

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 merger 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.[38]

Product scope

54. The Parties overlap across a significant number of healthcare services provided to patients that are commissioned by local CCGs and NHSE Their overlapping services can be broadly categorised as follows:

   (a) **Elective services**: Planned specialist medical care usually following referral from a primary or community health professional such as a GP;[39]

   (b) **Non-elective services**: Services that are not scheduled arising when admission is unpredictable because of clinical need (eg following an A&E attendance);

   (c) **Community services**: 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.

   (d) **Private patient services:** Care not funded by the NHS and instead paid for by the patients.

55. The Parties submitted that the CMA should follow its past approach and that of its predecessor authorities[40] in the assessment of healthcare mergers.

56. In line with past decisional practice, including *CMFT/UHSM* and the CMA's guidance, the CMA has adopted the following approach:[41]

   (a) Each specialty is a separate frame of reference and, within each specialty:

[38] Merger Assessment Guidelines, paragraph 5.2.2.
[39] UHB does not provide maternity services, and therefore there is no overlap between the Parties in this area.
[40] Namely, the Office of Fair Trading and the Competition Commission.
[41] NHS Mergers Guidance, paragraphs 6.37 to 6.39.

- the provision of elective services[42] is a separate frame of reference from the provision of non-elective services; and

- the provision of outpatient services, inpatient services, and day-cases are also separate frames of reference,

(b) The provision of community services is a separate frame of reference from services which are provided in hospital settings, although there may be an asymmetric constraint from hospital-based to community-based services; and

(c) The provision of private patient services is a separate frame of reference from services provided through the NHS;

57. The CMA also considered whether certain specialties should be aggregated (for example because some investment decisions to improve quality are taken on a wider level than individual specialties) or whether there are narrower segmentations than those described above. The CMA did not conclude on the precise scope of the product market within and between specialties, but possible aggregations or narrower segmentations have been taken into account in the competitive assessment section below.

Geographic Scope

58. The CMA has previously found that location is important to patients and GPs when they choose a hospital, and hospitals providing the same services in different locations are not perfect substitutes for one another. Hospitals that are near one another may be expected to exert a stronger competitive constraint than hospitals located further away.[43] The CMA has in the past used catchment area analysis to identify the area over which merging parties are likely to be important alternatives and as such those where the merger is most likely to affect competitive conditions.[44]

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[42] Specialised services (commissioned nationally by NHSE) and routine services (commissioned locally by CCGs) can both be part of the elective specialty. 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'. In line with previous cases, on a cautious basis, the CMA carries out an in-depth competitive assessment for specialised services in this case, given that segment is subject to more intense competition for the market. (see Chapter 11 of the CMFT/UHSM Report).
[43] See for example the Report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust (**Bournemouth and Poole Report)**, 17 October 2013, paragraph 5.56.
[44] See, for example, the Bournemouth and Poole Report, paragraphs 5.54 to 5.71.

Parties' submissions

59. The Parties submitted that it was not necessary to conclude on the geographic frame of reference as the more detailed patient flow analysis using Hospital Episode Statistics (**HES**) takes account of the wide set of GPs that make referrals to the Parties' hospitals.

60. The Parties' internal documents occasionally refer to their 'catchment areas'.

    (a) UHB told the CMA that it defines catchment as the 'the geographical boundary within which the Queen Elizabeth Hospital is the closest hospital for its population'. The area predominantly covers South Birmingham.

    (b) HEFT considers its potential catchment area is as 'the Lower Super Output Areas (LSOA) which fall into an amalgamated 20 minute drive-time around each of the three main sites: Heartlands Hospital, Solihull Hospital and Good Hope Hospital.'[45]

61. The CMA considers that the Parties compete in Birmingham and Solihull and parts of the surrounding area in the West Midlands. In line with previous cases, the CMA considers that it is not necessary to precisely set out the exact boundaries of the geographic frame of reference, since the CMA's competitive assessment includes all GPs that make referrals to the Parties.

Conclusion on frame of reference

62. For the reasons set out above, the CMA has considered the impact of the Merger in the following frames of reference:

    (a) Each specialty is considered separately and, within each specialty, the CMA separately considered:

    - elective and non-elective care;
    - outpatient, inpatient and day-case care; and
    - community and hospital-based care.

    (b) Private and NHS-funded services are considered separately from each other.

[45] Strategic Plan Document for 2013-14, Heart of England NHS Foundation Trust, page 7.

Competitive Assessment

63. The CMA assessed whether the Merger might lead to horizontal unilateral effects with regard to the provision of healthcare services to patients in the local healthcare economy.

64. In undertaking this assessment, the CMA first considered arguments relating to the degree of competitive interaction between the Parties in general and, in light of the Parties' submissions on the counterfactual, the extent of the competitive constraint that HEFT could exert on UHB. Whilst the CMA did not identify a hospital-wide SLC, this analysis provided relevant context to the CMA's assessment of individual specialties and the balancing of the potential anti-competitive effects against the likely benefits arising from the Merger.

65. The CMA then proceeded to investigate individual specialty-level theories of harm.

Degree of competition between the Parties

66. In gauging the extent of competitive interaction between the Parties (and, in particular, the extent to which HEFT would exercise a competitive constraint on UHB absent the Merger), the CMA took into account the following factors:

    (a) the extent to which the Parties monitor each other and their competitors;

    (b) the extent to which current tariff arrangements (ie PbR rules) provide incentives for hospitals to compete for patients;[46]

    (c) the impact of capacity constraints on the Parties' ability to attract additional patients;

    (d) the impact of any policy shift towards increased provider collaboration on the role of competition.

The Parties' view

67. The Parties told the CMA that improvements in quality are not solely dependent on provider competition, and "*the systems of regulation and monitoring that are in place ensure that quality will be upheld even in the absence of competition*". The Parties made the following submissions in relation to the role of competition and other types of incentive they respond to.

[46] Providers are commonly paid at nationally mandated prices for every consultation or treatment made, based on 'payment-by-results' ('PbR') rules.

(a) As regards the role of competition in general:

(i) patient choice of hospital is likely to be influenced by the overall reputation of the trust;

(ii) the financial challenge facing many trusts means attainment of financial performance targets[47] and securing payments from the Sustainability and Transformation Fund (**STF**) is now their primary objective; and

(iii) the emergence of system-wide STPs requires stronger collaboration between providers, and emphasises performance of LHE as a whole.

(b) As regards the role of competition in the Parties' ordinary course of business:

(i) HEFT has not undertaken any competitor analysis except those required by Monitor/NHSI in the strategic plans;

(ii) PbR received in 2015/2016 only accounted for 16% of UHB's total income;[48]

(iii) the Parties '*do not actively canvass General Practitioners (**GPs**) to attract referrals since their clinics are already above capacity*'; and

(iv) neither Trust monitors its financial performance at the specialty level, instead financial reporting is monitored against divisional and group income.[49]

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[47] Financial control totals were introduced by NHS England and NHS Improvement in the financial year ended 31 March 2017. The control total regime comprises one of a wider set of measures to strengthen the financial and operational performance of NHS providers. Financial control totals, once agreed between providers and NHS Improvement, are the minimum level of financial performance that NHS provider boards must deliver, and for which they will be held directly accountable, thus providing a degree of financial constraint on providers. Providers that agree and meet their financial control totals can access the Sustainability and Transformation Fund.

[48] The Parties also cited in this regard an NHS Confederation review, which stated that "the total number of block contracts commissioned by CCGs for elective care procedures have increased by nearly 50% between 2013/14 and 2015/16".

[49] UHB has four operational divisions grouped by services and/or specialties as follows: (A): Theatres, Short Stay Surgery, Critical Care, Imaging, Medical Physics Laboratories, Pharmacy, Therapies; Anaesthetics; (B): Cardiac, Cardiology & Vascular Services, Renal Medicine & Surgery, General Surgery & Breast Surgery; Liver Medicine & Liver Surgery, Gastro and Endoscopy; (C) Emergency Dept. (A&E), Clinical Decision Unit, Pain Services, Diabetes, Endocrinology, Dermatology, Rheumatology, Ophthalmology and HIV services, Outpatients & Community Sexual Health Services, Elderly & General Medicine, Wards, Lung Function and (D): Neurology & Neurosurgery, Trauma, Burns, Plastics, Oncology, Haematology & Palliative Care, ENT, Maxillo-Facial and Urology. HEFT's divisions are Clinical Support Services, Women's & Children's, Emergency, Medicine and Surgery.

Third party views

68. NHSI told the CMA that the unsuccessful interventions at HEFT between 2012 and 2015 "*demonstrates that HEFT was unable to respond to its regulator, let alone competition*".[50]

69. One CCG submitted that hospitals can actively compete for patients. For example, hospitals can attract additional referrals from GPs by organising educational events to help GPs become aware of referral pathways.

70. A competing healthcare provider told the CMA that that it may compete with UHB or HEFT by direct communication with GPs to make them aware of the clinical services that they offer and the relevant outpatient waiting times.

CMA's assessment

Level of competitive monitoring

71. HEFT has not undertaken any competitor analysis, except that required by Monitor, in its strategic plans. UHB does monitor other providers, including HEFT, in the West Midlands regularly:

   (a) UHB gathered information on general performance of other providers in its monthly Surveillance Report Team Brief.[51] UHB submitted that it used the surveillance information for benchmarking and managing capacity pressure.

   (b) UHB's Strategic Plan documents, produced for Monitor, contained a detailed analysis of UHB's '*key competitors within the local health economy*', and discussed developments in GP referrals between UHB and these competitors.[52]

   (c) UHB's Operational Plan documented competitive interactions between providers. It also indicated that other providers (such as SWBH and Worcestershire NHS Trust) were less of a competitive constraint on UHB.

   (d) UHB identified HEFT and SWBH as other major providers. UHB presented its own market shares as well as those of HEFT and SWBH in a presentation to CCGs.

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[50] NHSI letter to the CMA, 10 August 2017.
[51] These briefs discussed general issues such as personnel changes, financial developments, new facilities and A&E performance of other providers, but not specialty-level performance of other providers.
[52] Strategic Plan Document for 2013-14, University Hospitals Birmingham NHS Foundation Trust.

72. UHB told the CMA that it used the surveillance information mentioned under paragraph 71(a) for benchmarking and managing capacity.

73. However, the CMA notes that UHB considered competition to be a relevant factor in its investment appraisals, albeit other non-competition factors seemed to be more prominent. Specifically:

(a) A 'market analysis' of UHB's competitive position is required for a business case.[53] However, UHB submitted that it did not put weight on market analysis, stating that "*no business cases in FY2016/17 included a formal market analysis*".[54]

(b) The CMA reviewed the top 5 business cases of each of the Parties in FY2015/16, measured by budget.[55] The CMA has not seen any indication that these investments were proposed directly in response to competition for patients. Instead, the business cases identified quality improvements and reputation enhancement as objectives (eg. to reduce waiting times, to support and educate workforce, to improve recruitment and retention, and to reduce medical admissions).

74. The CMA recognises that there are various reasons, other than to compete for patients, that may explain why the Parties monitored competitors. They include, for example demand management and regulatory requirements. Importantly, the internal documents discussed capacity and regulatory issues much more extensively than they discussed competition issues. This suggests that the Parties are likely to place more weight on dealing with regulation and addressing capacity than with monitoring competitors and responding to competition.

Tariff arrangements and incentives to compete for patients

75. The CMA assessed whether existing tariffs provide some incentives for the Parties to compete for patients. The CMA found that, whilst PbR revenues only accounted for 16% of UHB's overall revenues, the percentages of PbR

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[53] See response to RFI1, 12b, UHB Business case guidance v12, Section 2.3, which states that 'It is important to undertake an analysis of the Trust's position in the market: Provide detail of who else provides the service and the competitive strength of their position'.

[54] See response to RFI2, Q13.

[55] The Parties submitted the following business cases: UHB: (1) Renal Transplant Surgery Business Case, (2) Inpatient Ward Nursing Establishment Business Case, (3) Junior Specialist Doctor Business Case, (4) Acute Medical Clinic Development Business Case. For HEFT the parties submitted: (1) Urology Robotic Surgery Business Case, (2) Neuromuscular Business Case, (3) Intestinal Failure Business Case, (4) Electrophysiology Business Case and (5) Overnight Renal Dialysis Business Case.

revenue were much higher within elective services (ie 83% for UHB and 97% for HEFT).[56]

76. The CMA considers that the Parties have not provided the CMA with sufficient evidence to support their claims that use of PbR has been reduced in Birmingham and Solihull recently, or that tariffs may not cover marginal cost. Birmingham Crosscity and Solihull CCGs told the CMA that over 80% of the elective activity they commission from the Parties is PbR-based.

77. Therefore, the CMA considers, at least for the purposes of its assessment at Phase 1, that PbR is being used for most elective services and that it provides some incentives for hospitals to compete.

Capacity constraints and the Parties' ability to attract additional patients

78. The CMA notes that there is some evidence that capacity constraints have somewhat limited the Parties' ability to treat more patients. For example, the CMA has received evidence that:

   (a) the Parties have failed some key national targets (ie 18-week referral to treatment in several elective specialties; 4-hour A&E waiting time) and have received financial penalties accordingly;

   (b) their bed occupancy rates were consistently above the recommended operational standard of 85%;[57] and

   (c) UHB attempted to turn down elective patients outside its catchment area in five specialties in 2014 due to referral growth in excess of contractual plan.[58]

79. However, whilst capacity constraints may weaken the Parties' ability to compete at present and for some time in future, the CMA is of the view that there may be scope to treat additional patients in some specialties in the medium or long term. For example, a hospital can increase capacity by reducing length of stay and managing beds more effectively, as the Parties have done to some extent.[59] Whilst the Parties are likely to continue to face

[56] The percentages are calculated by dividing 'Tariff revenue' by Total revenue based on the Parties' responses to information requests.
[57] The National Audit Office suggested that hospitals with average occupancy levels in excess of 85% could expect to have regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections, while the Department of Health also said that occupancy of greater than 85% was a cause for concern.
[58] These specialties are pain, dermatology, general surgery, Urology, ENT. See the Parties' response to RFI2, Q16.
[59] Parties' responses to information requests. See also paragraph 25 of the CMFT/UHSM report.

capacity pressure in the medium term, which limits their ability to compete for patients, this does not eliminate the role of competition altogether.

Increased provider collaboration and its potential effect on the role of competition

80. The CMA notes that under most models of collaboration, each provider is still paid for the patients that it treats. Each Foundation Trust may therefore still be incentivised to provide high quality across many aspects of its services.

81. However, collaboration may affect, for example, capital investment and hiring decisions, as they are taken with a wider view. A provider does not necessarily make these decisions with a view to increasing its own volume of patients. Instead, such decisions are likely to be taken by a wider group with differing interests. This is in line with the CMA's findings in *CMFT/UHSM*, which concluded that the recent policy developments towards more collaboration (eg STP and financial control totals) have constrained the independence of Foundation Trusts but have not eliminated competition in the NHS.[60]

82. Therefore, the CMA considers that increased collaboration could reduce the set of parameters over which competition takes place and thus could reduce (but not remove) the role of competition in the LHE.

Conclusion on the level of competitive interaction between the Parties

83. The CMA recognises that HEFT faced significant management issues prior to UHB's intervention, which led to a decline in HEFT's performance prior to the Intervention. This was evidenced by low CQC ratings,[61] low staff survey scores,[62] and breaches of targets and higher than expected mortality rates which necessitated regulatory intervention. The decline in these quality measures seems consistent with the CMA's analysis of HES data, which suggested that fewer patients or their GPs saw HEFT as an alternative to UHB than vice versa.[63]

[60] See paragraph 4.36 of the CMFT/UHSM report.
[61] In 2013, CQC rated HEFT as 'requires improvement' or 'inadequate' in 92% of the 60 different areas.
[62] As measured by the percentage of staff recommending their organisation to a friend or relative, staff engagement score and the percentage of staff recommending their organisation as a place to work, and staff sickness rates.
[63] The analysis found that of all GPs that had referred patients to HEFT in 2013-2015, the vast majority (85% in outpatient, 97% in inpatient and 98% in day-case) had also referred patients to UHB. By contrast, of all GPs that had referred patients to UHB, a smaller proportion (64% in outpatient, 87% in inpatient and 87% in day-case) also referred patients to HEFT.

84. Notwithstanding the above, the Parties overlap in a significant number of elective specialties and that the HES data suggests that HEFT was seen as an alternative to UHB by some patients and GPs, both before and during the Intervention.

85. On this basis, the CMA believes that HEFT would constrain UHB, albeit to a limited extent for the foreseeable future, if it were to remain independant.

Theories of harm

86. There are, broadly speaking, two different models of competition in the provision of NHS healthcare services: competition to attract patients (that is, competition ‘in’ the market) and competition to attract contracts to provide services (that is, competition ‘for’ the market).[64]

87. As stated above, in the background section, the CMA considers that competition in the NHS is possible where patients have a choice between NHS service providers. Patient choice helps to incentivise providers to improve quality and to attract patients and GPs. Mergers between providers of NHS acute services may dampen this incentive if they remove a significant alternative for patients and thereby significantly reduce the competitive constraints on the merging providers. This could reduce the quality of the merged trust’s offering.[65] A reduction in competition may have an adverse impact upon clinical quality and patient experience.[66]

88. The CMA considered a number of horizontal theories of harm and where appropriate assessed both competition in and competition for the market, in relation to the following categories of services:

    (a) unilateral effects in the provision of acute non-elective services;

    (b) unilateral effects in the provision of services to private patients;

    (c) unilateral effects in the provision of specialised services;

    (d) unliateral effects in the provision of community services; and

    (e) unilateral effects in the provision of acute elective services.

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[64] For previous hospital cases which have discussed the role of regulation in driving quality, see Annex 2 of CMFT/UHSM, paragraph 82 ff, ASP/RSC, paragraphs 6.68 ff, Frimley Park/Heatherwood and Wexham Park, paragraph 18 ff, and Bournemouth/Poole, paragraphs 2.22 to 2.24. For comparison, also see Arriva Rail North/Northern rail franchise final report, paragraph 8.1 ff.
[65] NHS Mergers Guidance, paragraph 1.5.
[66] NHS Mergers Guidance, paragraph 6.48. 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 waiting times, cleanliness and parking facilities

Non-elective services, private patient services, specialised services and community services

89. The CMA examined whether the Merger would remove an important alternative for patient in the supply of non-elective healthcare services or healthcare services to private patients. The CMA did not identify competition concerns with regard to these services.

    (a) **Non-elective services**: the CMA found that the Parties did not materially compete. Most patients either attended via ambulance or attended the nearest A&E department, hence choice of hospital is limited, and the CMA has not seen evidence that quality of non-elective services is a significant driver of residual choice. Moreover, the Parties' A&E departments have faced significant capacity constraints in recent years which limited their incentive to attract patients.[67]

    (b) **Private patient services**: the CMA found that private patients accounted for a negligible proportion of the Parties' activity. Moreover, there are several other private providers around Birmingham and Solihull offering services in the specialties where the Parties overlap.[68]

90. The CMA also examinated whether the Merger would remove an important alternative for commissioners with regard to NHS specialised services and community services, given the importance of 'competition for the market' in these services. Such a reduction in choice for commissioners when they wish to tender a contract might dampen providers' incentives to drive up quality or innovation in that service. The CMA did not identify competition concerns with regard to these services:

    (a) **Specialised services**: NHSE told the CMA that it has no relevant reconfiguration plans, other than for two services which will largely affect areas outside Birmingham.[69] Furthermore, NHSE submitted that the Merger would enhance UHB's capacity to develop highly-specialised work.

    (b) **Community Services**: the CMA found that the Parties derived a small proportion of their revenue in community services and did not overlap in the services currently provided. Whilst the Parties competed against each

[67] This finding is consistent with CMFT/UHSM, paragraphs 12.14-12.28.
[68] These providers include the Westbourne Centre, BMI (The Priory, The Edgbaston, The Droitwich Spa, The Meriden), Spire (Parkway, Little Aston), West Midlands Private Hospital, and Nuffield Health (Wolverhampton, Warwickshire).
[69] HIV and Vascular Surgery.

other in one tender in the past, several other providers, including non-NHS providers, are available who can offer similar community services.

Elective services

91. The CMA then assessed the likelihood of the Merger resulting in horizontal unilateral effects in the supply of elective services for each specialty, by focussing on the closeness of competition between the Parties and competitive constraints remaining post-Merger from alternative suppliers.

Closeness of competition

92. The CMA assessed NHS referrals using HES data. Using Parties' shares of referrals from each referrer (usually a GP practice) to either UHB or HEFT (the 'anchor hospital'), the CMA estimated the share of referrals which would go to each alternative provider if in a hypothetical scenario the anchor hospital became unavailable. The referral analysis provides a starting point for the assessment of the closeness of competition between the Parties, and provides some insight into the choices available to patients at each referrer.[70]

93. In line with previous cases,[71] most recently *CMFT/UHSM*, to assess the closeness of competition between the Parties in the supply of NHS elective services, the CMA applies filters to the HES data. This involves:[72]

   (a) identifying the services in which the Parties overlap on a clinical specialty level;[73]

   (b) omitting from any further analysis clinical specialties where the Parties' share of referrals reallocated to the other Party was under 40% for both anchor hospitals; and

   (c) excluding from further analysis those specialties for which over 90% of the Parties' outpatient referrals are derived from sources that do not involve patient choice of provider (such as referrals from another consultant, or referrals from an A&E department).

94. The purpose of filtering is to remove from further analysis those specialties where there is no realistic prospect of significant competition concerns. The CMA acknowledges some limitations with the filter analysis, but considers

[70] A detailed explanation of the referral analysis can be found in Appendix C of the CMFT/UHSM Report.
[71] Ashford and St Peter's/Royal Surrey County.
[72] See paragraph 10.48 and Appendix C of the CMFT/UHSM Report for further explanation of these filters.
[73] The CMA considered the Parties to overlap in a specialty and treatment setting if both parties recorded at least 100 outpatient episodes per year, or both parties recorded at least 50 day-case admissions per year, or both parties recorded at least 50 inpatient admissions per year. See footnote 167 of the CMFT/UHSM Report.

that, overall, it provides a useful screening tool to identify which specialties require further assessment.

95. For each specialty, the CMA assessed outpatient, inpatient and day-case settings separately, in line with the product frame of reference. In specialties where the Parties focus on differentiated sub-specialisations, the CMA sought clear-cut evidence on the degree of such differentiation (e.g. explanation of why the Parties' offerings within the specialty are not demand- or supply-side substitutes, and quantification of the proportion of patients or revenues relating to these sub-specialisations within a specialty).

96. The CMA recognises that the referral analysis may not fully capture competitive dynamics between providers in inpatient or day-case activity.[74] This is because patients are entitled to choose their first outpatient appointment under NHS regulations,[75] whilst they cannot exercise a direct choice for inpatient and day-case treatments as they are typically admitted following an outpatient appointment.

97. However, some patients (or their GPs) may well be expecting inpatient or day-case treatments when they make their first outpatient appointment.[76] These patients may take the hospital's quality for inpatient and day-case services into account when exercising choice. As such, the referral analysis for outpatients partially encompasses patients' preference for inpatient and day-case treatments, but it does not distinguish between patients who choose solely on the basis of outpatient services and patients who consider inpatient and day-case quality. Therefore, referral analyses that focus on inpatient and day-case specifically can provide additional insight into the closeness of competition between the Parties specifically in those settings.

The Parties' views

98. The Parties submitted that UHB and HEFT are not close competitors because UHB focuses on specialised services and on complex cases, whilst HEFT focuses on routine treatments for patients located in its proximity.

99. The Parties submitted that the Merger will not give rise to a realistic prospect of an SLC in any of the overlapping specialties. They submitted that the '*referral ratio acts as a filter…[and] is not on its own dispositive on whether there will be a substantial lessening of choice/competition*'.[77] They stated that

[74] See paragraphs 10.49-10.54 of the CMFT/UHSM Report.
[75] See paragraphs 33-34 above.
[76] See paragraph 10.51 of the CMFT/UHSM Report.
[77] Merger Notice.

‘the computed ratios will tend to overestimate the extent of competition/choice’ for the following reasons:[78]

(a) the referral analysis is based on historical data that does not accurately reflect forward-looking dynamics, since HEFT would be expected to decline as a viable choice absent the Merger;

(b) the referral analysis does not capture the effects of collaboration;

(c) hospital quality and patient choice are affected by wider ‘whole of hospital’ dynamics rather than specialty-setting combinations;

(d) the referral analysis does not reflect fundamental drivers of hospital performance and incentives to compete given capacity constraints, and the existence of regulatory support structures that protect or drive quality in the NHS;

(e) where the proportion of the Trust’s activity in a specialty used in the referral ratio calculation is low, it indicates that patient choice could influence only a small share of elective activity;

(f) the referral ratio may fail to capture the effects of differentiation within specialties (e.g. sub-specialisations); and

(g) a study by KPMG suggested that the tariffs received may not cover the true cost of providing the treatment in six specialties.

100. For each specialty which did not pass the filters set out in paragraph 93, the Parties put forward additional reasons why the Merger does not give rise to a realistic prospect of an SLC, which included:

(a) coding inconsistencies in the HES data;

(b) differentiation between the services offered by the Parties;

(c) the impact of collaboration; and

(d) the impact of capacity constraints.

CMA’s assessment

101. This section first presents results of the referral analysis. It then addresses the Parties’ comments on the limitations of the referral analysis.

[78] Merger Notice.

Results of referral analysis

102. The CMA's referral analysis assessed data for two periods:

(a) FY2013/14 and FY2014/15, during which HEFT operated entirely independently from UHB and therefore the results do not reflect any potential effects of the Intervention (the **pre-Intervention data**).

(b) FY2015/16: data which includes partially the period following the Intervention (the **post-Intervention data**).

103. As discussed at paragraph 48 et seq. above, in principle, the Intervention in late October 2015 could affect the degree of competition observed between the Parties in two opposite directions. In light of this uncertainty, the CMA considers it appropriate to be cautious with those specialties which fail the filters in one time period but not another. Accordingly, the CMA has excluded only specialties which pass the filters listed at paragraph 93 above using data from both time periods.[79]

104. The referral analysis identified 25 specialties for which the Parties are potentially close competitors using the filters.[80] Table 1 below lists the 25 specialties failing the filters. Annex 1 provides further detail on the specialties and settings (ie outpatient, inpatient and day-case) concerned.

Table 1: Specialties failing filters

1) General Surgery
2) Urology
3) Breast Surgery
4) Colorectal Surgery
5) Upper Gastrointestinal Surgery
6) Vascular Surgery
7) Ear, Nose and Throat
8) Plastic Surgery
9) Pain Management
10) Gastroenterology
11) Endocrinology
12) Clinical Haematology
13) Diabetic Medicine
14) Cardiology
15) Transient Ischaemic Attack

[79] The CMA notes that the available data does not allow the CMA to readily separate pre- and post-intervention periods. In any event, the data only covers 5 months post-Intervention and it is likely that any effects of the Intervention on referral patterns could only be observed after some time had elapsed.

[80] 20 specialties failed the filters when using the pre-Intervention data. Under the post-Intervention data, 22 specialties failed the filters.

16) Respiratory Medicine

17) Respiratory Physiology

18) Nephrology

19) Medical Oncology

20) Neurology

21) Rheumatology

22) Geriatric Medicine

23) Speech And Language Therapy

24) Interventional Radiology

25) Chemical Pathology

Assessment of the Parties' submissions on the referral analysis

105. This section addresses the Parties' comments on the relevance of referral analysis.

106. First, the Parties submitted that historical data used in referral analysis does not reflect forward-looking dynamics. The CMA believes that recent regulatory developments may have already affected competition between NHS providers, and it is uncertain how future policy changes may further affect competition. Moreover, if HEFT's management issues have undermined its competitiveness, the CMA would also expect the analysis (which covered a two-year period before UHB's intervention) to pick up some of the impact. Therefore, the CMA does not believe that recent data would materially overstate the degree of future competition. In any event, the CMA took into account the limited ability of HEFT to respond to competition in its overall assessment.

107. Second, the Parties pointed to the importance of collaboration in the NHS in general and regarding several specialties that failed the filters.[81] The CMA recognises that the level of collaboration in the NHS may reduce the role of competition as explained in paragraph 78 above. However, the CMA considers that the Parties have not provided clear-cut evidence to illustrate that collaboration has replaced or undermined competition substantially in the specialties listed in Table 1. In particular, the Parties did not set out why collaboration would remove the incentive to compete. The CMA has taken the impact of collaboration into account when discussing the overall importance of competition (see paragraph 78 above).

108. Third, the Parties' claim that hospital quality and patient choice are affected by wider 'whole of hospital' dynamics. The CMA considers that, in practice, both hospital-wide and specialty-level factors are likely to be at play. For example,

[81] Eg Endocrinology, ENT, Cardiology, Respiratory Medicine, Clinical Oncology and Pain Management.

the CMA has seen evidence that the Parties made consultant appointments and business cases to improve quality on a specialty level. Given NHS providers face significant financial resource constraints, the CMA believes they may well prioritise investments in specialties that are financially sustainable.[82] Furthermore, 'hospital wide' effects can arise from the aggregation of specialty-level effects (see below). A specialty-level assessment therefore remains relevant.

109. In addition to the clinical specialty-level competition effects, there may also be effects across the whole hospital that may arise as a result of the Merger. This is because the Merger may reduce the Parties' incentive to improve some aspects of quality that are common across hospitals (rather than associated with one particular elective service).

110. Similar to *CMFT/UHSM* (see paragraphs 10.145-10.146), the CMA considers that given the limited likely impact of the SLCs in elective services (see paragraphs 231 below), hospital-wide factors are unlikely to materially worsen across the whole trusts as a result of the Merger (examples of hospital wide factors include infection rates, waiting times, the ratio of clinical staff to patients.). The CMA therefore believes that the Merger will not result in any horizontal unilateral effect across the whole trusts (or any of their hospitals).

111. Fourth, the Parties submitted that the referral rates do not adequately reflect drivers in the LHE. As discussed in paragraphs 78-79 and 35-36 above, the CMA considers that capacity constraints and regulation may limit, but not remove the role of competition, and has taken account of capacity constraints and regulation in the overall assessment.

112. Fifth, the Parties contend that patient choice could influence only a small share of 'elective' activity. The CMA recognises that some elective activities are not directly derived from a source that offered patient choice. As described in paragraph 93(c), the CMA applied a filter to rule out competition concerns in specialties where less than 10% of the outpatient activities originate from a source with patient choice. However, the CMA notes that activities within the same specialty and setting are likely to share substantial common resources, and that hospitals may not be able to differentiate quality levels for activities with patient choice and activities without patient choice. Therefore, a reduction in quality due to an SLC may affect all patients in the specialty, whether they face a choice of hospital or not.

113. Sixth, the Parties submit that the KPMG report shows that PbR tariffs do not cover the full costs of (some of their) elective activities. The CMA considers

[82] UHB's business case guidance considers financial impact when appraising investment decision.

that the KPMG study did not show that the hospitals covered in the study would make a loss for treating every additional patient, save for some complex procedures. This is because the study mainly considered complex specialised service procedures,[83] and it appeared to assess margins based on average cost rather than marginal cost.[84] The CMA therefore considers it reasonable to presume that national tariffs provide some incentives for hospitals to compete for patients both in general and for the specialities that fail the filters.[85]

114. In summary, the CMA's view is that the referral analysis provides a useful screening tool to identify specialties where the Parties are potentially close competitors. However, the CMA took the Parties' comments into account when interpreting the results and when attempting to gauge the strength and scope of any potential SLC and its impact on patient outcomes.

Differentiation of the Parties' offerings within a specialty

115. The Parties submitted that the referral ratio may fail to capture differentiation within specialties. They stated that UHB and HEFT are highly differentiated with regard to several specialties:

(a) **Cardiology**: there is overlap between the Parties' general cardiology provision, but UHB has highly specialised services not offered at HEFT.

(b) **Endocrinology**: UHB has a wide range of sub-specialist interest and treats complex patients, whilst HEFT has a large-scale service with high demand from its catchment area.

(c) **Nephrology**: UHB and HEFT offer complementary services.

(d) **Upper Gastrointestinal (GI) surgery**: UHB is a major tertiary upper GI surgery unit and HEFT does bariatric surgery which is not offered by UHB.

(e) **Urology**. Both Parties offer urology services and treat several cancer and non-cancer diseases, but have a high degree of sub-specialisation.

[83] Specialised services tend to involve complex and costly procedures. The fact that a hospital may expect to make a loss in certain specialised services procedures does not imply it make a loss for all activities under the specialty.
[84] Even if a hospital were loss-making in a specialty overall, if tariffs exceeded marginal costs, it would create an incentive to attract additional patients to recoup fixed costs.
[85] Ie Colorectal and Vascular Surgery.

(f) **Vascular surgery**: the actual case mix of UHB and HEFT is different. However, the CMA notes that HEFT stated that it covers a full range of diagnosis and treatment options.

116. For all specialties listed above the CMA considers that the degree of differentiation between the Parties' offerings is not apparent to such an extent as to rule out a realistic prospect of the Merger resulting in an SLC. The CMA recognises that, if there are clear differentiation in sub-specialisations between the Parties, and that if these sub-specialisations are not supply- or demand-side substitutes, then the Merger would be unlikely to create incentives to reduce quality for those non-overlapping segments. However, the CMA considers that while differentiation within a specialty where the Parties do offer some of the same services may reduce the scale of an SLC resulting from the Merger (either because incentives are affected to a lesser degree or because a smaller number of patients are affected) it would not itself remove the potential for competition between the Parties.

Specialties not the basis to choose hospitals

117. The Parties told us that activities in Chemical Pathology and Speech and Language Therapy are undertaken in support of other clinical specialties, and that these specialties are not the basis on which patients choose hospitals. They referred to the CMA's Final Report in *CMFT/UHSM* in support of their claim.[86] Furthermore, the Parties contended that elective patient choice comprises a very small component of activity in Transient Ischaemic Attack, since most activity is unscheduled and urgent.

118. The CMA recognised that, in principle, the scope for providers to compete for patients may be limited in specialties that do not offer material patient choice. However, the CMA considered that the Parties have not provided clear-cut evidence to illustrate the degree of patient choice that may exist in their own activities (eg quantification of proportion of patients or revenues associated with activity where choice is not meaningful). On a cautious basis, the CMA was not able to generalise the conclusions in *CMFT/UHSM* to the present case, and therefore could not rule out concerns in Chemical Pathology, Speech and Language Therapy.[87] Similarly, the CMA would generally expect

[86] See paragraphs 10.57 and 10.61 of the CMFT/UHSM Report. In NHSI's response to the Issues Paper, NHSI provided similar comments and cited the CMFT/UHSM Report.
[87] In CMFT/UHSM, the CMA found that Speech and language therapy had a low proportion of first outpatient referrals from sources that involve patient choice (around 14%) and that these referrals are nearly all to UHSM (see paragraph 10.57 of the CMFT/UHSM Report). In the case of UHB and HEFT, the CMA found that a higher proportion (21%) of first outpatient referrals were from sources that involve patient choice. The Parties did not provide further evidence as to why concerns would not arise for these patients. Similarly, with regard to Chemical Pathology, the CMA concluded in CMFT/UHSM that 'the majority of pathology is done 'behind the scenes' in

that elective activity is not, by definition, unscheduled and urgent, and therefore did not have sufficient evidence to rule out concerns with regard to elective activity in Transient Ischaemic Attack.

119. In any event, as explained in paragraph 93(c) above, the filter applied by the CMA ruled out concerns in specialties that did not involve meaningful patient choice.

120. The Parties have provided the CMA with information about the number of patients and revenue affected per elective specialty. This is summarised in Table 2 below.

Table 2: Revenue and patients affected in the elective specialties

Specialty (Treatment Function Code)	Elective Revenue (FY 15/16)*	Total unique elective patients (FY 15/16)*
1. GENERAL SURGERY (100)	UHB: £5.2m HEFT: £7.9m	UHB: 9,670 HEFT: 10,079
2. UROLOGY (101)	UHB: £8.4m HEFT: £10.8m	UHB: 10,758 HEFT: 16,337
3. BREAST SURGERY (103)	UHB: £2.2m HEFT: £4.1m	UHB: 5,221 HEFT: 10,450
4. COLORECTAL SURGERY (104)	UHB: £4.0m HEFT: £2.0m	UHB: 5,681 HEFT: 5,357
5. UPPER GASTROINTESTINAL SURGERY (106)	UHB: £0.6m HEFT: £1.0m	UHB: 1,209 HEFT: 2,817
6. VASCULAR SURGERY (107)	UHB: £3.1m HEFT: £2.7m	UHB: 3,129 HEFT: 4,555
7. ENT (120)	UHB: £5.5m HEFT: £30.5m	UHB: 14,264 HEFT: 21,602
8. PLASTIC SURGERY (160)	UHB: £6.0m HEFT: £0.7m	UHB: 7,232 HEFT: 1,223
9. PAIN MANAGEMENT (191)	UHB: £1.3m HEFT: £1.4m	UHB: 2,127 HEFT: 3,542
10. GASTROENTEROLOGY (301)	UHB: £5.3m HEFT: £11.0m	UHB: 10,136 HEFT: 22,120
11. ENDOCRINOLOGY (302)	UHB: £1.7m HEFT: £0.9m	UHB: 4,797 HEFT: 3,869
12. CLINICAL HAEMATOLOGY (303)	UHB: £5.4m HEFT: £6.2m	UHB: 8,840 HEFT: 6,881
13. DIABETIC MEDICINE (307)	n/a	UHB: 4,562 HEFT: 8,658
14. CARDIOLOGY (320)	UHB: £4.9m HEFT: £9.3m	UHB: 11,351 HEFT: 19,224
15. TRANSIENT ISCHAEMIC ATTACK (329)	UHB: £0.2m HEFT: £0.04m	UHB: 517 HEFT: 129

support of other specialties' (see paragraph 10.61), but the Parties cited the CMFT/UHSM Report without providing supporting evidence that the same finding applies in the case of UHB and HEFT.

Specialty (Treatment Function Code)	Elective Revenue (FY 15/16)*	Total unique elective patients (FY 15/16)*
16. RESPIRATORY MEDICINE (340)	UHB: £1.2m HEFT: £3m	UHB: 3,456 HEFT; 8,183
17. RESPIRATORY PHYSIOLOGY (341)	UHB: £0.07m HEFT: £1.3m	UHB: 451 HEFT: 2,899
18. NEPHROLOGY (361)	UHB: £4.9m HEFT: £1.2m	UHB: 6,607 HEFT: 2,804
19. MEDICAL ONCOLOGY (370)	UHB: £0.4m HEFT: £0.8m	UHB: 268 HEFT: 449
20. NEUROLOGY (400)	UHB: £2.3m HEFT: £1.3m	UHB: 8,679 HEFT: 5,379
21. RHEUMATOLOGY (410)	UHB: £1.8m HEFT: £2.2m	UHB: 4,862 HEFT: 6,688
22. GERIATRIC MEDICINE (430)	n/a	UHB: 3,920 HEFT: 5,368
23. SPEECH AND LANGUAGE THERAPY (652)	n/a	UHB: 1,077 HEFT: 799
24. INTERVENTIONAL RADIOLOGY (811)	UHB: £0.9m HEFT: £1.9m	UHB: 1,220; HEFT: 1,532
25. CHEMICAL PATHOLOGY (822)	UHB: £0.003m HEFT: £0.4m	UHB: 452 HEFT: 3,136
Total SLC specialties	UHB: £67m HEFT: £103m	UHB: 130K HEFT: 174K

** Excludes specialised services.*

121. The CMA has also assessed in greater detail the revenues and patients affected by looking at only the settings that failed the *CMFT/UHSM* filters (see Annex 1), eg in General Surgery the referral ratio was above 40% with regard to Inpatients only, whereas in Upper Gastrointestinal Surgery the referral ratios were above 40% for Inpatients, Outpatients and Daycase. The aggregate figures are set out below in table 3.

Table 3: Aggregate affected turnover and patients of the Parties

Measure	Turnover (HEFT + UHB)		Number of patients (HEFT + UHB)	
	All settings (Outpatient + Inpatient + Daycase)	Only settings failing filters	All settings (OP + IP + DC)	Only settings failing filters
Scale of SLC*	£170 m**	£94 m	304,000	200,000
Parties' total turnover / total patients	£1,243 m***	£1,243 m***	991,000	991,000

% of SLC as Parties' total turnover	14%	8%	31%	20%

** Excludes specialised services*
*** Ie the sum of the Parties' revenue in table 2 above in the ultimate row, second column*
**** Clinical income only*

Alternative suppliers

122. Unilateral effects are more likely where customers have little choice of alternative supplier. The CMA assessed whether there were alternative suppliers that would exert a competitive constraint on the merged entity.

123. The Parties mentioned the following competitors to the Parties: SWBH, Spire, and the University Hospitals Coventry and Warwickshire NHS Trust (**UHCW**). These three competitors were however only mentioned in relation to certain specialties.UHB, HEFT, and SWBH are the three major NHS acute hospital trusts in Birmingham and Solihull. There are two other NHS trusts in Birmingham providing specialist services: Birmingham Women's and Children's FT (**BWC**), offering specialist paediatric and women care, and Royal Orthopaedic Hospital NHS FT, which is a specialist orthopaedic centre. Furthermore, there are eight NHS acute trusts located in other parts of the West Midlands.

124. Table 4 below lists the CQC ratings of these trusts and the distance between their acute hospitals and the Parties. Figure 1 shows their locations on a map.

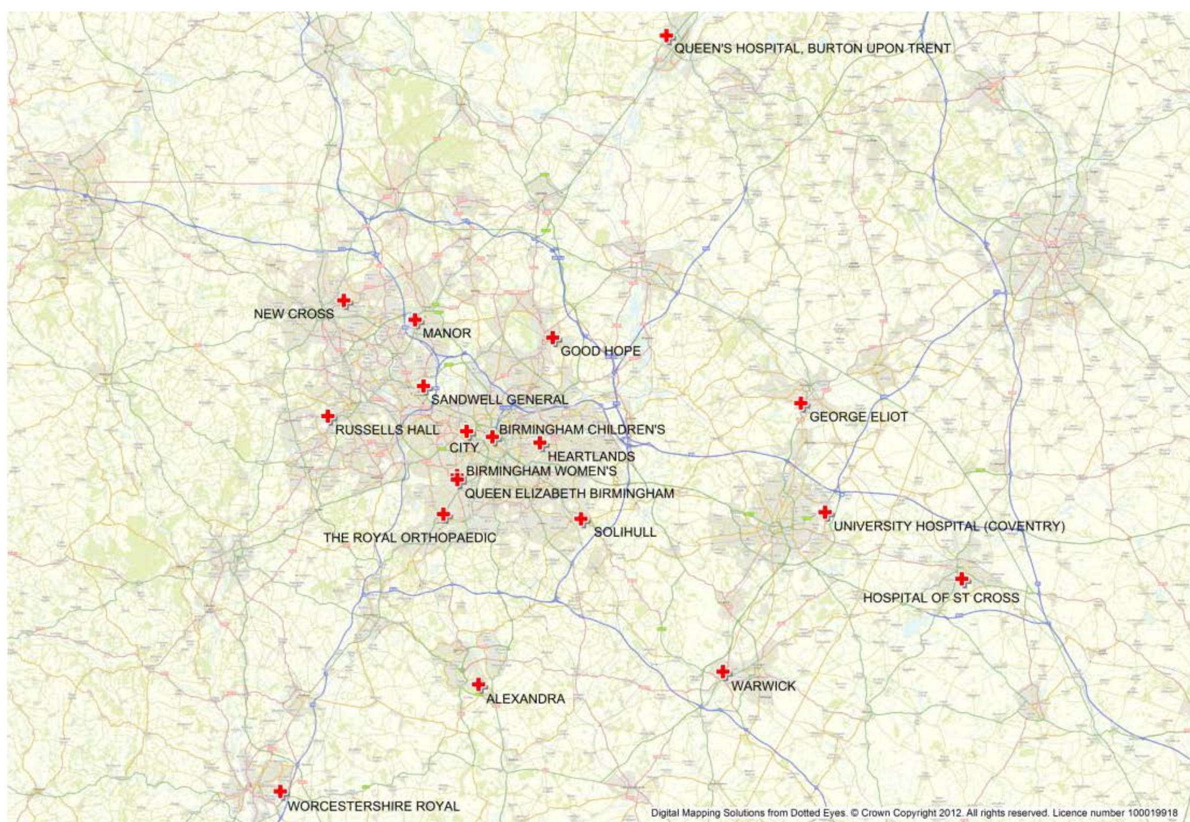
Table 4: Other acute hospitals in the West Midlands

Trust	Most recent CQC rating	Hospital	Distance to UHB (Queen Elizabeth Birmingham)	Distance to closest HEFT site
Sandwell and West Birmingham Hospitals NHS Trust (SWBH)	Requires Improvement	City Hospital, Birmingham	3.5 miles	5.2 miles (Heartlands)
		Sandwell General Hospital	7.4 miles	9.4 miles (Good Hope)
Walsall Healthcare NHS Trust	Inadequate	Walsall Manor Hospital	15.1 miles	9.7 miles (Good Hope)
Dudley Group NHS Foundation Trust	Requires Improvement	Russells Hall Hospital	10.7 miles	15.1 miles (Heartlands)
	Requires Improvement	University Hospital	28.8 miles	20.2 miles (Heartlands)

University Hospitals Coventry and Warwickshire NHS Trust (UHCW)		Hospital of St. Cross	38.8 miles	29.1 miles (Solihull)
Worcestershire Acute Hospitals NHS Trust	Inadequate	Alexandra Hospital	14.8 miles	16.3 miles (Solihull)
		Worcestershire Royal Hospital	26 miles	31.4 (Solihull)
Royal Wolverhampton NHS Trust	Requires Improvement	New Cross Hospital	16.5 miles	7.5 miles (Heartlands)
Burton Hospitals NHS Foundation Trust	Requires Improvement	Queen's Hospital	27.9 miles	18.5 miles (Good Hope)
South Warwickshire NHS Foundation Trust (SWFT)	Requires Improvement	Warwick Hospital	30.1 miles	22.9 miles (Solihull)
George Eliot Hospital NHS Trust	Good	George Eliot Hospital	27.7 miles	21.1 miles (Solihull)

Source: Parties

Figure 1: Map of UHB, HEFT and other acute hospitals in the West Midlands



Source: Merger Notice.
Note: HEFT operates Good Hope, Heartlands and Solihull. UHB operates Queen Elizabeth Birmingham.

125. The majority of the trusts listed above received either a ‘Requires improvement’ or ‘Inadequate’ rating from the CQC, which in part reflects the capacity and financial pressure they face, similar to many NHS trusts in England. Most of the trusts, except for SWBH, are located significantly further away from the Parties, and given the importance to patients of proximity, they are likely to be regarded as weaker alternatives by patients in the Birmingham area.

126. The CMA therefore believes that the ability of these trusts to offer a meaningful competitive constraint is limited.

Barriers to entry and expansion

127. Entry, or expansion of existing firms, can mitigate the initial effect of the merger on competition, and in some cases may mean that there is no SLC. In assessing whether entry or expansion might prevent a substantial lessening of competition, the CMA considers whether such entry or expansion would be timely, likely and sufficient.[88] In terms of timeliness, the CMA's guidelines indicate that the CMA will look for entry to occur within two years.[89]

128. The Parties have not submitted that there is easy entry or expansion in general, and no other evidence has been provided to the CMA to indicate that entry or expansion is likely on a significant scale in the near future.

129. Based on the CMA’s experience in previous NHS merger cases and in the absence of evidence indicating entry or expansion in this case, the CMA currently believes that entry or expansion would not be sufficiently timely or likely to prevent a realistic prospect of an SLC as a result of the Merger.

Third party views

130. The CMA contacted patient representatives, GP representatives, competitors, CCGs, NHSE and NHSI. Only one third party raised a substantive concern, regarding potential customer foreclosure.

131. Specifically, a third-party NHS provider contended that a significant part of its revenue in specialised [✂] Service is dependent on referrals from HEFT. It submitted that it would face a deficit absent referrals from HEFT, and therefore the sustainability of that service would be affected.

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[88] Merger Assessment Guidelines, paragraph 5.8.3
[89].Merger Assessment Guidelines, paragraph 5.8.11

132. The CMA notes that a potential competition concern might arise if both (a) NHSE plans to reconfigure the service, and (b) if the foreclosure strategy would preclude the third party from bidding for the service or substantially weaken it as a bidder, thus reducing the number of credible options available to NHSE and the intensity of competition for the market.

133. However, the CMA takes the view that customer foreclosure concerns would be unlikely to arise in this case. NHSE told the CMA that there are no plans to reconfigure specialised [✄]. It also submitted that, to its knowledge, UHB does not have the capacity to take on [✄] referrals from HEFT. Further, NHSE stated that it encourages providers to make referral decisions based on the patients' best interest (eg taking into account their location).

134. In any event, HEFT only accounted for a small proportion of the tertiary referrals in [✄] received by that third party, and there are 4 trusts other than the Parties that currently refer patients. On this basis, the CMA concludes that the merged entity would be unlikely to have the ability to engage in a customer foreclosure strategy.

135. No other third parties raised competition concerns about the Merger.

136. Third party comments have been taken into account where appropriate in the competitive assessment above.

Conclusion on substantial lessening of competition

137. Based on the evidence set out above, the CMA believes that it is or may be the case that the Merger may be expected to result in an SLC as a result of horizontal unilateral effects in relation to the 25 specialties listed in Table 1.

Exceptions to the duty to refer

138. Where the CMA's duty to refer is engaged, the CMA may, pursuant to section 33(2)(c) of the Act, decide not to refer the merger under investigation for a Phase 2 investigation on the basis that any relevant customer benefits (**RCBs**) in relation to the creation of the relevant merger situation concerned outweigh the SLC concerned and any adverse effects of the SLC concerned (the **RCB exception**). The CMA has considered below whether it is appropriate to apply the RCB exception to the present case.

139. The Parties submitted a full benefits case. On 28 July 2017, NHSI gave its advice on RCBs pursuant to section 79(5) of the Health and Social Care Act 2012 (**HSCA**).

Legal Framework

140. The CMA will examine the evidence put forward by the merging parties, together with NHSI's advice on the benefits accruing to patients as a result of the merger. If the evidence received is sufficient for the CMA to establish that there are RCBs, it will then consider if these outweigh the likely adverse effects of the merger on patients and/or commissioners.[90]

141. Weighing up the benefits against the adverse effects on patients involves consideration of the facts and circumstances of each individual case. In exercising its discretion to decide whether the claimed RCBs are such as to outweigh the SLC concerned and any adverse effects of the SLC, the CMA has regard both to the magnitude of the benefits and the probability of them occurring, and sets this against the scale of the identified anticompetitive effects and the probability of them occurring.[91] The RCBs do not need to be in the same market(s) or specialty as the CMA's SLC finding.

142. Only a benefit that meets the three conditions set out in section 30 of the Act can be considered an RCB:

   (a) The benefit must be a **benefit to relevant customers in the form** of:

      (i) lower prices, higher quality or greater choice of goods or services in any market in the United Kingdom … or

      (ii) greater innovation in relation to such goods or services'.[92]

   (b) the benefit is expected to accrue to relevant customers within the UK within **a reasonable period** as a result of the creation of the relevant merger situation;[93] and

   (c) the benefit is **unlikely to accrue without the creation of that situation** or a similar lessening of competition'.[94]

Types of benefits that may represent RCBs

143. The assessment of whether benefits claimed by merger parties constitute RCBs must be assessed on a case-by-case basis.[95]

[90] CMA 29, paragraph 7.24.
[91] CMA 29, paragraph 7.26.
[92] Section 30(1)(a) of the Act and see also CC8, paragraph 1.14.
[93] Section 30(1)(b)(ii) of the Act.
[94] Section 30(3) of the Act and see also CC8, paragraph 1.16.
[95] CMA29, paragraph 7.14.

144. The types of benefits that NHS providers have previously submitted (either to NHSI, or the CMA) include higher-quality services through implementing a particular model of care, service reconfiguration, increased consultant or staff cover and access to equipment. They have also included greater innovation through research and development and greater ability to attract funding for research and development and financial savings.[96]

145. In the context of the health sector and NHS mergers, 'relevant customers' include patients and/or commissioners.[97]

Role of NHSI in the CMA's assessment of RCBs

146. Section 79 of the HSCA requires NHSI to provide advice on RCBs to the CMA in Phase 1 as soon as reasonably practicable after receiving notification that the CMA is investigating a merger involving an NHS foundation trust.[98]

147. NHSI's advice is not binding on the CMA. However, the CMA will place significant weight on NHSI's advice, given NHSI's role and expertise as sectoral regulator.[99]

Potential benefits arising from the Merger

148. The Parties submitted that the Merger will give rise to a wide range of benefits (including many in addition to those that they have proposed as RCBs, which are nevertheless associated with a merger between two large NHS trusts.[100]

149. NHSI has found, in general, that improvements in clinical service delivery and financial savings, similar to many of the potential benefits claimed by the Parties, can be achieved through mergers between NHS providers.[101]

150. The Parties identified over 360 items of patient benefit and improvement in clinical quality that would be delivered by the merged trust, which would help to realise the aims of the STP for the Birmingham and Solihull footprint[102] and deliver improved healthcare for the local population.

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[96] CMA29, paragraph 7.13.
[97] See section 30(4) of the Act and CMA29, paragraph 7.3.
[98] CMA29, paragraph 7.5.
[99] CMA29, paragraph 7.6.
[100] See paragraphs 157 to 164 below.
[101] See NHSI (May 2016), Improvements NHS providers have achieved through mergers and Aldwych Partners (May 2016), Benefits from mergers: lessons from recent NHS transactions.
[102] Sustainability and Transformation Plans were introduced by NHS England and NHSI (through joint planning guidance for the financial year ended 31 March 2017) to help ensure that health and social care services were built around the needs of local populations. This was achieved by requiring 44 regions or geographical footprints across England to produce a multi-year plan, demonstrating how each region would develop high-quality, sustainable health and social care services over the next five years. The final plans were published in December 2016.

151. In identifying RCBs, the Parties identified 30 clinical services where there were likely to be overlaps between the two trusts. For each of these services, the Parties identified relative strengths and weaknesses of the services provided by them, as well as opportunities for benefit realisation.

152. From these 30 clinical services, the Parties then developed a number of clinical case studies to demonstrate the benefits arising from the Merger. The selection of clinical services for the case studies was based on identifying those service changes that were likely to have significant impact for patients of the Parties and for the wider LHE, but could be delivered within current commissioning expectations and without large scale service reconfiguration.

153. The Parties claim that there are clear benefits that will be deliverable in many other clinical services, but that these benefits require detailed operational planning and cannot be expected to be delivered in the short term, and that more substantial reconfiguration of services may be possible, but will need to be coordinated with the wider LHE.

154. In addition to clinical benefits, the Parties also expect benefits to accrue from the Merger in clinical support service functions, such as pharmacy, laboratory sciences, diagnostics and therapies services.

155. For the purposes of its assessment at Phase 1, the CMA focussed on those benefits which the Parties submitted as potential RCBs within the meaning of the Act and did not seek to determine whether additional benefits might arise from the Merger. As such, the CMA's assessment of RCBs may understate the overall magnitude of actual benefits arising from the Merger.

Assessment of RCBs

156. In this section, the CMA outlines the proposed RCBs and NHSI's advice on those proposed RCBs. The CMA then considers whether the proposed RCBs are RCBs within the meaning of Section 30 of the Act, drawing both on NHSI's advice and a number of general considerations relating to the implementation and the merger specificity of the RCBs.

RCBs proposed by the Parties

157. The Parties claimed that the Merger will enable them to embed and sustain improvements already made at HEFT since the Intervention and further develop services across the merged trust. The Parties submitted that the Merger will give rise to a number of cross-cutting RCBs affecting all of the services to be provided by the Parties, as well as further RCBs in specific clinical services.

158. The cross-cutting RCBs include:

(a) consolidation of the performance gains HEFT made post-Intervention;

(b) reduction in the variation of the treatment of patients and improved patient safety and outcomes through the integration of appropriate clinical services and electronic systems to standardise clinical practice, protocols and quality standards;

(c) improved staff retention through the pooling of staff across the merged trust, which will provide greater career and developmental opportunities;

(d) development of clinical services and sites through the integration of the administrative, education and training, financial, logistic and procurement services of both trusts;

(e) improved research and development opportunities by combining the experience of innovation, research and development and the existing relationships with academic partners of the two trusts, as well as the combining of a diverse patient population, which will enable the merged trust to become world leading in medical research and innovation; and

(f) the creation of a more resilient organisation, which will be better able to influence and act as a supportive partner within the LHE.

159. The Parties have also developed a number of case studies to demonstrate proposed RCBs arising from the Merger in specific clinical services.

160. Following the Intervention, the Parties identified two clinical services provided by HEFT (neurology and interventional radiology) that required immediate attention in the interest of patients. In addition, the Parties are also currently taking action to stabilise HEFT’s plastic surgery service.

161. The Parties submitted that they expected RCBs to arise in the following clinical services:

(a) **Gastroenterology and liver medicine**: the Merger will enable improved patient access to the service through shorter patient pathways, increased capacity and the development of primary care provision.

(b) **Diabetes**: the Merger will deliver better care in community settings, a more informed patient population, improved patient access to diabetes services and reduced hospital admissions.

(c) **Vascular surgery**: the Merger will allow the merged trust to deliver world-class service to the combined patient population and drive the focussed delivery of vascular services across primary, secondary and tertiary care.

(d) **Cardiology**: the Merger will result in improved patient access to cardiology services, reduced length of stay, a reduction in hospital admissions, the provision of a robust seven-day service and improved outreach and community follow-up care.

(e) **Nephrology**: the Merger will enable the merged trust to share good practice, offer more home haemodialysis, improve training, benefit from greater business bargaining power and expand some services (eg HIV).

162. The Parties claimed that the proposed changes in these five services will affect a large number of patients and will also have the potential to deliver genuinely radical change in care pathways and care delivery. They stated that the necessary changes can be delivered within the context of current expectations on contracting and will not require wholesale reconfiguration of services or necessitate large movement of patients.

163. The Parties also claimed that many of the proposed changes will enhance delivery of community based services and ambulatory pathways, as well as improving patient access to secondary and tertiary services within the LHE.

164. The Parties argued that the proposed RCBs are either specific to the Merger or would be deliverable under an accelerated timescale due to the Merger.

NHSI's advice on the proposed RCBs

165. NHSI advised the CMA that, following the Intervention, UHB had already delivered significant improvements for a large number of HEFT patients and was likely to deliver further improvements for both UHB and HEFT patients as a result of the Merger.

166. NHSI advised the CMA that these improvements meant that patients were receiving and would receive safer, higher quality care, and therefore, these improvements should be considered as RCBs:

(a) Improved waiting times for diagnosis and treatment, which now met national standards.

(b) Improved monitoring of and response to clinical quality issues.

(c) Improved governance at HEFT.

(d) Stabilisation of clinical services in urgent need (ie neurology, interventional radiology and plastic surgery).

(e) Workforce improvements.

(f) Improved use of clinical IT.

(g) Improved culture and staff morale.

(h) Specific improvements in gastroenterology and liver medicine and vascular surgery.[103]

167. NHSI said that the Parties' plans to achieve improvements in diabetes, cardiology, and nephrology represented the wider opportunities created by the Merger, but that it had not assessed these proposals against the CMA framework, as the plans were only in the early stages of development.[104]

168. NHSI said that the strategic rationale for the Merger was well-reasoned and aligned to the strategic objectives of the Birmingham and Solihull STP.[105]

169. Further, NHSI advised the CMA that:

(a) it supported the Merger (subject to completion of its merger assurance process), as the solution to the long-standing governance, quality and financial problems at HEFT;[106]

(b) the UHB leadership had the capability, capacity and expertise to successfully execute the Merger;[107]

(c) the current arrangement between UHB and HEFT was not sustainable, given the extent of ongoing support required from UHB and the resulting strain on leadership capacity, as well as UHB's unwillingness to continue under current arrangements indefinitely;[108]

(d) it was unlikely that NHSI would be able to appoint a leadership team with the cohesion, experience and situational awareness as provided by UHB since the Intervention;[109] and

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[103] NHSI advice, pages 20 and 21.
[104] NHSI advice, page 54.
[105] NHSI advice, page 17.
[106] NHSI advice, page 6.
[107] NHSI advice, page 17.
[108] NHSI advice, page 16.
[109] NHSI advice, page 16.

(e) the Merger was necessary to embed and sustain the improvements made at HEFT since the Intervention and deliver the full range of potential benefits proposed by the Parties in their benefits submission.[110]

170. NHSI told the CMA that the Merger was a significant undertaking requiring careful management. NHSI intends to complete its analysis of the Parties' financial case and integration planning shortly, in order to assure that any risks to the successful execution of the Merger are carefully identified and managed by the Parties.[111]

General considerations relating to the implementation and merger specificity of the proposed RCBs and other potential benefits of the Merger

171. Before assessing whether each of the proposed RCBs is an RCB within the meaning of the Act, the CMA sets out a number of general considerations that are relevant to the Merger, the proposed RCBs and all of the various potential benefits of the Merger. These considerations relate to the **risks relating to the implementation of benefits** (and how the Parties and NHSI will mitigate these risks) and the need for the Merger (rather than any other form of collaboration between the Parties) to ensure **effective implementation** of the benefits.

Implementation

172. The CMA is aware that NHS mergers are complex transactions, which face heightened operational challenges and significant regulatory and clinical pressures to maintain quality and service levels. They can therefore raise significant implementation risks to the prompt realisation of benefits.[112]

173. In this case, there are a number of factors that support the Parties' realisation of benefits within a reasonable period from the Merger:

(a) NHSI advised that UHB has significant capability in and experience of implementing large scale changes, demonstrated by the improvements at HEFT since the Intervention;

(b) the Parties have undertaken a significant amount of planning work in relation to the implementation and delivery of the proposed RCBs;

[110] NHSI advice, page 6.
[111] NHSI advice, page 18.
[112] See NHSI, Literature review: the experiences of healthcare providers in delivering merger objectives, May 2016.

(c) the Parties engaged with numerous key stakeholders, which may be expected to assist in the delivery of the proposed RCBs;

(d) the Merger is widely supported by key stakeholders; and

(e) the Merger is subject to NHSI's merger assurance regime.

174. Each of these factors are discussed further below.

- *UHB capability and experience*

175. The CMA believes that, given the experience and reputation of UHB's senior leadership team in implementing large scale change, the merged trust should be well placed to execute the Merger successfully.

176. First, UHB has a proven international reputation for its quality of care, information technology, clinical education and training and research.[113]

177. Second, in addition to providing management support to HEFT, UHB has previously successfully supported several other hospitals, eg the George Eliot Hospital. In fact, NHSI directed HEFT to appoint the UHB leadership to its executive team because:

(a) UHB was a high performing trust, which was rated by the CQC as good overall and outstanding on leadership at both a senior management level and an executive level;

(b) UHB had a culture of safety and improvement through all levels of the organisation, and this has led to positive change for patients;

(c) UHB had established clear lines of responsibility and accountability together with leadership that inspired confidence, and this had helped to support a culture of innovation, which had enabled staff to take opportunities to enhance the services provided by the trust; and

[113] For example, UHB has the second largest renal dialysis programme in the UK and the largest solid organ transplantation programme in Europe; UHB is a Level 1 trauma centre and host of the National Institute for Health Research Surgical Reconstruction and Microbiology Research Centre, UHB has led the largest Genomic Medicine Centre in the UK under the national 100,000 Genomes Project, bringing together 18 NHS trusts with linked data platforms and patient sample pathways; UHB, as part of Birmingham Health Partners (a strategic alliance between UHB, the University of Birmingham and Birmingham Women's and Children's NHS Foundation Trust. It focuses on the identification, adoption and spread of innovation and best practice, through the alignment of healthcare delivery, research and training), opened the Institute of Translational Medicine, a world-class clinical research facility; UHB was designated as an NHS Global Digital Exemplar by NHS England, reflecting UHB's health informatics capabilities; and UHB established the Centre for Rare Diseases, which undertakes research, in order to understand the molecular causes of rare diseases and so provide a basis for improving the diagnosis, clinical management and treatment of these disorders.See Benefits submission, paragraph 1.3.2.-1.3.4

(d) the UHB Board had significant capabilities and transactional experience at both an executive and non-executive level.[114]

178. Third, NHSI told the CMA that since the Intervention, UHB had stabilised the most urgent problems at HEFT, improved the safety and quality of care across the trust and put in place new staff engagement, reporting and governance structures, which had begun to foster an improved culture of safety and improvement.[115] NHSI said that the CQC, in its most recent inspection, had found that HEFT, while still needing to address some issues, was heading in the right direction with improvements already evidenced in a range of areas. NHSI also said that commissioners had noted that there was a greater sense of control at HEFT and that improvements to performance against national standards had had a positive impact on patients.[116]

179. Fourth, in the longer term, NHSI said thatthe UHB leadership had the capability, capacity and expertise to successfully execute the Merger, citing the following factors:

(a) UHB has a history of successfully delivering large scale projects, including consolidating two hospital sites into one new private finance initiative site and being established as a major trauma centre;

(b) UHB indicated that it was committed to increasing its capability, capacity and expertise in areas where it identified that this was necessary; and

(c) UHB has managed HEFT since October 2015 and therefore, it had benefited from insight into the significant challenges faced by HEFT.[117]

- *Planning work undertaken to date*

180. Since the Intervention, UHB has focused on improving clinical governance and financial performance at HEFT, in order to stabilise the trusts. The Parties have also commissioned (but not yet completed or fully implemented) a number of work programmes:

(a) **Governance**: the Parties told the CMA that prior to the Intervention, there was no sustainable, embedded organisational governance infrastructure for all divisions within HEFT set against the trust's quality and safety

[114] NHSI advice, page 17.
[115] NHSI advice, page 21.
[116] NHSI advice, page 22.
[117] NHSI intends to examine the successful execution of the Merger in greater detail as part of its merger assurance process. NHSI advice, page 18.

strategy and assurance frameworks. The Good Governance Institute[118] conducted a review of HEFT and UHB used its recommendations to inform corporate structure with appropriate lines of accountability and assurance through to the Board.

(b) **Organisational structure**: the Parties said that HEFT did not have the leadership skills and capacity at all levels to deliver new ways of working and appropriate ways of leading that promoted the trust safety culture. UHB has developed and implemented a new operational delivery structure, which ensures clear roles, responsibilities and accountabilities across the trust.

(c) **Financial performance**: the Parties told the CMA that prior to the Intervention, HEFT's financial position significantly detoriated, resulting in its inability to deliver the previous Financial Recovery Plan committed to NHSI. UHB has (with EY) prepared a Financial Recovery Plan and a long term financial model, which will form the basis of financial trajectories for the trust in the future, and has put in place enhanced cash management procedures to preserve HEFT's cash balances whilst distressed funding support is agreed with NHSI and other measures explored. The Parties said that the actions taken to address HEFT's financial position since the Intervention has reduced the deficit by £47.5 million.

(d) **Estates and Infrastructure**: the Parties submitted that the estates infrastructure and equipment at HEFT was not up to the requisite standard to facilitate the provision of safe and effective care due to the deterioration of condition, poor space utilisation and functional suitability. UHB has undertaken an independent estates review and produced a Strategic Building Programme, identifying £105 million for investment in necessary estates improvements across HEFT in the first five years following the Merger and £671 million in total by 2032.

The Parties said that the UHB management team at HEFT had been successful in gaining access to HM Treasury funding of circa £87 million (of which the £3.1 million had been made available) to support the initial phase of the Strategic Building Programme relating to the development of a new Ambulatory Care and Diagnostic facility. The Parties stated that the track record of the UHB leadership team to deliver on large capital

[118] The Good Governance Institute supports better governance practice and ensures organisations develop a focus on leadership and strategy. It works with NHS, third sector and commercial organisations, helping them improve through board development and implanting good governance practice.

schemes would have provided significant assurance to HM Treasury of the UHB's capacity to deliver the scheme on time and to budget.[119]

(e) **Information and communications technology**: UHB has undertaken a preliminary review of information and communications technology, which suggest that HEFT's current infrastructure is unfit for purpose. An infrastructure survey is currently in progress.

(f) **Staff engagement**: the Parties said that HEFT had been increasingly unable to recruit and retain staff, but that the response to the Intervention had been extremely positive. In October 2015, scores from the NHS Friends and Family Test[120] found that 54% of HEFT staff would recommend HEFT as a place to work and 64% would recommend HEFT as a place to be treated. By March 2016, these scores had risen to 62% and 73% respectively.

(g) **External stakeholder engagement**: UHB has undertaken significant pro-active and effective external engagement with key stakeholders in the LHE (see paragraphs 184 to 187). The Parties told the CMA that the Interim Chair and Chief Executive were playing an integral part in the development of the local STP and were developing meaningful relationships with HEFT's local commissioners.

181. The Parties submitted that the Intervention had delivered operational and financial stabilisation at HEFT, which had been reflected in improved operational performance and staff morale.

182. The Parties have provided the CMA with a Clinical Workstream Project Plan and a number of plans relating to the development of IT infrastructure at HEFT, which demonstrates that they are well placed to deliver their proposals.

183. The CMA therefore, and having regard to the NHSI advice, believes that the actions undertaken by UHB since the Intervention to HEFT means that the trusts are well-placed to deliver the proposals set out in their benefits submission.

- *Stakeholder engagement and support*

184. In developing their benefits submission, the Parties have engaged with over 130 clinicians and clinical managers within the two trusts and with other key

[119] Response to issues letter, 10 August 2017, Annex A.
[120] The NHS Friends and Family Test was launched in 2013 to help service providers and commissioners understand whether their patients were happy with the service provided or where improvements were needed. The test has been rolled out across most NHS services. The responses of patients to the test are used to create an overall score for each provider, which is published on the NHS Choices website.

stakeholders within the LHE, in order to ensure that they were involved in the process of identifying the implications of an integrated single trust.

185. The Parties said that the key internal and external partners included:

(a) clinicians, including all divisional directors and clinical service leads from both trusts;

(b) estates and facilities directors from both trusts;

(c) executive directors and operational directors from both trusts;

(d) research and innovation teams from both trusts;

(e) workforce and education teams from both trusts;

(f) accountable officers of the three local CCGs (South Central CCG, Birmingham and Solihull CCG and Birmingham Cross City CCG);

(g) Regional Director and Medical Director of NHSE for the West Midlands;

(h) CEO and Chief Officer for Strategy and Innovation of Birmingham Women's and Children's NHS FT;

(i) CEO, Director of Nursing and Director of Business and Organisational Development of Birmingham Community Healthcare FT; and

(j) Directors of public health and adult social care.

186. The Parties told the CMA that the stakeholder engagement demonstrated that there was widespread support for the Merger, as it was likely to improve patient access and equity to services, result in a robust accountability framework, provide greater bargaining power vis-à-vis suppliers, standardise clinical polices and pathways and improve and eliminate variations in patient outcomes. The Merger is supported by all key stakeholders, including NHSI, clinicians across both trusts, commissioners and other local providers.

187. The CMA believes that the high levels of engagement undertaken by the Parties across management and clinical workforces, as well as wider stakeholders, increase the likelihood that the proposed RCBs will be delivered.

- *Regulatory oversight*

188. In addition to the CMA's merger assessment, the Merger is subject to NHSI's merger assurance process. NHSI told the CMA that it had already assessed

the strategic rationale for the Merger and found that it was well reasoned and aligned to the strategic objectives of the Birmingham and Solihull STP.[121]

189. NHSI will continue to conduct its assurance work over the next few months, which will focus on quality, finance, transaction execution and strategy.[122] As part of its assurance work (relating to the transaction execution domain), NHSI will assess whether the Parties have a robust benefits realisation plan.[123]

Merger specificity

190. There are a number of general considerations that are particularly relevant for the CMA's assessment of the Merger specificity of the various potential benefits claimed by the Parties.

191. In the CMA's assessment of the proposed RCBs, the CMA assesses whether each RCB is unlikely to accrue without the Merger (or the creation of a similar lessening of competition). However, the CMA has also identified several reasons why, in general, the proposed RCBs are more likely to be realised through the Merger than by other means.

- *Role of UHB absent the Merger*

192. The Parties submitted that the Intervention by NHSI reflected the failure of various regulatory interventions, which included enforcement undertakings, the imposition of licence restrictions, independent reviews and the secondment of Executive and Improvement Directors.[124]

193. The Parties do not believe that the current position of UHB is sustainable, as while the interim arrangements have delivered considerable performance, financial and governance improvements to HEFT, over time there will be a risk of confusion of accountabilities, duplication of lines of governance and potential conflicts of interests due to the presence of two Boards.

194. The Parties also submitted that the withdrawal of UHB from HEFT would be inappropriate, as sustaining the improvements at HEFT that have been delivered since the Intervention will require the same consistent and strategic approach, which can only be delivered through the Merger. Any future

[121] NHSI advice, page 17.
[122] NHSI response to CMA Issues Letter.
[123] NHSI response to CMA Issues Letter.
[124] The actions taken by NHSI to improve HEFT prior to UHB's intervention is summarised in section 2 of NHSI's advice to the CMA.

organisational structure that reduces the clarity and consistency of leadership currently in place would have a very negative effect on performance.

195. The Parties told the CMA that discussions with both clinical and non-clinical staff since the Intervention had indicated that if UHB was to withdraw from HEFT, this would have an adverse impact on the work that had been carried out to date to stabilise HEFT.

196. The Parties believed that if the Merger does not proceed and UHB withdraws from HEFT, the resulting deterioration in performance at HEFT could be expected to deliver a return to the situation prior to the Intervention, if not worse, because:

(a) recruiting a CEO of suitable experience and calibre would be extremely challenging in the current climate (some 18% of CEO roles at NHS trusts are filled on an interim or acting basis);

(b) HEFT would be required to replace six other members of the executive team with more than 40 years' experience at Board level (33% of NHS trusts have at least one interim board member or vacancy on their executive team); and

(c) the withdrawal of UHB would have significant negative impact on staff morale at HEFT.

197. NHSI said that that the current arrangement between UHB and HEFT was not sustainable, given the extent of ongoing support required from UHB, as well as UHB's unwillingness to continue the current arrangements indefinitely.[125]

198. NHSI told the CMA that the Merger was necessary to embed and sustain the improvements at HEFT and deliver the full range of potential benefits. NHSI said that the leadership of UHB had been critical to the successful adoption of the policies and processes that were an important part of the improvements delivered to date, and UHB's continued presence was required to embed a culture of continuous improvement and to ensure the gains made were not lost.[126]

199. NHSI told the CMA that it was unlikely that NHSI would be able to appoint a leadership team with the cohesion, experience and situational awareness as provided by UHB since the Intervention.[127]

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[125] NHSI advice, page 16.
[126] NHSI advice, page 6 and NHSI response to CMA Issues Letter.
[127] NHSI advice, page 16.

200. The CMA therefore believes that the continued presence of UHB's senior leadership, predicated on the Merger, is essential for the long-term stability of HEFT and the delivery and sustainability of the proposed RCBs.

- *Scale and complexity of change*

201. The CMA believes that the nature and scale of the proposed RCBs, and the operational challenge of implementation, is so significant that the only way to realistically deliver on the full potential of the benefits is through the Merger.

202. In the absence of the Merger, the CMA does not think that change of the type and scale of the proposed RCBs is likely, given the time needed to and the complexity of putting in place multiple cooperative agreements or similar arrangements.

- *Barriers to working together*

203. The Parties claim that since the Intervention, it has been possible for clinical teams to engage in productive dialogue about service development, whereas previously the environment for such collaboration was not present and many clinical services across the trusts developed independently of each other. For example, the oral and maxillofacial surgery services provided in the LHE is based on a hub and spoke model, whereby UHB is the main hub provider and HEFT is one of the providers networked to UHB.

204. The Parties told the CMA that UHB and HEFT renegotiated the service level agreement for the service at Solihull Hospital every year and for most years since the introduction of the care model, there had been no agreement between them as to the exact size and shape of the service, resulting in regular disputes in relation to payments of service level agreement costs. The Parties told the CMA that prior to the Intervention, UHB had served notice to HEFT, as it had not been possible to agree a way forward for the service.

205. The Parties claim that their experiences in the provision of oral and maxillofacial services demonstrates the problems that arise when two large NHS trusts attempt to collaborate to deliver services without any real strategic direction or consistency of leadership. The CMA believes that the Merger is likely to remove many of these barriers to effecting change by establishing a single accountable board and governance structure.

Assessment of the proposed RCBs

206. The CMA's assessment of each of the proposed RCBs is summarised in Table 5 below and a more detailed assessment can be found in Annex 2.

Table 5: Summary of assessment of proposed RCBs

Proposed RCB	*Is the proposed RCB likely to improve patient and/or commissioner outcomes?*	*Can the proposed RCB be expected to accrue within a reasonable period from the Merger?*	*Is the proposed RCB unlikely to accrue without the Merger?*	*Is the proposed RCB an RCB within the meaning of the Act?*
Cross-cutting RCBs				
Improved waiting times for diagnosis and treatment	Yes HEFT meeting national targets for referral to treatment times, cancer waiting times, and time from referral to diagnostic tests, resulting in improved patient access and outcomes and improved quality and safety of care. Merger is likely to sustain improvements already delivered and deliver further improvements for patients.	Yes Improvements delivered since the Intervention will be consolidated by the Merger and further improvements are likely and may be expected to accrue within a reasonable period from the Merger.	Yes Improvements already delivered due to capability and expertise of UHB leadership team, but Merger necessary to embed and sustain improvements and deliver further improvements.	Yes
Improved clinical quality monitoring	Yes Changes to monitoring at HEFT has improved safety and quality of care and made it more likely that safety and quality issues will be identified and addressed. Merger is	Yes Improvements delivered since the Intervention will be consolidated by the Merger and further improvements are likely and may be expected to accrue within a reasonable period from the	Yes Improvements already delivered due to capability and expertise of UHB leadership team, but Merger necessary to embed and sustain improvements and deliver further	Yes

	likely to sustain improvements already delivered and deliver further improvements for patients.	Merger.	improvements.	
Improved governance	Yes Good governance is critical to providing safe, high quality care and improved governance at HEFT has led to better care for patients. Merger is likely to sustain improvements already delivered and deliver further improvements for patients.	Yes Improvements delivered since the Intervention will be consolidated by the Merger and further improvements likely and may be expected to accrue within a reasonable period from the Merger.	Yes Improvements already delivered following the Intervention but Merger necessary to embed and sustain improvements and deliver further improvements.	Yes
Improved culture and staff morale	Yes Culture of safety and improvement, along with higher staff morale, has led to better care for patients. Merger is likely to sustain improvements already delivered and deliver further improvements for patients.	Yes Improvements delivered since the Intervention will be consolidated by the Merger and further improvements are likely and may be expected to accrue within a reasonable period from the Merger.	Yes Improvements already delivered following the Intervention but Merger necessary to embed and sustain improvements and deliver further improvements.	Yes
Improved use of clinical IT	Yes Implementation of PICS at HEFT will reduce errors, missed drug doses, provide efficient early warning of deterioration of inpatient	Yes Implementation of PICS likely to be delivered within three years of Merger, as UHB has a track record of delivering improvements and high	Yes Improvements unlikely to accrue without continued leadership of UHB, which is best placed to implement and embed PICS at	Yes

	care and enable the setting of targets for continuous improvement	quality care and has already delivered substantial improvements at HEFT	HEFT	
Workforce improvements	Yes Improved recruitment and retention of staff, creating larger pools of staff and improved education and training of staff will result in reduced spending on locum and agency staff, greater patient access to out of hours services and sub-specialists, a better skilled workforce and higher quality care for patients. Merger is likely to sustain improvements already delivered and deliver further improvements for patients.	Yes UHB has a track record of delivering improvements and high quality care and has already delivered substantial improvements at HEFT. Improvements delivered since the Intervention will be consolidated by the Merger and further improvements are likely and may be expected to accrue within a reasonable period from the Merger.	Yes Improvements already delivered following the Intervention but Merger necessary to embed and sustain improvements and deliver further improvements.	Yes
Clinical services RCBs				
Neurology	Yes Stabilisation has resulted in improved referral to treatment times at HEFT. Merger is likely to sustain improvements already delivered and deliver further improvements for patients.	Yes Improvements delivered since the Intervention will be consolidated by the Merger and further improvements are likely and may be expected to accrue within a reasonable period from the Merger.	Yes Improvements already delivered following the Intervention but Merger necessary to embed and sustain improvements and deliver further improvements.	Yes

Interventional radiology	Yes Stabilisation has made the service at HEFT save for patients, although further recruitment necessary. Merger is ikely to sustain improvements already delivered and deliver further improvements for patients.	Yes Improvements delivered since the Intervention will be consolidated by the Merger and further improvements are likely and may be expected to accrue within a reasonable period from the Merger.	Yes Improvements already delivered following the Intervention but Merger necessary to embed and sustain improvements and deliver further improvements.	Yes
Plastic surgery	Yes Stabilisation has resulted in improved referral to treatment times at HEFT. Merger likely to sustain improvements already delivered and deliver further improvements for patients.	Yes Improvements delivered since the Intervention will be consolidated by the Merger and further improvements are likely and may be expected to accrue within a reasonable period from the Merger.	Yes Improvements already delivered following the Intervention but Merger necessary to embed and sustain improvements and deliver further improvements.	Yes
Gastro-enterology and liver medicine	Yes Proposed reconfiguration of endoscopy services is likely to result in improved patient flow and productivity, reduced waiting times and improved outcomes for some patients and improved patient experience. Implementation of community based and nurse-delivered hepatology service is likely to result	Yes Proposed reconfiguration of endoscopy services within three years of Merger is likely, although further work necessary to confirm future timeframes for approval of business cases and implementation of the service delivery model. Implementation of community based and nurse-delivered hepatology service likely to be delivered within 18	Yes Proposed reconfiguration of endoscopy services likely to be achieved more quickly as a result of the Merger, as implementing changes in the absence of the Merger would be more difficult, given nature and scale of proposed reconfiguration. Implementation of community based and nurse-delivered hepatology service is unlikely to be delivered without the Merger, given HEFT's past difficulties in developing	Yes

	in reduced admissions, reduced length of stay, improved patient access and delivery of care closer to home.	months of the Merger, given planning work already undertaken and in progress, levels of clinical engagement and UHB track record of implementing change.	a specialist liver service and UHB's successful implementation of an ambulatory model of care.	
Vascular surgery	Yes Optimising use of hybrid theatre is likely to result in improved patient access and experience. Consolidation of subspecialties onto single sites will improve patient outcomes (relationship between increased volumes and improved outcomes).	Yes Implementation in progress and high levels of clinical engagement.	Yes Proposals unlikely to be delivered without the Merger, given nature and nature and scale of proposed reconfiguration.	Yes
Cardiology	Yes Proposal likely to result in improved patient access and quality of care, causing reduced length of stay, improved patient outcomes and experience.	No Plans are in early stages of development and further planning work required to identify optimal service redesign.	N/A Proposal likely to represent improvements for patients, but cannot be expected to accrue within a reasonable period from the Merger, and therefore, we did not deem it necessary to consider whether it was unlikely to accrue without the Merger.	No
Nephrology	Yes Proposal likely to result in delivery of care closer to home, easier	No Plans are in early stages of development and further planning	N/A Proposal likely to represent improvements for patients, but cannot be expected to	No

	relocation of urgent dialysis, adoption of best practice and better value for money.	work required to identify optimal service redesign.	accrue within a reasonable period from the Merger, and therefore, we did not deem it necessary to consider whether it was unlikely to accrue without the Merger.	
Diabetes	Yes Proposals likely to result in reduced morbidity and complications, resulting in reduced hospital admissions, and a better educated diabetic population.	No Plans are in early stages of development and further planning work required to identify optimal service redesign.	N/A Proposal likely to represent improvements for patients, but cannot be expected to accrue within a reasonable period from the Merger, and therefore, we did not deem it necessary to consider whether it was unlikely to accrue without the Merger.	No

Source: CMA analysis, Parties' benefits submission, NHSI's advice on benefits submission.

Conclusion on RCBs

207. The CMA believes that the Merger will give rise to the following RCBs:

(a) Improved waiting times for diagnosis and treatment for at HEFT.

(b) Improved monitoring of and response to clinical quality issues at HEFT.

(c) Improved governance at HEFT.

(d) Improved culture and staff morale at HEFT.

(e) Improved use of clinical IT and in particular, the implementation of PICS at HEFT.

(f) Workforce improvements, including improved recruitment and retention of staff.

(g) Stabilisation of the neurology service provided by HEFT.

(h) Stabilisation of the interventional radiology service provided by HEFT.

(i) Stabilisation of the plastic surgery service provided by HEFT.

(j) Proposed reconfiguration of the gastroenterology and liver medicine service provided by the merged trust.

(k) Proposed reconfiguration of the vascular surgery service provided by the merged trust.

Assessment of the magnitude of the SLC and the RCBs and the probability of their occurrence

208. The CMA assessed the magnitude of the RCBs identified and balanced them against the nature of the SLCs and the magnitude of their adverse effects. This assessment was predominately qualitative, although the CMA has considered quantitative indicators where available.

209. The CMA was mindful of the broad time frame within which each of the patient benefits comprising the RCBs can be expected to be implemented (within a reasonable timeframe of the Merger), noting that some benefits are likely to be implemented more quickly than others (for example, in general, the CMA

would expect patient benefits involving site consolidation to be slower to implement than patient benefits involving consultant rota reconfigurations).[128]

Nature of the SLC and the magnitude of its adverse effects

210. The CMA found that the Merger may be expected to give rise to an SLC in the 25 elective specialties listed in paragraph 104, table 1.

211. The CMA believes that any adverse effects resulting from the SLC the CMA has identified are likely to be significantly constrained by the following factors concerning the nature of competition between NHS foundation trusts in general, and specifically as between the Parties:

(a) the role of competition in the LHE and regulation (see paragraphs 35-36 and 74-74 above);

(b) capacity constraints (see paragraphs 78-79 above);

(c) increased collaboration between NHS service providers (see paragraphs 80-82 above);

(d) differentiation between the Parties (see paragraph 116 above);

(e) the relatively weak position of HEFT prior to the Intervention (see paragraphs 40-41 above); and

(f) the number of patients and turnover of the elective specialties affected by the SLC (see tables 2 and 3 above) both in absolute terms and relative to the Parties' total activities.

212. On the basis of these factors, the CMA believes that it may be the case that the Merger may be expected to result in an SLC,[129] and that the potential for HEFT to exert a strong competitive constraint on UHB in the counterfactual is limited. In particular, the CMA has had regard to the significant challenges experienced by HEFT since 2012 until the Intervention. The CMA further considers that potential competition concerns have been identified with regard to a small percentage of services provided by the Parties, representing 8-14% of total turnover at most, or 20-30% of the patients (see paragraph 121, table 3).

[128] CMA29, footnote 94.
[129] The level of the CMA's belief in this case as to the likelihood of an SLC is merely on the 'may be the case' standard, rather than on the 'is the case' (more likely than not) standard. Compare the CMA's Guidance on the Exceptions to the duty to refer and undertakings in lieu of reference (OFT1122), paragraph 2.33 and (CMA64), paragraph 33.

Magnitude of the RCBs

213. Table 6 below summarises the nature and magnitude of the RCBs that the CMA has found are likely to arise from the Merger.

Table 6: Summary of nature and magnitude of RCBs

RCB	*Nature of benefit*	*Scale of benefit*
Cross-cutting RCBs		
Improved waiting times for diagnosis and treatment	HEFT meeting national targets for referral to treatment times, cancer waiting times, and time from referral to diagnostic tests, resulting in improved patient access and outcomes and improved quality and safety of care	All HEFT patients
Improved clinical quality monitoring	Changes to monitoring at HEFT has improved safety and quality of care and made it more likely that safety and quality issues will be identified and addressed	All HEFT patients (146,000 clinical errors avoided per year)
Improved governance	improved governance at HEFT has led to safer, higher quality care for patients	All HEFT patients
Improved culture and staff morale	Development of a culture of safety and improvement and higher staff morale at HEFT has led to better care for patients	All HEFT patients
Improved use of clinical IT	Implementation of PICS at HEFT will reduce errors, missed drug doses, provide efficient early warning of deterioration of inpatient care and enable the setting of targets for continuous improvement	All HEFT patients
Workforce improvements	Improved recruitment and retention of staff, creating larger pools of staff and improved education and training of staff will result in reduced spending on locum and agency staff, greater patient access to out of hours services and sub-specialists, a better skilled workforce and higher quality care for patients	All patients across merged trust
Clinical services RCBs		
Neurology	Stabilisation has resulted in improved referral	5,000 to 6,000 HEFT patients

	to treatment times at HEFT	per year
Interventional radiology	Stabilisation has made the service at HEFT save for patients	3,400 HEFT patients per year
Plastic surgery	Stabilisation has resulted in improved referral to treatment times at HEFT	1,200 to 1,600 HEFT patients per year (and 3,500 to 4,000 HEFT patients per year currently treated at UHB)
Gastro-enterology and liver medicine	Proposed reconfiguration of endoscopy services is likely to result in improved patient flow and productivity, reduced waiting times and improved outcomes for some patients and improved patient experience Implementation of community-based and nurse-delivered hepatology service is likely to result in reduced admissions, reduced length of stay, improved patient access and delivery of care closer to home	17,000 patients per year across merged trust 40,000 episodes of follow up care per year across the merged trust
Vascular surgery	Optimising use of hybrid theatre is likely to result in improved patient access and experience Consolidation of subspecialties onto single sites will improve patient outcomes	180 to 200 patients per year across merged trust 130 patients per year across merged trust

Source: CMA analysis, Parties' benefits submission, NHSI's advice on benefits submission, Parties' response to issues letter.

214. The Parties told the CMA that (in relation to the cross-cutting RCBs focussed on improving services HEFT), if the services at HEFT were to see a similar improvement in outcomes to that seen at UHB over the past ten years, then a significant benefit in mortality and morbidity could be expected across all patient groups.

215. NHSI told the CMA that the improvements already delivered at HEFT had likely affected, and would continue to affect,t a substantial majority of the 1.3 million patients treated by HEFT every year and that the number of patients affected by the RCBs would far outnumber those that may be affected by the adverse effects of the SLC.[130]

[130] NHSI response to CMA Issues Letter.

216. NHSI told the CMA that the Intervention had already resulted in reductions in waiting times across HEFT and safer and higher quality services as a result of enhanced clinical quality monitoring, governance, and a culture focused on safety and continual improvement. NHSI told the CMA that it expected these improvements to be sustained and built upon in the years following the Merger.[131]

217. The CMA believes that the Merger is likely to give rise to substantial benefits to patients in the form of improved access to clinical services, particularly in relation to out of hours care, care close to home and access to sub-specialists, and improved safety and quality of care, which is likely to result in improved patient experience and improved patient outcomes, notably reduced time to treatment and reduced mortality and morbidity rates. The CMA therefore believes that the magnitude of the RCBs is significant.

218. The CMA notes that the cross-cutting nature of many of the RCBs, particularly in relation to the implementation of clinical IT systems and processes and a number of workforce improvements, will render it likely that all patients of the merged trust will benefit from those RCBs, and thus are of a large scale.

219. The CMA also believes that there is a high probability of the RCBs occurring, having regard to the expertise of the UHB management, the track-record of UHB in realising a number of benefits since Intervention, and NHSI's advice in this regard. In addition, the CMA considers that the continuing regulatory oversight by NHSI and others will ensure that the RCBs yet to be attained will be realised within a reasonable period after the Merger.

Conclusion on the magnitude of the SLC and the RCBs

220. The CMA has found a realistic prospect that the Merger may be expected to result in an SLC in 25 elective specialties listed in paragraph 104 above. However, the CMA believes thatany adverse effect resulting from this SLC is likely to be significantly constrained by the nature of competition between NHS foundation trusts in general, and specifically as between the Parties.

221. The CMA has found substantial beneficial effects on the health and wellbeing of patients from the RCBs associated with the Merger. In particular, the CMA has given material weight to the reduction in mortality and complications and morbidity for a significant number of patients which are likely to result from the Merger and the wider cross-cutting benefits, which the CMA considers to be extremely significant benefits, in addition to the Merger's likely beneficial impact on patient access and on the hospital experience for a significant

[131] NHSI response to CMA Issues Letter.

number of patients. These, in the CMA’s view, are likely collectively to amount to a substantial improvement in patient care in the LHE.

Conclusion on the application of the RCB exception

222. Taking all the above factors into consideration, the CMA believes that the relevant customer benefits in relation to the creation of the relevant merger situation outweigh the SLC and any adverse effects of the SLC. As such, the CMA believes that it is appropriate for it to exercise its discretion to apply the RCB exception.

Decision

223. Consequently, the CMA 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 and the creation of that situation may be expected to result in a substantial lessening of competition within a market or markets in the United Kingdom. However, pursuant to section 33(2)(c) of the Act, the CMA believes that the relevant customer benefits brought about by the Merger outweigh the substantial lessening of competiton and any adverse effects of the substantial lessening of competition concerned.

224. The Merger will therefore **not be referred** under section 33 of the Act.

Kate Collyer
Deputy Chief Economic Adviser
Competition and Markets Authority
30 August 2017

ANNEX 1 – TABLE OF ELECTIVE SPECIALTIES WITH REFERRAL RATIOS

Overlapping specialty (Treatment Function Code)	FY2013-2015 (Pre-Intervention)						FY2015-2016 (Post-intervention)						SLC
	UHB Anchor			HEFT Anchor			UHB Anchor			HEFT Anchor			
	IP	DC	OP	IP	DC	OP	IP	DC	OP	IP	DC	OP	
	HEFT share	HEFT share	HEFT share	UHB share	UHB share	UHB share	HEFT share	HEFT share	HEFT share	UHB share	UHB share	UHB share	SLC
1. GENERAL SURGERY (100)	31%	30%	19%	27%	35%	24%	20%	25%	16%	42%	24%	24%	Y
2. UROLOGY (101)	28%	28%	35%	42%	48%	34%	27%	27%	36%	50%	41%	32%	Y
3. BREAST SURGERY (103)	67%	30%	35%	28%	14%	31%	41%	29%	39%	21%	19%	31%	Y
4. COLORECTAL SURGERY (104)	25%	26%	71%	70%	85%	76%	31%	40%	85%	71%	87%	74%	Y
5. UPPER GASTROINTESTINAL SURGERY (106)	71%	79%	79%	66%	74%	78%	90%	55%	78%	63%	92%	74%	Y
6. VASCULAR SURGERY (107)	44%	38%	33%	63%	68%	44%	47%	36%	30%	54%	62%	50%	Y
7. TRAUMA & ORTHOPAEDICS (110)	15%	16%	20%	13%	17%	11%	17%	14%	21%	19%	11%	13%	N
8. ENT (120)	26%	35%	37%	54%	59%	52%	28%	38%	40%	59%	54%	50%	Y
9. OPHTHALMOLOGY (130)	3%	13%	15%	7%	10%	13%	7%	14%	15%	5%	10%	11%	N
10. PLASTIC SURGERY (160)	9%	0%	29%	80%	56%	63%	19%	18%	27%	70%	56%	64%	Y
11. THORACIC SURGERY (173)	87%	0%	0%	30%	0%	0%	74%			25%			N
12. PAIN MANAGEMENT (191)	0%	20%	20%	33%	52%	29%		24%	21%		55%	35%	Y
13. GENERAL MEDICINE (300)	11%	0%	6%	0%	0%	9%		1%	11%		13%	3%	N
14. GASTROENTEROLOGY (301)	20%	33%	37%	32%	47%	44%	26%	42%	37%	46%	55%	45%	Y
15. ENDOCRINOLOGY (302)	0%	0%	73%	0%	0%	67%			73%			64%	Y
16. CLINICAL HAEMATOLOGY (303)	27%	20%	29%	36%	48%	54%	38%		38%	54%	45%	61%	Y

Overlapping specialty (Treatment Function Code)	FY2013-2015 (Pre-Intervention)						FY2015-2016 (Post-intervention)						SLC
	UHB Anchor			HEFT Anchor			UHB Anchor			HEFT Anchor			
	IP	DC	OP	IP	DC	OP	IP	DC	OP	IP	DC	OP	
	HEFT share	HEFT share	HEFT share	UHB share	UHB share	UHB share	HEFT share	HEFT share	HEFT share	UHB share	UHB share	UHB share	SLC
17. DIABETIC MEDICINE (307)	0%	0%	34%	0%	0%	24%			41%			40%	Y
18. BLOOD AND MARROW TRANSPLANTATION (308)							100%			100%			N
19. CLINICAL IMMUNOLOGY AND ALLERGY SERVICE (313)					0%								N
20. CARDIOLOGY (320)	21%	35%	46%	59%	41%	71%	21%	39%	39%	60%	40%	63%	Y
21. TRANSIENT ISCHAEMIC ATTACK (329)	0%	0%	37%	0%	0%	51%			28%			86%	Y
22. DERMATOLOGY (330)	33%	22%	30%	63%	33%	31%		17%	32%		33%	30%	N
23. RESPIRATORY MEDICINE (340)	44%	34%	49%	10%	27%	44%	12%	35%	52%	9%		49%	Y
24. RESPIRATORY PHYSIOLOGY (341)	0%	0%	99%	0%	0%	71%			100%			7%	Y
25. NEPHROLOGY (361)	21%	24%	28%	54%	60%	75%	9%	31%	23%	79%	55%	49%	Y
26. MEDICAL ONCOLOGY (370)	27%	14%	42%	51%	10%	31%	46%		30%	69%		74%	Y
27. NEUROLOGY (400)	0%	0%	32%	0%	0%	67%		11%	28%		80%	66%	Y
28. RHEUMATOLOGY (410)	0%	18%	23%	0%	29%	40%		19%	29%		37%	49%	Y
29. GERIATRIC MEDICINE (430)	0%	0%	11%	0%	0%	25%			44%			37%	Y
30. PHYSIOTHERAPY (650)	0%	0%	17%	0%	0%	39%			16%			33%	N
31. OCCUPATIONAL THERAPY (651)	0%	0%	16%	0%	0%	56%			17%			55%	N
32. SPEECH AND LANGUAGE THERAPY (652)	0%	0%	17%	0%	0%	47%			18%			33%	Y
33. DIETETICS (654)	0%	0%	16%	0%	0%	24%			15%			25%	N
34. CLINICAL ONCOLOGY (800)	48%	41%	20%	79%	51%	43%	52%		4%	71%		6%	N
35. INTERVENTIONAL RADIOLOGY (811)	50%	11%	86%	100%	86%	25%	100%	48%	51%	25%	84%	34%	Y
36. CHEMICAL PATHOLOGY (822)	0%	0%	48%	0%	0%	42%			53%			44%	Y

Failed 40% threshold but passed CMFT/UHSM Filters

CMA
Competition & Markets Authority

ANNEX 2 – DETAILED ANALYSIS OF EACH OF THE PROPOSED RELEVANT CUSTOMER BENEFITS

1. This Annex is structured as follows.

   (a) The CMA first summarises the nature and scale of each proposed RCB.

   (b) The CMA then considers whether the proposed RCB is likely to improve outcomes for patients and/or commissioners, whether it may be expected to accrue within a reasonable period from the Merger and whether it is unlikely to accrue without the Merger (or a similar lessening of competition).

   (c) Finally, the CMA concludes whether each proposed RCB is an RCB within the meaning of section 30 of the Act.

2. The CMA first assessed cross-cutting RCBs before considering clinical RCBs.

Cross-cutting RCBs

Improved waiting times for diagnosis and treatment

Proposed RCB

3. The Parties told the CMA that, prior to the Intervention, HEFT was failing to meet a number of operational targets in respect of patient care. The Parties told the CMA that the Intervention had resulted in the improvement in the quality and timeliness of patient care across all specialties.

4. The Parties claim that the Merger will sustain the improvements delivered to date and drive further improvements in the quality of services in a sustainable and equitable manner across the LHE.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

5. NHSI told the CMA that since the Intervention, it had observed measurable improvements for patients of HEFT across several key metrics:

(a) **Improved waiting times from referral to treatment**: HEFT had met the referral to treatment target[1] every month from February 2016 to April 2017 across all elective care specialities. Prior to the Intervention in October 2015, HEFT had not met the target since February 2015.

(b) **Improved waiting times for cancer patients**: HEFT had met the targets for referral to first consultant appointment for most months since the Intervention, and had also met the targets for referral to treatment for all months since the Intervention.[2]

(c) **Improved waiting times for patients needing diagnostics**: HEFT had met the target for performing diagnostic tests for 99% of patients within six weeks of a test request for every month since February 2016. Prior to the Intervention, HEFT had been below target since September 2014.[3]

6. NHSI told the CMA that HEFT's adherence to these national targets demonstrated an improving overall picture of increasing quality, safety and performance at HEFT, which was positively impacting on patients in terms of improved access to services, improved outcomes and an increase in the safety and quality of care.[4]

7. The CMA's view is that the improved waiting times for diagnosis and treatment experienced at HEFT following the Intervention has improved the quality and safety of patient care, resulting in improved patient outcomes, and improved patient access to the services provided by HEFT. The CMA believes that the Merger is likely to sustain the improvements already delivered and deliver further improvements for patients.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

8. NHSI told the CMA that the improvements in the safety and quality of care provided by HEFT had already been delivered by UHB, although there was more work to be done to embed the new ways of working that had been introduced.[5]

[1] NHS providers are required to ensure that 92% of patients begin their consultant-led treatment within 18 weeks of referral to the provider by the patient's GP. The target applies to non-emergency consultant-led cases only.
[2] For referrals in relation to suspected cancer, a range of different waiting time standards apply, including (for urgent referrals) a maximum of two weeks from GP referral to a first appointment with a cancer specialist, and a maximum wait of 62 days from GP referral to first treatment.
[3] NHSI advice, page 24.
[4] NHSI advice, page 23.
[5] NHSI advice, page 22.

9. The CMA notes the improvements already delivered by UHB. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-merger integration and realisation of further benefits. These factors are outlined in paragraphs 172 to 189 of the decision.

10. The CMA's view is that the improvements in waiting times for diagnosis and treatment at HEFT delivered since the Intervention will be consolidated by the Merger and, given the nature and scale of the improvements delivered to date, further improvements are likely and may be expected to accrue within a reasonable period from the Merger.

Is the proposed RCB unlikely to accrue without the Merger?

11. NHSI advised the CMA that the improvements in the safety and quality of care would have been unlikely to accrue without the Merger, because UHB had delivered the stability, structure, governance and financial leadership necessary to enable clinicians to deliver quality care for HEFT patients, and the improvements that had been delivered depended on the specific cohesion and credibility of the UHB leadership team.[6]

12. NHSI further advised that the continued leadership of UHB was necessary to embed the improvements made so far, continue their development and ensure they were not lost.[7]

13. The CMA's view is that the improvements in waiting times for diagnosis and treatment at HEFT delivered to date would have been unlikely without the Intervention, and that the continued presence of UHB, which is dependent on the Merger, is necessary to embed and sustain these improvements and to deliver further improvements.

14. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

15. The CMA believes that improved waiting times for diagnosis and treatment is an RCB. The improvements delivered to date have improved outcomes for patients and would have been unlikely without the Intervention and will be

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[6] NHSI advice, page 34.
[7] NHSI advice, page 34.

consolidated by the Merger. The CMA believes that further improvements are likely and may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Improved clinical quality monitoring

Proposed RCB

16. The Parties told the CMA that following the Intervention, UHB implemented robust structures and processes for measuring, managing and improving clinical quality for patients at HEFT, including:

    (a) monthly root cause analysis meetings chaired by the Chief Executive to analyse incidents and put actions in place to address problems;

    (b) monthly unannounced Board of Directors governance visits to wards and departments, with actions plans to address issues identified;

    (c) monthly clinical quality monitoring group meetings to ensure HEFT was effectively monitoring quality, safety and clinical effectiveness, taking action in response to clinical indicators, benchmarking against other hospitals and achieving quality objectives; and

    (d) weekly meetings of a new Clinical and Professional Review of Incidents Group, chaired by the Interim Medical Director, to meet with staff across both trusts and share actions and learning.

17. NHSI told the CMA that in addition to these new structures, a number of work streams were in progress to align HEFT's quality monitoring processes in specific areas with those currently in place at UHB.[8]

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

18. NHSI told the CMA that the new structures had been well received and embraced by clinical and managerial staff across HEFT, demonstrated by an increase in the overall reporting rate from about 5,000 incidents reported prior to the second quarter of the financial year ended 31 March 2016 to 7,000 in the third quarter of the financial year ended 31 March 2017.[9]

[8] NHSI advice, page 28.
[9] NHSI advice, page 28.

19. NHSI told the CMA that 181 actions were in progress relating to a range of identified issues at HEFT, including infection outbreaks, unexpected deaths after planned surgery, patient falls and delays or errors relating to medication.[10]

20. NHSI told the CMA that these changes represented real improvements for patients, because they had strengthened oversight of safety and quality and made it more likely that risks and problems would be identified and addressed.[11]

21. The CMA's view is that the clinical quality monitoring systems and processes established at HEFT following the Intervention has improved the quality and safety of patient care, resulting in improved patient outcomes. The CMA believes that the Merger is likely to sustain the improvements already delivered and deliver further improvements for patients.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

22. NHSI told the CMA that improvements in safety and quality of care had already been delivered by UHB, although there was more work to be done to embed the new ways of working that had been introduced.[12]

23. The CMA notes the improvements already delivered by UHB. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-merger integration and realisation of further benefits. These factors are outlined in paragraphs 172 to 189 of the decision.

24. The CMA's view is that the improvements in the monitoring of clinical quality at HEFT delivered since the Intervention will be consolidated by the Merger and, given the nature and scale of the improvements delivered to date, further improvements are likely and may be expected to accrue within a reasonable period from the Merger.

Is the proposed RCB unlikely to accrue without the Merger?

25. NHSI advised the CMA that the improvements in the safety and quality of care were unlikely to accrue without the Merger and that the continued presence of

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[10] NHSI advice, page 27.
[11] NHSI advice, page 27.
[12] NHSI advice, page 22.

UHB was necessary to embed the improvements made so far, continue their development and ensure they were not lost.[13]

26. NHSI advised the CMA that the improvements in the safety and quality of care would have been unlikely to accrue without the Merger for the reasons outlined in paragraph 235 above.

27. The CMA's view is that the improvements in the monitoring of clinical quality at HEFT delivered to date would have been unlikely without the Intervention, and that the continued presence of UHB, which is dependent on the Merger is necessary to embed and sustain these improvements and to deliver further improvements.

28. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

29. The CMA believes that improved clinical quality monitoring is an RCB. The improvements delivered to date have improved outcomes for patients and would have been unlikely without the Intervention and will be consolidated by the Merger. The CMA believes that further improvements are likely and may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Improved governance

Proposed RCB

30. The Parties told the CMA that prior to the Intervention, there was a lack of leadership and at accountability at HEFT required to instil a culture of safety and improvement. This was demonstrated by reviews conducted by a number of external parties, including the CQC,[14] the Good Governance Institute (see paragraph 180(a)) and Deloitte.[15]

31. The Parties told the CMA that following the Intervention, UHB had restructured governance at HEFT to clarify roles and accountabilities and

[13] NHSI advice, page 34.
[14] At the end of 2013, a CQC inspection found that the trust required improvement.
[15] In November 2014, an independent review by Deloitte found that the leadership of HEFT did not meet the standards required to govern an NHS foundation trust.

ensure senior managers and the Board had a clear line of sight into performance across all areas. Further, the Parties told the CMA that job descriptions had been composed or clarified for both clinical and non-clinical staff.

32. The Parties claim that the changes to governance at HEFT intend to enable the Board to identify service care quality or delivery issues early and provide remedial action to ensure that problems are addressed and patients receive high quality care.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

33. NHSI told the CMA that it had concerns about persistent deficiencies in leadership and governance at HEFT since late 2013, but that previous regulatory action and initiatives undertaken by HEFT had not proved successful in addressing these issues.[16]

34. NHSI told the CMA that good governance was critical to providing safe, high quality care and had led to better care for HEFT patients.[17]

35. The CMA's view is that the improved governance structures and processes implemented at HEFT following the Intervention has improved the quality and safety of patient care, resulting in improved patient outcomes. The CMA believes that the Merger is likely to sustain the improvements already delivered and deliver further improvements for patients.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

36. NHSI told the CMA that improvements in safety and quality of care had already been delivered by UHB, although there was more work to be done to embed the new ways of working that had been introduced.[18]

37. The CMA notes the improvements already delivered by UHB. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-Merger integration and realisation of further benefits. These factors are outlined in paragraphs 172 to 189.

38. The CMA's view is that the improvements in governance at HEFT delivered since the Intervention will be consolidated by the Merger and, given the nature

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[16] NHSI advice, page 29.
[17] NHSI advice, pages 28 and 29.
[18] NHSI advice, page 22.

and scale of the improvements delivered to date, further improvements are likely and may be expected to accrue within a reasonable period from the Merger.

Is the proposed RCB unlikely to accrue without the Merger?

39. NHSI advised the CMA that the improvements in the safety and quality of care would have been unlikely to accrue without the Merger for the reasons outlined in paragraph 235 above.

40. The CMA's view is that the improvements in governance at HEFT delivered to date would have been unlikely without the Intervention, and that the continued presence of UHB, which is dependent on the Merger, is necessary to embed and sustain these improvements and to deliver further improvements

41. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

42. The CMA believes that improved governance is an RCB. The improvements delivered to date have improved outcomes for patients and would have been unlikely without the Intervention and will be consolidated by the Merger. The CMA believes that further improvements are likely and may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Improved culture and staff morale

Proposed RCB

43. Following the Intervention, UHB has looked to translate into sustainable ways of working and routine behaviours the principles and ideals of highest quality care, prudent and effective financial management and constantly improving performance and a motivated and happy workforce.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

44. NHSI told the CMA that there was emerging evidence of widespread improvements in culture and staff morale at HEFT, which had created an

environment in which staff could continuously strive to address problems and improve quality:

(a) There were increasing numbers of HEFT staff responding positively about the trust in the Friends and Family test (see paragraph 180(f).

(b) The CQC inspected HEFT in September and October 2016 and observed improvements across a range of areas since its previous inspection report.[19] The CQC rated HEFT as 'good' under the well-led domain[20] and noted that:

(i) there was a strong theme of improvement and control from the new leadership of the trust, and staff felt they had been involved in the vision and strategy for the trust;

(ii) managers were seen by staff to be knowledgeable, approachable and supportive;

(iii) there was evidence of a positive culture, with staff encouraged to speak freely and raise concerns so action could be taken; and

(iv) performance information was cascaded to all levels, with staff able to identify risks and mitigating actions.[21]

45. NHSI told the CMA that there was evidence that the improved approach to quality and safety had translated into safer care for patients:

(a) There had been a major improvement in the management of sepsis[22] patients through use of an innovative alert system, which had improved STAT[23] administration of antibiotics in one hour of target time to 79%.

(b) The proportion of patients receiving assessment for venous thromboembolism[24] had improved past the national target of 95% since March 2016.

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[19] The previous inspection was undertaken in December 2014 and the report published in June 2015.
[20] HEFT was not given an overall rating and the other domains were not given a trust level rating, given the differences in scope of the 2014 and 2016 inspections.
[21] NHSI advice, pages 25 and 26.
[22] Sepsis is a life-threatening condition, where the body's response to infection damages other tissues and organs.
[23] STAT is a common medical abbreviation, meaning immediate.
[24] Venous thromboembolism is a blood clot (thrombus) that has formed in a vein, most commonly the deep veins of the legs. If it dislodges from its site of origination and travels along the blood vessel, it is called an embolism. An embolism can cause partial or total blockage of blood flow in the affected vessel.

(c) There had been a steady reduction in the number of urinary tract infections acquired by patients of HEFT.

(d) The number of patients responding to the Friends and Family Test increased by 300% (to 205,822 patients) between the financial years ended 31 March 2015 and 31 March 2016, and 83% of these patients reflected positive on the care and treatment that they had received.[25]

46. NHSI advised the CMA that there were still areas across HEFT that required improvement. For example, NHSI told the CMA that the safe domain for urgent and emergency care at Birmingham Heartlands Hospital was downgraded by the CQC to 'inadequate' in its latest inspection, and HEFT was still not meeting the target to see 95% of patients within four hours in A&E (in common with many other trusts across England and Wales).[26]

47. NHSI told the CMA that there was compelling evidence to indicate that a culture of safety and improvement, along with higher staff morale, led to better care for patients.[27]

48. The CMA's view is that the improved culture and staff morale at HEFT following the Intervention has improved the quality and safety of patient care, resulting in improved patient outcomes. The CMA believes that the Merger is likely to sustain the improvements already delivered and deliver further improvements for patients.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

49. NHSI told the CMA that improvements in safety and quality of care had already been delivered by UHB, although there was more work to be done to embed the new ways of working that had been introduced.[28]

50. The CMA notes the improvements already delivered by UHB. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-merger integration and realisation of further benefits. These factors are outlined in paragraphs 172 to 189 of the decision.

51. The CMA's view is that the improvements in culture and staff morale at HEFT delivered since the Intervention will be consolidated by the Merger and, given the nature and scale of the improvements delivered to date, further

[25] NHSI advice, pages 26 and 27.
[26] NHSI advice, pages 26 and 27.
[27] NHSI advice, page 25.
[28] NHSI advice, page 22.

improvements are likely and may be expected to accrue within a reasonable period from the Merger.

Is the proposed RCB unlikely to accrue without the Merger?

52. NHSI advised the CMA that the improvements in the safety and quality of care would have been unlikely to accrue without the Merger for the reasons outlined in paragraph 235 above.

53. The CMA's view is that the improvements in culture and staff morale at HEFT would have been unlikely without the Intervention and that further improvements are unlikely without the continued presence of UHB, which is dependent on the Merger taking place. The CMA's view is that the improvements in culture and staff morale at HEFT delivered to date would have been unlikely without the Intervention, and that the continued presence of UHB, which is dependent on the Merger, is necessary to embed and sustain these improvements and to deliver further improvements

54. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

55. The CMA believes that improved culture and staff morale is an RCB. The improvements delivered to date have improved outcomes for patients and would have been unlikely without the Intervention and will be consolidated by the Merger. The CMA believes that further improvements are likely and may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Improved use of clinical IT

Proposed RCB

56. UHB is one of the most digitally mature trusts in the NHS[29] and is a Global Digital Exemplar (see footnote 116 above). UHB has developed its own

[29] UHB was ranked second of 239 trusts in the 2015/16 NHS Digital Maturity Survey, with an overall score of 89.3.

tailor-made advanced clinical decision making system, known as the Prescribing and Information Communication System (PICS).[30]

57. In contrast, HEFT is significantly less digitally mature,[31] and does not have a single electronic patient record system and instead, uses a number of different third party and bespoke systems. The Parties told the CMA that the clinical IT systems at HEFT were not fit for purpose and required modernisation.

58. The Parties proposed to implement, and embed the use of, PICS at HEFT within three years of the Merger. The Parties told the CMA that the implementation of PICS presented an opportunity to transform care quality monitoring and achieve the improvements seen at UHB over the past 10 years, resulting in a reduction in missed doses of antibiotics and other drugs, efficient early warning of deterioration inpatient care, improved quality of patient outcome data and reduced mortality rates.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

59. NHSI told the CMA that embedding the use of PICS within the culture at HEFT, as had been achieved at UHB, was likely to result in the following improvements for patients:

(a) **Reduction in and prevention of errors** (as well as enabling management and staff to analyse and rectify problems): NHSI told the CMA that PICS had reduced potential errors by 66% and prevented about 146,000 potential errors each year at UHB.

(b) **Reduction in missed drug doses**: NHSI told the CMA that every drug prescribed or administered was recorded within PICS (as were reasons for non-administration), and that the system provided an audit trail, giving visibility of prescribing and administration practices. NHSI told the CMA that the reduction in missed drug doses at UHB had led to improvements in mortality rates, with particular improvements observed following the introduction of clinical dashboards and root cause analysis meetings that relied on PICS data.

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[30] PICS is an electronic, rules based, decision support system which operates in all inpatient, outpatient and day case areas. It supports full e-prescribing and drug administration for both routine and chemotherapy treatments, requesting and reporting of laboratory investigations, clinical observations and assessments and extensive order communications, including imaging requests and internal referrals. The PICS system is available for purchase by other healthcare providers.

[31] HEFT was ranked 182nd in the 2015/16 NHS Digital Maturity Survey, with an overall score of 53.3.

(c) **Efficient early warning of deterioration of inpatient care**: NHSI told the CMA that PICs could be used to set up alerts for individual physiological parameters, enabling clinicians to intervene earlier and potentially avoid deterioration in their patients' condition.

(d) **Setting targets for continuous improvement**: NHSI told the CMA that UHB mapped its performance against a clinical dashboard of indicators, and that the number and complexity of indicators used by UHB to monitor and improve performance was rapidly increasing in line with the trust's focus on continuous improvement.[32]

60. The CMA's view is that the improved use of clinical IT at HEFT is likely to lead to improvements in the quality and safety of patient care.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

61. The Parties told the CMA that in planning for the implementation of PICs at HEFT, they had identified haematology and oncology as potential departments for early adoption of the system (to enable electronic prescribing to be implemented for chemotherapy), and then planned to roll out across other departments in a staged manner.

62. The Parties told the CMA that the staged rollout would allow for clinical champions of the new system to be developed and learning to be disseminated through the organisation in an iterative way, and that this approach was undertaken successfully at UHB.

63. NHSI advised the CMA that the Merger was likely to result in successful implementation of the PICS system at HEFT and use of the system to achieve improvements for patients within a reasonable period (ie three years) from the Merger. NHSI told the CMA that the achievements at UHB in respect of the use of clinical IT were replicable at HEFT, particularly given UHB's experience with PICS and UHB's proposal to implement the system at HEFT within three years of the Merger.[33]

64. NHSI told the CMA that commissioners also believed that the improvements for patients that would result from the use of clinical IT would be delivered based on UHB's track record of continuous quality improvement.[34]

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[32] NHSI advice, pages 38 to 40.
[33] NHSI advice, page 43.
[34] NHSI advice, page 44.

65. The CMA therefore believes that UHB is likely to implement PICS at HEFT within three years of the Merger and ensure that the system is appropriately used to drive continuous improvement in the quality and safety of care provided to patients of HEFT.

66. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-merger integration and realisation of benefits. These factors are outlined in paragraphs 172 to 189.

Is the proposed RCB unlikely to accrue without the Merger?

67. NHSI advised the CMA that the improvements in clinical IT were unlikely to accrue without the continued leadership of UHB, as UHB was uniquely placed, given the significant improvements achieved for its patients, to lead the implementation of PICS at HEFT.[35]

68. NHSI told the CMA that although the PICS system was available for purchase and could therefore be implemented by HEFT in the absence of the Merger, the Merger would facilitate the transformation necessary to embed the use of the system within HEFT and ensure that it was used not just to collect and analyse data, but also to address clinical issues and improve the quality of care for patients.[36]

69. The CMA's view is that the implementation of PICS and the embedding of the use of clinical IT to foster a culture of continuous improvement at HEFT requires the continued leadership of UHB, which is dependent on the Merger.

70. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205.

Is the proposed RCB an RCB within the meaning of the Act?

71. The CMA's view is that the improved use of clinical IT is an RCB, as it is likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the Merger and is unlikely to accrue without it.

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[35] NHSI advice, page 44.
[36] NHSI advice, page 44.

Workforce improvements

Proposed RCB

72. The Parties told the CMA that UHB and HEFT had a combined workforce of approximately 20,000 staff (covering clinical, clinical support and back office functions) and that they incurred significant transaction costs as staff moved between the two organisations, including time lost to organisational induction, mandatory training and acclimatisation with different IT systems.

73. The Parties claim that the Merger will result in improvements for patients across services due to the opportunities created by combining workforces:

    (a) Improved recruitment and retention of high quality, appropriately skilled staff, thereby reducing reliance on locum and agency staff.

    (b) Creating larger pools of staff for particular services to enable improved out of hours and on-call working arrangements that would allow increased sub-specialisation and support the move to seven-day services.

    (c) Improved education and training for clinical and non-clinical staff through standardised training programmes and wider offer of training opportunities across the merged trust.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

74. NHSI told the CMA that UHB had already started to deliver workforce improvements at HEFT, such as its successful recruitment of posts in neurology and interventional radiology.

75. NHSI said that the opportunities created by combining the workforce of the two trusts were likely to lead to real improvements for patients:

    (a) NHSI told the CMA that UHB's strong reputation, the opportunities for professional development offered by its services and its track record in recruitment would enhance the merged trusts ability to fill vacant roles at HEFT and would likely reduce spending on locum and agency staff.

    (b) NHSI told the CMA that the larger combined workforce pool was likely to offer greater opportunities for patients to access to subspecialists and out-of-hours services that they may not have had previously, as well as providing enhanced training opportunities for staff.

(c) NHSI told the CMA that UHB had a positive attitude to training and that it expected UHB to instil the same positive approach at HEFT, resulting in a better skilled workforce and higher quality care for patients.[37]

76. The CMA therefore believes that the proposed workforce improvements are likely to improve patient access to the services provided by the merged trust and result in higher quality care. The CMA's view is that the workforce improvements experienced at HEFT following the Intervention has improved the quality and safety of patient care, resulting in improved patient outcomes,. The CMA believes that the Merger is likely to sustain the improvements already delivered and deliver further improvements for patients.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

77. NHSI said that the improvements from a combined workforce, as set out in the previous chapter, were likely to be delivered in a reasonable timeframe.[38]

78. NHSI told the CMA that its view was based on UHB's track record and the improvements it had already started to implement at HEFT, such as its successful recruitment of posts in neurology and interventional radiology.[39]

79. The CMA's view is that the workforce improvements at HEFT delivered since the Intervention will be consolidated by the Merger and, given the nature and scale of the improvements delivered to date, further improvements are likely and may be expected to accrue within a reasonable period from the Merger. The CMA believes that UHB is well placed to implement its proposed workforce improvements in a timely manner following the Merger due to its experience in delivering such large-scale change, demonstrated by stabilising a number of clinical services in need of urgent recruitment post-Intervention.

80. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-merger integration and realisation of benefits. These factors are outlined in paragraphs 172 to 189.

Is the proposed RCB unlikely to accrue without the Merger?

81. NHSI advised the CMA that the improvements already made at HEFT in respect of recruitment and workforce culture suggested that further

[37] NHSI advice, pages 41 to 42.
[38] NHSI advice, page 44.
[39] NHSI advice, page 44.

improvements could not be achieved without the Merger, including UHB using its proven ability to recruit highly-qualified staff.[40]

82. The CMA's view is that the workforce improvements at HEFT delivered to date would have been unlikely without the Intervention, and that the continued presence of UHB, which is dependent on the Merger, is necessary to embed and sustain these improvements and to deliver further improvements

83. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205.

Is the proposed RCB an RCB within the meaning of the Act?

84. The CMA's view is that workforce improvements is an RCB. The improvements delivered to date have improved outcomes for patients and would have been unlikely without the Intervention and will be consolidated by the Merger. The CMA believes that further improvements are likely and may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Clinical services RCBs

Neurology

Proposed RCB

85. Neurology is the study and treatment of nervous system disorders, such as multiple sclerosis and epilepsy.

86. The Parties told the CMA that prior to the Intervention, the neurology service at HEFT was at risk, as it operated in isolation to the hub and spoke model providing neurology services across the West Midlands, where there were established referral pathways for complex care to the designated specialist hub (UHB). The Parties told the CMA that the HEFT service was inconsistent with and of lower quality than all other regional neurology provision.

87. In order to stabilise the service, the Parties have recruited a neurology consultant into a joint post working for both UHB and HEFT. The Parties also intend to shortly commence further recruitment for joint points for neurology

[40] NHSI advice, page 45.

consultants and specialist nurses, in order to enable the trusts to run nurse-led clinics and to implement integrated pathways and joint continuing professional development (**CPD**) and governance arrangements.

88. The Parties expect the integration of HEFT into the existing hub and spoke network to improve the quality of care, provide a more robust model of care delivery, improve patient access to the service, result in more robust governance and CPD functions and improve prospects for further recruitment.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

89. NHSI told the CMA that since UHB began its work to stabilise the neurology service at HEFT, there had been an improvement in referral to treatment times (in contrast to the aggregate performance of other hospitals in the region where performance had declined).[41]

90. NHSI told the CMA that approximately 5,000 to 6,000 neurology patients treated at HEFT each year could benefit from a better service, including through reduced waiting times.[42]

91. The CMA's view is that the stabilisation of the neurology service at HEFT has improved the quality of the service provided to neurology patients, resulting in improved patient outcomes. The CMA believes that the Merger is likely to sustain the improvements already delivered and deliver further improvements for patients.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

92. NHSI told the CMA that improvements in safety and quality of care had already been delivered by UHB, although there was more work to be done to embed the new ways of working that had been introduced.[43]

93. The CMA notes the improvements already delivered by UHB in relation to the neurology service provided by HEFT. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-merger integration and realisation of further benefits. These factors are outlined in paragraphs 172 to 189 of the decision.

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[41] NHSI advice, page 31.
[42] NHSI advice, page 31.
[43] NHSI advice, page 22.

94. The CMA believes that the improvements delivered in the neurology service at HEFT since the Intervention will be consolidated by the Merger and, given the nature and scale of the improvements delivered to date, further improvements are likely and may be expected to accrue within a reasonable period from the Merger.

Is the proposed RCB unlikely to accrue without the Merger?

95. The Parties said that the neurology service problems at HEFT had been present for some time and had not been addressed until the Intervention.

96. The Parties expect that the Merger will ensure the continued development of the service in line with regional neurology provision and the enhanced benefits that can be delivered from an integrated workforce.

97. NHSI advised the CMA that the improvements in the safety and quality of care would have been unlikely to accrue without the Merger for the reasons outlined in paragraph 233 above.

98. NHSI said that for those services at HEFT recently stabilised by UHB (ie neurology, interventional radiology and plastic surgery), the services would likely return to being understaffed and sub-optimal absent the Merger.[44]

99. The CMA's view is that the improvements to the neurology service at HEFT delivered to date would have been unlikely without the Intervention, and that the continued presence of UHB, which is dependent on the Merger, is necessary to embed and sustain these improvements and to deliver further improvements.

100. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205.

Is the proposed RCB an RCB within the meaning of the Act?

101. The CMA therefore believes that the stabilisation of the neurology service at HEFT is an RCB. The improvements delivered to date have improved outcomes for patients and would have been unlikely without the Intervention and will be consolidated by the Merger. The CMA believes that further

[44] NHSI response to issues letter, page 7.

improvements are likely and may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Interventional radiology

Proposed RCB

102. Radiology involves diagnosing and treating a wide range of conditions and diseases. Interventional radiology is a sub-specialty of radiology that uses minimally invasive image-guided techniques. Interventional radiology is used in conjunction with other specialities to provide surgery without having to use an open surgical procedure, which has resulted in improved outcomes and reductions in length of stay for patients.

103. The Parties told the CMA that prior to the Intervention, staff shortages placed the interventional radiology service at HEFT at risk. The Parties told the CMA that patients presenting at HEFT were being transferred to UHB for interventions, leading to a change in their clinical team, increased length of stay and potential risk of deterioration in clinical condition due to the transfer.

104. The parties told the CMA that UHB had a large and highly specialised interventional radiology service, which attracted staff and enabled UHB to develop the service in response to clinical need.

105. Following the Intervention, the Parties agreed that the urgency of the situation demanded action prior to any Merger decision. To date, the Parties have undertaken the following actions:

   (a) The divisional team at HEFT has been instructed to proceed with recruitment.[45]

   (b) The HEFT Deputy Medical Director has met with teams at both sites to identify options for improving recruitment.

   (c) Refurbishment of the main interventional radiology facility at Birmingham Heartlands Hospital is currently in progress.

106. The Parties expect the Merger to remove organisational barriers and enhance service delivery at HEFT by developing sub-specialist services, which will address current staff recruitment issues.

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[45] The Parties agreed to include a fellowship or sub-specialty training opportunity with access to UHB facilities and expertise to enhance the attractiveness of the posts. Two consultants, to fill joint posts, have been successfully recruited so far and will be in place in October 2017 and January 2018. However, while recruiting was underway, an existing interventional radiology consultant at HEFT resigned.

107. The Parties expect the proposed service change to:

(a) secure the delivery of care in a number of services which depend on access to interventional radiology, such as urology, maternity and gynaecology and trauma and general surgery;

(b) reduce length of stay for some patient groups;

(c) improve the quality and safety of care; and

(d) result in the avoidance of transfers of patients from HEFT to UHB.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

108. NHSI told the CMA that following the Intervention, the interventional radiology service at HEFT was now safe, but that it required ongoing work from management to ensure that the necessary changes were made.[46]

109. The CMA's view is that the stabilisation of the interventional radiology service at HEFT following the Intervention has improved the quality of the service provided to approximately 3,400 neurology patients each year, resulting in improved patient outcomes, and improved patient access to the services provided by HEFT. The CMA believes that the Merger is likely to sustain the improvements already delivered and deliver further improvements for patients.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

110. NHSI told the CMA that improvements in safety and quality of care had already been delivered by UHB, although there was more work to be done to embed the new ways of working that had been introduced.[47]

111. The CMA notes the improvements already delivered by UHB in relation to the interventional radiology service provided by HEFT. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-merger integration and realisation of further benefits. These factors are outlined in paragraphs 172 to 189.

112. The CMA's view is that the improvements in the interventional radiology service at HEFT delivered since the Intervention will be consolidated by the Merger and, given the nature and scale of the improvements delivered to

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[46] NHSI advice, page 32.
[47] NHSI advice, page 22.

date, further improvements are likely and may be expected to accrue within a reasonable period from the Merger.

Is the proposed RCB unlikely to accrue without the Merger?

113. The Parties told the CMA that interventional radiology trainees approaching the end of their training have a broad choice of posts to apply for (as there is a shortage of available consultants) and due to the issues with the service at HEFT, trainees in the local area were more likely to apply for posts at UHB.

114. The Parties argued that the Merger will result in recruitment into a joint interventional radiology service, effectively enabling the merged trust to rebuild the service at HEFT.

115. NHSI advised the CMA that the improvements in the safety and quality of care would have been unlikely to accrue without the Merger for the reasons outlined in paragraph 232.

116. NHSI said that for those services at HEFT recently stabilised by UHB (ie neurology, interventional radiology and plastic surgery), the services would likely return to being understaffed and sub-optimal absent the Merger.[48]

117. The CMA believes that the improvements to the interventional radiology service at HEFT delivered to date would have been unlikely without the Intervention, and that the continued presence of UHB, which is dependent on the Merger, is necessary to embed and sustain these improvements and to deliver further improvements.

118. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205.

Is the proposed RCB an RCB within the meaning of the Act?

119. The CMA's view is that the stabilisation of the interventional radiology service at HEFT is an RCB. The improvements delivered to date have improved outcomes for patients and would have been unlikely without the Intervention and will be consolidated by the Merger. The CMA believes that further

[48] NHSI response to Issues Letter.

improvements are likely and may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Plastic surgery

Proposed RCB

120. Plastic surgery is a branch of surgery specialising in repairing and reconstructing missing or damaged tissue and skin, usually because of surgery, illness, injury or an abnormality present from birth.

121. HEFT provides a small plastic surgery service, which is part of its general surgery service (sitting alongside breast surgery). The Parties submitted that this service at HEFT was unlikely to be sustainable in its present form due to recruitment and training challenges.[49] The Parties further stated that although the service delivered a good service in a limited range of clinical areas and supported some of the other clinical HEFT services, there were large areas of specialty care that were not able to benefit from the relatively small team.

122. UHB is now providing support to HEFT and has agreed a plan to jointly recruit more consultants into the plastic surgery service. The Parties expect that the Merger will enable the implementation of a hub and spoke model, in line with regional service provision, whereby UHB is the hub provider and the other hospitals, including HEFT, are networked to UHB.[50]

123. The Parties told the CMA that the proposed service change would improve patient access to the service and improve the range of services offered by HEFT, as well as the clinical pathways to those services.[51]

Is the proposed RCB likely to improve patient outcomes?

124. NHSI said that since stabilisation of the plastic surgery service at HEFT began, there had been an improvement in referral to treatment times (in contrast to the aggregate performance of other hospitals in the region where performance has declined).[52]

[49] The service at HEFT has always been provided by two whole time equivalent (WTE) substantive posts, but one surgeon has resigned and a replacement post has been advertised.
[50] UHB is one of the largest plastics centres in the UK, providing specialist tertiary services for the West Midlands and secondary care for Central and South Birmingham. UHB also provides a spoke service to other geographical areas and trusts including Wolverhampton, Walsall, Burton, Hereford and Worcester.
[51] The Parties told the CMA that the proposed service change would particularly benefit trauma patients with severe lower limb injuries (approximately 40 patients per year), who currently suffer from delays in referral pathways, but under the new arrangements would have direct and timely access to multidisciplinary management.
[52] NHSI advice, page 33.

125. The CMA's view is that the stabilisation of the plastic surgery service at HEFT following the Intervention has improved the quality and safety of patient care, resulting in improved patient outcomes, The CMA believes that the Merger is likely to sustain the improvements already delivered and deliver further improvements for patients.

126. The CMA believes that the proposed service change will benefit approximately 1,200 to 1,600 plastic surgery patients currently treated at HEFT each year, and some of the approximately 4,000 HEFT patients referred to UHB due to lack of capacity at HEFT.[53]

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

127. NHSI told the CMA that improvements in safety and quality of care had already been delivered by UHB, although there was more work to be done to embed the new ways of working that had been introduced.[54]

128. The CMA notes the improvements already delivered by UHB in relation to the plastic surgery service provided by HEFT. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-merger integration and realisation of further benefits. These factors are outlined in paragraphs 172 to 189.

129. The CMA's view is that the improvements in the plastic surgery service at HEFT delivered since the Intervention will be consolidated by the Merger and, given the nature and scale of the improvements delivered to date, further improvements are likely and may be expected to accrue within a reasonable period from the Merger.

Is the proposed RCB unlikely to accrue without the Merger?

130. The Parties argue that the Merger (and the subsequent integration of the plastic surgery service) will enable HEFT to address the recruitment challenges more quickly than currently, as the implementation of new surgical services by expansion of the existing workforce at UHB and development of cross-trust delivery will be deliverable in a shorter timescale than appointing new staff and growing the service in a standalone manner at HEFT.

131. The Parties also expect that an integrated service would improve the prospects for training placements for both deanery-funded trainees and

[53] NHSI advice, page 33.
[54] NHSI advice, page 22.

international fellowship opportunities through the established UHB programme.

132. NHSI advised the CMA that the improvements in the safety and quality of care would have been unlikely to accrue without the Merger for the reasons outlined in paragraph 232.

133. NHSI said that for those services at HEFT recently stabilised by UHB (ie neurology, interventional radiology and plastic surgery), the services would likely return to being understaffed and sub-optimal absent the Merger.[55]

134. The CMA's view is that the improvements to the plastic surgery service at HEFT delivered to date would have been unlikely without the Intervention, and that the continued presence of UHB, which is dependent on the Merger, is necessary to embed and sustain these improvements and to deliver further improvements

135. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205.

Is the proposed RCB an RCB within the meaning of the Act?

136. The CMA believes that the stabilisation of the plastic surgery at HEFT is an RCB. The improvements delivered to date have improved outcomes for patients and would have been unlikely without the Intervention and will be consolidated by the Merger. The CMA believes that further improvements are likely and may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Gastroenterology and liver medicine

Proposed RCB

137. Gastroenterology is the study of the digestive system and its disorders. Hepatology is the study of diseases that affect the liver, gallbladder, biliary tree and pancreas and has developed as a sub-speciality of gastroenterology.

138. Gastroenterology and hepatology are delivered as separate specialities at UHB, with hepatology and specialist liver transplant services delivered via a

[55] NHSI response to issues letter, page 7.

dedicated specialist Liver and Hepato Pancreato Biliary Unit. HEFT does not have a specialist liver service and hepatology is delivered as part of the gastroenterology service.

139. The Parties told the CMA that both HEFT and UHB's capacity in gastroenterology (and particularly in endoscopy)[56] was over saturated and that both trusts were dependent on waiting list initiatives and extended operating hours to meet current demand.

140. To address these concerns, the Parties propose to:

(a) centralise endoscopic ultrasonography work in gastroenterology at one acute site (to be determined);

(b) deliver outpatient endoscopy and screening services from a remote site (or from Solihull Hospital);

(c) deliver elective inpatient and day case endoscopy services from Birmingham Heartlands, Good Hope and Solihull Hospital;

(d) streamline and shorten cancer pathways; and

(e) work with consultants to create more flexible ways of working across all of the sites across the merged trust.

141. The Parties expect these proposals to benefit 17,000 endoscopy patients per year.[57]

142. The Parties also intend to implement at HEFT a community based and nurse-led hepatology service, similar to that provided at UHB. The service would use data to identify and separate patients with chronic liver from the general gastroenterology clinic population, and these patients (approximately 2,500 per year) would be seen at specialist liver clinics at Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital).[58]

143. The Parties expect their proposals to improve patient access to gastroenterology and hepatology services and shorten patient pathways, thereby enabling earlier intervention and resulting in improved outcomes.

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[56] Endoscopy refers to the examination of the interior of a hollow organ or cavity of the body using an endoscope, (a long, thin, flexible tube that has a light source and camera at one end). An endoscopy can be used to investigate symptoms, remove a small sample of tissue for further analysis (biopsy) and to help perform surgery.
[57] NHSI advice, page 47.
[58] NHSI advice, page 47.

Is the proposed RCB likely to improve patient outcomes?

144. NHSI advised the CMA that in relation to the proposed reconfiguration of endoscopy services:

(a) the centralisation of endoscopic ultrasonography work onto one acute site and offering outpatient and screening endoscopy services from a dedicated site was likely to result in improved patient flow and productivity for these services, reduced waiting times for some patients and improved patient experience;

(b) streamlined and shorter patient pathways for cancer patients had the potential to enable earlier intervention and for patients to see improvements in outcomes as a result of being correctly diagnosed treated sooner;

(c) it expected workforce related proposals to be more attractive to staff when led by UHB and recruitment to be more successful when involving joint appointments; and

(d) these changes were likely to mean improved experience for all patients requiring endoscopy service and improved access to care (associated with reduced delays) and earlier intervention, which could improve outcomes for some patients.[59]

145. NHSI advised the CMA that in relation to the community based and nurse-delivered ambulatory hepatology service:

(a) the implementation of an ambulatory model of care would deliver improvements for patients associated with reduced admissions and reduced length of stay from better management of these patients in the community; and

(b) delivering care to patients with chronic liver disease in specialist liver clinics at all three HEFT sites would improve patient access and enable care to be delivered closer to patients' homes, and reduce pressure on the tertiary unit at UHB.[60]

146. The CMA's view is that the Parties' proposed reconfiguration of gastroenterology and hepatology services is likely to result in improved patient

[59] NHSI advice, page 47.
[60] NHSI advice, page 48.

access to these services, resulting in reduced time to treatment and earlier intervention, and therefore contributing to improved patient outcomes.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

147. The CMA understands that that the Parties expect their proposals for endoscopy service to be achieved within three years from the merger. To date, the Parties have developed an indicative timeline with key milestones, such as agreeing consultant job plans, designing clinical rotas, identifying clinical protocols requiring harmonisation, mapping current and future state patient pathways and models of care and commencing work on a business case for service delivery options.[61]

148. NHSI told the CMA that:

(a) the improvements from delivering the endoscopy proposals were likely to be achieved within a reasonable timeframe; and

(c) while further work was necessary to confirm future timeframes for approval of business cases and implementation of the service delivery model, it was satisfied that work would commence sufficiently quickly after merger such that implementation within three years appeared credible and feasible.[62]

149. The Parties have set out the steps that they propose to take to implement the community based and nurse-delivered ambulatory hepatology service:

(a) Review consultant and specialist nurse job plans across the trusts to support the development of a business case to restructure existing plans to facilitate cross-site working, and future recruitment needs.

(b) Establish off-site clinics and services that can be delivered closer to the community.

(c) Restructure the management of this service, including the appointment of a Director of Liver Services responsible for strategy and planning.

150. The Parties have established a project group, including managerial and clinical representation from both trusts, to determine the deliverables of the proposal. The group expects to shortly have developed a projected timeframe

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[61] NHSI advice, page 50.
[62] NHSI advice, page 50.

for delivery, identified the relevant stakeholders who need to be involved in implementing the proposals, and be ready to develop the requisite business cases.[63]

151. The Parties expect the proposal to be delivered in around 18 months after the Merger.

152. NHSI advised that the Parties' community based and nurse-delivered ambulatory hepatology service proposal was likely to be delivered within a reasonable timeframe from the merger, because:

   (d) significant development work had already been undertaken and continued to progress at pace;

   (e) the proposals were clinically led and developed;

   (f) the Parties were in a state of readiness to develop business cases; and

   (g) UHB had a strong track record of implementing service change.[64]

153. The CMA believes that the parties are well placed to deliver their proposals for gastroenterology and hepatology following the merger, given the planning activity undertaken to date and the capability and experience of UHB in implementing large scale service change.

154. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-merger integration and realisation of further benefits. These factors are outlined in paragraphs 172 to 189.

155. The CMA's view is that the Parties' proposed reconfiguration of gastroenterology and hepatology services may be expected to accrue within a reasonable period from the Merger.

Is the proposed RCB unlikely to accrue without the Merger?

156. The Parties argue that the historical division of services between HEFT and UHB has precluded effective development of clinical networks, and the volume of work and capacity constraints affecting HEFT has resulted in a lack of investment and development for the service and its patients.

157. The Parties claim that the Merger will provide the organisational leadership, vision and managerial experience necessary to develop the proposed

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[63] NHSI advice, page 51.
[64] NHSI advice, page 51.

integrated service network and model, and that in the absence of the Merger, services would continue to develop in isolation.

158. NHSI advised the CMA that, given the scale of the reconfiguration proposed and practical difficulties associated with implementing the proposals in the absence of the Merger, the endoscopy proposals were likely to be facilitated and achieved more quickly through merger:

(i) The services at both UHB and HEFT were currently operating at capacity and were using waiting list initiatives and extended operating hours to meet current demand.

(ii) The historical division of services between UHB and HEFY had so far precluded the effective development of clinical networks.

(iii) Reconfiguration of the endoscopy service without merger would likely require the Parties entering some kind of partnership or similar arrangement, and achieving the improvements associated with the proposed reconfiguration in this manner would be more difficult than achieving them through a merger.[65][66]

159. NHSI advised the CMA that the improvements associated with the Parties' ambulatory hepatology proposal were unlikely to be delivered without the Merger or a similar lessening of competition due to HEFT's historical inability to successfully develop a specialist liver service and to separate liver patients from the wider gastroenterology clinic cohorts.[67]

160. NHSI told the CMA that UHB had successfully implemented an ambulatory model of care and therefore, it was well placed to expand this model of care to HEFT. Further, NHSI considered that the implementation of PICS at HEFT would facilitate the identification of patients with chronic liver disease, so they could be directed to the planned specialist liver clinics.[68]

161. The CMA's view is that the proposed reconfiguration of endoscopy services is likely to delivered more quickly as a result of the Merger and the ambulatory hepatology proposal is unlikely to be delivered without the leadership and experience of UHB, which is dependent on the Merger.

[65] For example, appropriate governance and reporting arrangements for staff working across multiple sites would be likely to be more difficult to put in place where there were two organisations and two sets of service management teams that would need to agree and cooperate to make the partnership work.
[66] NHSI advice, page 52.
[67] NHSI advice, page 52.
[68] NHSI advice, page 53.

162. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205.

Is the proposed RCB an RCB within the meaning of the Act?

163. The CMA therefore believes that the claimed benefits arising from the proposed reconfiguration of gastroenterology and hepatology services are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without it.

Diabetes

164. Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are two main types of diabetes:

(a) Type 1 diabetes, where the body's immune system attacks and destroys the cells that produce insulin, a hormone that allows the body to maintain the appropriate level of blood sugar.

(h) Type 2 diabetes, where the body does not produce enough insulin, or the body's cells do not react to insulin.

165. The Parties told the CMA that the diabetes services provided by UHB and HEFT were in urgent need of improvement and development, in order to meet current and future demand, and if significant change was not implemented, there would be a decline in the quality of care and corresponding increases in morbidity and complication rates.

166. The Parties claim that there needs to be growth in the size of the diabetes service and a change in delivery to place greater emphasis on community-based care. The Parties expect the development of more effective community services to reduce the volume of avoidable hospital admissions, thus improving the quality of care for patients and reducing morbidity and complications rates.

167. NHSI told the CMA that the Parties' proposals in relation to diabetes, cardiology and nephrology represented the potential wider opportunities created by the Merger. NHSI told the CMA that they did not assess the

Parties' proposals against the CMA framework for assessing RCBs, as the proposals were in an early stage of development.[69]

168. The CMA's view is that the proposed reconfiguration of the diabetes service to be provided by the merged trust is likely to improve patient outcomes, but the CMA is unable, at this stage, to assess whether it can be expected to accrue within a reasonable period from the Merger. Therefore, the CMA does not think that the proposed RCB is an RCB within the meaning of the Act.

Vascular surgery

Proposed RCB

169. Vascular surgery is a surgical subspecialty in which diseases of the vascular system, or arteries and veins are managed by medical therapy, minimally invasive catheter procedures and surgical reconstruction.

170. Both UHB and HEFT operate arterial surgical centres (hubs) networked with other hospitals and both trusts achieve good patient outcomes. HEFT has a hybrid theatre, which combines an operating room with advanced imaging technology, enabling consultants to perform open and endovascular surgery without having to transfer to a vascular theatre). The theatre is currently utilised four days per week and there is capacity to expand the service.

171. The parties propose to integrate their services, thereby improving patient access to vascular surgery, and in particular, the hybrid theatre at HEFT, and reducing time to surgery, resulting in reduced length of stay. The parties also intend to reconfigure some elements of the service to enable each trust to focus on their areas of specialism (eg UHB specialises in open aneurysm surgery[70] and lower limb revascularisation[71] and HEFT specialises in endovascular aortic aneurysm surgery).[72]

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

172. NHSI advised the CMA that the integration of vascular surgery services across the merged trust would likely result in greater productivity and better

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[69] NHSI advice, page 54.
[70] Open aneurysm surgery refers to open surgery to repair the swelling of an artery or cardiac chamber.
[71] Lower limb revascularisation is the restoration of blood circulation to the leg, achieved by unblocking obstructed or disrupted blood vessels or by surgically implanting replacements.
[72] Endovascular aortic aneurysm surgery is a minimally invasive procedure (performed using imaging guidance) to repair the swelling of an artery or cardiac chamber.

patient experience due to increased access to the hybrid theatre for a wider population, meaning UHB patients who need to progress their interventional radiology procedure to open surgery would not be transferred as an emergency to a surgical theatre.[73]

173. NHSI also said that the consolidation of subspecialties on a single site would result in the concentration of patient volumes on fewer sites, enabling clinicians to develop their expertise, resulting in improved patient outcomes.[74]

174. The CMA's view is that the Parties' proposed reconfiguration of vascular surgery is likely to result in improved patient access to these services, resulting in reduced time to surgery and improved patient outcomes.

175. The CMA understands that the proposal to increase access to the hybrid theatre will benefit 180 to 200 patients each year, and the consolidation of subspecialties on to a single site would benefit 130 patients requiring lower limb revascularisation each year.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

176. The Parties told the CMA that since the Intervention, the Parties' vascular surgery teams had begun aligning clinical policies. Following the merger, the parties intend to undertake a process of joint governance and quality review, which will lead to the harmonisation of pathways and protocols and the reorganisation of some subspecialties, and establish a staffing model and expectations for cross site working, which they expect will take six months.

177. NHSI said that the Parties' proposals to optimise access to the hybrid theatre and the organisation of subspecialties were likely to be delivered within a reasonable timeframe, as the teams were already engaged in the process and clinicians were working together on clinically led proposals and plans.[75]

178. The CMA believes that the parties are well placed to deliver their proposals for vascular surgery following the merger, given the planning activity undertaken to date and the capability and experience of UHB in implementing such service change.

[73] NHSI advice, page 49.
[74] NHSI advice, page 49.
[75] NHSI advice, page 51.

179. The CMA also believes that there are a number of additional considerations that support the Parties' plans for post-merger integration and realisation of further benefits. These factors are outlined in paragraphs 172 to 189.

180. The CMA therefore believes that the Parties' proposed reconfiguration of vascular surgery may be expected to accrue within a reasonable period from the Merger.

Is the proposed RCB unlikely to accrue without the Merger?

181. The parties told the CMA that in the absence of the Merger:

   (i) it was unlikely that a separate organisational structure would bring the necessary focus to clinical teams to working in a unified way for the development of vascular services in line with national guidelines (ie the consolidation of sites); and

   (ii) it was likely that either the service provided by UHB or HEFT would need to be moved in its entirety to consolidate into a larger unit.

182. The Parties told the CMA that the Merger would allow a single organisation to deliver all aspects of vascular surgery in appropriate volumes, using current infrastructure and technology to maximise effectiveness whilst maintaining access to the specialty at all current sites.

183. NHSI advised the CMA that the Parties' vascular surgery proposals and their resulting benefits for patients were unlikely to be delivered without the Merger, as the wide-ranging reorganisation of subspecialties to make the most of the particular strengths of each trust was likely to be too difficult to implement under separate organisational structures.[76]

184. NHSI also said that although some joint working could be delivered without the Merger, this would require the Parties to enter into partnership arrangements to support different ways of working and service delivery, which would not deliver the same extent of improvements for patients. NHSI found that it was unlikely that the scale of integration envisaged by the Parties would achieved by these kinds of arrangements.[77]

185. The CMA's view is that the proposed reconfiguration of vascular surgery is unlikely to be implemented timely and effectively through any form of

[76] NHSI advice, page 53.
[77] NHSI advice, page 53.

collaboration other than the Merger due to the nature and scale of the proposed service change.

186. There are also a number of considerations that are relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that, absent the Merger, effective implementation of the proposed changes outlined in the Parties' benefit submission is unlikely. These considerations are outlined in paragraphs 190 to 205.

Is the proposed RCB an RCB within the meaning of the Act?

187. The CMA's view is that the claimed benefits arising from the proposed reconfiguration of vascular surgery are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Cardiology

188. Cardiology is a branch of medicine dealing with disorders of the heart as well as parts of the circulatory system.

189. Both UHB and HEFT are designated centres for the emergency treatment of heart attacks and they both also provide some specialist services. Although both the Parties provide a good service and there are established pathways for patients to access complex specialist care in a timely manner, referral patterns, particularly in relation to electrophysiology,[78] reflect poor historical relations between the trusts.

190. The Parties propose to improve patient pathways, share good practice, harmonise clinical protocols and improve patient access to cardiology services across the merged trust. The Parties expect that the proposed service change will lead to patients accessing consistent and timely high quality care, which will lead to reduced length of stay and improved patient outcomes and experience.

191. NHSI told the CMA that the Parties' proposals in relation to diabetes, cardiology and nephrology represented the potential wider opportunities created by the Merger. NHSI told the CMA that they did not assess the Parties' proposals against the CMA framework for assessing RCBs, as the proposals were in an early stage of development.[79]

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[78] Cardiac electrophysiology is the study of the electrical activities of the heart.
[79] NHSI advice, page 54.

192. The CMA's view is that the proposed reconfiguration of the cardiology service to be provided by the merged trust is likely to improve patient outcomes, but the CMA is unable, at this stage, to assess whether it can be expected to accrue within a reasonable period from the Merger. Therefore, the CMA does not believe that the proposed RCB is an RCB within the meaning of the Act.

Nephrology

193. Nephrology is a branch of medicine dealing with the disease of the kidneys. The Parties told the CMA that both UHB and HEFT had excellent reputations for renal care, but that the Merger would lead to joint working and consolidation of nephrology services at each trusts, enabling the merged trust to better utilise satellite dialysis units such that patients could access these units closer their home. The Parties also claim that the Merger would enable improved arrangements for providing dialysis units temporarily closed due to operational issues, leading to an increased capacity and capability to more easily urgently relocate dialysis patients to other units.

194. NHSI told the CMA that the Parties' proposals in relation to diabetes, cardiology and nephrology represented the potential wider opportunities created by the Merger. NHSI told the CMA that they did not assess the Parties' proposals against the CMA framework for assessing RCBs, as the proposals were in an early stage of development.[80]

195. The CMA's view is that the proposed reconfiguration of the nephrology service to be provided by the merged trust is likely to improve patient outcomes, but the CMA is unable, at this stage, to assess whether it can be expected to accrue within a reasonable period from the Merger. Therefore, the CMA does not believe the proposed RCB is an RCB within the meaning of the Act.

[80] NHSI advice, page 54.