Anticipated acquisition by Aintree University Hospital Foundation Trust of Royal Liverpool and Broadgreen University Hospitals NHS Trust

Decision on relevant merger situation and substantial lessening of competition

ME/6815/19

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SUMMARY

Background

1. Aintree University Hospital Foundation Trust (**AUHFT**) and Royal Liverpool and Broadgreen University Hospitals NHS Trust (**RLBUHT**) plan to merge to form a single NHS Foundation Trust (the **Merger**). AUHFT and RLBUHT are together referred to as the **Parties**. The Parties notified the Merger to the CMA on 22 March 2019.

2. The Competition and Markets Authority (**CMA**) believes that it is or may be the case that the Parties will cease to be distinct as a result of the Merger; and that the turnover test is met. Accordingly, arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation.[1]

3. The Parties are university teaching hospitals which provide general NHS hospital services predominately to the city of Liverpool and the north Mersey area, and specialised services regionally to Merseyside, Cheshire, North Wales and the Isle of Man. The Parties are located near to each other and overlap in the provision of NHS elective services, NHS specialised and community services, NHS non-elective services and private patient services.

Competitive Assessment

4. In any merger control investigation, the CMA will assess the extent and nature of current (or pre-merger) competition. The current status of public policy choices about the role of competition within the provision of healthcare services is therefore a particularly relevant factor in the review of NHS mergers.

5. In its recent merger investigations between NHS hospitals in Manchester, Birmingham and Derby/Burton,[2] the CMA found that NHS providers were facing significant growth in demand for services, financial pressures, capacity constraints and greater levels of regulatory oversight. In these recent cases, the CMA also found that, although the relevant NHS service providers still competed for patients to some extent, competition between them was more limited than had previously been the case due to an increasingly more collaborative approach across the NHS in response to these constraints. In particular, the NHS Long Term Plan, the Five Year Forward View, local Sustainability and Transformation Partnerships (**STPs**) and the introduction of control totals have all dampened the role of competition for patients between NHS providers and placed far greater emphasis on collaboration and integration across providers within the Local Health Economy (**LHE**).

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[1] As set out in the merger notice, under section 56AA of the National Health Service Act 2006, upon the grant of application being made by NHS Improvement all the property and liabilities of RLBUHT are transferred to AUHFT and RLBUHT will be dissolved and its establishment order revoked. Following the Merger, AUHFT will continue as an NHS Foundation Trust and AUHFT and RLBUHT will cease to be distinct from each other.

[2] *University Hospitals Birmingham/Heart of England:* *University Hospitals Birmingham/Heart of England* (30 August 2017), (hereafter UHB/HEFT Decision). *Derby/Burton:* *Derby Teaching Hospitals/Burton Hospitals* (2018). *Bournemouth/Poole:* *Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust* (2013). For Manchester, see Report on the anticipated merger between Central Manchester University Hospitals and University Hospital of South Manchester of 1 August 2017 (hereafter CMFT/UHSM Report): *Central Manchester University Hospitals/University Hospital of South Manchester* (2017).

6. The evidence in this case shows that the continuation of the direction of national policies combined with local factors has substantially reduced the role of competition in organising the provision of NHS services in the Liverpool and north Mersey area.

7. In assessing the potential impact of the Merger on competition in the provision of healthcare services, the CMA found each specialty to constitute a separate product frame of reference and, within each specialty, treated elective and non-elective services, as well as outpatient and inpatient (including day case) activities as separate frames of reference. The CMA distinguished between the provision of community services and services which are provided in hospital settings. The CMA also distinguished between private services and NHS services,[3] and assessed the Merger on the basis of its impact on competition both 'in' and 'for' the market.

8. With regard to elective services,[4] the CMA has previously considered that NHS policies limit the role of competition,[5] and these policies have developed over time such that the role of competition in the provision of elective services is limited at best, being replaced by increased collaboration between NHS service providers. The CMA took into account that for the past two years the Parties have been paid to provide elective services solely under a block contract system and have not been reimbursed under the Payment by Results (**PbR**) system. The CMA has found that this has very substantially reduced their incentive to compete for patients. The CMA also took into account capacity and regulatory constraints, and the existence of other providers in the area.

9. The CMA did not identify competition concerns with regard to the provision of private patient services, non-elective services, specialised services or community services. In each case there was either no overlap, limited scope for patients to choose which hospital to attend, or a sufficient number of alternative healthcare providers in the area.

10. The CMA therefore believes that the Merger will not give rise to a realistic prospect of a substantial lessening of competition (**SLC**).

11. The Merger will therefore **not be referred** under section 33(1) of the Enterprise Act 2002 (the **Act**).

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[3] Within private services, each specialty constitutes a separate market and within each specialty, markets can be defined along inpatient and outpatient lines (as with NHS services).
[4] Such services are typically planned or scheduled in advance and usually require a referral from a GP or other primary care provider.
[5] *Derby/Burton* decision 2018: *Derby Teaching Hospitals/Burton Hospitals.*

ASSESSMENT

Parties

12. AUHFT manages Aintree Hospital in North Fazakerley, Liverpool. It provides a full range of general hospital services to the local population of 330,000 people, covering the northern part of Liverpool and North Merseyside. Additionally, AUHFT provides specialised services to a broader catchment area of around 2 million people covering Cheshire, Merseyside, North Wales and the Isle of Man. The income of AUHFT in the financial year 2017/18 was £351 million, generated entirely in the UK.[6] In the financial year 2017/18, AUHFT reported a deficit of £26.9 million.

13. RLBUHT manages two sites: (i) the Royal Liverpool University Hospital and the Liverpool University Dental Hospital, which are co-located in the city centre next to the University, and (ii) the Broadgreen Hospital in a suburb to the east of the city. RLBUHT provides general acute hospital services to around 750,000 people in total and specialised services to a broader catchment area of around 2 million people covering Cheshire, Merseyside, North Wales and the Isle of Man. The income of RLBUHT in the financial year 2017/18 was £515 million, generated entirely in the UK.[7] In the financial year 2017/18, RLBUHT reported a deficit of £39.2 million.

Transaction

14. The Merger will be structured as an acquisition by AUHFT of RLBUHT under sections 56A and 56AA of the National Health Service (NHS) Act 2006, but it is being treated by the Parties as a merger of equal partners, rather than as an acquisition. The key terms of the Merger will be set out in a Transaction Agreement pursuant to which RLBUHT will be dissolved and its establishment order revoked; all of the property and liabilities of RLBUHT will be transferred to AUHFT; and RLBUHT employees will transfer to AUHFT. Following the Merger, AUHFT will continue as an NHS Foundation Trust (**FT**).

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

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[6] In the financial year 2018/19 AUHFT's income was £340 million.
[7] In the financial year 2018/19 RLBUHT's income was £497 million.

Jurisdiction

16. Each of AUHFT and RLBUHT is an enterprise and these enterprises will cease to be distinct as a result of the Merger.[8]

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

18. 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.

19. The initial period for consideration of the Merger under section 34ZA(3) of the Act started on 1 July 2019 and the statutory 40 working day deadline for a decision is therefore 23 August 2019.

Background

20. This section provides, first, a brief overview of the policy and regulatory background relevant to the Merger, and to the role of competition in the NHS generally; and second, an overview of the local health economy in which the Parties are active. The implications of these factors for the Merger are considered in the competitive assessment section.

Regulation and competition in the NHS sector

21. The Health and Social Care Act 2012 (the **HSCA**) strengthened the incentives for NHS providers to compete for patient referrals by maintaining and improving the quality of patient care, with a view to making the NHS more responsive, efficient and accountable.[9]

Regulation

22. This section provides a brief overview of the policy and regulatory bodies related to the Merger.

[8] Section 79 (1) and (3) of the Health and Social Care Act (HSCA) 2012 state that where the activities of one or more NHS foundation trusts and the activities of one or more businesses cease to be distinct, this is to be treated as being a case in which two or more enterprises cease to be distinct enterprises for the purposes of Part 3 of the Act. AUHFT is an NHS foundation trust.
[9] The HSCA also established that mergers involving NHS foundation trusts were caught by the Enterprise Act 2002 and gave the CMA (and Monitor) the power to enforce the Enterprise Act 2002.

23. The Department of Health is responsible for the NHS, public health and social care in England. It develops policy, introduces legislation and allocates funding from HM Treasury to the NHS.

24. Clinical Commissioning Groups (**CCGs**) are clinically-led bodies responsible for the planning and commissioning of healthcare services for their local area. CCGs commission most secondary care services (ie medical services provided by specialists or consultants in a field of medicine, whether in a hospital or community setting).

25. NHS England (**NHSE**) is responsible for setting the direction of the NHS and improving care. It is also the commissioner of primary healthcare services (ie medical services provided by general practitioners (**GPs**), dental practices, community pharmacies and high street optometrists) and specialised tertiary healthcare services (ie services provided in more specialised medical centres), and is responsible for overseeing the operation of CCGs.

26. NHS Improvement (**NHSI**) authorises and regulates NHS FTs, sets prices for NHS services (the National Tariff) and supports commissioners. NHSI also oversees NHS trusts in England, and assists and supports NHS trusts to ensure continuous improvement in quality and the financial sustainability of NHS services. On 1 April 2019 NHSE and NHSI came together to act as a single organisation. [Please see End Note 1]

27. The Care Quality Commission (**CQC**) is an independent regulator of standards in health and adult care. It monitors services to make sure that they are safe, effective, caring, responsive to patient needs and that providers are well led. It carries out unannounced inspections and gives ratings of acute hospitals.

28. In its competitive assessment of the Merger, the CMA has taken into account how each of these bodies provide safeguards on hospital quality.

How competition works between NHS hospitals

29. There are two models of competition in the provision of NHS healthcare services.[10] These are competition *for* the market to attract contracts to provide services to patients, and competition *in* the market to attract patients.

30. Although, in the main, providers are free to decide which clinical services they will offer (including how much of their capacity to devote to each clinical area

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[10] CMA guidance on the review of NHS mergers (CMA29), paragraph 6.5 at Review of NHS mergers: CMA29 - GOV.UK.

and the degree of specialisation that they offer), competition for the market occurs as commissioners often use tenders to select providers[11] that are best placed to offer certain services to patients. Providers therefore have an incentive to maintain their reputation for quality and value in order to demonstrate their credibility and to maximise their chance of winning a contract. These are often services with no or little patient choice and may be elective or non-elective treatments.

31. NHS providers in England receive income by attracting patients for elective treatments and maternity services.[12] Historically, providers were paid at uniform nationally-mandated prices (the National Tariff) for every consultation or treatment made (in most services), based on PbR rules. The PbR payment model has therefore given providers incentives to improve quality to attract patient referrals from GPs.[13] Patient choice and the introduction of incentives for NHS providers to compete for patients have been the reasons why the CMA has had a role in reviewing NHS mergers.[14]

32. However, as discussed in more detail below, current market conditions and recent policy development have significantly limited the Parties' incentives to compete for elective patients. These policy developments are expected to further decrease the role of competition in the NHS (and, in turn, the CMA's role in the review of NHS mergers) going forward.

Current policies in the NHS

33. [✂] NHSI told the CMA that the changes in policy and payments regime increasingly promote collaboration and diminish the role of competition to such an extent that it is unlikely that NHS mergers could result in an SLC. An overview of NHSI's views is provided below.

34. Since the introduction of the HSCA in 2012, the challenges facing the NHS have increased significantly. The increase in demand for NHS services – most notably resulting from an ageing population and increases in long term conditions – have put financial and operational pressure on the healthcare system. In response to these challenges, NHSI and NHSE have introduced new policies, which have shifted the focus towards encouraging performance

[11] In this decision the terms 'provider' and 'trust' are used interchangeably.
[12] NHS providers have to be accredited under the 'Any Qualified Provider' system
[13] *Derby/Burton* decision 2018, paragraph 38: *Derby Teaching Hospitals/Burton Hospitals*.
[14] CMA guidance on the review of NHS mergers (CMA29), paragraph 1.3 at Review of NHS mergers: CMA29 - GOV.UK.

improvements by promoting greater collaboration and away from competition. [Please see End Note 2]

35. In October 2014, NHSE published the Five Year Forward View,[15] which set out vision for greater integration of services and cooperation between providers. Although the Five Year Forward View did not set out exactly how these changes should happen, it suggested some steps that could be taken to support new ways of working, for example, allowing CCGs to move away from the activity-based payments envisaged by the PbR reimbursement regime. NHSI told the CMA that the Five Year Forward View received widespread support from the healthcare sector and the government, suggesting that the system designed by the HSCA was not working and not suited to meeting the NHS's challenges. NHSI noted that *'there was no reference to competition in the Forward View. The Forward View shifted the focus of improving NHS services from incentives which facilitated competition to a future of increased collaboration and integration*'.

36. STPs were announced in December 2015 as the next step for implementing the Five Year Forward View. STPs are made up of local commissioners, GPs and NHS providers and present an opportunity for the commissioners and providers to make decisions about local care together.

37. In January 2019, NHSE and NHSI published the NHS Long Term Plan (**LTP**), which sets out a comprehensive vision for moving the NHS to a new model of service delivery based on even greater collaboration and integration between health care providers than set out in the Five Year Forward View. This includes introducing new local health system partnerships called Integrated Care Systems (**ICSs**) and changes to payment mechanisms and licensing.

38. The LTP announced that the STPs will be developed into ICSs by April 2021. Like STPs, the intention is for ICSs to combine providers and commissioners into an LHE with shared goals and shared decision making. ICSs will be supported by more regulatory and contractual mechanisms – they will be codified through contracts between partner organisations which should redefine their relationships and incentives. While the exact details of how the ICSs will work are still being finalised, NHSI told the CMA that key features are likely to include the following:

    (a) each ICS will typically have a single CCG, which is expected to cover a larger area than the footprints of the current CCGs. There will be a single set of commissioning decisions for local health systems;

[15] NHS Five Year Forward View (2014)

(b) providers are likely to be bound into ICSs through potential new licence conditions (subject to consultation) requiring them to take responsibility for wider objectives in relation to the use of NHS resources and population health and longer-term contracts that include clear requirements to collaborate in support of system objectives;

(c) ICSs will implement local contracts to enable collaboration, which could include contracts which give a lead provider responsibility for integration of services for population;

(d) ICSs will agree system-wide objectives with NHSE and NHSI and be accountable for their delivery; and

(e) primary care networks will be members of ICSs, helping set the strategy of a local area – this will enhance links between primary and secondary providers. [Please see End Notes 3, 4 and 5]

39. How the LTP ambition and ICSs for the Liverpool area are envisaged to be developed are outlined below where the CMA discusses the One Liverpool initiative.

40. NHSI told the CMA that competition is no longer an effective force for performance improvement, both generally and in this particular LHE: '**[✂]** *competition is not a suitable organising principle for NHS acute services and is unlikely to incentivise quality improvements. Instead, these key stakeholders have decided that organising the NHS around collaborative local systems is the most suitable way to improve quality for patients* […] *we now think that competition has reduced considerably since the introduction of the Act and is to a large extent no longer an operative force for performance improvement within the NHS'*.

41. NHSI told the CMA that '*it is important to think of* [the LTP] *as the effective policy for how the structures and rules of the NHS will develop. We therefore think that the LTP should be the primary policy document for assessing the role of competition in the NHS*'.

42. The CMA understands from NHSI that STPs and ICSs will change the relationship between the NHS organisations in each local health area. After a period where key policies in place were to promote competition between trusts, the introduction of STPs and ICSs indicates a shift away from the HSCA; these changes have removed the expectation that the trusts should operate focusing on their own interests only and created an expectation that the trusts should make decisions in a local system through collaboration and partnership with commissioners and providers, balancing the needs of different organisations to benefit patients. Additionally, these changes also

envisage increasing links between the provision of secondary and primary care systems. Funding will also be made available to systems to deliver the visions of the LTP. Therefore, NHSI states: '*By 2021, all providers and commissioners are expected to contract through ICSs. The intention is that they will facilitate a collaborative approach that will drive improvements to patient care. An intentional consequence of this is that providers and purchasers no longer act in the manner required for competition to provide effective incentives for performance improvement'*. [Please see End Note 6]

43. This means that providers and purchasers are no longer expected to contract with each other through a simply transactional relationship, per the HSCA. Rather, these reforms require them to develop strategies for the local health economy and to create payment mechanisms to allow the realisations of such strategies. NHSI told the CMA that this may affect the scope for competition between the trusts in the following ways:

(a) if providers internalise the budgetary impact of any revenue increases on care purchasers, this is likely to dampen the providers' incentives to generate additional patient activity via performance improvement (although they may continue to do so via other mechanisms); and

(b) the future contractual mechanism in which neighbouring providers are expected to work together to develop strategy and achieve improvements in care quality may reduce the scope and incentive for providers to increase their market share at the expense of their neighbours.

44. NHSI told the CMA that '*our view is that the Forward View, STP and LTP reforms promote collaboration and diminish competition to such a degree that we think it is unlikely any hospital mergers should result in a significant lessening of competition'*.

45. The CMA notes that similar sentiments about the trajectory of policy changes and the role of competition in the NHS were expressed by the House of Commons Health and Social Care Committee. For example, it recently reported that '*the current legislation was designed to encourage choice and competition in the NHS, rather than collaboration. Since the NHS Five Year Forward View, the NHS has had to use workarounds to overcome barriers posed by the legislation'*.[16]

[16] 'NHS Long-Term Plan: legislative proposals', Fifteenth report of session 2017-19, 24 June 2019.

Other impacts on Trusts' decision-making

46. The changes in the institutional environment discussed above have been accompanied by a series of other changes to policy and incentives, which have changed the decision-making process of the NHS providers and, in turn, reduced their ability to respond to market incentives. This has had the greatest effect on FTs (such as AUHFT).

47. Since 2013, a series of measures have been introduced which have significantly affected the landscape in which FTs operate and has weakened their incentives to compete for market share:

    (a) The Trust Development Authority (**TDA**) and Monitor merged in June 2015 (creating NHSI), which reduced the difference in the regulatory environment facing ordinary NHS trusts and NHS FTs, which has led to the implementation of the Single Oversight Framework (**SOF**). The SOF was established in 2016 for measuring and managing the performance of NHS providers, making no distinction between ordinary trusts and FTs, meaning that both types of trusts were assessed in the same way. The SOF is part of a regulatory shift towards a centrally-led performance management and improvement support, rather than encouraging providers to respond individually to economic incentives. [Please see End Note 7]

    (b) Since financial year 2017/18, as NHS provider deficits became pervasive, system 'control totals' (ie provider revenue) have been agreed between NHS providers and NHSI. In late-2018, it was announced that the NHS would move away from imposing control totals at the provider level, to imposing them at the local health system (ie STP/ICS) level. NHSI told the CMA that this change moves the NHS further away from the approach of viewing NHS providers as individual market actors, towards a future in which financial planning and decision-making is undertaken at local health system level. The CMA believes that this policy development has reduced provider incentives to compete (especially since an important element of the FT framework was that FTs could invest any surplus revenue into the hospital).

    (c) NHSE and NHSI came together to act as a single organisation in April 2019. NHSI told the CMA that, while previously commissioners and providers were regulated separately, the new regulatory framework has been established to support the introduction of a collaborative system.

48. In addition, in order to support the implementation of the LTP, NHSE and NHSI have proposed a number of changes to primary legislation which are

intended to accelerate the move away from a competitive market dynamic towards a more collaborative dynamic, including:

(a) removing mergers involving NHS FTs from the scope of the Enterprise Act 2002, thus removing the CMA's jurisdiction to review NHS mergers;

(b) removing the concurrent powers of NHSI to enforce competition law;

(c) giving NHSE and NHSI the power to direct NHS FTs to merge;

(d) a requirement for FTs to seek NHSI's approval to borrow capital for investment purposes; and

(e) permitting NHS providers and commissioners to form joint committees with decision-making powers. [Please see End Note 8]

49. Although these changes and the timing for any changes are uncertain, they clearly continue the trajectory of NHS policy that moves away from each trust acting independently and toward a system of greater collaboration and integration of healthcare providers within a local health economy. [Please see End Note 9]

Use of block contracts by local commissioners

50. NHSI told the CMA that the changes in the payment regime have further reduced incentives for competition between trusts. This has been done primarily through reforms in the Five Year Forward View, STPs and the LTP, which have reduced the link between activity and payments, focusing instead on payments to develop integrated care and more suitable care for patients. In this context, NHSI told the CMA that: [Please see End Note 10]

(a) The shift away from activity-based funding (which is the basis of the PbR system and which has provided much of the rationale for the CMA's involvement in NHS mergers) began with the Five Year Forward view, which called for greater flexibility in payment mechanisms, including the use of non-activity-based contracts (including block contracts). By breaking, at least (in the CMA's view) for the purposes of substantive competition assessment the link between activity and revenue these changes have substantially decreased the incentives for hospital trusts to compete for patient referrals from GPs. [Please see End Note 11]

(b) While the size of block payments is sometimes determined by historical activity levels, leaving some incentives for performance improvement, and a system of block contracts could accommodate some incentives to compete, if selective contracting were present, any competitive incentives

would only exist where the block payment exceeds the cost of service provision, which has mostly not been the case in recent years. These fiscal constraints have led to a situation in which the ability to retain and reinvest surpluses no longer gives rise to meaningful competitive incentives, as for most providers there is no surplus to reinvest.

(c) The LTP signals that the move away from activity-based reimbursement is likely to accelerate over the coming years. The LTP does not refer to payment mechanisms in terms of incentivising competition and proposes to '*move to a blended payment model*',[17] creating shared incentives for providers and commissioners to work together to reduce avoidable admissions and to '*minimise transactional burdens and friction and provide space to transform services*'.

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

Capacity constraints

51. NHSI told the CMA that, in addition to the policy changes discussed above at paragraphs 33 to 50, severe capacity constraints currently faced by trusts throughout England, including the Parties, further limit their abilities to respond to competitive incentives.

52. For competition to provide effective incentives to compete on quality, providers must have an incentive to increase their market share and have the capacity to accommodate the additional patients. NHSI told the CMA that capacity constraints have long been a characteristic of the NHS elective care.[18] While, in general, capacity constraints do not necessarily preclude increases in production,[19] the capacity constraints experienced by NHS trusts in recent years make it increasingly difficult for them to identify additional efficiency improvements that can be undertaken in order to accommodate increases in activity.[20]

53. In addition, the sector has seen substantial shortages in the supply of doctors and nurses, which constitutes another constraint on the providers' capacity to

[17] Ie partway between block funding and activity-base funding.
[18] Capacity constraints are typically measured by waiting times or by bed occupancy rates.
[19] For instance, production may be increased even where capacity constraints exist where providers are able to undertake efficiency improvements.
[20] Capacity utilisation has increased, and operational performance has deteriorated on every available metric since 2015. NHSI told the CMA that the increased utilisation of non-elective services by the ageing population is likely to be a contributing factor for this trend.

accommodate additional patients that may result from quality improvements, hence further limiting the scope for competition.

Competition in the Liverpool and north Mersey area

54. Both Parties are university teaching hospitals which provide general hospital services to the city of Liverpool and the north Mersey area, and specialised services regionally to Merseyside, Cheshire, North Wales and the Isle of Man.

55. The main commissioner of acute care provided at AUHFT is NHS South Sefton CCG, but services are also commissioned by a number of other CCGs and a significant proportion of its income derives from NHS Liverpool CCG. NHSE also commissions specialised services, health and justice services, public health and secondary care dental from AUHFT.

56. The main commissioner of acute care provided at RLBUHT is NHS Liverpool CCG, but services are also commissioned from a number of other CCGs. NHSE also commissions specialised services, armed-forces services, public health and secondary care dental services from RLBUHT.

57. A number of other providers of NHS and private patient services exist in the areas where the Parties operate, notably (for NHS services) Southport and Ormskirk Hospital NHS Trust, St Helens and Knowsley Hospital Services NHS Trust and Liverpool Heart and Chest Hospital NHS Foundation Trust; and (for private services) Spire Liverpool Hospital, Spire Murrayfield Hospital in Wirral, Fairfield Independent Hospital in St. Helens, Nuffield Health Hospital in Chester, BMI the Beaumont Hospital in Bolton and the Christie Private Care in Manchester as well as other NHS trusts.

58. The Parties submit that Liverpool is characterised by poor health outcomes and is among the areas with the highest rates of social deprivation and health inequality in England. According to the NHS Liverpool CCG, 30% of Liverpool's population lives with at least one long term condition, which presents the LHE with a significant challenge in providing the local population with the right health and care services.

The One Liverpool initiative and local partnerships

59. In addition to the general submissions described above relating to the decreasing role of competition between the NHS trusts and the effects these changes have on the merging Trusts' incentives to compete, the merging Trusts submitted that the 'One Liverpool' initiative, a local plan to implement national policies to work towards greater collaboration between trusts, has

also been put in place. This initiative aims to establish a more integrated health and social care system in order to address increasing financial pressures and clinical sustainability challenges faced by the trusts in the Liverpool area.

60. The Parties submitted that the current service configuration where two similarly-sized acute trusts co-exists within a city of the size of Liverpool leads to a significant duplication of services across the Parties and does not meet the strategic vision described in 'One Liverpool', and said that, in particular, the fragmentation of services creates additional challenges associated with the delivery of high-quality patient care.

61. In addition, both Parties belong to the north Mersey Local Delivery System (**LDS**) – a component of Cheshire and Merseyside STP. The STP plans for 35 acute specialties to be reconfigured across AUHFT, RLBUHT and the Liverpool Heart and Chest Hospital to establish single service, system-wide services. This provides a good indication of the level of integration and collaboration between providers in the local area.

The Parties' submission on the role of competition in their activities

62. The Parties submitted that competition is no longer the key driver of quality in Liverpool, because financial and other pressures have led to a number of changes in the regulatory landscape. The Parties stated that these changes overall have led to collaboration being considered the key driver of quality improvements in the NHS and have substantially diminished the ability and incentives for competition between NHS trusts and, in particular, the Parties. They said that incentives for the Parties to compete have been dulled by the following:

(a) The introduction of the Cheshire and Merseyside STP, aimed at enabling decision-making based on clear clinical strategies and demand across the entire system in the interests of the LHE, which has led to pathways and services in the LHE being planned at the STP-level in order to minimise costs and foster effective care across the healthcare system, which, in turn, has limited individual trusts' ability to make independent decisions in relation to the services they provide.

(b) The introduction of the SOF in 2016 to assess hospitals in terms of their quality, finance, operational performance, leadership and improvement capability and strategic change. The SOF segments providers on a scale of 1 to 4, with 1 being the best and 4 being the worst. Each segment is associated with a different degree of decision-making autonomy granted to providers. In February 2019, nearly half (ie 70 out of 148 acute

providers) of providers were in segments 3 or 4 which implies limited sovereign decision-making ability, and, in turn, less scope to compete for patients through taking independent strategic initiatives.

(c) With respect to the Parties, RLBUHT is currently assigned to segment 3 and, as a result, is currently subject to mandated interventions by NHSI regarding finance, use of resources and operational performance. AUHFT is currently assigned to segment 2 and has been offered targeted support from NHSI relating to finance, use of resources and operational performance, which it has accepted. The Parties submit that, given the NHSI's focus on collaborative service delivery, this further limits their ability to make decisions in their own self-interest.

(d) The use of block contracts as a means of payments to the Parties. Both Parties operate under the Acting as One block contract framework,[21] whereby payment and service provision are agreed across a number of CCGs and providers. As with other block contracts, the payments to providers operating under the Acting as One framework are largely fixed regardless of patient volumes, thus greatly limiting their incentives to attract additional patients from other providers.

63. The Parties submitted that, because of the facts set out above, any reduction in competition as a result of the Merger will be very limited and therefore '*a higher threshold should be applied by the CMA compared to previous mergers of NHS organisations*'.[22]

Counterfactual

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

65. For anticipated mergers the CMA generally adopts the prevailing conditions of competition as the counterfactual against which to assess the impact of the merger. 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 these conditions continuing is not

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[21] Paragraphs 9.21 and 9.22 of the merger notice: '*Under the Acting as One agreement (like other block contract arrangements in the NHS), neither AUHFT nor RLBUHT has an incentive to take on additional patients, at the margin. […] Providers operating under this contract (or other block contracts) where the amount paid to the provider is fixed regardless of patient volumes will have a lesser incentive to attract patient referrals than those providers operating under a PbR arrangement, where an activity-based tariff is applied'.*
[22] Paragraph 8.4 of the Accompanying submission to the merger notice.

realistic, or there is a realistic prospect of a counterfactual that is more competitive than these conditions.[23]

66. The Parties submitted that it may be appropriate for the CMA, in its Phase 1 review, to use the existing level of competition as the benchmark against which to assess whether the realistic prospect of an SLC test has been met in one or more routine elective care specialties. The Parties also submitted that, **[✂]** changes to clinical services that involve increased collaboration would be likely, given commissioner and NHSI support.

67. For the purposes of its assessment of the Merger, the CMA adopted the prevailing conditions of competition as the relevant counterfactual. However, in line with previous decisions, the CMA has taken into account the financial and clinical difficulties[24] faced by the Parties in its competitive assessment.

Frame of reference

68. Market definition provides a framework for assessing the competitive effects of a merger and involves an element of judgement. The boundaries of the market do not determine the outcome of the analysis of the competitive effects of the merger, as it is recognised that there can be constraints on merging parties from outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others. The CMA will take these factors into account in its competitive assessment.[25]

Product scope

69. In line with past decisional practice, the CMA has adopted the following approach for determining the relevant product frames of reference for its assessment of the Merger:

    (a) Each specialty is considered a separate frame of reference and within each specialty:[26]

[24] The Parties submitted that **[✂]**.
[25] *Merger Assessment Guidelines*, paragraph 5.2.2.
[26] These delineations are applicable to both NHS and private patient services.

(i) the provision of elective services[27] is a separate frame of reference from the provision of non-elective services;[28]

(ii) within elective services, the provision of specialised services[29] as a separate frame of reference; and

(iii) within each of elective services and non-elective services, the provision of outpatient (**OP**) services is a separate frame of reference from the provision of inpatient (**IP**) services (the latter including day-cases (**DC**)).[30]

(b) the provision of community services[31] 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[32] is a separate frame of reference from services provided through the NHS.

Geographic scope

70. In line with previous decisions, the CMA has adopted the following approach:[32]

(a) **For elective services:** the CMA considers that the geographic frame of reference is informed by GP patient referral information which indicates that the Parties face their most relevant competitive constraints in the Liverpool and north Mersey area; and

(b) **For non-elective services:** the CMA considers that the geographic frame of reference is informed by the willingness of patients to travel for

[27] Planned specialist medical care usually following referral from a primary or community health professional such as a GP. Maternity and some paediatric services are also typically included in this category, however since neither of the Parties provide maternity or paediatric services, the CMA has not considered the provision of these services further.
[28] Services that are not scheduled, arising when admission is unpredictable because of clinical need (eg following an A&E attendance). Consistent with previous decisions, the CMA will not further consider non-elective services.
[29] Services in respect of rare, cost-intensive, or complex conditions as specified in NHSE's 'Manual of Prescribed Specialised Services'.
[30] Some previous decisions have treated DC as a separate frame of reference, but based on discussions with NHSI, the CMA has combined them with IP in this decision. The facilities and staff required to deliver both are similar, and most DC treatments are also provided with an overnight stay, ie as IP treatments, at particular times or by particular providers.
[31] 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.
[32] Care not funded by the NHS and instead paid for by patients or their insurers.

consultation or treatment, taking into account travel distance and travel time.

(c) **For specialised and community services:** the CMA considers that the geographic frame of reference is informed by the geographic scope of relevant contracts and previous bidding contracts.

(d) **For private healthcare services:** the CMA considers that the geographic frame of reference is likely to be at least as large as for elective services. In the Private Healthcare Market Investigation, the CMA found that the average travel time for private hospital patients was just over 30 minutes.[33]

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

Conclusion on frame of reference

72. For the reasons set out above, the CMA has considered the impact of the Merger in Liverpool and the north Mersey area in each frame of reference, taking into account the policy changes in the NHS which have diminished the role of competition.

Competitive assessment

Horizontal unilateral effects

73. Horizontal unilateral effects may arise when one firm merges with a competitor that previously provided a competitive constraint, allowing the merged firm profitably to raise prices or to degrade quality on its own and without needing to coordinate with its rivals.[34] Horizontal unilateral effects are more likely when the merging parties are close competitors.

74. Competition in the NHS takes place where patients have a choice between NHS service providers, incentivising providers to improve quality. Mergers between providers of NHS acute services may dampen this incentive if they remove a significant alternative for patients, resulting in lower quality.[35]

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[33] Private Healthcare Market Investigation Final Report, 2 April 2014, footnote 52.
[34] *Merger Assessment Guidelines*, from paragraph 5.4.1.
[35] CMA guidance on the review of NHS mergers (CMA29), paragraphs 1.5 and 6.48 at Review of NHS mergers: CMA29 - GOV.UK. Examples of clinical factors include infection rates, mortality rates, ratio of nurses or doctors to patients, equipment, best practice. Examples of non-clinical factors include cleanliness and parking facilities.

The existing competitive landscape in the sector

75. In any merger control investigation, the CMA will assess the extent and nature of current (or pre-merger) competition. The current status of public policy choices about the role of competition within the provision of healthcare services is therefore a particularly relevant factor in the review of NHS mergers.

76. The CMA recognises that the Parties are public service providers that operate in a heavily regulated environment, with numerous safeguards overseen by the CQC and NHSI, as well as the local CCGs. This regulation limits the extent to which competition can affect the quality and range of healthcare services offered.

77. In recent decisions on NHS mergers, the CMA has found that current policies, such as the introduction of the Five Year Forward View and the STPs, had encouraged greater levels of collaboration and collective responsibility in the provision of NHS services within LHEs. In these decisions, the CMA found that these policy developments, combined with increased financial and capacity constraints, had led to a reduced emphasis on competition and concluded that regulation and available capacity might determine behaviour more than competition, especially in the delivery of NHS elective services (although the delivery of other services will also be affected). Nevertheless, in these previous decisions the CMA ultimately considered that, notwithstanding these developments, sufficient scope for competition remained to be worthy of consideration for merger control purposes.

78. The evidence available in this case is that the continuation of the direction of national policies combined with local factors (such as the use of block contracts) has substantially reduced the effectiveness of competition as a means of organising the provision of NHS services in the Liverpool area.

79. In light of the facts described above, the CMA believes that the role for competition between NHS providers (including the Parties) is significantly diminished. The consequences for the effects of the Merger are discussed below.

Competitive assessment by service type

80. Historically, competition in the NHS within England takes place where patients have a choice between NHS service providers which aims to incentivise providers to improve quality. Mergers between providers of NHS acute

services may dampen this incentive if they remove a significant alternative for patients, resulting in lower quality.[36]

81. The CMA assessed the impact of the Merger in each frame of reference, taking into account the policy changes in the NHS (explained in paragraphs 32 to 50 above) which have diminished the role of competition.

Elective services

82. In assessing the impact of the Merger in elective services, the CMA took into account the evidence on the role of competition in the wider NHS as discussed above; the Parties' internal documents; the views of CCGs in the LHE; that all the Parties' revenue for NHS elective services was from block contracts; capacity constraints; and the presence of alternative providers for patients in the Liverpool and north Mersey area.[37]

83. The CMA found that the Parties' ordinary course internal documents (such as the Parties' board papers) generally support the position that collaboration, rather than competition, is the primary driver of the Parties' activities, and found limited evidence to suggest that the Parties' decision-making has been influenced by each other's activities.

84. The CMA has further considered the impact of the increased role of provider collaboration and financial constraints faced by the Parties on their incentives to compete. As part of this assessment, the CMA has also taken into account the context of the LHE, including the challenges that the Parties face and the approach taken by the CCGs and other NHS acute providers, as well as the state of public health in Cheshire and Merseyside areas. These considerations provide important background for understanding the much reduced role of competition and for assessing the potential impact of the Merger.

85. The CMA considers that while historically the PbR payment model has given NHS service providers incentives to improve quality to attract additional patient referrals, recent developments described above indicate that the role of competition has diminished further since the CMA's previous investigations, especially those pre-dating the Five Year Forward View.[38] Competition is

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[36] CMA guidance on the review of NHS mergers (CMA29), paragraphs 1.5 and 6.48 at Review of NHS mergers: CMA29 - GOV.UK. Examples of clinical factors include infection rates, mortality rates, ratio of nurses or doctors to patients, equipment, best practice. Examples of non-clinical factors include cleanliness and parking facilities.
[37] See paragraph 58.
[38] In particular, *Bournemouth/Poole:* *Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust* (2013) and *Manchester Hospitals*: *Central Manchester University Hospitals/University Hospital of South Manchester* (2017).

therefore no longer is the key organising principle of the NHS as the 2012 reforms and the HSCA envisaged it to be.

86. Even if some scope for competition in a form of remaining PbR agreements remains, the CMA considers that the proportion of activity governed by block contracts has been increasing significantly over the past few years, at the expense of PbR agreements, and this trend is expected to continue going forward. In addition, the fiscal constraints faced by the majority of trusts coupled with ongoing capacity and workforce shortages have led to a situation in which the ability to retain and reinvest surpluses no longer provides meaningful competitive incentives,[39] and it is not believed that the situation will change in the near future.

87. Both Parties earn the majority of their revenue from block contracts.[40] In 2018/19, AUHFT received **[✂]** of its revenue from block contracts, and RLBUHT **[✂]**. Importantly, all elective activity was remunerated through block contracts at an agreed level, thereby dampening very substantially the trusts' incentives to compete for additional patients.

88. The CMA notes that the views expressed by the Parties' co-ordinating CCGs, the NHS Liverpool and the NHS South Sefton CCGs, confirm the growing role of collaboration between the trusts in the Cheshire and Merseyside STP. The CCGs have also confirmed **[✂]**.[41] They have also indicated that the main driver of patient choice was not the quality, but location; and did not expect the Merger to have any real effect on competition or choice, especially given that the services will continue to be provided across both Parties' sites.

89. The CMA considers that the One Liverpool initiative means that the extent of competition that may have existed between the Parties in the past would have been further diminished in the future.

90. As discussed at paragraphs 51 to 53 above, the NHS as a whole is facing capacity constraints. The Parties submitted a number of specific examples of capacity constraints due to a combination of increased volume of treatments required, infrastructure issues and staffing shortages. While some of these constraints may be transitory, the overall picture is consistent with a situation where the Parties have limited ability to treat additional patients overall, which would reduce any incentives to attract additional patient referrals. The CMA notes that, due to the interconnected nature of resources to treat patients

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[39] For example, most trusts have neither the capacity/workforce to accommodate additional patient volumes nor any surpluses to reinvest in order to improve the quality of services.
[40] Block contracts are types of contracts where payments do not vary with fluctuations in the level of activity, but instead pay a fixed sum of money. This is unlike the PbR reimbursement regime which paid a fixed a price per treatment that exceeded the costs of production for most providers.
[41] **[✂]**

between elective and non-electives services, and to a lesser extent across specialties, there are unlikely to be significantly different incentives in individual elective specialties.

91. Based on the evidence described above, the CMA considers that competition is not a key driver for making operational decisions in the Liverpool and north Mersey area and, consistent with both national policy and local planning, is unlikely to play a significant role in setting standards for elective services in the foreseeable future. Therefore, the CMA considers that the Merger will not affect the Parties' incentives or behaviour in the provision of elective services. Accordingly, the CMA considers that the Merger will not give rise to a realistic prospect of an SLC in the supply of elective services.

Non-elective services

92. In previous cases,[42] the CMA found that there was no material competition between providers in non-elective services. Most patients either attend via ambulance or attend their nearest A&E department, meaning there is limited active patient choice. The CMA has also not seen evidence that the quality of non-elective services is a significant driver of any residual choice. In addition, the CMA found that payments to trusts for non-elective services are subject to a 'marginal rate tariff', under which providers who go beyond a baseline level are paid at a marginal rate for each additional patient treated. This funding formula dampens trusts' incentives to go beyond their baseline level, meaning that the Parties have less incentive to attract patients for non-elective services than they do for elective servicers. The evidence available to the CMA is consistent with the same finding in this case.

Private Patient services

93. The Parties overlap in a number of private patient specialities, however with the exception of ophthalmology, private patient services account for only a marginal part of the activity seen at the merging Trusts,[43] and activity in individual frames of reference is minimal.[44] Accordingly, the CMA has limited its analysis to the provision of private ophthalmology services only. The

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[42] *University Hospitals Birmingham/Heart of England:* University Hospitals Birmingham/Heart of England (2017). *Derby/Burton:* Derby Teaching Hospitals/Burton Hospitals (2018). *Bournemouth/Poole:* Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust (2013) and *Manchester Hospitals*: Central Manchester University Hospitals/University Hospital of South Manchester (2017).
[43] AUHFT's total private patient income in 2017/18 was £1.6 million, representing 0.46% of its total income during that period. During the same period, RLBUHT's income associated with the provision of private patient services was £0.5 million, representing 0.13% of its total income. The Parties submit that RLBUHT does not have dedicated private patient facilities and as a result sees only limited number of private patients.
[44] This applies to RLBUHT, which typically sees less than six patients per specialty per annum.

evidence shows that other providers offer a greater volume of private ophthalmology services and will continue to constrain the Parties post-Merger.[45,46]

94. For the reasons set out above, the CMA considers that the Merger will not give rise to a realistic prospect of an SLC in relation to the supply of non-elective or private patient services.

95. For specialised services and community services, providers compete *for* the market, via tenders to obtain contracts with commissioners to provide such services to patients. The CMA examined whether the Merger was likely to remove an important alternative for commissioners.

Specialised services

96. While both Parties provide specialised services, there appears to be a lack of overlap, and no evidence of competition between the Parties when bidding for the provision of specialised services, and the evidence is consistent with the interaction between the Parties being collaborative in nature. The Parties provide different specialised services. The only areas of potential overlap between the Parties are the provision of specialised orthopaedics (provided as part of specialised trauma services at AUHFT and as part of specialised surgical services at RLBUHT) and specialised cancer services (although the Parties appear to focus on different sub-specialties within this group). During the past three years, the Parties bid for four specialised service contracts: in three of the four tenders the Parties submitted joint bids and only RLBUHT participated in the fourth tender.

Community services

97. Neither Party is currently commissioned to provide community services and have not bid against each other for community services within the last three years. The Parties explained that they have only participated in one tender for community services during the last three years, where they submitted a joint bid to provide community services that had been provided by Liverpool

[45] Other nearby providers of private patient services include Spire Liverpool Hospital, Spire Murrayfield Hospital in Wirral, Fairfield Independent Hospital in St. Helens, Nuffield Health Hospital in Chester, BMI the Beaumont Hospital in Bolton and the Christie Private Care in Manchester as well as other NHS trusts such as Wirral University Teaching Hospital NHS Foundation Trust. All but Christie Private Care in Manchester also provide private ophthalmology services.
[46] Third-party responses did not indicate that the Parties were considered as particularly strong providers of private ophthalmology services and showed that a large number of alternative providers offering credible alternatives will remain post-Merger; and no relevant competition concerns were raised by third parties.

Community Healthcare NHS Trust as part of the dissolution of that organisation in 2017.

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

Conclusion on horizontal unilateral effects

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

Third party views

100. The CMA contacted Liverpool CCG and South Sefton CCG. Both CCGs support the Merger. The CMA also sent an Invitation to Comment to other CCGs and NHS providers in the Liverpool and north Mersey area as well as to NHSE. Only NHSE responded to the Invitation to Comment, expressing its support for the Merger. The CMA also contacted providers of private services in the Liverpool and north Mersey area.[47] No relevant competition concerns were raised by third parties about the Merger.

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

Decision

102. Consequently, the CMA does not believe that it is or may be the case that the Merger may be expected to result in an SLC within a market or markets in the United Kingdom.

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

[47] See footnote 46 above.

Colin Raftery
Senior Director, Mergers
Competition and Markets Authority
22 August 2019

Following publication of the Long Term Plan, NHS England and NHS Improvement continue to develop its proposed policies, including further engagement with the sector. NHS England and NHS Improvement have also consulted on the legislative proposals contained in the Long Term Plan. As a result, NHS Improvement informed the CMA that this consultation may influence the final plan and requested a number of clarifications to its position set out in the following End Notes. These adjustments do not materially change the substance of this decision. At the time of the CMA decision, NHS England and NHS Improvement had not published the final legislative proposals.

End Notes

1. Paragraph 26, first sentence: ‘supports commissioners’ should be ‘supports providers’.

2. Paragraph 34, first sentence: ‘Since the HSCA in 2012’ should be ‘Since the implementation of the HSCA in 2013.

3. Paragraph 38, second sentence: ‘combine’ should be ‘bring together’ and ‘with shared goals’ should be ‘to formulate shared goals’.

4. Paragraph 38(b): replace paragraph with ‘providers are likely to be required to take responsibility for wide objectives in relation to use of NHS resources and population health, under the conditions of their licence’.

5. Paragraph 38(c): ‘ICSs will implement local contracts’ should be ‘ICSs will oversee the implementation of local contracts’.

6. Paragraph 42, NHSI quote: ‘contract through ICSs’ should be’ contract through an ICS process’.

7. Paragraph 47(a), first sentence: ‘merged’ should be ‘formed a single organisation’. Second sentence: ‘and managing the performance of NHS providers’ should be ‘and performance oversight of NHS providers’.

8. Paragraph 48: NHSI told the CMA that the proposed changes to legislation are not final recommendations which will be published in due course.

9. Paragraph 49: This is the CMA’s view.

10.Paragraph 50, second sentence: ‘reforms’ should be ‘policies’.

11.Paragraph 50(a), first sentence: NHSI told the CMA that the PbR system was replaced by the national tariff from 2014. This sentence should be replaced with: ‘The shift away from activity (which is the basis of the national prices under the national tariff) began with the Five Year Forward View, which called for greater flexibility in payment mechanisms (including, but not limited to the use of non-activity based contracts).