OFFICE OF FAIR TRADING

Acquisition by University College London Hospitals NHS Foundation Trust of Royal Free London NHS Foundation Trust's neurosurgery services

ME/5574-12

The OFT's decision on reference under section 33(1) given on 21 February 2013. Full text of decision published 6 March 2013.

Please note that the square brackets indicate figures or text which have been deleted or replaced in ranges at the request of the parties or third parties for reasons of commercial confidentiality.

PARTIES

1. **University College London Hospitals NHS Foundation Trust** (UCLH) is a foundation trust based in London. It was authorised as a foundation trust in 2004 and provides a range of acute and specialist healthcare services from eight hospitals[1] with neurosurgery services[2] provided at the National Hospital for Neurology and Neurosurgery (NHNN). For the financial year ending 31 March 2012, UCLH had a total operating income of approximately £773.7 million of which approximately £556.6 million was derived from the provision of secondary or tertiary services to Primary Care Trusts (PCTs).[3]

[1] University College Hospital, Royal National Throat, Nose and Ear Hospital, Royal London Hospital for Integrated Medicine, Hospital for Tropical Diseases, University Hospital Macmillan Cancer Centre, National Hospital for Neurology and Neurosurgery, Heart Hospital and Eastman Dental Hospital.

[2] Neurosurgery is the specialty related to the surgical treatment of disorders of the brain, spinal cord and other parts of the nervous system.

[3] Primary Care Trusts are currently responsible for the procurement of healthcare services in their local area. This will change from 1 April 2013 when new commissioning groups will be tasked with this role.

2. **Royal Free London NHS Foundation Trust** (RFH) is a foundation trust based in London. It was authorised as a foundation trust on 1 April 2012. It provides acute and specialist healthcare services including neurosurgery. The neurosurgery unit at the RFH includes intracranial, complex and routine spinal work and all acute neurosurgery activity. For the financial year ending 31 March 2011, RFH had a turnover of approximately £556.5 million. For the last financial year, the annual turnover attributable to the transferring neurosurgery services was approximately £8.5 million.

TRANSACTION

3. The transaction involves the transfer of all neurosurgery inpatient and daycase services from RFH to UCLH.[4] The parties entered into an agreement for the transfer of such neurosurgery services in two phases: phase one involved the transfer of intracranial, complex spine and all acute neurosurgery activities and phase two, the transfer of routine spinal work. Outpatient services will remain at the RFH.[5]

4. According to the parties, phase one completed on 16 June 2012. It involved the transfer of patients[6] and their records, contracts with the relevant commissioning groups, funding by the London Deanery for neurosurgery medical training[7] and approximately 55 members of staff including consultants, junior doctors, nurses and radiographers.[8] Phase

[4] It is noted that these neurosurgery services will transfer to UCLH's campus at NHNN, Queen's Square, London.

[5] It is noted that UCLH intend to set up a service level agreement with RFH to provide neurosurgeon support for certain outpatient services.

[6] It is estimated that the total number of patients affected by this transaction is approximately 920.

[7] The London Deanery is one of 14 deaneries which manage the delivery of postgraduate medical training in the UK and provides funding for junior doctor training posts to all Trusts including foundation trusts which have authorised training posts. Seven posts have historically been approved at the RFH, four fully funded, one funded at 50 per cent and two funded by the Trust directly.

[8] 55.4 whole time equivalent posts: 9.5 medical posts, 30.8 nursing posts, 4.1 admissions/pre-admissions staff, one ancillary post, 4.4 radiology posts and 5.6 administrative staff.

two is anticipated to complete before April 2013 and will consist of the remaining staff, patients, records and contracts.[9]

Rationale

5. The parties stated that the provision of neurosurgery services is highly specialised and that the transfer will ensure that patients can benefit from high quality specialised treatment around the clock provided by a larger pool of supported specialist staff with improved access to state-of-the-art facilities for diagnosis and treatment.

JURISDICTION

Enterprises ceasing to be distinct

6. An 'enterprise' is defined in the Enterprise Act 2002 (the Act) as the activities or part of the activities of a business, and a business includes a professional practice which is carried on for gain or reward or which is an undertaking in the course of which goods or services are supplied otherwise than free of charge.

7. The OFT found in its recent decision in *Royal Bournemouth/Poole Hospital*[10] that NHS foundation trusts may be considered 'enterprises' for the purposes of the Act.

8. In addition to the above, the OFT notes that the recent enactment of the Health and Social Care Act 2012 (HSCA)[11] confirmed that mergers

[9] The transfer was approved by the Joint Health Overview and Scrutiny Committee (JHOSC) which is made up of the Chairpersons of the Health Overview Committees from five London boroughs: Barnet, Haringey, Camden, Islington and Enfield. It was established in January 2010 to engage with the NHS on the North Central London Services and Organisation Review. From August 2010 its role involves the scrutiny of broader strategic changes relating to health service provision across the five London boroughs.

[10] ME/5351/12 – Anticipated merger between the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust, OFT decision dated 8 January 2013, at paragraph 4.

[11] The relevant section is section 79.

involving foundation trusts may be treated as two or more enterprises ceasing to be distinct under Part 3 of the Act.

9. As such, the OFT considers that the parties, as foundation trusts, are enterprises for the purposes of the Act. The OFT has gone on to consider whether the transfers of part of those enterprises, that is, in this case, certain neurosurgery services alone constitute enterprises ceasing to be distinct.

10. The OFT's guidance states that:

'An 'enterprise' may comprise any number of components, most commonly including the employees working in the business and the assets and records needed to carry on the business, together with the benefit of existing contracts and/or goodwill. In some cases, the transfer of physical assets alone may be sufficient to constitute an enterprise: for example, where the facilities or site transferred enables a particular business activity to be continued. Intangible assets such as intellectual property rights are unlikely, on their own, to constitute an 'enterprise' unless it is possible to identify turnover directly related to the transferred intangible assets that will also transfer to the buyer. In interpreting these principles, the OFT will have regard to the following specific considerations.

- The transfer of 'customer records' is likely to be important in assessing whether an enterprise has been transferred.
- The application of the TUPE regulations would be regarded as a strong factor in favour of a finding that the business transferred constitutes an enterprise.[12]

11. In this case, both phases one and two of the transfer of neurosurgery services include the transfer of patients, their records and staff. In the

[12] OFT Mergers – Jurisdictional and Procedural Guidance, OFT527, paragraph 3.10. See also the Joint publication of the OFT and Competition Commission, Merger Assessment Guidelines, OFT 1254, dated September 2010. There is a third consideration noted in the Guidelines relating to the payment for the goodwill obtained by the purchaser but this is not considered relevant in this specific case.

NHS, payment follows the patient.[13] As such, the transfer of patients and their records is analogous to the transfer of customer records which is an important consideration in assessing whether an enterprise has been transferred. The transfer also provides UCLH with the opportunity to earn revenues from the London Deanery and research. Likewise, both phases involve the transfer of staff under TUPE regulations.

12. The parties submitted that the date of the phase one transfer is relevant as it pre-dates the entry into force of section 79 of the HSCA.[14] The parties stated that it is unclear whether foundation trusts may be considered 'enterprises' as per the definition set out in section 129 of the Act. Moreover, the parties stated that, even if UCLH and RFH were considered enterprises by virtue of the Act, it is not certain that the transferring assets would themselves constitute an enterprise.

13. However, the parties recognised that if both phase one and phase two were considered together as a single relevant merger situation, it is probably the case that part of the neurosurgery activities of RFH have ceased to be distinct from those of UCLH and therefore the OFT would have jurisdiction to review both phases.

14. As set out above, the OFT considers that enterprises have been transferred by virtue of section 129 of the Act, and, in any event, as noted by the parties, the HSCA applies to one of the transfers under consideration. The OFT has therefore considered whether the phase one and phase two transfers constitute a single relevant merger situation that is partially completed or comprises successive events occurring within a period of two years.[15]

15. Section 27 of the Act applies to the time when enterprises cease to be distinct. In this case, the OFT considers, on the basis of the evidence available, that the phase one and two transfers are inextricably linked

[13] Payment is primarily provided on a per-episode basis with the intention that the money follows the patient. The main means of payment is 'payment by results'.

[14] Section 79 of the HSCA came into force on 1 July 2012.

[15] Section 27(2) or section 27(5) of the Act respectively.

and amount to two successive events occurring within a period of two years and therefore can be treated, for the purposes of the Act, as one transfer of an enterprise. This is without prejudice to the fact that the HSCA was not in force at the time of the first transfer given that the phase one transfer would amount to an 'enterprise' under the Act in any event.

16. As such, for the reasons given above, the OFT considers that the phase one and two transfers (the **Target Services**), by virtue of section 27(5) of the Act, are together arrangements that are in progress or contemplation which if carried into effect will result in the creation of a relevant merger situation.[16]

Share of supply test

17. As stated above, the turnover of the Target Services is valued at approximately £8.5 million. As such, the turnover test, as set out in section 23 of the Act, is not met.

18. The parties have a combined share of supply of NHS neurosurgery services within London of 29.33 per cent, with an increment of 7.84 per cent attributable to RFH (based on the parties' estimates).

19. The OFT therefore considers that the share of supply test is met as the parties have a combined share of supply in excess of 25 per cent, with an increment attributable to RFH, in a substantial part of the UK. Consequently, the OFT considers that it is or may be the case that a relevant merger has been created and that arrangements are in progress or contemplation which, if carried into effect, will result in the creation of a relevant merger situation as per section 23 of the Act.

[16] The OFT is also aware of two previous transfers involving neurosurgery services from the RFH to UCLH. These being the transfer of acoustic neuroma services (non cancerous tumour of the ear canal) in 2010 and the transfer of neuro-oncology services (cancer affecting the brain, spinal cord or nervous system) in April 2011 (discussed further as part of the counterfactual analysis). The OFT has used its discretion and not included the 2011 transfer as part of its assessment of this Transaction.

COUNTERFACTUAL

20. The OFT's approach to the appropriate counterfactual is outlined in section 4.3 of the Merger Assessment Guidelines (the Guidelines).[17] The OFT considers the effect of the merger against the most competitive counterfactual (provided that situation is realistic). The description of the counterfactual is affected by the extent to which events or circumstances and their consequences are foreseeable, thus enabling the OFT to predict with confidence the appropriate counterfactual.

21. In practice, the OFT generally adopts the prevailing conditions of competition as the counterfactual.[18] However, where the OFT considers that the prevailing conditions of competition are not realistic based on the evidence available, it will assess the merger against an alternative counterfactual.

22. The parties submitted that the relevant counterfactual is the unplanned cessation of neurosurgery at RFH for reasons of clinical safety. The parties stated that this would have occurred as the London Deanery had informed RFH that, due to its size, its neurosurgery medical rota was not sustainable and that the funding for training posts would be removed from the RFH from 1 June 2012.

23. The parties submitted that there would have been a transfer to UCLH in an unplanned way in the absence of a structure/planned transfer of neurosurgical services. The parties stated that a structured transfer of these specialist services was required for patient safety.

24. In forming a view on an 'exiting firm' scenario, the OFT will consider:[19]

    (i) whether the firm would have exited (through failure or otherwise) and if so

[17] Merger Assessment Guidelines, *supra.*

[18] *Ibid*, paragraph 4.3.5.

[19] Merger Assessment Guidelines, *supra,* paragraph 4.3.8.

(ii) whether there would have been an alternative purchaser for the firm or its assets to the acquirer under consideration, and
(iii) what would have happened to the sales of the firm in the event of its exit.

25. The exiting firm scenario may be satisfied where an entity is likely to exit for financial or other strategic reasons. In many cases, an entity can show that it is failing financially but there will be other cases where exit is inevitable for strategic or other reasons. In this case, the parties stated that there were strategic reasons, based on clinical and funding concerns, for exit of the RFH neurosurgery services being a likely possibility within the foreseeable future.

26. In satisfying the above test, the OFT must be satisfied that it was inevitable that the services would have exited the market and that there was no substantially less anti-competitive purchaser for these services.[20]

27. The OFT's investigation has shown that the chronology of events leading up to an agreement in relation to the Transfer Services from RFH to UCLH is complex. It is clear that the parties had entered into discussions about the reconfiguration of neurosurgery services between the two trusts from as early as 2009. The evidence provided shows that the parties had identified as an objective the provision of unified neurosurgery services to eliminate duplication across the trusts' sites. In August 2010, acoustic neuroma surgery[21] was transferred from RFH to UCLH. Following on from this, neuro-oncology services transferred from RFH to UCLH in April 2011.

28. Further discussions continued in relation to the transfer of the remaining neurosurgery services, although these were not confirmed at this date. In November 2011, as noted above, the London Deanery informed RFH that if its neurosurgery services and training were not reconfigured, the number of trainees should be reduced to two on a non-resident rota. The basis for the London Deanery's concerns were that there had been a failure at the RFH to plan promptly and

[20] Ibid, paragraph 4.3.10.

[21] See footnote 16.

adequately for the training changes flowing from the previous neurosurgery reconfigurations in 2010 and 2011 (described above). This, the parties stated, led to the RFH's Board deciding on 28 March 2012 to transfer the remaining neurosurgery services to UCLH.

29. Whilst the OFT accepts the threat of the imminent removal of the London Deanery funding may have impacted on training posts at the RFH and added a sense of urgency to the parties' discussions, the evidence provided does not support a conclusion that absent the merger exit was inevitable. This is for two interrelated reasons. First, the earlier transfers, in particular the transfer of neuro-oncology services, had a direct impact on the overall sustainability of service rotas for the remaining services at the RFH and, in turn, therefore played a part in the London Deanery's decision to remove funding for training posts. Put simply, these earlier transfers had left RFH with insufficient rotas to sustain an effective neurosurgery unit. It is notable that the RFH's neurosurgery unit was the smallest unit in the UK with only five consultant neurosurgeons.

30. Second, even though these earlier transfers may have left RFH in a precarious position, it is not clear to the OFT whether it was inevitable that RFH's remaining neurosurgery services would have exited the market absent the merger. This is because, even without the funding, it may have been possible for RFH to find other options to continue the services. Although the parties noted that there is a limited number of alternative trained specialist staff to provide neurosurgery services of the kind remaining at RFH and that obtaining locum cover for the training posts would not have been feasible in the mid-to-long term, the evidence available from the parties does not demonstrate that the exit of RFH's neurosurgery services as a whole was inevitable absent the merger.

31. Even if the OFT did consider that it could confidently predict, on the basis of the evidence available, that exit of RFH's neurosurgery services would have occurred absent the Transaction, the OFT would need to satisfy itself that there was no less anti-competitive purchaser who could have credibly acquired the services. The evidence indicates that other potential hospitals were not considered and therefore it has not been possible to satisfy this limb of the test. Given that neither limb

one or two of the exiting firm scenario is satisfied, it has not been necessary for the OFT to consider limb three.

Conclusion on the counterfactual

32. In light of the above the OFT has considered the impact of the Transaction against the prevailing pre-merger conditions of competition, that being the existence of a separate RFH neurosurgery unit as existed prior to the phase one transfer in June 2012.

FRAME OF REFERENCE

Introduction

33. The parties are both acute hospital service providers with activities in neurosurgery. Neurosurgery is a clinical specialty related to the surgical treatment of disorders of the brain, spinal cord and other parts of the nervous system. Neurosurgical services in the UK are provided from regional neuroscience centres servicing populations of between one and 3.5 million.[22] There are currently about 25 neurosurgery departments in separate acute hospitals in the United Kingdom.

34. In order to analyse the competitive effects of a transaction, the OFT seeks to identify an appropriate frame of reference/relevant market. The OFT's starting point in identifying an appropriate frame of reference is generally to consider whether narrow candidate markets can be widened through substitution on the demand-side. If appropriate, the OFT then considers if substitution on the supply-side allows several products that are not demand-side substitutes, to be aggregated into one wider market.[23]

35. In the case of hospital mergers, the OFT's starting point is to consider the narrowest set of substitute clinical services from the demand-side (patient/commissioner perspective) in which the merger parties overlap and then to consider the incentives of a hypothetical monopolist to

[22] According to the Intercollegiate Surgical Neurosurgery Curriculum Programme, dated August 2010, which sets out the syllabus for the training of NHS neurosurgeons.

[23] Merger Assessment Guidelines, *supra*, paragraph 5.2.6 to 5.2.19.

raise prices, lower quality or reduce access. In the case of NHS hospital mergers, demand-side substitution may relate to decisions by:

(i) the patient or the GP making the referral to the secondary care provider (secondary care)
(ii) the consultant/trust making a referral for a tertiary (or specialist) treatment (tertiary/specialist care) or
(iii) the payer (the NHS commissioners).

36. In NHS hospital mergers, an analysis of the supply-side involves an examination of the extent to which a supplier of alternative clinical services would have the ability and incentive to switch in an easy and timely manner (typically within two years) into the provision of a service or procedure in response to a decrease in the quality of the services provided by a hypothetical monopolist supplier.[24]

37. The OFT also considers that the pathway for the provision of patient care can, where appropriate, be divided into primary, secondary and tertiary services. This segmentation has relevance to market definition given that there are often different types of services, in terms of actual care provided and the level of complexity. There are also different suppliers providing such services at each stage of the pathway for a given specialty. A simple way to describe this segmentation is by reference to the suppliers/parties involved at each stage of the provision of a clinical service to a patient:

(i) primary care where a patient presents to a GP with a medical problem (patient and GP)
(ii) secondary care, when the patient is referred from a GP to a consultant (patient, GP or other healthcare professional and consultant) and
(iii) tertiary (or specialist) care, when the patient is referred from a consultant to a specialist consultant (patient, consultant and specialist consultant).

[24] *Ibid*, paragraph 5.2.17. The OFT took this approach in its recent decision in Royal Bournemouth/Poole, *supra*.

38. Tertiary or specialist services address more complex clinical situations than 'routine'[25] clinical conditions and may be purchased by specialised commissioning groups. These are distinct from the commissioners of primary and secondary services for their local and/or regional areas.

39. The OFT also considers that non-elective care requires spare capacity to meet uncertain demand and that the conditions of this demand are different depending on the services (that is, there may not be any patient choice in an emergency situation). These aspects of service provision may limit the ability and the incentive for a provider to switch providing these services in response to a five per cent price rise or equivalent decrease in quality.

Relevant Product Scope

The parties' views

40. The parties stated that the relevant product market is the provision of neurosurgery services to NHS patients[26] that includes routine elective, non-elective and specialist services, submitting that it is not appropriate to segment the provision of neurosurgery into these three separate categories for the purposes of market definition. They stated that, from a demand-side, there is no substitutability between different treatments, these being required on the basis of clinical need (that is, they are all differentiated services).

41. From a supply-side, according to the parties, there are many factors that suggest that one market for neurosurgery services is appropriate. These factors are:

    - neurosurgery is a core surgical specialty with a separate NHS speciality code (code 150)

[25] Routine elective clinical care can be planned and typically requires a referral from a GP or an allied healthcare professional. Non-elective care is provided in an unplanned or in urgent circumstances.

[26] The parties submit that there is a separate relevant market for the provision of neurosurgery services to private patients. As the OFT has not identified any prima facie concerns in relation to the provision of neurosurgery services to private patients this is not discussed further.

- a neurosurgery department must, for clinical reasons, provide a full suite of neurosurgery services
- individual neurosurgeons must be able to provide the full range of neurosurgery services set out in the Intercollegiate Surgical Curriculum Programme, and
- there are no clinical or operational reasons to consider emergency treatment (non-elective treatment) and elective treatment, or in-patient and out-patient episodes as distinct product markets.

42. The parties also submitted that changes that will be brought about by the HSCA (discussed further below) support their contention that neurosurgery services are highly specialised and should be treated, from a market definition perspective, differently from other types of non-specialist medical services.

43. Specifically, the current responsibility for commissioning (the term used for purchasing health services) specialist services, including specialist neurosurgery services, lies with each of the ten separate regionally based Specialised Commissioning Groups (SCGs) acting on behalf of their member PCTs. Within the Greater London area, this includes the London SCG and to some degree the South of England SCG. As a result of the HSCA, the responsibility for commissioning some specialist services will pass to the NHS Commissioning Board (NHS CB) from 1 April 2013.

44. The parties stated that this change means that from a demand-side all neurosurgery services will be commissioned by the NHS CB and from a supply-side, all neurosurgery providers will be expected to provide a full range of both routine elective and non-elective services.[27] The parties also stated that this delineation is irrespective of the source of referral or patient pathway.

[27] The parties did highlight a distinction for paediatric neurosurgery which is provided predominantly by Great Ormond Street Children's Hospital. However, as the parties do not overlap in the provision of neurosurgery services to children the OFT is of the view that it is not necessary to consider this further.

The OFT's views

45. The OFT's investigation has shown that, within the provision of neurosurgery, there may be services which are more complex or specialised than others. This is supported by the parties' internal documents which drew a distinction between 'high volume general neurosurgery' and 'highly specialised services'.

46. From a demand-side, the OFT considers that there are generally different pathways to patient care dependent on the type of referral and that these may often be associated with routine and specialist neurosurgery services (see paragraph 37 above). In this case, it is noted that the parties are both part of University College of London Partners,[28] and as such have agreed (albeit without a binding commitment) to provide services (including neurosciences) within this network and most tertiary referrals would then come from this associated hospital network. This system of tertiary referrals is very different from primary referrals where GPs may use 'Choose and Book' to select amongst all potential providers of neurosurgery services.

47. The OFT notes the parties' rejection of patient pathway analysis and its use in the segmentation of neurosurgery services into routine, specialist and non-elective services. They stated that whilst primary referrals may relate to more frequent or less complex neurosurgery treatments, the condition is assessed by the same consultants using the same equipment regardless of the pathway. Furthermore, it may often be the case that what presents as a 'routine' neurosurgery issue transpires to be extremely serious or complex.

48. From a supply-side perspective the OFT notes the comments set out in the Intercollegiate Surgical Curriculum Programme that NHS neurosurgery consultants must be competent to manage unselected emergency and urgent admissions to a regional neurosurgical unit and will be capable of taking full responsibility for the continuing care of patients in a neurosurgical unit. Furthermore, it is set out in the

[28] UCL Partners is one of five accredited academic health science systems in the UK bringing together clinicians from partnership trusts with the aim of delivering outcomes in research, education and patient care.

curriculum that an NHS neurosurgery consultant must be proficient in all aspects of the clinical and emergency operative management of patients presenting with the essential neurosurgical conditions.[29]

49. The OFT considers that the classification of all neurosurgery services as specialised services for the purposes of the NHS CB could support a finding that it is not appropriate to consider a segmentation of neurosurgery services by routine and specialist for the purposes of assessing this Transaction.

50. The OFT notes that the NHS CB will be responsible for planning, commissioning and contracting specialised services using a national provider and service map and that this is different to the current arrangements where PCTs commission and contract for a local population. The OFT also observes that the NHS CB will be assisted by Local Area Teams (LATs),[30] that will, in relation to London, be contracting with all London providers for all neurosurgery activity but on the basis of all of the population across the country. In a sense, there remains a local component over which is transposed a national need and requirement for a specialised service with a limited number of specialists able to provide such services across the country.

51. As part of its incoming remit to commission specialist services, the NHS CB, supported by clinical advisory groups, has consulted on which services should be considered 'specialised services or prescribed services' and it has defined all neurosurgery activity as falling within the sole remit of the NHS CB.[31] Consequently, from 1 April 2013, all neurosurgery activity will be commissioned by the NHS CB for all patients in England. In other words, unlike the vast majority of other

[29] These are noted to include cranial trauma, spontaneous intracranial haemorrhage, hydrocephalus, intracranial tumours, CNS infections, spinal trauma, benign intradural tumours, malignant spinal cord compression, degenerative spinal disorders and emergency paediatric care.

[30] 'Securing equity and excellence in commissioning specialised services' prepared by the specialised services commissioning transition team and published November 2012 provides an overview of the pending changes in commissioning.

[31] It is noted that the following two treatment categories are excluded: all discharges or transfers with a diagnosis of head injury and hospital stay under 48 hours and peripheral nerve surgery for carpal tunnel syndrome, ulnar nerve entrapment, radial nerve entrapment, tarsal tunnel syndrome or common peroneal nerve entrapment.

healthcare services, which are commissioned by locally based clinical commissioning groups, neurosurgery will be directly commissioned on a national basis.

52. Notwithstanding the above, the OFT considers that it may not be feasible for a trust unilaterally to begin providing a tertiary service. The OFT considers that is likely that a provider of tertiary or specialist neurosurgery services would be able to begin providing routine neurosurgery services in the same specialism, but that a provider of routine neurosurgery services would not be able to switch to providing a specialist neurosurgery service.

53. In relation to the distinction between elective and non-elective care, the OFT considers that non-elective care requires spare capacity to meet uncertain demand and that the conditions of this demand are different depending on the service (that is, there may not be any patient choice in an emergency situation).These aspects of service provision may limit the ability and the incentive for a provider to switch to providing non-elective neurosurgery services.

Conclusion on the relevant product scope

54. The OFT has considered the parties' arguments carefully. It notes that there are some arguments from a supply-side perspective, including the pending changes to the manner in which neurosurgery services are commissioned from April 2013, that suggest a wider relevant product scope to include all routine, specialist and non-elective neurosurgery services. In contrast, from a demand-side perspective, the OFT's view is that as patients cannot substitute between different kinds of neurosurgery a segmentation between routine, specialist and non-elective neurosurgery services would be more appropriate.

55. However, as the OFT has not identified any competition concerns arising from the transaction on the basis of a distinction between routine/specialist or elective/non-elective it has not been necessary to conclude on the precise product scope and it has assessed the case below taking all neurosurgery services together (unless specified).

Relevant Geographic Scope

56. The OFT will consider the competitive effects of a transaction in the relevant product market in a relevant geographic area/market. The principles for analysing the relevant geographic scope are set out in the Guidelines.[32]

57. Consistent with the OFT's approach in its decision in Royal Bournemouth/Poole the OFT asked the parties to provide catchment area analysis for 80 per cent of their neurosurgery activity. In addition, by way of a sensitivity check, the OFT also asked the parties to provide the 70 per cent and 90 per cent catchment areas for their activities.

58. The data provided by the parties indicates that UCLH has a wider catchment area for neurosurgery services than RFH and this is consistent with the parties' submission that UCLH is a national centre of excellence in neurosurgery with a strong reputation. Indeed, the OFT was informed by a third party that for some highly complex neurosurgery services (such as surgery for Parkinson's disease) at UCLH, the relevant geographic scope is national.

59. Tables 1 and 2 below provide information on the number of spells at each of the parties' sites by PCT and Clustered PCT which forms the basis for the OFT's consideration of the relevant catchment area.

[32] *Supra*, paragraphs 5.2.21 to 5.2.27.

Table 1. Number of spells at RFH for neurosurgery activity by PCT and Clustered PCTs[33]

Clustered PCTs	Activity (volumes)	Per cent
North London	**279**	**61.7**
NCL Cluster	235	52.0
NWL Cluster	39	8.6
NEL Cluster	5	1.1
North East of London	**157**	**34.7**
Hertfordshire PCT	108	23.9
East of England SHA	49	10.8
South London	**5**	**1.1**
Other areas	**3**	**0.7**
South East of London	**3**	**0.7**
Midlands	**4**	**0.9**
Not Applicable	**1**	**0.2**
Total	**452**	**100**

Source: OFT analysis of data provided by the merger parties.

60. Table 1 shows that the 95 per cent catchment area of RFH includes PCTs in North London and to the North East of London. The 70 and 80 per cent catchment areas could include North London and some parts of the PCTs to the North East of London. A market delineation including North London and the Hertfordshire PCTs is consistent with evidence provided by Commissioners, other third parties and the parties' internal documents.

[33] Based on HRG data supplied by the parties on activity by provider and PCT.

Table 2. Number of spells at UCLH for Primary Care neurosurgery activity by PCT and Clustered PCTs[34]

Clustered PCTs	Activity (volumes)	Per cent
North London	**3,874**	**63.4**
NCL Cluster	2,239	36.7
NWL Cluster	896	14.7
NEL Cluster	739	12.1
South London	**567**	**9.3**
SEL Cluster	364	6.0
SWL Cluster	203	3.3
North East of London	**755**	**12.4**
Hertfordshire PCT	439	7.2
East of England SHA	316	5.2
South East of London	**432**	**7.1**
South East Coast SHA	432	7.1
Other areas	**273**	**4.5**
Midlands	**75**	**1.2**
#N/A	**133**	**2.2**
Grand Total	**6,109**	**100**

Source: OFT analysis of data provided by the parties

61. Table 2 shows that the 85 per cent catchment area for neurosurgical services of UCLH includes all PCTs in Greater London (North and South London PCTs) and North East of London. The 75 per cent catchment area includes North London PCTs and PCTs to the North East of London, again taking evidence from the parties, Commissioners and other third parties into account.

62. The data indicates that UCLH has a wider catchment area than RFH and this is consistent with the parties' submission that UCLH is a centre of excellence in neurosurgery with a strong reputation.

63. The OFT tested whether, for the purposes of assessing this transaction, a narrower catchment area for routine neurosurgery services was appropriate. Although the parties were not able to provide

[34] Based on data supplied by the parties for first neurosurgery outpatient appointments.

this information, the North Central London Commissioning Group (North Central London CG) suggested that a higher rate of referrals to the parties came from within North Central London than from North London and Hertfordshire. The OFT has set this information against the comments of the North Central London CG that there is no formal catchment area and that it is supportive of the transaction.

Conclusion on relevant geographic frame of reference

64. In light of the above, and considering all of the evidence received, the OFT considers that the narrowest relevant geographic scope is the PCT areas in North London and Hertfordshire. It has not been necessary to define a relevant geographic market for UCLH because the OFT's main theory of harm pertains to the constraint the merger removes on RFH.

COMPETITIVE EFFECTS

65. The OFT considered whether unilateral effects were likely to arise in relation to the provision of neurosurgery services in the areas of North London and Hertfordshire as a result of the Transaction. In particular, the OFT is concerned about the loss of the constraint that UCLH places on RFH.

66. The OFT considered whether the Transaction might reduce the parties' incentives to undertake investment or actions (for example to continue to enhance the quality of those services over the minimum required standards), to compete for patient income by not undertaking the same level of investment, or actions which attract patients to a particular hospital (such as shorter waiting times and better auxiliary services). This can occur, for example, following the cessation of services at one of the parties' sites, a reduction in patient choice of provider, or the increase in distance the patient must travel for care. As part of its assessment, the OFT considered whether the Transaction would increase travelling time for patients or reduce the choice available.

67. In addition, the parties' internal documents suggest that the overarching plan is to 'develop and implement a single neurosurgery service in North Central London'. This development, or steps towards it, would remove commissioner's choice of provider in North London or

at the least remove the commissioner's ability to generate competition to be the sole North London provider.

68. The parties stated that there are features to the NHS health economy that would affect any attempt by the parties to engage in unilateral behaviour post-transaction. These features are:

(i) the presence of a mandatory national tariff for most acute treatments through PbR[35] set annually by the Department of Health, and the downward pressure both on PbR and non-tariff prices, negate the parties' ability to exercise market power by raising prices and

(ii) NHS providers cannot limit output by deciding to limit the number of patients they accept for treatment. On the contrary, NHS providers are obliged to treat all clinically appropriate referrals under the Standard Contract.

69. The parties referred to the non-competitive drivers of quality such as the Care Quality Commission (CQC),[36] the General Medical Council (GMC),[37] the National Standard Contract,[38] which allows Commissioners to specify certain quality standards from providers, and the regulation by Monitor of foundation trusts.

70. The parties stated that innovation in the provision of health services is generally fostered through collaboration rather than competition. The

[35] See footnote 13 above.

[36] The CQC sets standards for the providers of clinical services and all providers must be registered with it. If a provider fails to satisfy the requirements set by the CQC, it has the power to issue warning notices, impose or change conditions of registration, or suspend or cancel such registration.

[37] The GMC is responsible for the registration and licensing of doctors. It is also introducing a process of five-yearly 'revalidations' for practising doctors aimed at improving the quality of care.

[38] The parties also highlighted the introduction by the Department of Health of 'Commissioning for Quality and Innovation' by which NHS providers may earn an additional 2.5 per cent of contract revenue if certain 'stretch' quality indicators are met.

parties referred to UCLH's academic and research partnerships via UCL Partners, through shared learning, best practice, and appropriate funding.

71. In light of the OFT's theory of harm, and consistent with its competitive assessment in Royal Bournemouth/Poole, the OFT considered the shares of supply attributable to the parties, whether they are close competitors and the competitive strength of the remaining constraints on the parties post-transaction.

Share of supply

72. The parties' estimated shares of supply of neurosurgery services in North London and Hertfordshire are set out in Table 3 below.

Table 3: Shares of supply based on referrals from North London and Hertfordshire (1 April 2011 to 31 March 2012).[39]

Provider	Activity	Per Cent
University College London Hospitals NHS FT	2524	33.2
Royal Free Hampstead NHS FT	1039	13.6
Combined UCLH & RFH	**3563**	**46.8**
Imperial College Healthcare NHS Trust	1676	22.0
Barts Health NHS Trust	1197	15.7
Barking Havering and Redbridge University Hospitals NHS trust	678	8.9
Cambridge University Hospitals NHS FT	305	4.0
King's College Hospital NHS FT	127	1.7
St. George's Healthcare NHS Trust	66	0.9
Total	7612	100

Source: parties' estimates

73. The parties' combined share of supply post-transaction is approximately 47 per cent with an increment of 13.6 per cent and, as such, is at a level to raise prima facie competition concerns. [40]

74. In terms of other service providers active in the same geographic area, the OFT observes that Imperial College Healthcare NHS Trust (Imperial) and Barts Health NHS Trust (Barts) had shares of supply in excess of RFH. Other suppliers with shares of supply in this geographic area below 10 per cent include Barking Havering and Redbridge University Hospitals NHS Trust (Barking), King's College Hospital NHS Foundation Trust (King's) and St. George's Healthcare NHS Trust (St. George's). On a cautious basis, the OFT considers Cambridge University Hospitals NHS Foundation Trust (Cambridge) only in relation to the competitive constraint it poses in relation to the northern part of the relevant catchment area.

[39] Based on code 150 (neurosurgery) inpatient spells.

[40] This is consistent with the approach taken by the OFT in its decision in Royal Bournemouth/Poole, supra, paragraphs 69-70.

75. The OFT notes that King's and St. George's receive a limited amount of activity from this geographic catchment. This corroborates the OFT's understanding that referral patterns break across the River Thames.

Closeness of competition

76. Given the relatively high combined shares of supply in the geographic frame of reference, albeit with two providers having higher market shares than RFH, the OFT has considered how closely the parties compete with each other. This is because, in general, the level of competition loss resulting from the merger of two competitors depends, in part, on the closeness of the competition between them. The OFT analysed the following elements in assessing the level of closeness between the parties: the geographic proximity of the parties' neurosurgery units, parties' internal documents, the level of care quality and likely diversion (switching) between the parties.

77. The parties' hospitals are approximately four miles and a 15 minute drive-time apart. In geographic terms, UCLH is the closest competitor to RFH whereas Barts is closer to UCLH than RFH is. Figure 1 in Annexe A shows a map of the neurosurgery providers in the greater London area and the presence of providers to the west (Imperial), the east (Barts and Barking[41]), and the south (King's and St. George's).

78. RFH's internal documents highlight UCLH as a particularly strong constraint in all aspects of neuroscience and the parties informed the OFT that in the event that RFH were to close its neurosurgery service, the majority of patients would switch to UCLH.

79. The OFT, therefore, considers that diversion may be higher between UCLH and RFH given the geographic proximity of the parties in relation to each other and the fact that UCLH has a reputation as a centre of excellence in neurosurgery. It is also the case that both parties achieve acceptable levels of quality in provision of neurosurgery services, with SHMI figures below the national average.[42]

[41] Neurosurgery services are provided at Barking's Queen's Hospital site.

[42] SHMI is the Summary Hospital-level Mortality Indicator, a ratio between the actual mortality rate following a treatment for a healthcare service and the number of expected patient deaths on the basis of the average mortality rates in England.

80. In summary, therefore, the evidence available to the OFT points to the parties' neurosurgery services being close competitors. Set against this, and before turning to the strength of remaining neurosurgery service providers, the OFT notes that RFH's neurosurgery unit may have been weakening as a competitive constraint on UCLH with the London Deanery indicating a significant reduction in trainee posts and associated funding without service reconfiguration.

81. The OFT considered third party comments that the combination of the removal of the London Deanery funding coupled with the low levels of activity, below critical mass, would have resulted in unviable neurosurgery services at the RFH. Whilst the evidence is not sufficient to satisfy the exiting firm test, discussed above, the OFT has taken this information into account when assessing the competitive constraint that RFH would have on UCLH absent the Transaction. The OFT notes that this does not take account of the loss of competitive constraint of UCLH on RFH absent the Transaction.

Strength of remaining neurosurgery service providers

82. As the OFT considers that the parties are close competitors and that the loss of competition may therefore lead to competitive harm it has gone on to consider whether there are competitive constraints post-merger which would be sufficient to counteract any potential harm occasioned by this loss of close competition. In this context, as seen above, post-transaction there will remain at least five neurosurgery service providers which are active and compete in the same geographic area as the merger parties, namely: Barts, Imperial, Barking, King's and St. George's. The OFT also notes, on a cautious basis, that Cambridge imposes a competitive constraint on the northern area of the relevant catchment.

83. The OFT notes the parties' submission[43] that a patient resident in North London will have the choice of six providers of neurosurgery services (including UCLH) within 15 miles of RFH's site (three centres within five miles and five within nine miles). The parties set this against other parts of England such as Oxford where a patient has an option of two

[43] The parties state that this information is based on data from the NHS Choices website.

neurosurgery centres within 48 miles, in Manchester, an option of three within a 20 mile radius and in Birmingham, one within 15 miles and four within 20 miles.

84. Third parties noted that Imperial is a strong constraint on the parties. In relation to Barts, one third party advised that it had a different catchment area to the RFH and therefore was a weak constraint on it. However, it did consider it was a stronger competitor to UCLH than RFH due to its close geographic proximity to it. Another third party indicated that Barts was a strong constraint because it provides a full range of brain and spinal services.

85. Third party information was mixed on the strength of King's and St. George's. This is mainly driven by the fact that they are in the South East London, Kent and East Sussex catchment area. However, in its response, King's indicated that it competes with both parties for all neurosurgery services.

86. The OFT obtained the views of the relevant commissioning groups:

- The North Central London CG expressed its support for the Transaction, noting that there were risks associated with the RFH unit, given its small size (the smallest stand-alone neurosurgery unit in the country). It noted significant benefits to the merger that it considers would result in increased quality of patient care.

- The London SCG stated that whilst the Transaction reduces the number of providers in terms of the absolute numbers of service providers available, it was not clear that this would result in a significant reduction in competition. It also noted that the increase in size of the unit should lead to improvement in patient outcomes, improved sub-specialisation as a consequence of which education and research would improve.

- The South of England SCG noted that the Transaction would not be problematic from a competition point of view and was likely to be beneficial to patients. It considers that there is sufficient coverage to continue to offer multiple choice of providers post-transaction,

although it noted that RFH and UCLH only account for approximately six per cent of its demand for neurosurgery services.

87. In light of the above, the OFT considers that there will be sufficient choice of remaining neurosurgery providers post-transaction to mitigate any competition concerns arising from the Transaction. Within the relevant catchment area there will be Barts, Barking, Imperial, King's and St. George's. Barts and Imperial have market shares in excess of RFH with 15.7 per cent and 22 per cent respectively, and Barking, King's and St. George's have shares of 8.9, 1.7 and 0.9 per cent respectively. All of the above neurosurgery services have in excess of five neurosurgeons and all offer a wide range of neurosurgery services.

88. The SHMI data also suggests that Barking, St. George's and King's hospitals perform better than the national average with Barts and Imperial slightly worse than average (that is, Barts and Imperial have a higher than expected mortality rate).

89. Whilst, on a cautious basis, the OFT does not consider Cambridge to exert a complete constraint on the parties, it is not fanciful to suggest that it provides a partial competitive constraint on the parties in the northern part of the relevant catchment area, namely within the area covered by the Hertfordshire PCTs. Cambridge is also noted to perform better than the national average in terms of its SHMI.

Conclusion on unilateral effects

90. The OFT believes that there will be sufficient remaining competitive constraints post-transaction with a comparable neurosurgery offering to mitigate any unilateral effects arising from the Transaction.

BUYER POWER

Changes in NHS commissioning

91. As set out in the Guidelines, the existence of countervailing buyer power will be a factor in making a substantial lessening of competition finding less likely.[44] In this case, there will be one customer for

[44] Merger Assessment Guidelines, supra, paragraphs 5.9.1 on.

neurosurgery services in England, the NHS CB, who will commission services on a national level. As such, all providers of neurosurgery services regardless of its catchment area will be required to comply with the nationally set criteria.

92. As discussed above, the OFT considers it appropriate to take account of the changes to commissioning which will take effect from 1 April 2013.[45] As all neurosurgery activity has been designated as a specialised service it will be solely commissioned by NHS CB regardless of whether the treatment in question may have been classified as routine, specialist or non-elective.

93. The OFT has considered whether the changes in the commissioning landscape will provide the NHS CB some level of countervailing buyer power from 1 April 2013.

94. The parties submitted that the shift to the NHS CB will create a new dynamic and that the NHS CB will be able to actively use its position as the sole commissioner of specialised services to exercise buyer power. In support of this submission the parties refer to the comments of Sir David Nicholson, Chief Executive Officer of the NHS CB in which he is quoted as saying the NHS CB would use its position as 'a big, powerful commissioner'[46] in the reconfiguration of specialised services.

95. The OFT notes that according to the Manual for Prescribed Specialist Services[47] there are currently 25 Adult Neuroscience Centres active in the provision of adult specialist neurosciences services (which includes neurosurgery services). As such, the NHS CB will have a number of providers against which to benchmark against the national quality criteria.

[45] The National Health Services Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (SI 2012/2996), made under the NHS Act 2006 and HSCA allocates responsibility to the NHS CB for commissioning of specialist services for rare and very rare conditions.

[46] As reported in the Health Services Journal dated 14 January 2013.

[47] Prepared by the specialist services commission transitional team dated November 2012 and available: www.commissioningboard.nhs.uk/resources/spec-comm-resources .

96. The OFT was also informed that whilst the transaction leads to a reduction in choice of provider, the NHS CB will have other levers by which to exert buyer power. These were noted to be quality standards that may be specified in the commissioning contracts.

97. The OFT is conscious that these changes are not yet in place and therefore there is some degree of uncertainty as to how it will operate in practice. As such, given the fact that the new arrangements are not in place, it is too early to judge whether the NHS CB will have buyer power in this context and the OFT has not, therefore, been able to place reliance on this factor in reaching this decision.

BARRIERS TO ENTRY AND EXPANSION

98. As the Transaction does not raise a realistic prospect of a substantial lessening of competition the OFT has not needed to consider whether there are any barriers to entry and expansion in the provision of neurosurgery services in the UK. Notwithstanding this, the OFT considers that barriers to entry or expansion are likely to be high given the highly specialised nature of neurosurgery services, the level of training required to obtain consultancy status and lack of surplus trained consultant or junior staff in the United Kingdom and the specific and technical equipment required to perform such services.

THIRD PARTY VIEWS

99. Third party views have been incorporated throughout the decision where relevant.

100. One third party trust did raise a concern about the lack of supporting medical specialties at UCLH which would impact the admission of patients with certain co-morbidities. However, this impact was not qualified to any great degree and this concern was not raised by the commissioning groups or any other third party.

CONCLUSION ON THE COMPETITIVE ASSESSMENT

101. In light of the OFT's assessment that there is no realistic prospect of unilateral effects arising from the transaction, the OFT finds that there is

no realistic prospect of a substantial lessening of competition in the provision of neurosurgery services in North London.

RELEVANT CUSTOMER BENEFITS

102. As the OFT has concluded that there is no realistic prospect of a substantial lessening of competition, the OFT has not needed to considered whether there are any exceptions to the duty to refer.

103. For completeness, it is noted that the OFT's duty to refer under section 33 of the Act is subject to the application of certain discretionary exemptions of which relevant customer benefits is one. These are set out in section 33(2)(c) of the Act.

104. The parties submitted that the transaction is likely to give rise to several customer benefits, namely:

    (i) improvements to service quality in neurosurgery services
    (ii) financial benefits and
    (iii) benefits to RFH from ceasing neurosurgery provision.

105. As provided for under section 79(5) of the HSCA, Monitor, the independent regulator for foundation trusts, is required to provide the OFT with advice on the following matters:

    (i) The effect of the matter under investigation on benefits (in the form of those within section 30(1)(a) of the Act (relevant customer benefits) for people who use health care services provided for the purposes of the NHS, and
    (ii) Such other matters relating to the matter under investigation as Monitor considers appropriate.

106. Monitor provided the OFT with its preliminary views under section 79(5) on 4 February 2013.[i] In this preliminary advice it concluded that the Transaction is unlikely to result in relevant customer benefits for patients.

107. However, in light of the OFT's conclusion that there is no realistic prospect of a substantial lessening of competition, it has not

considered it necessary to take the preliminary views of Monitor into account.

ASSESSMENT

108. The parties overlap in the provision of neurosurgery services in North London. This transaction concerns the transfer of the neurosurgery services based at RFH to UCLH, including intracranial, complex and routine spine and all acute neurosurgery services. The transaction comprises two phases: phase one, which completed on 16 June 2012 and involved intracranial, complex spine and all acute neurosurgery services; and phase two, which is anticipated to complete before April 2013 and involves routine spinal services.

109. The OFT has assessed phase one and two together as per section 27(5) of the Act, that being two successive events occurring within a period of two years being treated as one transfer of an enterprise.

110. The parties have a combined share of supply of NHS neurosurgery services in London of 29.33 per cent with an increment of 7.84 per cent and therefore the share of supply test as per section 23 of the Act is satisfied.

111. The OFT considered the parties' submission that the relevant counterfactual in this case was the exit of the RFH's neurosurgery unit absent the transaction. The OFT assessed the evidence provided against the exiting firm test and concludes that, as neither limb one or two of the test are satisfied, it would assess the Transaction using the counterfactual of a separate neurosurgery unit at the RFH as it existed prior to the phase one transfer. The OFT has taken the imminent removal of the London Deanery funding for training into account in its competitive assessment.

112. The OFT considers that it is appropriate to segment the provision of neurosurgery services into routine, specialist and non-elective services. However, as the OFT has not identified any competition concerns arising from the Transaction on the basis of such a distinction, it has not needed to conclude on the precise product scope.

113. On the basis of data provided by the parties relating to the catchment area for the RFH, the OFT concludes that the most appropriate relevant geographic market for the purposes of assessing the Transaction is the area covered by the PCTs in North London and Hertfordshire.

114. The theory of harm considered by the OFT was whether the transaction would reduce the parties' incentives to undertake investment or actions to compete for patient income by not undertaking the same level of investment, or actions which attract patients to a particular hospital. It also considered whether the Transaction would increase travelling times for patients or reduce the choice available.

115. From the evidence available, the OFT concludes the parties are close competitors with a share of supply of 47 per cent, with an increment of 13.6 per cent, within the relevant geographic scope. It was also noted that they have comparable quality indicators.

116. However, the OFT also took into consideration the removal of the London Deanery funding issue to inform its view on the level of competitive constraint imposed by RFH on UCLH absent the merger. The OFT finds that the evidence suggests that the number of trainees, and associated funding, would have been reduced to two from seven. On this basis, the OFT considers that RFH may have been a weaker constraint on UCLH going forward absent the merger.

117. The OFT assessed the remaining competitive constraints within the relevant catchment area and finds that there will be sufficient competitive constraint post-transaction to mitigate any competition concerns arising. Five neurosurgery centres will remain in the catchment area post-transaction. In particular, the OFT notes that Barts and Imperial have market shares in excess of that of RFH, with Barking, King's and St. George's having further market shares of 8.9, 1.7 and 0.9 per cent respectively. In addition, the OFT has noted a competitive constraint from Cambridge primarily in the north of the catchment area.

118. The OFT also noted that the care quality indicator, SHMI, also suggests that Barking, St. George's, King's and Cambridge perform better than the national average with Barts and Imperial slightly worse than it. Furthermore, the OFT noted that all of the remaining competitive

constraints provide a wide range of neurosurgery services with a greater number of neurosurgeons than RFH.

119. Finally, the OFT has taken into account the comments of third parties, the vast majority of whom did not express any competition concerns arising from the Transaction. The relevant commissioning groups noted that the Transaction did remove a choice of provider but it was difficult to identify the competition concerns arising.

120. The OFT also considered whether the changes in the commissioning of neurosurgery services from 1 April 2013 would demonstrate the existence of countervailing buyer power. Although there may be some local dimension to the commissioning of neurosurgery services post April 2013, there will be a national approach to specialised commissioning which includes all neurosurgery services. However, as these new arrangements are not in place, the OFT has not placed any reliance on these changes in reaching its decision.

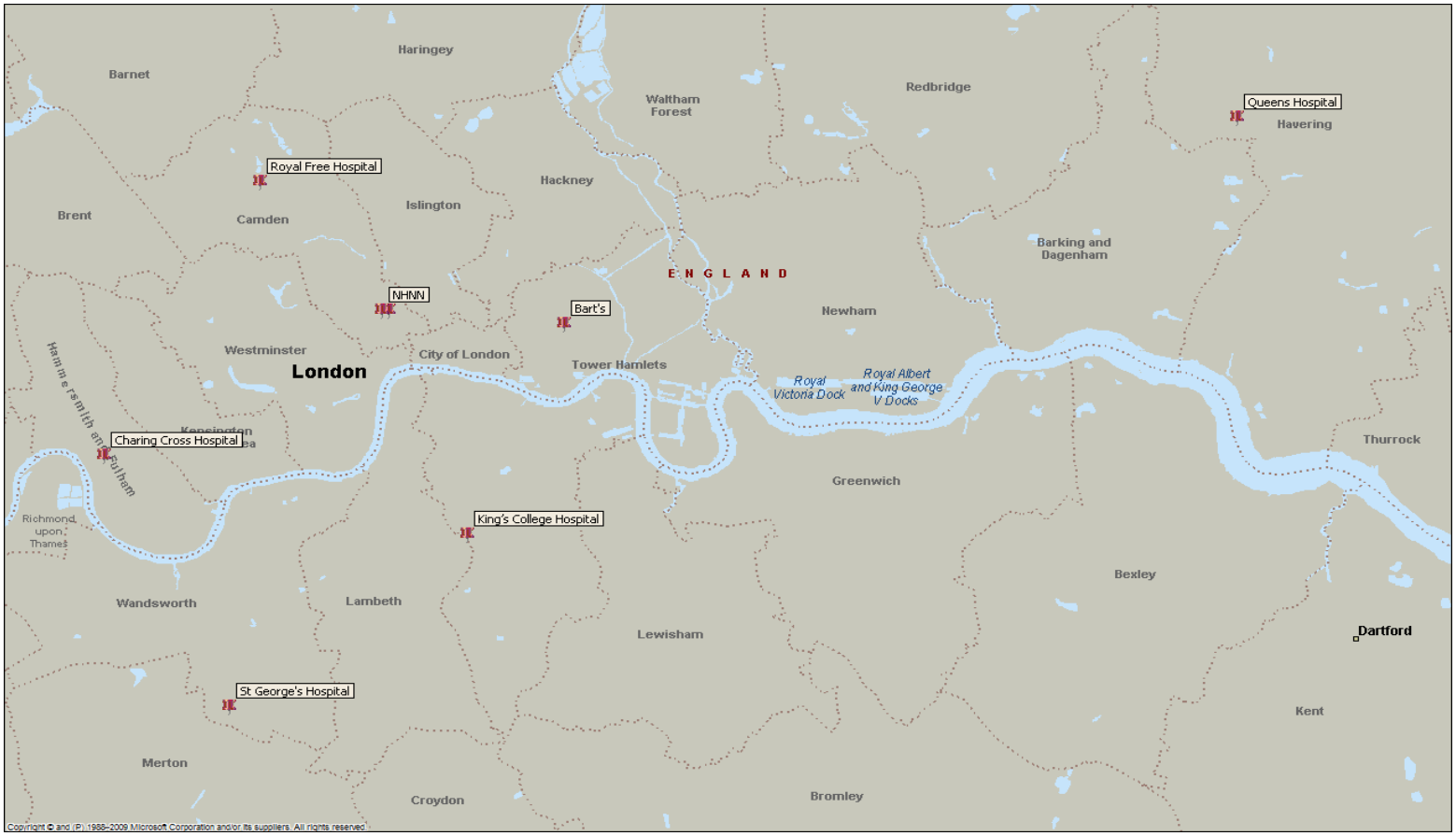
121. As the OFT has concluded that there is no realistic prospect of a substantial lessening of competition it has not needed to take into account the preliminary advice received from Monitor with respect to relevant customer benefits.

122. For the reasons outlined in this Decision, the OFT does not believe that it is or may be the case that the merger may be expected to result in a substantial lessening of competition within a market or markets in the United Kingdom.

123. This merger will therefore **not be referred** to the Competition Commission under section 33(1) of the Act.

Annexe A

Figure 1: Providers of neurosurgery services in the greater London area.



[i] Monitor subsequently provided its final advice to the OFT on 21 February 2013. A non-confidential version of Monitor's advice is published on its website at: www.monitor-nhsft.gov.uk.