CO·OPERATION & COMPETITION PANEL
FOR NHS-FUNDED SERVICES

Merger of the provider services arms of NHS Richmond and NHS Hounslow

EXECUTIVE SUMMARY

1. The Cooperation and Competition Panel (CCP) has examined the proposed merger of the provider services arm of NHS Hounslow (Hounslow Provider Services) with the provider services arm of NHS Richmond (Richmond Provider Services). We have recommended to the London Strategic Health Authority (NHS London) that the transfer be allowed to proceed.

2. Under this transaction, Hounslow Provider Services will transfer to NHS Richmond. NHS Hounslow will enter into a community services agreement with NHS Richmond for the provision of community services by the merged entity. NHS Hounslow will retain full ownership and control over the buildings currently used by Hounslow Provider Services.

3. A management alliance between Richmond Provider Services and Hounslow Provider Services came into effect in April 2009. We consider that the effect of the management alliance was to bring Richmond Provider Services and Hounslow Provider Services under common control. In our view the management alliance constituted a merger under the Principles and Rules of Cooperation and Competition (Principles and Rules) that should have been notified to the CCP before it came into effect. The proposed transfer of Hounslow Provider Services to Richmond Provider Services is a further step in the integration of the two entities.

4. When considering a merger, we assess whether it may give rise to costs[1] to patients or taxpayers as a result of a loss of choice or competition and, where this is the case, whether these costs are offset by benefits to patients or taxpayers arising from the merger.

5. In assessing the possible costs to patients and taxpayers of this merger, we have examined the services to patients currently provided by Richmond Provider Services and Hounslow Provider Services, and considered whether the merger, in reducing the number of bidders for community services contracts, would have a significant impact on patient choice or competition.

6. Our conclusion and recommendation are based on our evaluation that the merger is unlikely to impose any material costs on patients or taxpayers by reducing the scope for patient choice or competition. This is because there is a substantial number of potential providers of community services in Richmond and Hounslow and the surrounding South West London area. As a result, our view is that the loss of one competitor would not have a material effect on the extent of patient choice or competition. Given this, it has not been necessary for us to evaluate the patient and taxpayer benefits which NHS Richmond and NHS Hounslow consider would accrue as a result of the transaction.

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[1] It should be noted that, for the purposes of this report, the term 'cost' is used to refer to any detriment, whether financial or otherwise.

PARTIES

7. NHS Richmond is the Primary Care Trust (PCT) for the London Borough of Richmond upon Thames. It is responsible for commissioning health services on behalf of the local population (approximately 180,100 people[2]), as well as directly providing services through its community health services provider, Richmond Provider Services, which has been operating in a management alliance with Hounslow Provider Services since April 2009. In 2008/09, the income of Richmond Provider Services was approximately £25.98 million[3], with around 91 per cent of this generated from the commissioning arm of NHS Richmond. The community services provided by Richmond Provider Services are set out in Appendix A.

8. NHS Hounslow is the PCT for the London Borough of Hounslow. It is responsible for commissioning health services on behalf of the local population (approximately 222,600 people[4]), as well as directly providing services through its community health services provider, Hounslow Provider Services, which has been operating in a management alliance with Richmond Provider Services since April 2009. In 2008/09, the income of Hounslow Provider Services was approximately £26.42 million[5], with around 90 per cent of this generated from the commissioning arm of NHS Hounslow. The community services provided by Hounslow Provider Services are set out in Appendix B.

TRANSACTION

9. The transaction being reviewed by the CCP is:

   (i) the management alliance between Richmond Provider Services and Hounslow Provider Services, which came into effect in April 2009; and

   (ii) the proposed transfer of Hounslow Provider Services to NHS Richmond.

10. The terms of the proposed transfer are to be set out in two draft agreements: (i) 'Phase One: HR and certain Financial Services'; and (ii) 'Phases Two and Three: Transfer of Community Services and Related Corporate Services'. Both agreements are between NHS Richmond, NHS Hounslow and Richmond Provider Services.

11. The management alliance entered into in April 2009 was the result of option appraisals carried out separately by NHS Richmond and NHS Hounslow, and the resulting business cases that were then separately approved by the boards of NHS Richmond and NHS Hounslow. It was the

[2] Source: *Population – Mid-2008 Resident Population Estimate (2001 Census based)*, Office for National Statistics.
[3] Joint Service Line Review - report for the Richmond PCT Board, October 2008, p35. We note that this income differs from the total income reported in Appendix A. The parties indicate this is because the sources of the information they used are different.
[4] Source: *Population – Mid-2008 Resident Population Estimate (2001 Census based)*, Office for National Statistics.
[5] Joint Service Line Review - report for the Hounslow PCT Board, October 2008, p35. We note that this income differs from the total income reported in Appendix B. The parties indicate this is because the sources of the information they used are different.

preliminary step in the transfer of Hounslow Provider Services to Richmond Provider Services. The option appraisals took place in the context of the broader policy requirement for greater separation between the commissioner and provider arms of PCTs.[6] The management alliance involved the creation of a joint provider committee (a sub-committee of both PCT boards) and a single management team across the two providers. The management alliance gave both parties the ability to influence each other's policy in respect of their provider arms.

12. We consider that the effect of the management alliance was to bring Richmond Provider Services and Hounslow Provider Services under common control. In our view the management alliance constituted a reviewable merger under the Principles and Rules and should have been notified to the CCP before it came into effect.

13. The risks to organisations of putting a merger into effect without CCP approval is that the CCP's subsequent review concludes that the merger is inconsistent with the Principles and Rules and recommends that that action be taken to address the loss of patient choice and competition resulting from it. This might be a recommendation that the merger parties be separated. This could have significant consequences for employees and even patients. For the avoidance of doubt, the CCP expects parties to seek prior approval for management alliances which constitute reviewable mergers. Where there is any uncertainly as to whether a proposed management alliance constitutes a reviewable merger under the Principles and Rules, parties should seek informal advice from the CCP.

JURISDICTION

14. The transaction, which we consider to be both the management alliance and the proposed transfer, is a merger for the purposes of a CCP review, as Hounslow Provider Services will be, and has effectively been since April 2009, under the control of NHS Richmond.

15. Following notification of the transaction, we decided that it met our acceptance criteria for a merger inquiry. Specifically:
    (i) the proposed arrangement falls within the scope of Principle 9[7] of the Principles and Rules;
    (ii) the CCP is the most appropriate body to consider this matter;
    (iii) NHS Richmond and NHS Hounslow had made available sufficient relevant and applicable information on the case to the CCP; and
    (iv) the combined turnover of NHS Richmond and Hounslow Provider Services exceeds the relevant threshold of £35 million.

16. As a result, we accepted the case on 14 August 2009, published a notice to this effect on our website on that date, and invited submissions by interested individuals and organisations.

[6] Department of Health, *Transforming Community Services: Enabling new patterns of service provision*, January 2009.
[7] Principle 9 states: 'Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money.' The Principles and Rules for Cooperation and Competition are available at http://www.ccpanel.org.uk/content/Principle-and-rules-for-Cooperation-and-Competition.pdf.

Consistent with our draft interim merger guidelines[8] we are required to complete our Phase 1 review by 12 October 2009.

17. Our review of this merger, and our advice and recommendations in relation to it, fall within the broader regulatory framework overseen by the SHAs and ultimately the Secretary of State for Health. NHS London, as the SHA responsible for NHS Richmond and NHS Hounslow, will consider our advice and any recommendations in relation to the proposed merger, and may require NHS Richmond and NHS Hounslow to implement our recommendations.

18. In considering this transaction as a merger, we have had regard to Principle 9 of the Principles and Rules. We have not reviewed the transaction process for consistency with the Principles and Rules. Pursuant to the CCP's terms of reference, to the extent that this gives rise to any procurement questions, the CCP will consider these questions only on appeal from SHAs' dispute resolution processes; to the extent that it gives rise to any conduct issues, a complaint must be made to the CCP before we can investigate the issue(s).

19. Also consistent with our terms of reference, we have not considered the appropriateness of NHS Richmond as an acquirer of Hounslow Provider Services, other than in terms of the impact of the merger on patient choice and competition. Responsibility for the selection of NHS Richmond as the acquirer of Hounslow Provider Services and for the delivery of those services following the merger remains with NHS Hounslow and NHS Richmond respectively and, in relation to service quality, also the Care Quality Commission in due course.

FRAMEWORK FOR MERGER ASSESSMENT

20. The framework that we use to assess mergers between healthcare providers is set out in the Principles and Rules and our draft interim merger guidelines.

21. The relevant provision of the Principles and Rules is Principle 9, which states:

> 'Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money.'

22. Our draft interim merger guidelines set out a cost-benefit framework for the assessment of mergers under this Principle.[9] That is, where a merger may give rise to costs to patients or taxpayers as a result of a loss of choice or competition, then these will be weighed up against

[8] The CCP's draft interim merger guidelines are available at www.ccpanel.org.uk.

[9] A merger might give rise to costs to patients and taxpayers if it diminishes patient and commissioner choice and competition. As set out in the *Framework for Managing Choice and Competition,* published by the Department of Health on 16 May 2008, patient choice and competition in the NHS can be expected to improve quality and safety in service provision, improve health and well-being, improve standards and reduce inequalities in access and outcomes, lead to better informed patients, generate greater confidence in the NHS, and provide better value for money.

any benefits to patients or taxpayers that may arise from the merger so as to determine whether the proposed transaction is likely to result in a net benefit to patients and taxpayers.[10]

23. Consistent with this framework, this report provides an assessment of the costs to patients and/or taxpayers that may arise from the proposed merger. We have not considered it necessary to assess the benefits to patients and/or taxpayers that may arise from the proposed merger, as we have not identified any significant costs.

DEVELOPMENT OF CHOICE AND COMPETITION IN COMMUNITY SERVICES

24. The following paragraphs set out the broader context in which the proposed merger is taking place in terms of the development of choice and competition in community services. This is important as our assessment needs to consider the impact of the merger on both patient choice and competition currently, and the capacity for choice and competition to develop in the future.

25. The Department of Health's vision for community services was set out in the *NHS Next Stage Review: Our vision for primary and community care* published in July 2008. In relation to the development of choice and competition in community services, it stated that there would now be a 'stronger focus on extending patient choice in ... community care' (p.27), and that 'patient choice should extend to a wide range of community-based services' (p.28) as a means of helping to drive continuous quality improvement.

26. There are, of course, many other components of the Next Stage Review vision for community care that go beyond patient choice and competition, such as listening and responding to patients and local communities, ensuring that services fit together, and promoting healthy lives. However, as our analysis of this merger requires us to consider its impact on patient choice and competition, it is on these aspects that we have focused as they provide the context for our assessment of the merger's impact.

27. *Transforming Community Services: Enabling new patterns of provision*, published in January 2009, sets out how the Next Stage Review vision for community care will be realised. The guiding principles set out in this document in relation to patient choice and competition state that:
    - 'Proposals [for future organisational options for community services] must enable patient choice and personalisation' (p.19); and
    - 'PCTs should also encourage – where necessary – entry by other appropriate potential providers' (p.20).

28. In preparing commissioning strategies for community services, PCTs are required to 'set out an indication of which services may be subject to seeking "any willing PCT-accredited provider"

[10] Where the CCP finds that there are no costs to patients or taxpayers arising from a merger, it will not necessarily critically evaluate patient or taxpayer benefits ascribed to the merger by the merger parties.

(AWPP) status or competitive tendering, and over what timescale' (p.28).[11] PCTs are required to engage in a planning process to deliver these objectives.

29. Further, PCTs are advised that in 'drawing up their supply-side strategy [they] will have to balance the need to sustain viable, high-quality suppliers, whilst promoting choice and innovation through encouraging new entrants. In particular, the PCT will need to be clear about any shifts towards vertical or horizontal integration, which result in a reduction in competition or choice. The development of existing provider organisations should not in the medium term concentrate the provision of services in a more limited number of organisations' (p.30).

30. The Department of Health told us that they expect all PCTs to begin to develop commissioning specifications for transforming community services, giving a priority to common long-term conditions and end of life care. This is in the context of PCTs needing to offer patients with long-term conditions choice, linked to the roll-out of individual care plans. The Department of Health has produced a standard community services contract for use in the commissioning of community services[12].

DEVELOPMENT OF PATIENT CHOICE AND COMPETITION IN COMMUNITY HEALTH SERVICES IN RICHMOND AND HOUNLSOW

31. NHS London has previously told us that it expects PCT commissioners to have articulated their commissioning strategy for community services for two to three priority areas by the end of October 2009, and for their entire commissioning strategy for community services to be complete by September-November 2010. It said that it would be reasonable to assume that for some community services patient choice and competitive tendering would be the appropriate way forward. As part of the commissioner performance regime, NHS London will be ensuring that PCTs are making progress against their commissioning strategy during 2010-11 and thereafter.

32. Both NHS Richmond and NHS Hounslow have told us that, in order to meet their World Class Commissioning objectives, they are currently preparing detailed commissioning strategies for their existing community services over the next two to three-year period. Accordingly, a number of services will be put out to tender over that period.

33. In addition, both NHS Richmond and NHS Hounslow plan to commission a number of new or reconfigured services over the next five years. For NHS Richmond these include:
    - 'staying healthy' services, including sexual health;

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[11] The AWPP model is a variant of the basic any willing provider (AWP) model which is described in the PCT Procurement Guide (Department of Health, May 2008). It retains the core features of the AWP model, namely open access for providers of defined services who: are registered with the Care Quality Commission to provide the defined service; agree to comply with appropriate standard NHS contract terms; are paid at the national tariff or some other agreed local common rate for the services; and who get no guarantee of activity volumes. In addition, the relevant PCT is able to set service specific accreditation requirements, such as service standards or access requirements.

[12] The standard contract is available at http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dH_091451

- Expert Patient Programme (EPP) (enabling patients to manage their own long-term conditions);
- development of polyclinics;
- new community-based services for cardiology, urology, dermatology, gynaecology, general surgery, ENT and orthopaedics; and
- stroke prevention and community rehabilitation services.

34. For NHS Hounslow, new or reconfigured services to be commissioned include:
    - increase in GP capacity (extended opening hours and patient walk in service at the polyclinic practice);
    - rapid response / Hospital @ Home Service; and
    - GP out of hours services as part of the Urgent Care Centre proposals.

35. NHS Richmond and NHS Hounslow have told us that they do not anticipate that their commissioning strategies would change if the proposed transaction were to proceed. Further, NHS Richmond and NHS Hounslow would enter into the Department of Health's standard community services contract with any provider it contracts with to provide community services (be that Richmond Provider Services, Hounslow Provider Services, or any other provider), regardless of whether the merger of Richmond Provider Services, Hounslow Provider Services took place or not. The transaction would therefore have no effect on the timing of the competitive tendering of community services.

ASSESSMENT OF MERGER COSTS

36. To assess the likely effect of the merger on patients and taxpayers as a result of any loss of choice or competition arising from this merger (i.e. the costs of the merger), this section assesses the extent of any loss of patient choice or competition in the supply of community health services in Richmond and Hounslow as a result of the merger. The effect of the loss of a potential competitor (i.e. as a result of it merging with another potential competitor) is measured not only by how many other potential competitors remain, but by their relative credibility as bidders in relation to the merging parties.[13]

37. Appendix C discusses the services and geographic area (i.e. the markets) in which the merging parties compete (market definition). As set out in this Appendix, our assessment of the effect of this merger would not vary with our findings on market definition; we therefore do not consider it necessary to identity precisely the market that is most appropriate for analysing the effects of the merger. However, for the purposes of explaining our competitive assessment of this merger, we refer to the market for community services in Richmond and Hounslow.

[13] Our assessment of the impact of this merger was based on a review of the current situation and the existing provider landscape. We are aware that in developing their options for Transforming Community Services, some PCTs in South West London and surrounding areas are considering mergers of their community services provider arms. We have not taken these possible future transactions into account.

38. The proposed merger might reduce competition in community health services due to the loss of a potential provider of community health services.[14] In particular, there are two ways in which the loss of a potential provider might reduce competition:
    (i) first, through removing a potential bidder/entrant in the supply of community health services; and
    (ii) second, through removing an actual provider of community health services, thereby reducing patient choice (under an Any Willing Provider model of service provision).

39. At the present time the predominant mode of choice and competition in community services in Richmond, Hounslow and elsewhere, is commissioner choice and competition for the market. The Any Willing Provider model, which would introduce patient choice and competition in the market, has not to date been widely used. As a result, in evaluating the impact of the merger we have focused on the effect on commissioner choice.

40. When assessing the competitive impact of a merger, we consider its impact in comparison with a situation where the merger did not take place (i.e. the 'counterfactual').

41. NHS Richmond and NHS Hounslow both considered a range of potential alternatives to the proposed merger. Undertaking separate option appraisal exercises, both considered that the establishment of their provider services arms as autonomous provider organisations, distinct from NHS Richmond and NHS Hounslow and distinct from one another, to be the next best alternative to a merger with an existing provider arm. As a result, we consider that the appropriate counterfactual to the proposed merger is the establishment of Richmond Provider Services and Hounslow Provider Services as separate autonomous provider organisations.

42. To assess the effect of the proposed merger on competition, we examined the extent of competition in community services currently and how this would be likely to develop in the near future. In doing so, we considered:

    (i) the overlap in services provided by Richmond Provider Services and Hounslow Provider Services;
    (ii) evidence from third party bidding over the past three years;
    (iii) the future bidding intentions of third parties; and
    (iv) NHS Richmond and NHS Hounslow's assessment of who they consider their potential competitors to be.

Overlap in services provided by Richmond Provider Services and Hounslow Provider Services

[14] We considered and dismissed other ways in which the merger might affect competition. The merger would not significantly increase the incentive and ability of the providers to coordinate their behaviour due to uncertainty around the commissioning plans of PCTs and future structure of the supply-side. We also considered whether there was scope for the merged entity to 'bundle' services, so as to extend market power from one provider in one market (service line) into another (i.e. conglomerate effects). These effects would only materialise if the market was narrower than community health services; however, commissioners decide how and which services are tendered, making it difficult (if not impossible) for the merged entity to 'bundle' services together.

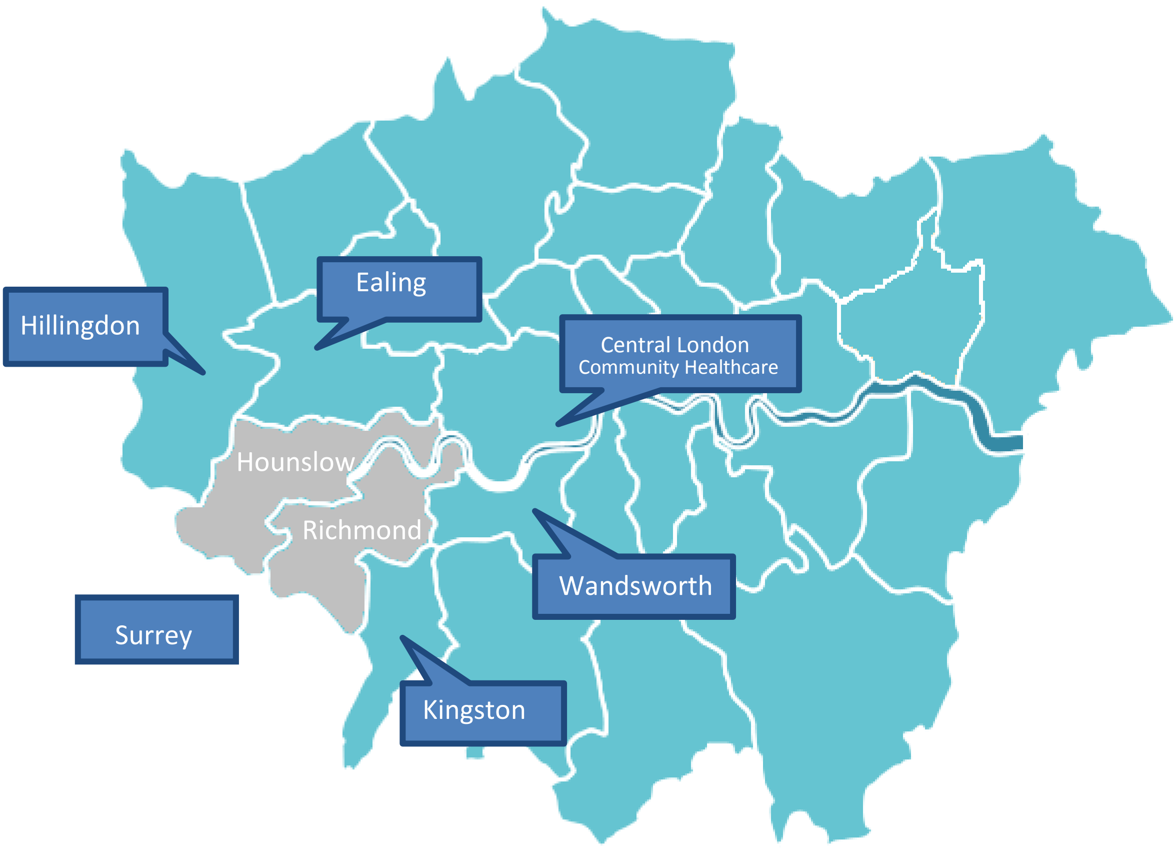
43. Each party provides a similar, broad range of community services, including some specialist services. Due to the different way the parties organise and group their service lines we have not been able to precisely identify the number or value of overlap service lines. The parties, following an internal review of service provision, identified that of 41 service lines only 16 were unique to one or other of the parties. Moreover, they found that even within those 16 services there was overlap with other services.

44. The parties identified the following services as being truly unique to Hounslow: dental services, wheelchair service, hand injuries, stop smoking and therapy & tissue viability service provided to West Middlesex University Hospital. They identified the following services as being truly unique to Richmond: inpatients, walk in centre, respiratory care, paediatric community nursing, paediatric dietetics and portage. Based on this information, we estimate that at least 60% of income received by each PCT provider arm is generated from overlap services.

Evidence from third party bidding

45. Analysing evidence from third parties on their past bidding behaviour, we found that most PCT provider arms had in the past either bid for community service contracts within, or adjacent to, the area in which they are located (Figure 1 provides a map of the London and immediate area PCT boundaries). For example: [✂]

Figure 1: PCT area boundaries[15]



Source: London SHA, adapted by the CCP

Future bidding intentions of third parties

46. As service provision strategies are likely to evolve, we also asked providers where they would consider bidding in future. For example: [✂]

47. The evidence we have considered indicates that PCT provider arms located adjacent to NHS Richmond and NHS Hounslow are likely to be potential bidders for competitively tendered community services in these local markets. In the future we expect that an increasing number of bids will come from PCT providers that are not adjacent, particularly since some providers are already bidding for services outside their immediate and adjacent areas and others have indicated that they would consider doing so in the future.

48. Other NHS organisations could also potentially offer community services in Richmond and Hounslow. Of particular relevance to this merger are those acute providers in close geographic proximity to these areas. For example: [✂]

[15] The map refers to PCT provider services organisations serving populations in and around Richmond and Hounslow and does not reflect the provider landscape across London SHA.

49. We note that acute providers are likely to become closer competitors in the future, as contracts for services that were previously provided in an acute setting are competitively tendered for provision in a community setting in the future.

50. There are also a number of independent and third sector organisations that could provide services under a patient choice model, or bid for certain individual community services contracts that might be let by either NHS Richmond or NHS Hounslow. Analysing recent bidding data for community service tenders that have been commissioned by seven PCTs in the London area[16], we found that of the 28 tendered contracts 15 were for healthy lifestyle (smoking, obesity, sexual health) and substance misuse services, and of these all but one were won by either independent/third sector organisations, primary care organisations or mental health trusts. Of the remaining 13 contracts, covering services including dermatology, end of life care and phlebotomy, bids came from a range of organisations including acute providers, mental health trusts and the independent/third sector.

The parties' assessment of their potential competitors

51. NHS Richmond told us that it considers its competitors for community services to include other PCT providers, in particular Wandsworth and Kingston (which are both adjacent to the Richmond PCT area).[17] For some services it considers local acute hospitals, in particular Kingston and West Middlesex University Hospital, and independent sector providers, such as SERCO and Clinicenta, as competitors.[18]

52. NHS Hounslow told us that it considered it considers its competitors for community services to include other PCT providers, in particular Ealing & Harrow, Central West London Community Healthcare and Surrey Health.[19] However, it considers any other PCT provider in the South East of England to be a potential competitor in the future. It also believes there to be a number of emerging private sector primary care providers which it considers may expand into community care, notably Harmoni (which provides out of hours primary care in Ealing) and Green Brook (who have recently taken on GP PMS practices formerly managed by Hounslow Provider Services), and that there are a number of private sector companies (for example Clinicenta and Medihomes) operating in specialist niches such as diagnostics, sexual health services, post-surgical care at home and rehabilitative therapies.[20] It also considers the local acute hospital

[16] We analysed bidding data for community services contracts that had been commissioned in PCT areas surrounding Richmond and Hounslow over the period January 2006 to July 2009. Those who responded to our request for this data and who had awarded contracts over that period were [✂]. Although we recognise that bidding behaviour may vary across the London area, we do not consider that such variation is sufficiently significant to alter our analysis.

[17] In total, NHS Richmond identifies 15 (out of 24) service lines identified in Appendix A, representing around 60% of its income, where other PCT provider arms provide competition. These include district nursing and physiotherapy services.

[18] Services identified by NHS Richmond where PCT provider arms were not identified as competitors, but acute providers were, represent around 35% of its income and include: children's continuing care; paediatric audiology, and walk in centre. Services identified by NHS Richmond where PCT provider arms were not identified as competitors, but independent/third sector organisations were, was limited to sexual health.

[19] In total, NHS Hounslow identifies 18 (out of 26) service lines identified in Appendix B, representing over 80% of its income, where other PCT provider arms provide competition. These include district nursing, physiotherapy and paediatric speech and language therapy services.

[20] NHS Hounslow has recently contracted Clinicenta to provide Acute Home Care services for the next 5 years, although we note that this service is to provide additional capacity and will operate alongside rather than replace the service provided by Hounslow Provider Services.

(West Middlesex University Hospital) as a potential competitor, particularly in respect of care pathways that span secondary care.

Conclusion

53. We considered the potential concern that, in the context of competitively tendered services, a merger may adversely affect patients and taxpayers if it is the case that the merging parties would often be the two most effective competitors, with other alternatives being significantly less preferred than the merging parties. We consider that Richmond Provider Services and Hounslow Provider Services are likely to have been close competitors in respect of community services in the absence of the merger.

54. However, we consider that a significant number of alternative bidders are also credible and effective. Therefore, if Richmond Provider Services and Hounslow Provider Services were to merge, thereby removing a competitor from the market, the effect on competition would not be significant.

55. We also considered whether potential suppliers of community health services in Richmond and Hounslow would face significant barriers to entry that would render it difficult for them to compete against the proposed merged entity in the future. We note that NHS Hounslow, in its proposed transfer of Hounslow Provider Services to NHS Richmond, will retain the buildings required for the delivery of community services. Given this, we have not identified any significant barriers to entering the market for the supply of community services in Richmond and Hounslow.

ASSESSMENT OF MERGER BENEFITS

56. In assessing whether a proposed merger could be expected to give rise to an adverse effect on patients and/or taxpayers, we will have regard to any benefits to patients and/or taxpayers arising from the merger (see paragraphs 5.51 to 5.60 of the draft interim guidelines)[21]. In respect of patients, these benefits may take the form of higher quality services, a greater choice of services or greater innovation in relation to such services. In respect of taxpayers, the benefit is likely to be a better price paid by commissioners for services from the merged entity. Such benefits must be expected to accrue within a reasonable period from the merger and be unlikely to accrue without the merger.

57. Given that we have not identified any significant costs as a result of this merger, it has not been necessary for us to analyse the presence or extent of these benefits in detail, nor their likelihood to materialise within a reasonable time period. We note, however, that our assessment would only consider benefits that it is anticipated would accrue as a direct result of the merger. Although in this case the assessment of benefits was unnecessary, we consider that the benefits the parties considered would accrue did not appear to be merger-specific, and as a result, may not have been relevant to any benefit assessment. For the avoidance of doubt, when submitting a case to be considered by the CCP, parties should submit a robust, merger-specific benefits case

[21] The CCP's draft interim merger guidelines are available at www.ccpanel.org.uk.

to us at the beginning of the inquiry process, as it will not be clear at that stage whether there might be costs to patients or taxpayers.

ADVICE AND RECOMMENDATIONS

58. In conclusion, we find that the proposed merger between NHS Richmond and Hounslow Provider Services will not adversely affect the extent of patient of choice and competition that takes place in community services in the boroughs of Richmond upon Thames and Hounslow in the future, because of the considerable amount of potential credible bidders in those areas.

59. As we have not identified any significant costs to patients and taxpayers of the proposed merger, it has not been necessary for us to consider any benefits to patients and taxpayers that could be expected to accrue as a result of the merger.

60. Based on these considerations, we consider that the proposed merger is consistent with the Principles and Rules of Cooperation and Competition and recommend that it be allowed to proceed. We note, however, that we might not come to the same conclusion in respect of similar proposed mergers in the future. This is because as further consolidations take place, the competitive landscape is likely to change. Each proposed merger will be assessed having regard to the competitive landscape which exists at the relevant time.

61. It is noted that the analysis, advice and recommendations set out in this report have been given by the CCP on the basis of information it has received to date. Should there be any change in respect of any of the matters referred to in this report, including but not limited to the terms of the proposed merger and the commissioning strategies of NHS Richmond and NHS Hounslow, we expect the parties to re-refer the matter to us for further consideration.

12 October 2009

APPENDIX A

COMMUNITY HEALTH SERVICES PROVIDED BY RICHMOND PROVIDER SERVICES

Service Group	Service Line	Income (£ '000)	% of income
Adult Services	District Nursing & Community Matron Services	4,454	21%
Adult Services	Inpatients	4,106	19%
Children and Young People's Services	Health Visiting (including Specialist Health Visiting) & School Nursing	3,663	17%
General All Ages Services	Walk In Centre	1,500	7%
Adult Services	Musculoskeletal Physiotherapy	1,099	5%
Children and Young People's Services	Children's Continuing Care Team, Children's Community, Nursing Team and Community Paediatric Medical Service	870	4%
Children and Young People's Services	Paediatric Speech and Language Therapy Service	756	3%
Adult Services	Intermediate Care	657	3%
Adult Services	Podiatry Services	599	3%
Adult Services	Community Neuro-rehabilitation Team (including adult speech and language therapy)	546	3%
Non Core Services	Diagnostics support to Walk in Centre	470	2%
Children and Young People's Services	Safeguarding Function	416	2%
Adult Services	Continence Services	391	2%
Children and Young People's Services	Paediatric Occupational Therapy	358	2%
Adult Services	Community Physiotherapy	267	1%
Non Core Services	Family Planning & Reproductive Health	267	1%
Children and Young People's Services	Paediatric Physiotherapy	258	1%
Adult Services	Respiratory Care Team	208	1%
Children and Young People's Services	Newborn Hearing Screening Programme	208	1%
Children and Young People's Services	Paediatric Audiology	175	1%
Non Core Services	Clinical Support for Outpatients	158	1%
Adult Services	Diabetes Services	123	1%
Adult Services	Tissue Viability Services	77	0%
Adult Services	Falls Team	70	0%
	Total	**21,696**	

Source: Joint Service Line Review - report for the Richmond PCT Board, October 2008, Table 4.

Notes:

1. Income relates to the 2008/09 financial year for all service lines except those General All Ages Services and Non-core Services where the income relates to estimates for 2009/10 financial year.
2. The Joint Service Line Review also identified a number of administration functions (inpatients, Adult Services and Children's Services) that have been excluded from the table. The combined budget for these services is approximately £1.072m for the 2009/10 financial year.

APPENDIX B

COMMUNITY HEALTH SERVICES PROVIDED BY HOUNSLOW PROVIDER SERVICES

Service Group	Service line	Income (£ '000)	% of income
Adult Services	District Nursing & Community Matron Services	5,110	25%
Children and Young People's Services	Universal Children's Services	2,421	12%
General All Ages Services	Combined Speech and Language Service (with West Middlesex University Hospital (WMUH))	1,396	7%
Adult Services	Musculoskeletal Physiotherapy and Hand Injuries	1,338	7%
Children and Young People's Services	Paediatric Speech and Language Therapy Service	1,007	5%
General All Ages Services	Learning Disabilities	993	5%
Children and Young People's Services	Specialist Children's' Services	980	5%
Adult Services	Community Rehabilitation Service	878	4%
Non Core Services	Community Dental Service	711	3%
Adult Services	Podiatry Services	693	3%
General All Ages Services	Combined Dietetics Service (with WMUH)	547	3%
Adult Services	Rotational Occupational Therapy posts (with WMUH)	492	2%
Adult Services	Smoking Cessation	470	2%
Adult Services	Continence Services	464	2%
Children and Young People's Services	Paediatric Audiology	437	2%
Non Core Services	Family and Reproductive Health Service	434	2%
Adult Services	Rapid Response Team	417	2%
Children and Young People's Services	Paediatric Physiotherapy	409	2%
Adult Services	Tissue Viability Services	408	2%
Children and Young People's Services	Newborn Hearing Screening Programme	275	1%
Adult Services	Diabetes Services	166	1%
General All Ages Services	Wheelchair Services	166	1%
Children and Young People's Services	Paediatric Occupational Therapy	140	1%
Children and Young People's Services	Safeguarding Function	111	1%
Adult Services	Healthy Lifestyles	66	0%
Adult Services	Expert Patient Programme	3	0%
	Total	**20,530**	

Source: Joint Service Line Review - report for the Hounslow PCT Board, October 2008, Table 4

Notes:

1. Income relates to the 2008/09 financial year for all service lines except those General All Ages Services and Non-core Services where the income relates to estimates for 2009/10 financial year.

APPENDIX C

MARKET DEFINITION

1. The most helpful way in which to assess the effect that a merger has on competition is by first identifying (or defining) the markets in which competition between the merging parties takes place. There are two dimensions to any market: a product dimension and a geographic dimension. The following paragraphs discuss the products (or, more specifically, services in this case[22]) and the geographic area in which competition between Richmond Provider Services and Hounslow Provider Services takes place.

2. A number of approaches have been employed by economists over the years to define markets in which the effects of a transaction or behaviour can be assessed. In line with international best practice, and consistent with our draft interim guidelines, the CCP uses the so-called 'hypothetical monopolist' test wherever feasible as the basis for identifying and defining the markets affected by a merger. The purpose of this test is to help identify a market, being a service or group of services and a geographical area in which they are supplied and where providers of those services compete with one another. It is within this market that the effects of a merger can be assessed.

3. Under the hypothetical monopolist test, consideration is given to the extent to which consumers (in this case, patients or commissioners) would respond if a hypothetical single provider of a service (or group of services) were to offer a poorer quality (or higher priced[23]) service (see paragraph 4.23 of the CCP's draft interim merger guidelines). Patients or commissioners may respond to lower quality (or higher prices in the case of commissioners) by using or commissioning a smaller volume of the service in question and they may use or commission other services or the same services from a provider in a different geographic area. When defining the product market, consideration is given to the other services patients and commissioners might use and when defining the geographic market, consideration is given to the other geographic areas where patients and commissioners might access services.

4. Healthcare markets are different from other markets as a result of the role played by both patients and commissioners, and we need to consider the responses of both when thinking about alternative service providers for the purposes of identifying a market affected by a merger. The capacity of patients or commissioners to access alternative service providers will be affected by whether, for example, the any willing provider model or competitive tendering is being used to supply services to patients.

5. In any merger, the services or geographic areas that are included in the market(s) identified as being affected by the merger can have a material bearing on the assessment of the extent to which choice and competition are affected by the merger. However, in other cases, particularly those which do not raise concerns it may have no bearing at all. That is, the CCP would reach the same conclusion that a merger did not give rise to a material adverse effect on patients or taxpayers regardless of how it defined the markets affected by the merger. In these latter cases,

[22] We use the terms 'product' and 'service' interchangeably in this document.
[23] Most services in the NHS are subject to fixed prices in the form of a tariff. In community services, however, there is no fixed tariff for services, the cost of which (or price) is the subject of negotiation with the PCT.

it will not usually be necessary for the CCP to reach a definitive conclusion on market definition, and in consequence, the CCP may choose not to do so in these cases.

Product market

6. The services supplied by Richmond Provider Services and Hounslow Provider Services are set out Appendices A and B.

7. In principle, the relevant product market(s) for our analysis might be:
   - separate product markets for each community service; or
   - a product market for a set of community services; or
   - a product market for all community services; or
   - a product market that includes community services and other health services such as acute services and/or primary care services.

8. In this case, we believe that the effects of the merger would be the same regardless of whether the relevant product market that is identified for the purpose of assessing competition is defined as separate product markets for the supply of individual community services or a single market for the supply of all community services. That is primarily due to the large number of actual and possible community services providers in the area capable of providing the services provided by Richmond Provider Services and Hounslow Provider Services either as a whole or individually.

9. We also considered the extent to which community service providers face competition from care provided in other settings (e.g. providers of acute care), and as a result, whether these services should also be included in the same market as community services for the purpose of assessing the effect on patient choice and competition arising from the merger. To do so, we used the framework of the hypothetical monopolist test, focusing on how patients might respond to changes in service quality from a position where only one community service provider was available to them.[24]

10. The product component of each community service can be thought of as consisting of two elements: the treatment that is provided (e.g. a dental treatment or a physiotherapy treatment) and the setting for that treatment (e.g. at home or at a community health facility). If there is only one community service provider available to a patient, then a patient, if dissatisfied with this service could, in principle, access the same treatment in an alternative setting (eg in an acute setting) if this was available.[25] If a sufficient number of patients were to do so in response to a small but significant reduction in service quality by the hypothetical sole provider, then the

[24]The PCT as commissioner could respond to a small but significant change in quality by changing provider. However, this would require them to facilitate entry of a new provider. We consider this to be more consistent with entry. The need for a PCT to contract with a new service provider for that service provider to be in a position to offer services to patients also means that we do not consider supply-side substitution (ie providers of care in non-community settings responding to a small but significant deterioration in quality by relatively quickly starting to offer community services in a community setting) to be possible at this stage.

[25]For simplicity this assumes that patients would not stop treatment altogether if they were dissatisfied with the quality of service in a particular setting.

alternative service should be included in the same product market as the community service(s) in question.[26]

11. For a number of reasons, including the inconvenience to patients of accessing treatments in an alternative setting, we think that it is unlikely that patients would significantly reduce the use of community services provided in a community setting in response to a small but significant reduction in the quality[27]. Commissioners will also be unlikely to fund provision of the same service in both a community and acute setting since the provision in an acute setting would be more expensive and would run counter to the Department of Health policy of moving healthcare into settings closer to the home. On that basis, we think it unlikely that the product market for individual community services or community services as a whole includes, for example, the same or substitute services provided in an acute setting.

12. Given these considerations, we believe the relevant product market for competitive analysis of community services is the supply of individual community services *or* community services as a whole. At this stage we consider it unlikely that the relevant product market(s) also includes other healthcare services, such as acute services.

<u>Geographic market</u>

13. The second dimension to a market is its geography. That is the area over which suppliers compete for patients. Candidate geographic markets for analysing this merger might, for example, be:
    a. the individual PCT area (e.g. separate markets for the NHS Richmond and NHS Hounslow areas) ;
    b. the individual PCT area and some or all adjacent PCT areas; or
    c. wider than the individual PCT area and all adjacent PCT areas.

14. For services provided by Richmond Provider Services and Hounslow Provider Services, residents do not currently have the opportunity to choose alternative providers outside of their PCT area. This is because it is their residential location that determines where they are eligible to access NHS-funded community services. As a result, if there were to be a reduction in service quality from their service provider, patients could not choose another from outside the individual PCT area. [28]

15. This would only change if commissioning arms of NHS Richmond and NHS Hounslow were to jointly commission jointly community services with other PCTs, and thus enable patients within to access services from elsewhere, or if they were to introduce an 'Any Willing Provider' model of provision for some services. As a result, the relevant geographic market for assessing the impact of the merger is the individual PCT areas of NHS Richmond and NHS Hounslow.

<u>Findings on market definition</u>

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[26]This, in essence, is the 'hypothetical monopolist' test.
[27] This assumes that the range of existing service provision remains and that provision in a community setting is not closed.
[28] This is reflected in the income profile of each provider arm, with around 90% generated from the host PCT commissioner.

16. In summary, the relevant product market for analysing this merger may be individual community services or community services as a whole. The relevant geographic markets for analysing the effects of this merger are the NHS Richmond and NHS Hounslow PCT areas.

17. As our assessment of the effect of this merger would not vary with our findings on market definition, we do not consider it necessary to identify precisely the market that is most appropriate for analysing the effects of the merger. However, for the purposes of explaining our competitive assessment we refer to the markets for community services in the NHS Richmond and NHS Hounslow PCT areas as the markets affected by this merger.