



CO-OPERATION & COMPETITION PANEL  
FOR NHS-FUNDED SERVICES

**Cooperation and Competition Panel**

**Merger of Buckinghamshire PCT's provider services arm with  
Buckinghamshire Hospitals NHS Trust**

**13 August 2010**

## Contents

EXECUTIVE SUMMARY .....	3
PARTIES .....	4
TRANSACTION .....	5
JURISDICTION .....	7
FRAMEWORK FOR ASSESSMENT .....	8
PATIENT CHOICE AND COMPETITION IN COMMUNITY AND ACUTE ELECTIVE CARE SERVICES.....	9
ASSESSMENT OF MERGER COSTS .....	10
ASSESSMENT OF BENEFITS .....	21
ADVICE AND RECOMMENDATIONS .....	29
APPENDIX 1 - COMMUNITY HEALTH SERVICES PROVIDED BY COMMUNITY HEALTH BUCKINGHAMSHIRE.....	32
APPENDIX 2 - MARKET DEFINITION .....	33
APPENDIX 3 - REMEDIES OFFERED BY BUCKINGHAMSHIRE HOSPITALS .....	39
APPENDIX 4 - REMEDIES OFFERED BY BUCKINGHAMSHIRE PCT .....	42
APPENDIX 5 - COOPERATION ARRANGEMENTS WITH GP BUSINESSES.....	45

## EXECUTIVE SUMMARY

1. The Cooperation and Competition Panel (CCP) has reviewed the merger of Community Health Buckinghamshire, the community health services provider arm of Buckinghamshire Primary Care Trust (PCT), with Buckinghamshire Hospitals NHS Trust (Buckinghamshire Hospitals). We have recommended to the Secretary of State for Health that the merger be approved on condition that certain measures to preserve patient choice and competition in acute elective care are adopted. These remedies will ensure the merger's consistency with the Principles and Rules for Cooperation and Competition (Principles and Rules).
2. The CCP, in reaching its findings, considered the effect of the merger on patient choice and competition in both community services and acute services. In acute services, the Panel concluded that the choice of acute elective care provider would be adversely affected for some patients by the merger. The Panel considered that patients using community services provided by the merged entity who need an acute care referral were significantly more likely to be referred to those acute services provided by the merged entity than they would have been prior to the merger.
3. To address this concern, we recommend that as a condition of approving this merger Buckinghamshire Hospitals commits to ensuring that any community services patients requiring acute elective care either be referred back to their GP or where a referral was being made by staff at its community services arm, these staff would provide patients with access to Choose and Book and impartial advice on choice of acute elective care provider. This is consistent with the CCP's recommendations in other mergers between providers of acute and community services.
4. In community services, we considered the effect of the merger on competition for community services contracts in Buckinghamshire. We concluded that the number of other credible competitors for community services contracts in Buckinghamshire meant that the merger would not adversely impact on competition for these contracts.
5. We also considered whether this merger could adversely affect patients' choice between providers of community services once the Any Willing Provider (AWP) model is introduced into community services in accordance with recent policy announcements by the Government.<sup>1</sup> With the policy of AWP in community services still under development, we could not be sufficiently sure of its impact to find that vertical integration between Community Health Buckinghamshire and Buckinghamshire Hospitals should be made subject to conditions to preserve patient choice of community services provider and the merger's consistency with the Principles and Rules. Nevertheless, we recognise that there is a possibility that the Government's policy of encouraging patient choice and competition in community services could be undermined by vertically integrated organisations, and recommend that the Government design appropriate safeguards when developing this policy.

---

<sup>1</sup> The Government's White Paper *Equity and Excellence: Liberating the NHS*, states that the NHS will move to an AWP approach as soon as possible for community health services (paragraph 4.24).

6. The Panel considered whether the merger would give rise to benefits to patients and taxpayers and reviewed the various benefits put forward by Buckinghamshire PCT and Buckinghamshire Hospitals. We did not consider that there was sufficient evidence that the merger would give rise to the benefits identified by the parties, or that the parties had sufficiently well developed integration plans that would allow the Panel to be confident that these benefits would be realised in practice. As a result, the Panel was not able to conclude that there were benefits to patients and taxpayers arising from the merger that should be balanced against the costs to patients and taxpayers arising from the loss of patient choice and competition that we identified.
7. Finally, we note that the implementation of this merger commenced during the course of the CCP's review with the transfer of Community Health Buckinghamshire staff to Buckinghamshire Hospitals. Had the CCP recommended that the merger not proceed, this may have resulted in significant costs to the parties, and uncertainty for staff, and possibly patients, in unwinding these arrangements. This risk could have been avoided had Buckinghamshire PCT brought this transaction to the CCP earlier.

## **PARTIES**

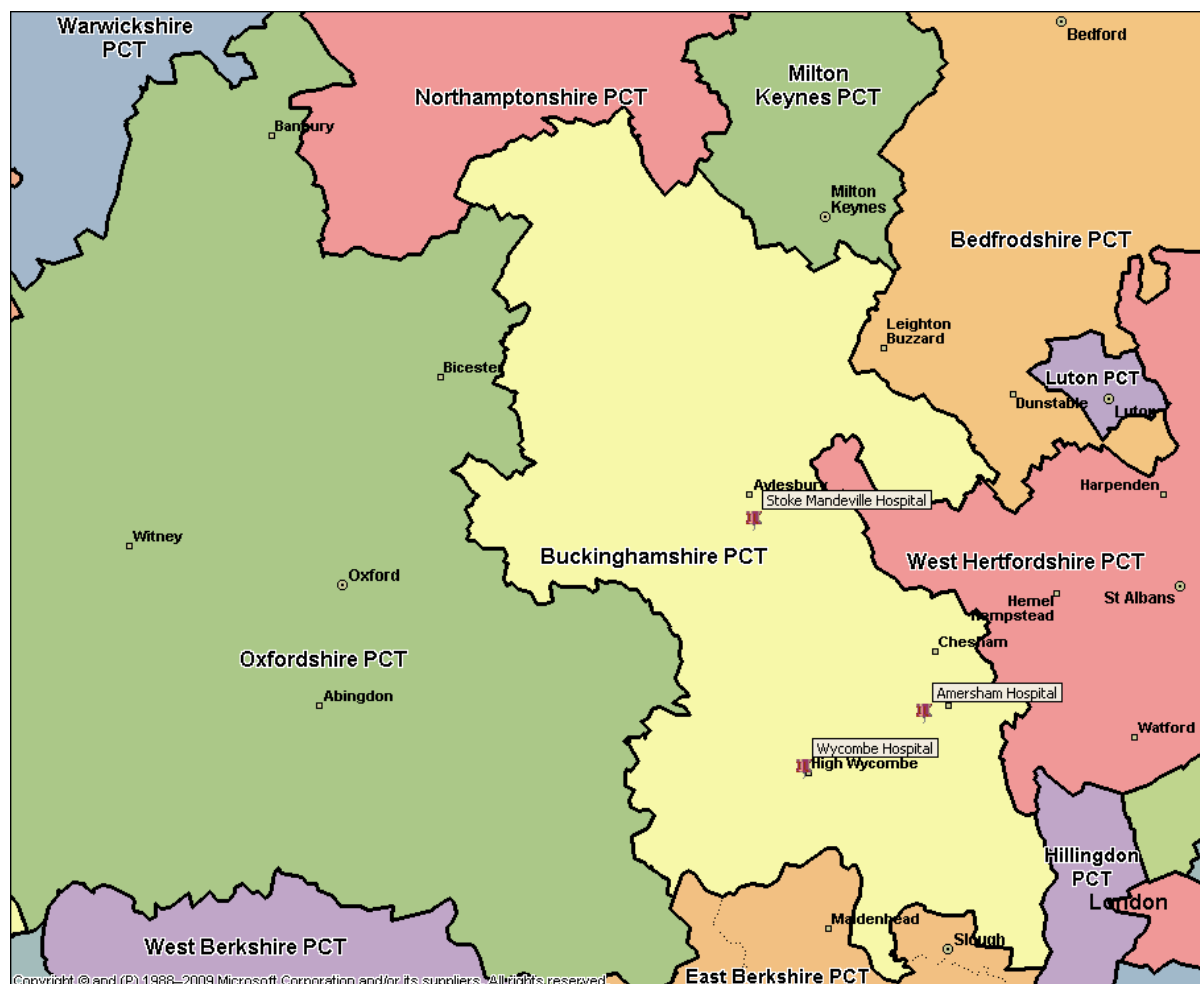
8. Buckinghamshire PCT is responsible for commissioning services on behalf of the population in its PCT area of approximately 500,000 people. Community Health Buckinghamshire has been operating as an autonomous provider organisation, within the PCT, since 1 April 2009. It had budgeted income in 2009/10 of around £41.5 million. The community services provided by Community Health Buckinghamshire are listed at Appendix 1.
9. Major services provided by Community Health Buckinghamshire include:
  - integrated care teams, which offer a range of nursing and rehabilitation services in a community setting (48 per cent of total expenditure);
  - specialist community public health nursing, comprising health visitors and school nurses (19 per cent of total expenditure); and
  - children and young people's therapy, comprising speech and language therapy, occupational therapy and physiotherapy (7 per cent of total expenditure).
10. Buckinghamshire Hospitals NHS Trust is an acute trust operating from sites in Amersham, Stoke Mandeville and Wycombe. The trust has a total of 788 beds across the three sites and, in addition to its core acute services, offers specialist treatment in burns, plastic surgery and spinal injuries. Buckinghamshire Hospitals also offers a number of community services in the south of the county as a result of the merger in 2003 between South Buckinghamshire NHS Trust and Stoke Mandeville Hospital NHS Trust, an integrated acute and community services provider, which created Buckinghamshire Hospitals NHS Trust. The community services offered by Buckinghamshire Hospitals had a combined value of £3.5 million per annum as at April 2010 and cover hospital at home/early discharge services; community paediatrics; sexual health services; speech and language therapy; community midwifery; and community nursing.<sup>2</sup>

---

<sup>2</sup> Buckinghamshire Hospitals was unable to tell us how much it spends on each of these community services individually.

11. Buckinghamshire Hospitals had budgeted income in 2009/10 of around £285 million. The CQC rated Buckinghamshire Hospitals as 'weak' for quality of financial management and 'good' for quality of services in 2008/09.

FIGURE 1  
Buckinghamshire and the surrounding area



Source: CCP

## TRANSACTION

12. The transaction being reviewed by the CCP is the proposed transfer of Community Health Buckinghamshire from Buckinghamshire PCT to Buckinghamshire Hospitals. It is the result of an options appraisal carried out by Buckinghamshire PCT, which took place in the context of the broader policy requirement for greater separation between the commissioner and provider arms of PCTs.<sup>3</sup>

13. The long list of options considered by the PCT was (in no particular order):

<sup>3</sup> Department of Health, *Transforming Community health services: Enabling new patterns of service provision*, January 2009. This requirement was subsequently confirmed in the Revision to the Operating Framework for the NHS in England 2010/11, which states at paragraph 18: "Separating PCT commissioning from the provision of services remains a priority. This must be achieved by April 2011 [...]".

- i. integration with other NHS organisations, e.g. acute providers or other PCT provider arms;
  - ii. integration with a non-NHS organisation, e.g. a local authority, a GP provider or a third sector organisation;
  - iii. become a stand-alone provider organisation, and then apply for Community Foundation Trust status;
  - iv. become a social enterprise; and
  - v. the direct provision of provider services hosted by a commissioning PCT or managed by an outside organisation through a management agreement.
14. Buckinghamshire PCT decided that options (iii) and (iv) should be ruled out, as it concluded that Community Health Buckinghamshire lacked the size and organisational capability to operate independently. It also decided against option (v), as this would mean that the PCT retained ultimate responsibility for Community Health Buckinghamshire.
15. The integration options that were considered were [redacted]. Following staff consultation, two options were shortlisted: a merger with Buckinghamshire Hospitals or a merger with another [redacted] Trust. Both parties submitted bids to Buckinghamshire PCT and a merger with Buckinghamshire Hospitals was selected as the preferred option.
16. Buckinghamshire Hospitals' bid for Community Health Buckinghamshire was supported by a partnership with three GP services providers in Buckinghamshire: Chiltern Health (2007) Limited, Vale Health Limited and The Practice PLC (together the GP Businesses).<sup>4</sup> Together, they represent 59 of 60 GP practices within the PCT area. In Buckinghamshire Hospitals' bid, the involvement of the GP Businesses was referred to as a 'partnership'. This 'partnership' as it was first presented to the CCP had the potential to represent a merger between the GP Businesses, Buckinghamshire Hospitals and Community Health Buckinghamshire, which would have required a review by the CCP under the Principles and Rules.
17. During the course of the CCP's review, the parties continued to negotiate their proposed arrangements, and the CCP considers that the current agreement between the parties, as set out in the Guiding Principles document (see Appendix 6) does not give rise to a reviewable merger. This is primarily because the GP Businesses will remain independent of the merged organisation. However, we note that cooperative agreements between GPs and providers of acute and community care can give rise to concerns under the Principles and Rules. We discuss this further in Appendix 5.
18. In April 2010, during the course of the CCP's review of this merger, the implementation of the merger commenced with the transfer of Community Health Buckinghamshire staff to Buckinghamshire Hospitals. Buckinghamshire PCT told us that this transfer was necessary because its existing arrangements for managing Community Health Buckinghamshire, through a

---

<sup>4</sup> Chiltern Health (2007) Limited is a provider organisation established by 34 GP practices within the Buckinghamshire Primary Care Collaborative, a practice based commissioning group for the south of Buckinghamshire. The Practice PLC is a primary care company providing community healthcare for the NHS with three GP practices located in Buckinghamshire. Vale Health Limited is a primary care provider organisation for the 22 GP practices in the north of Buckinghamshire.

management arrangement with Oxfordshire and Buckinghamshire Mental Health Trust, had come to an end. [X].

19. We note that the PCT was taking a considerable risk in putting in place this staff transfer. Had the CCP found the merger to be inconsistent with the Principles and Rules and recommended that the merger not proceed, this may have resulted in significant costs to the parties, and uncertainty for staff – and possibly patients – in unwinding these arrangements. This risk could have been avoided if Buckinghamshire PCT had managed the transaction process so that all of the necessary approvals were in place prior to the expiry of the management arrangement with Oxfordshire and Buckinghamshire Mental Health Trust.
20. We also note that the arrangement between April 2009 and April 2010, whereby Community Health Buckinghamshire was managed by Oxfordshire and Buckinghamshire Mental Health Trust should have been referred to the CCP for review under the Principles and Rules prior to implementation.

## JURISDICTION

21. The merger between Community Health Buckinghamshire and Buckinghamshire Hospitals is a transaction requiring review under the merger provisions of the Principles and Rules as it has resulted in Community Health Buckinghamshire coming under the control of Buckinghamshire Hospitals. Following notification of the transaction to the CCP, we decided that it met our acceptance criteria for a merger inquiry. Specifically:
  - i. the proposed arrangement falls within the scope of Principles 9 and 10 of the Principles and Rules (as set out at paragraph 26);
  - ii. the CCP is the most appropriate body to consider this matter;
  - iii. Buckinghamshire PCT and Buckinghamshire Hospitals had made available sufficient relevant and applicable information on the case to the CCP; and
  - iv. the combined turnover of Community Health Buckinghamshire and Buckinghamshire Hospitals exceeds the relevant threshold of £35 million.
22. As a result, we accepted the case on 15 February 2010, published a notice to this effect on our website on that date and invited submissions from interested individuals and organisations. We completed our Phase I review in advance of our deadline of 14 April 2010.<sup>5</sup> At the end of the Phase I review, the CCP decided the case should proceed to Phase II as there was a realistic prospect that the transaction would result in a material adverse effect on patients and/or taxpayers. A notice to this effect was posted on our website on 6 April 2010. We were required to complete the Phase II review by 7 September 2010.
23. Our review of this merger, and our advice and recommendations in relation to it, fall within the broader regulatory framework for transactions within the NHS overseen by the Secretary of State for Health and Monitor in relation to Foundation Trusts. The Secretary of State will consider our advice and recommendations in relation to the proposed merger.

---

<sup>5</sup> CCP, *Draft interim guidance on merger inquiries* (available at [www.ccpanel.org.uk/content/CONSULTATION-Mergers.pdf](http://www.ccpanel.org.uk/content/CONSULTATION-Mergers.pdf)).

24. We have reviewed the merger under Principles 9 and 10 of the Principles and Rules. We have not reviewed for consistency with the Principles and Rules the process by which Buckinghamshire Hospitals was selected as the preferred partner for Community Health Buckinghamshire. Pursuant to the CCP's terms of reference, to the extent that this process gives rise to any procurement questions, the CCP will consider these questions only on appeal from the SHA's dispute resolution process; to the extent that it gives rise to any conduct issue(s), a complaint must be made to the CCP before it can investigate.
25. Responsibility for the selection of Buckinghamshire Hospitals as the acquirer of Community Health Buckinghamshire, and for the delivery of those services following the merger, remains with Buckinghamshire PCT and, also in relation to service quality, the CQC. The CCP has, however, considered the possible impact of Buckinghamshire Hospitals' 'weak' financial rating on its delivery of community health services following the merger (see paragraphs 71-73).

## FRAMEWORK FOR ASSESSMENT

26. 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. The relevant provisions of the Principles and Rules are Principles 9 and 10, which state:

Principle 9: '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.'

Principle 10: 'Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money.'

27. Our draft interim merger guidelines set out a cost-benefit framework for the assessment of mergers under these Principles.<sup>6</sup> 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 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.<sup>7</sup>
28. Consistent with this framework, this report provides an assessment of the costs and benefits to patients and taxpayers that may arise from the proposed merger and sets out proposed measures to mitigate the costs we have identified.

---

<sup>6</sup> 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.

<sup>7</sup> 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.

## PATIENT CHOICE AND COMPETITION IN COMMUNITY AND ACUTE ELECTIVE CARE SERVICES

29. The merger between Community Health Buckinghamshire and Buckinghamshire Hospitals takes place in a broader policy context for patient choice and competition in acute elective and community health services. This broader context forms the backdrop to our assessment of how the merger will affect patient choice and competition in community and acute services in Buckinghamshire both currently and in the future. We set out in the following paragraphs the key points relevant to our assessment of this merger.
30. In acute care, patients have the right to choose their provider of acute elective care.<sup>8</sup> As of June 2010, there were more than 250 NHS and independent sector providers of acute elective care to NHS patients. The ability of patients to choose between providers, and the Payment by Results tariff system that remunerates providers according to the number of patients treated, gives providers an incentive to offer high quality services to patients. In non-elective acute care, patient choice and competition is more limited. PCTs, and the regional and national specialised commissioning teams, can use competitive tendering to select between potential providers of non-elective acute services. While there has only been a small number of PCT-led tenders for acute services over the past 3 years (according to data collected by the CCP), the threat of competitive tendering may still contribute to higher quality non-elective services.
31. In community services, there are two models of competition. First, competition *for* the market, where service providers compete for the right to provide services across a PCT or other locality, generally on an exclusive basis. Second, competition *in* the market, where patients can choose between competing providers of the same service. Competition *for* the market by way of competitive tendering is the predominant form of competition in community services. There were 100-150 PCT-led tenders for community services in 2009 compared with 60-80 tenders in 2008. The total value of these contracts is relatively small compared with the total value of expenditure by the NHS on community services. However, as with non-elective acute services, the threat of competitive tendering may contribute to higher quality services.
32. There are, as noted above, examples of patient-choice based competition in some community services in some regions. In addition, in some areas, including Buckinghamshire, patients may be able to choose to use different providers of community services that are more conveniently located, but are, for example, outside a patient's home PCT.
33. The Government has signalled greater use of patient choice in community health services in the future. The Revision to the Operating Framework for the NHS in England 2010/11 states: 'Looking forward, we shall develop proposals for a phased move towards an "Any Willing Provider" (AWP) model for community health services, addressing barriers to entry to greater participation by the independent and voluntary sector' (p.11). Further, the Government's White

---

<sup>8</sup> These rights are enshrined in the NHS Constitution 2008 and the Primary Care Trust (Choice of Secondary Care Provider) Directions 2009.

Paper *Equity and Excellence: Liberating the NHS*, states that the NHS will move to an AWP approach as soon as possible for community health services (paragraph 4.24).

## ASSESSMENT OF MERGER COSTS

34. This section sets out our assessment of the effect of the merger between Community Health Buckinghamshire and Buckinghamshire Hospitals on patient choice and competition and the resulting effect on patients and taxpayers (i.e. the costs of the merger). We discuss the effect of the merger on patient choice and competition in Buckinghamshire:

- first, in the supply of community services; and
- second, in the supply of acute elective care services.

Prior to this, we summarise our analysis of the market(s) affected by the merger, and the counterfactual against which we judge the effect of the merger.

35. Our analysis of the services and geographic area (the market or markets) in which the merging parties compete is set out in Appendix 2. We consider that the relevant product market for analysing this merger could either be individual community services and individual acute services; or community services as a whole and acute services as a whole. For ease of explaining our competitive assessment, however, we simply refer to community services as a whole and acute services as a whole. The relevant geographic market for analysing the effects of this merger on community services is the Buckinghamshire PCT area. The relevant geographic market for analysing the effects of this merger on acute care is likely to include at least Buckinghamshire Hospitals, Oxford Radcliffe Hospitals NHS Trust and Heatherwood & Wexham Park NHS Foundation Trust.

36. When assessing the impact of a merger on patient choice and competition, we compare the effect of the merger with the likely situation if the merger did not take place. This alternative scenario is known as the 'counterfactual'. In many merger reviews, the most appropriate counterfactual will be the pre-merger situation. However, all PCTs are required to divest their community health services provider arms prior to April 2011.<sup>9</sup> As a result, it may not be appropriate to consider the pre-merger situation as the counterfactual. Nevertheless, any alternative merger would also have to be reviewed for consistency with the Principles and Rules. Given this, for the purposes of accurately assessing the competitive effects of the proposed merger between Community Health Buckinghamshire and Buckinghamshire Hospitals, we assume that if this merger did not take place there would be a merger that does not raise concerns under the Principles and Rules.

## EFFECT OF THE MERGER ON PATIENT CHOICE AND COMPETITION IN COMMUNITY SERVICES

37. In this section we set out our assessment of the effect of the merger on patient choice and competition in community services. We consider whether the merger could adversely affect patients and taxpayers through its impact on:

---

<sup>9</sup> The *Revision to the Operating Framework for the NHS in England 2010* (21 June 2010), states at page 9: 'Separating PCT commissioning from the provision of services remains a priority. This must be achieved by April 2011, even if this means transferring services to other organisations while sustainable medium-term arrangements are identified and secured.'

- competition for community services contracts;
- patient choice-based competition in community services as it currently exists in Buckinghamshire;
- patient choice based competition in community services in Buckinghamshire once ‘Any Willing Provider’ of community services has been introduced; and
- Community Health Buckinghamshire’s services given Buckinghamshire Hospitals’ weak financial status.

#### *Competition for community services contracts*

38. If the merger removes a competitor for community services contracts, and there are insufficient other credible actual or potential providers of community services in Buckinghamshire, competition would be adversely affected by the merger. Accordingly, we are interested in the extent to which:

- i. the merging parties currently compete for community services contracts, or would do so in the future in the absence of the merger; and
- ii. other organisations compete, both currently or would do so in the future, for community services contracts in Buckinghamshire.

39. As set out in paragraph 10, Buckinghamshire Hospitals currently provides a number of community services in the south of Buckinghamshire as a legacy of the merger between the community and hospitals trust in 2003 that created the current Buckinghamshire Hospitals organisation. These same services are provided by Community Health Buckinghamshire in the north of the county. This seems to indicate that the merging parties could represent alternatives to one another for patients in Buckinghamshire PCT. The existence of Community Health Buckinghamshire and Buckinghamshire Hospitals as separate entities could in theory constrain the behaviour of each organisation in providing community services, as each would know that the PCT could seek to replace them as a service provider and the other organisation would be available to do so.

40. In practice, however, in the three community service tenders conducted by Buckinghamshire PCT over the past three years (and the five primary or mental health contracts tendered over the same period<sup>10</sup>) Community Health Buckinghamshire and Buckinghamshire Hospitals did not bid against each other. [X].

41. The lack of competition between the merging parties for community services contracts in the recent past, and Community Health Buckinghamshire’s weakness as a bidder indicates that the two organisations may only represent weak alternatives to one another for community services.

42. Looking forwards, Buckinghamshire PCT told us that it plans to commission six services (neurological care, sexual health, paediatric respite care, occupational therapy, speech and

---

<sup>10</sup> These tenders were for medical services (a consultant-led team of doctors who support those providing palliative care), children’s respite services and prison healthcare.

language therapy and specialist palliative care) in 2010/11 and will consider commissioning a further two care pathways<sup>11</sup> with a value of £13 million.

43. Buckinghamshire Hospitals told us that, in the absence of the merger, it would bid for community health services that are core to how it delivers patient care. We note that several of the services set out above fall within the existing portfolio of community services provided by Buckinghamshire Hospitals, and as a result, Buckinghamshire Hospitals could be expected to be a credible bidder for these contracts. If Community Health Buckinghamshire did not merge with Buckinghamshire Hospitals, but was to merge with another organisation, then it would be likely to re-emerge as a strong bidder for community service tenders in the future, in view of its incumbency advantage, geographic location and portfolio of community health services.
44. As a result, we consider that the merger would result in the removal of a future credible bidder for community services contracts in Buckinghamshire. Whether this would have a material effect on competition for community services contracts depends on whether there are sufficient other credible bidders for these contracts.
45. In assessing whether there are sufficient other credible bidders for community services contracts in Buckinghamshire, we grouped other potential bidders into three broad categories: other PCT provider arms; other NHS organisations, such as acute and mental health trusts; and independent and third sector providers.
46. In relation to other PCT provider arms, two provider arms (the East Berkshire PCT provider arm and Oxfordshire PCT provider arm) are currently contracted to provide community health services to patients registered with GPs in Buckinghamshire but where those patients would find it more convenient to access services in Berkshire or Oxfordshire. Buckinghamshire PCT's willingness to contract with these providers to provide services to patients registered with GPs in Buckinghamshire could be seen as indicative of the suitability of these PCT provider arms to supply services to the PCT more generally. We also note that another [redacted] PCT's provider arm has bid, albeit unsuccessfully, for two community services contracts in Buckinghamshire (child and adolescent mental health services (CAMHS) and prison health).
47. We asked PCT provider arms near Buckinghamshire whether they would bid in future tenders for community services in Buckinghamshire. Four PCT provider arms responded to our request for information. One [redacted] provider arm submitted that it would be likely to bid in Buckinghamshire and noted that it has recently bid in six different PCTs [redacted] and won contracts in three of these. Another [redacted] told us that it would be likely to limit its bidding to its own and neighbouring PCTs, of which Buckinghamshire is one. A further provider arm [redacted] stated that it did not intend to bid outside its own PCT area.<sup>12</sup>

---

<sup>11</sup> These would be urgent response, which would respond to a request for care or treatment in the community within 4 hours; and enablement and maintaining independence, which help people with long-term conditions or following discharge from hospital to manage at home.

<sup>12</sup> We note that the bidding intentions of these organisations could change if, for example if there is a change in ownership. However, in most cases, we expect future owners of PCT community services providers to continue to bid for community services contracts as a means of ensuring the continued value and stability of these organisations.

48. Based on current patterns of service provision, past bidding behaviour and future bidding intentions, we consider that at least five PCT provider arms are credible competitors [X] for community services contracts in Buckinghamshire. We also note that there may be other PCT provider arms that did not respond to our request, but could also be credible bidders to provide community health services in Buckinghamshire.
49. In relation to other NHS organisations, Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust has previously won a tender worth £17.4 million to provide child and adolescent mental health services across Buckinghamshire, has won community health services contracts in Oxfordshire, and [X]. Another mental health trust [X] has previously bid to provide services in Buckinghamshire, although this has been in the field of mental health services.
50. In terms of future intentions by other NHS organisations to bid for community services contracts in Buckinghamshire, eight acute trusts and two mental health trusts responded to our request for information regarding their bidding intentions in community services contracts.<sup>13</sup> Five acute trusts [X] told us they anticipated bidding for community services contracts in Buckinghamshire. Two trusts [X] told us they would not bid for community services contracts in Buckinghamshire.
51. Two independent sector providers responded to our information request [X]. One of these [X] told us it would bid around the country for the full range of community health services and had won a [X] contract to provide [X] across Buckinghamshire. Furthermore, it told us that it has bid in approximately 100 tenders nationwide to date.
52. In conclusion, we consider that there are a number of credible bidders for community services contracts in Buckinghamshire. Even though the merger would remove a bidder for future community services contracts, there would be a sufficient number of other credible bidders following the merger to ensure service quality and value for money.

#### *Current patient choice-based competition in community health services*

53. Currently, no community services in Buckinghamshire are provided under the AWP model. However, as we set out in paragraph 43, Buckinghamshire Hospitals provides some community services in the south of the county while Community Health Buckinghamshire provides these services in the north of the county, and it seems that some patients are able to choose between these two providers. In addition, patients are able to choose to access certain community services from Oxfordshire and Berkshire PCT provider arms where this is more convenient for the patient (see paragraph 46).
54. While some patients may be able to choose between Community Health Buckinghamshire and Buckinghamshire Hospitals (and other patients may be able to choose between one of these organisations and the PCT provider arms in Oxfordshire and Berkshire), it is unlikely that this is creating a competitive dynamic between these organisations such as to impact on standards of care or value for money. This is because in Buckinghamshire payment does not directly reflect the number of community services patients treated by the provider, and as a result, these

---

<sup>13</sup> These were [X].

community providers do not have an incentive to offer improved services as a means of attracting more patients and earning more revenue.<sup>14</sup>

55. The actual number of patients that are potentially choosing between Community Health Buckinghamshire and Buckinghamshire Hospitals is likely to be small. Buckinghamshire PCT told us that GP practices in the former Vale of Aylesbury PCT, which covers the north of Buckinghamshire, referred patients in the six overlap services to Community Health Buckinghamshire. In contrast, those GP practices located in the south of Buckinghamshire (previously Wycombe PCT and Chiltern and South Buckinghamshire PCT) referred patients for these six services to Buckinghamshire Hospitals. It is therefore patients of the GP practices along the north/south border, specifically two GP practices in Princes Risborough, which are most likely to have a choice of community services provider for the overlap services.<sup>15</sup>
56. To the extent that, before the merger, patients or GPs could choose between Community Health Buckinghamshire and Buckinghamshire Hospitals for certain community services, the merger removes patients' choice of provider (but not their ability to choose to access services in a more convenient location). However, as we discuss above, given that this choice is unlikely to be creating any competitive incentive for these two organisations to improve standards of care or value for money, the loss of this choice of provider is unlikely to have any adverse effect on patients.

#### *Patient choice-based competition in community health services under AWP*

57. In this section we analyse whether the merger's effect on community health services is consistent with Principle 10, which provides that vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and to protect the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money.

#### Introduction of the AWP model into community services

58. In the paragraphs which follow we consider the introduction of the AWP model of patient choice into community services, the ways in which this might occur and the consequences of this for integrated providers. The Government, as discussed in paragraph 33, intends to introduce the AWP model of patient choice into community services. While details of this policy are still being developed, we expect there to be a phased introduction by commissioners in which some community services will be subject to patient choice between competing providers relatively quickly, while other community services will remain subject to competitive tendering for some time.
59. As this policy is still under development, the CCP cannot, at this time, estimate the precise extent to which patients will have the opportunity to choose between competing providers for

---

<sup>14</sup> The block contracts that Buckinghamshire PCT agree with their providers specify a value for the annual payment by the PCT. Future payments may or may not increase to reflect additional activity in the previous year. There is no guarantee that any adjustment will be agreed nor of the size of any adjustment where it is agreed.

<sup>15</sup> The overlap services are those currently provided by both Community Health Buckinghamshire and Buckinghamshire Hospitals, and are: sexual health services; speech and language therapy; community paediatrics; community podiatry; and specialist multiple sclerosis and heart failure nurses.

different community services either in the very short-term or in the long-term. Nevertheless, we believe it is reasonable for us to conclude that for a material proportion of community services, government policy will be directed in the foreseeable future towards allowing patients to choose between competing providers.

60. Again, because this policy is still under development, the implementation mechanism is not yet clear, particularly in relation to patients who have received acute care and need subsequently to receive community care. One option is for patients to be referred from acute providers back to their GPs before they can receive community services. The GP then offers the patient choice of community services provider. Another option may be to allow the acute provider itself to offer choice of community services provider, e.g. using a system similar to the Choose and Book system use for acute elective care.
61. Acute providers that also provide community services may, however, have the incentive to direct their acute patients to their own community services provider.<sup>16</sup> Whether they will have the ability to do so depends on which mechanism is adopted to implement the policy. The ability will not be present if the patients are referred back to their GP (and the GP is not part of the integrated organisation). The ability is likely to be present if the acute services provider is responsible for offering choice.

#### Vertical effects of the merger on patient choice and competition in community services

62. As explained in paragraph 61 above, integrated organisations may have an incentive to retain patients within the integrated organisation, i.e. they do not have an incentive to direct patients to their competitors. Our experience of reviewing mechanisms for referrals from community to acute elective care, where patients already have the right to choose their care provider, is that integrated providers can make it difficult for patients to exercise choice by, for example, not providing patients with access to the Choose and Book system for acute elective care, and not requiring patients to return to their GP to be able to choose an alternative provider of acute elective care (see the CCP's report on the merger of the provider services arm of Croydon PCT and Mayday Healthcare NHS Trust of 20 April 2010 at paragraph 76).
63. As a result, we consider that without appropriate safeguards it is more likely than not that, in the future, integrated providers of acute and community care, such as the merged Community Health Buckinghamshire and Buckinghamshire Hospitals, will have the ability to constrain patients' choice of community service provider and effectively direct patients to their own community services arm.
64. Whether this constraint on choice by an integrated acute and community provider will restrict competition in community services will depend on the significance of the patients flows the integrated provider is able to direct to its own services and away from other community services providers. Where a significant proportion of the patients that require a given community service are diverted to the merged entity's own community services as a result of the merger it follows that rival community services providers will be denied access to these patients. If rivals cannot

---

<sup>16</sup> A merged organisation's incentive to refer patients from its own acute services to its community services depends on its capacity, its costs, and the tariff that it is paid.

access these patients, they will have no incentive to compete to provide high quality services as a means of attracting patients. It may also result in the partial or total withdrawal of services by other providers in the area, or the foreclosure of new entry by other providers.

65. As we do not yet know which community services will be opened to patient choice under the Any Willing Provider model of competition, and the proportion of patients that are likely to be referred to those services after receiving acute care, we do not know the number of patients that the merged entity is likely to refer from acute care to those community services where patients will have a choice of provider. This means that we cannot reach a view on the effect on other community services providers of the integration of Community Health Buckinghamshire and Buckinghamshire Hospitals and any change in referrals from acute to community care. As a result, we did not conclude that the vertical integration of Community Health Buckinghamshire and Buckinghamshire Hospitals is likely to result in a reduction in competition in community services.

#### Effect of the merger on the GP gatekeeper function in relation to referrals from acute to community care

66. We now assess whether the vertical integration between Community Health Buckinghamshire and Buckinghamshire Hospitals is likely to jeopardise the primacy of the GP gatekeeper function in relation to patients being referred from acute to community care, and thus cause the merger to be inconsistent with Principle 10 of the Principles and Rules (see paragraph [26]). The CCP considers that the gatekeeper function is the GP's role as (i) a first point of care before secondary care can be accessed by patients; and (ii) an informed and impartial adviser who determines when secondary care is needed and offers patients advice on available choices at that stage.

67. The GP gatekeeper function (together with the provisions of the NHS Constitution (section 2a) and the Primary Care Trusts (Choice of Secondary Care Provider) Directions 2009, paragraph 2) plays a key role in preserving patient choice in acute elective care. However, it is not clear to us that referrals from acute to community care fall within the intended scope of the GP gatekeeper function that is to be protected under Principle 10, and as yet there are no related regulatory provisions (such as those that apply to patient choice in acute elective care) to protect choice in community services.

68. As a result, we do not consider that the merger between Community Health Buckinghamshire and Buckinghamshire Hospitals has an adverse effect on the GP gatekeeper function in relation to referrals from acute to community care.

#### Conclusion on patient choice based competition in community services under AWP

69. In conclusion, we find that:

- i. Vertically integrated organisations are likely to have an incentive to refer patients from acute care to their own community services provider arm, and in the absence of appropriate safeguards are also likely to have the ability to do so. We cannot, however, conclude that this incentive will result in the merger between Community

Health Buckinghamshire and Buckinghamshire Hospitals being inconsistent with the Principles and Rules due to its effect on competition in community services. This is because we do not know whether the volume of patients that the merged entity is likely to refer from acute care to those community services where patient choice of provider is sufficient to affect competition in these services.

- ii. We also cannot conclude that the merger will be inconsistent with the Principles and Rules due to its effect on the GP gatekeeper function because the mechanism for the introduction of patient choice into community services, and in particular whether this will involve the GP, is not yet clear and there are no regulatory provisions governing this. Accordingly, we cannot reach an expectation that the merger will have an adverse effect on the GP gatekeeper function in relation to referrals from acute to community care.

70. These two findings regarding the impact of the merger on patient choice based competition in community services under AWP are primarily a result of this policy still being in the early stages of development. We recognise the possibility that, under certain circumstances, vertical integration could have an adverse effect on patient choice and competition in community services under AWP. As a result, we recommend that the Government in developing this policy design appropriate safeguards such that patient choice and competition are not unintentionally undermined.

#### *Financial status of Buckinghamshire Hospitals*

71. In most mergers the CCP will not seek to review the financial or clinical capacity of the parties to deliver services. The assessment of whether an organisation is an appropriate acquirer and provider of services is a question for the relevant PCT(s), the CQC and, in certain circumstances, the SHA(s) and Monitor. However, where an acquiring organisation is weak in either financial or clinical terms, it is possible that its acquisition of another organisation could have an adverse effect on patients and taxpayers as a result of a reduction in choice or competition.<sup>17</sup> This is particularly the case when, prior to the merger, the services were being provided to a satisfactory standard. A financially challenged organisation may also have an incentive to reduce the quality of services acquired, in order to reduce its financial deficit, and may be able to do so if commissioners are unable to monitor and safeguard the quality of services or tender for a new provider should services decline in quality.

72. When considering the financial and clinical strengths of acquiring organisations, for the purposes of its assessment under the Principles and Rules, the CCP generally relies on judgements made by those regulators responsible for assessing these matters and, in particular, the CQC. Buckinghamshire Hospitals has CQC ratings for 'Quality of Services' as 'good' and for 'Quality of Financial Management' as 'weak' for the year ended 2008/09. This financial management rating

---

<sup>17</sup> The financial or clinical status of an acquiring organisation is also likely to be relevant to the assessment of any benefits to patients and taxpayers that might be realised from a transaction.

is based on work carried out as part of the Audit Commission's Auditors' Local Evaluation Assessment.<sup>18</sup>

73. We understand that Buckinghamshire Hospitals' 'weak' financial rating was due to an annual deficit in 2008/09, and that this deficit – as measured for the purpose of the breakeven duty imposed on NHS Trusts by the Department of Health – has subsequently been eliminated in 2009/10. The aspects of financial standing and financial management reviewed by the Audit Commission as part of their Auditors Local Evaluation work did not deteriorate during 2009/10. As a result, we consider that any risk to patients and taxpayers as a result of the effect that the financial position of Buckinghamshire Hospitals could have on patient choice and competition is minimal.

#### **EFFECT OF THE MERGER ON PATIENT CHOICE AND COMPETITION IN ACUTE CARE SERVICES**

74. In this section we assess whether the merger between Community Health Buckinghamshire and Buckinghamshire Hospitals could affect patient choice and competition in acute elective care through:
- a. removing Community Health Buckinghamshire as a potential provider of acute elective care; and/or
  - b. the merged organisation reducing (or removing) patient choice and competition in acute elective care through influencing the referral of patients from its community health services to acute care services.

##### *Community Health Buckinghamshire as a potential provider of acute elective care*

75. There are two ways in which Community Health Buckinghamshire could, in the absence of the merger, be an actual or potential competitor to Buckinghamshire Hospitals for acute elective care. These are:
- a. where acute elective care that is currently provided by Buckinghamshire Hospitals is decommissioned and moved into the community; and
  - b. where Community Health Buckinghamshire is a possible entrant into the provision of acute elective care in an acute setting.
76. In respect of acute elective care that is decommissioned and moved into a community setting, we conclude in paragraphs 43 to 44 that if Community Health Buckinghamshire did not merge with Buckinghamshire Hospitals, but was to merge with another organisation, then it would be likely to re-emerge as a strong bidder for community service tenders in the future. However, we also conclude in paragraph 52 that while the merger would remove a bidder for future community services contracts, there would be a sufficient number of other credible bidders following the merger to ensure service quality and value for money. Since the credibility of these providers depends on incumbency, geographic location and portfolio of services, we also consider that following the merger there are likely to be a sufficient number of credible bidders for services that have been decommissioned in acute settings and moved into the community to ensure service quality and value for money.

---

<sup>18</sup> The Audit Commission's Auditors' Local Evaluation assessment covers five areas of financial reporting: financial management; financial standing; internal control; value for money (economy, efficiency and effectiveness).

77. In respect of acute elective care provided in an acute setting, we do not consider that Community Health Buckinghamshire is a potential provider of these services because of the barriers to entry (i.e. experience and infrastructure) that it would face, having never provided acute care services before.

78. We therefore do not consider that the merger gives rise to a loss of competition as a result of the loss of a potential provider of acute elective care in either a community or acute setting.

#### *Effect of vertical integration on flow of patients to acute elective care*

79. By bringing community health services and acute elective care under common control, the merged organisation may have the incentive and the ability to influence patients' choice of acute elective care provider, where patients are referred from its own community health services to acute elective care, and consequently impact on the extent of competition in acute elective services.

80. We first consider the impact on patient choice, including the GP gatekeeper function, and second, the impact on competition in acute elective services.

#### Impact on patient choice of acute care provider

81. Patients have the right, under the NHS Constitution 2008 and the Primary Care Trust (Choice of Secondary Care Provider) Directions 2009, to choose their provider of acute elective care in certain circumstances. To do so, they receive impartial advice from their GP or other healthcare professional, such as a specialist nurse, either using Choose and Book or by writing a letter directly to the acute provider.<sup>19</sup>

82. Under Principle 10 of the Principles and Rules, mergers should not undermine the GP gatekeeper function. The CCP considers that the gatekeeper function is the GP's role as: (i) a first point of care before secondary care can be accessed by patients; (ii) an informed and impartial adviser who determines when secondary care is needed and offers patients advice on available choices at that stage.

83. The merger of a community health services provider with an acute elective care provider could undermine the gatekeeper function, because where there are referrals from community care to acute care, the healthcare professional who refers the patient for acute elective care is an employee of the merged organisation.<sup>20</sup> The incentive to refer within that employee's own organisation depends on capacity, tariff and costs relative to tariff. In particular:

- a. where the acute provider earns the full value of the tariff for additional activity, the merged organisation is likely to have an incentive to increase the proportion of those

---

<sup>19</sup> We are aware that that in some cases acute providers may be unwilling to accept referrals from specialist nurses.

<sup>20</sup> This potential effect on the GP gatekeeper function arising from a merger between an acute services provider and a community health services provider only arises in relation to patients that might be referred from community health services to acute elective services, and not vice versa, because it is only in relation to acute elective services that patients have a choice of service provider.

patients referred for acute elective care to its own acute care services arm, assuming that the tariff covers its costs and a small profit margin; and<sup>21</sup>

- b. where an acute provider receives below tariff income from its PCT for activity conducted in excess of its contracted level, or where a hospital is operating at capacity, the incentive may be for the community health services provider to reduce the proportion of patients it refers to its acute care services arm.<sup>22</sup>

84. We then considered whether the merged organisation would have the ability to refer patients to its own acute elective care services. Buckinghamshire Hospitals told us that as part of an agreement with Buckinghamshire PCT designed to constrain onward referrals for care to reduce outpatient attendances, community services staff at the merged entity would not be able to refer patients directly to acute care, but would be required to refer patients back to their GP for onward referral to acute care as appropriate. We believe that, for as long as it is in place, this agreement will constrain the merged organisation's ability to refer patients to its own community services. However, we do not consider this agreement, on its own, to be sufficient to address our concerns in the absence of any additional commitments to the CCP not to alter the agreement post-merger. This is because it is the product of a bilateral arrangement between the parties rather than the implementation of a policy or direction and could be amended in accordance with its terms. In addition, the agreement is primarily aimed at reducing costs and if it is successful, the parties may amend or terminate the agreement. In such circumstances, in the absence of another provision, there would be no remaining means of addressing our concerns regarding referrals from community to acute care.

85. We then considered how many patients would be adversely affected by this loss of choice. The parties told us that less than one per cent of patients are referred from Community Health Buckinghamshire to Buckinghamshire Hospitals (147 in 2009/10). An example of a service where patients can be referred from a community service to an acute elective care service is community-based musculoskeletal (MSK) services.<sup>23</sup>

86. We therefore concluded that the merger is likely to have a material adverse effect on patients due to its impact on the GP gatekeeper function.

#### Impact of vertical integration on competition between acute care providers

87. We then considered whether this reduction in patient choice could also be expected to reduce competition between acute elective care providers. This could happen where the diversion of

---

<sup>21</sup> These incentives may differ across services and treatment types according to factors such as the relationship between the merged entity's costs and the tariff it receives under Payment by Results, the extent of spare capacity at the relevant hospital, and the perceived cost of treating any individual patient compared to the tariff received under Payment by Results.

<sup>22</sup> Although Buckinghamshire Hospitals does not currently have spare capacity, we expect capacity to increase as acute services are moved from an acute setting to a community setting in the near future. The *Department of Health (UK). Shaping the future NHS: long term planning for hospitals and related services. Consultation document on the findings of the national beds inquiry. London: Department of Health, 2000*, states: "The Government's Emergency Services Action Team (ESAT) report in 1997 included analyses showing that in acute hospitals average bed occupancy rates over 85% are associated with rapidly growing problems in handling emergency admissions. Subsequent analysis by the University of York has confirmed this conclusion. Managing peaks and troughs is also a matter of ensuring that resources are used appropriately and are deployed flexibly to match demand variations over the year."

<sup>23</sup> As more services are moved from an acute to a community setting, more patients needing acute episodes of treatment as part of their care pathway will be treated by Community Health Buckinghamshire which increases the scope for direct referrals from Community Health Buckinghamshire to Buckinghamshire Hospitals.

patients to the merged entity's own acute care services results in the merged organisation being able to offer a lower quality service without the fear of losing patients to alternative providers, or other providers of acute elective services partially or totally withdrawing services.

88. We considered a reduction in competition between acute elective care providers, as a result of the relationship between the merger parties, to be unlikely because: (i) a very small proportion of patients are referred for acute elective care by Community Health Buckinghamshire; and (ii) these referrals represent a very small proportion of other hospitals' acute care elective admissions. Although we expect referrals from community health services will increase in future (as more acute services are moved into a community setting), we do not expect this to be so significant that the merger would result in a reduction in, or removal of, competition in acute elective care.

### **CONCLUSION – ASSESSMENT OF COSTS**

89. In conclusion, we find that, as a result of vertical integration, the merger is likely to give rise to material adverse effects on patients due to its effect on the GP gatekeeper function and consequently patients' ability to choose between providers of acute elective care.<sup>24</sup>

90. We do not find that the merger will adversely affect competition for community services contracts. We also do not conclude that vertical integration between the parties will affect patient choice and competition in community services in the future under an AWP model. However, this finding is primarily a result of this policy still being in the early stages of development.

91. We recognise the possibility that, under certain circumstances, vertical integration could have an adverse effect on patient choice and competition in community services under AWP. As a result, we recommend that the Government in developing this policy design appropriate safeguards such that patient choice and competition is not unintentionally undermined.

### **ASSESSMENT OF BENEFITS**

92. Having concluded that the merger gives rise to costs to patients as a result of its impact on their ability to choose between providers of acute elective care, in this section we consider whether the merger gives rise to any benefits to patients and/or taxpayers that would be sufficient to outweigh these costs.

93. In assessing whether a proposed merger could be expected to give rise to an adverse effect on patients and/or taxpayers, we have regard to any benefits to patients and taxpayers arising from the merger.<sup>25</sup> 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.<sup>26</sup> The parties need to be able to produce evidence in support of any anticipated

---

<sup>24</sup> This consideration is given against a counterfactual in which patients are not, and will not be, able to choose a community health services provider.

<sup>25</sup> CCP, Draft interim guidelines on mergers (January 2009), paragraphs 5.51 to 5.60.

<sup>26</sup> This can be a result of (a) lower number of referrals (b) reduced community health services utilisation.

benefits for these to be taken into account by the CCP. In addition, the anticipated benefits of a merger must arise within a reasonable period of time following the merger and be unlikely to arise without the merger.

94. Given that we concluded that this merger is likely to result in a material adverse impact on patients and taxpayers as a result of its impact on patients' ability to choose their provider of acute elective care, in the following paragraphs we assess whether the merger also gives rise to any benefits to patients and taxpayers so as to reach a view on the overall effect of the merger on patients and taxpayers.

## **PATIENT BENEFITS**

95. The parties identified a number of benefits to patients would arise as a result of the merger in the documents provided to the CCP as part of this merger review. These benefits were, primarily, set out in: (a) Buckinghamshire Hospitals' submission to Buckinghamshire PCT as part of its bid for Community Health Buckinghamshire in January 2010; and (b) in the business case for the externalisation of Community Health Buckinghamshire following the bidding process, which was presented to the Buckinghamshire PCT board on 26 January 2010. Further information was also provided to the CCP in response to questions during our review.

96. In summary, the benefits to patients that the parties believe will arise as a result of the merger are as follows:

- vertical integration "leading to improved patient care and health outcomes as well as improved efficiency";<sup>27</sup>
- horizontal integration between services leading to improved staffing arrangements;
- enabling seamless care across a community and acute setting;
- reducing admissions and length of stay in hospital by being able to provide alternative models of care;
- creating a unified approach to governance;
- improving the career structure and training opportunities to improve staff morale;
- bringing about efficiencies by reducing duplication and wasted clinical time;
- enabling alternative models of care provision;
- improving prescribing; and
- allowing for greater utilisation of telemedicine.

97. In the following paragraphs, we assess the benefits put forward by the parties in terms of whether each benefit: (i) arises from the merger and would be unlikely to arise without the merger (ie the benefit is merger specific); (ii) is likely to be realised within a reasonable timeframe following merger (taking into account post-merger planning); and (iii) actually represents an improvement in care for patients.

98. The parties did not provide the CCP with a sufficiently detailed post-merger integration plan setting out how the potential benefits identified above would be realised in practice.<sup>28</sup> As a

---

<sup>27</sup> This is stated in the "Buckinghamshire Hospitals Community health services Proposal Integrated, efficient and patient centred care in Bucks January 2010".

result, we have, in large part, been unable to take these potential benefits account in our assessment because we cannot have sufficient confidence that the benefits will be realised. We consider that the parties to a merger should be able to provide the CCP with some kind of post-merger integration plan that sets out how the benefits arising from a merger will be realised. We note that in this case the merger was completed during the course of our review, and Buckinghamshire Hospitals remained unable to provide the CCP with an integration plan setting out the potential benefits identified above would be realised.

#### *Vertical integration*

99. Buckinghamshire Hospitals has stated that “[i]nternational experience of vertical integration has shown a proven link to improved patient care and better health outcomes as well as improved efficiency”. They stated that the health services in the Netherlands and Switzerland both have “arguably the most vertically integrated health services in Europe” and that mortality rates in the Netherlands and Sweden [sic] are lower than that of the UK. They also referred to a reduction in death rates of 73 per cent at Kaiser Permanente, an integrated care provider in America, which they attributed to its vertically integrated model of care.

100. The CCP agrees that this transaction will bring together two organisations that serve different parts of the same care pathway for at least some patients. However, whether this will improve services to patients depends on the changes that are made to those individual services following the merger. As a result, while the merger allows for vertical integration, this does not, of itself, give rise to any benefits to patients.

#### *Horizontal integration between services leading to improved staffing arrangements*

101. The parties told us that integration of the community-based dietetics services and the specialist sexual health services provided by both Community Health Buckinghamshire and Buckinghamshire Hospitals would improve staffing arrangements for those services.

102. We agree, in principle, that integrating the same services post-merger can allow more efficient and flexible use of staff, and thus benefit patients by improving the availability of a service, and potentially, reducing costs. This will, however, not always be the case. Whether there is a potential benefit depends on factors such as the specific nature of the staffing issue that is being addressed, whether there is sufficient additional staffing capacity in the merged entity to address temporary staff shortages in different locations, and whether plans to deliver greater workforce flexibility can be put in place.

103. In relation to the dietetics service, the lack of detail about the nature of the current staffing challenges, how the merger would allow this issue to be addressed, and the lack of a sufficient post-merger implementation plan that set out the steps to implementing a solution meant that we were unable to see how this potential benefit would be realised. As a result, we are unable to take this benefit into account in our analysis of the effects of the merger.

---

<sup>28</sup> On 10 August 2010, the CCP were provided with a 2 page summary of how integration would be managed.

104. In relation to specialist sexual health services, the parties told us that the merger would allow for senior clinical input to be maintained at the Community Health Buckinghamshire's site at Brookside. Previously, a consultant was employed at this site but had not been replaced since departing. The merger would allow these consultant inputs to be obtained from Buckinghamshire Hospitals. It is not, however, clear to us that Community Health Buckinghamshire could not obtain specialist consultant inputs at its Brookside facility in the absence of the merger, especially given that it had been doing so up until recently. To the extent that it might be more efficient to use consultant inputs from Buckinghamshire Hospitals post-merger, we did not see any evidence that would allow us to draw this conclusion.

*Enable seamless care across a community and acute setting*

105. The parties told us that their previous attempts to integrate services along care pathways have not been effective because of the problems caused by organisational boundaries. These problems related to communication, documentation, payment, and integration of specialist teams.

106. Diabetes services were highlighted as an area in which streamlining patient care was a benefit that would arise due to the merger. In particular, retinal screening would be able to take place at the same time as the annual diabetic review and the parties also told us that diabetic patients would have increased surveillance and improved treatment due to access to a co-ordinated multidisciplinary team. The parties did not, however, set out how these improvements would be pursued post-merger. As a result, the CCP cannot have sufficient confidence to conclude that this benefit will be realised in a reasonable timeframe post-merger.

107. The CCP considers that the merger may facilitate improvements in these areas but the parties did not provide sufficient evidence to show how these problems would be overcome after the merger was implemented.

*Reduce admissions and length of stay in hospital*

108. The parties have stated to us that, following the merger, 41 community beds would be established on two sites to replace the existing 42 community beds currently spread across four sites. The parties consider that this would allow cost savings of approximately £900,000 through changes in staffing rotas. Buckinghamshire Hospitals have said that these community beds would be used to reduce admissions into acute care and length of stay in acute care. The parties told us that improved use of community beds has, since staff transferred to Buckinghamshire Hospitals in April 2010, reduced delays in discharge from acute beds, reduced length of stay and facilitated care in settings closer to home. However, no evidence was submitted in support of this statement. Further, it was unclear from the documentation provided why the merger, while maintaining the same number of community beds, would lead to this benefit.

109. The Outpatient Parenteral Antimicrobial Therapy (OPAT) Service was offered as an example of where admissions could be reduced and/or length of stay shortened. OPAT works to deliver intravenous antibiotics to patients in the community rather than as an in-patient. This leads to

reduced bed days due to early discharge. The parties estimated that the reduction in bed days leads to a cost saving of £261,560.<sup>29</sup> The aspiration is to have a fully integrated service with GPs covering the costs of the prescribed antibiotics and to have referrals to the service from community and acute care. This service is currently only available 5 days per week, and the parties consider that the merger will allow it to be provided on a 7 day per week basis. It was not clear, however, from the materials provided to the CCP why this benefit was linked to the merger or how it would be realised in practice.

110. Post Acute Care Enablement (PACE) is a service to facilitate care for patients in the community rather than in an acute setting. The aim of the service is to reduce the duration of convalescence by providing more intensive therapeutic input than is available in hospital and by delivering care in the patient's home. PACE is put forward as a benefit by the parties which will be achieved through the merger. Before the merger, the program did not work as originally intended and the reasons given for this included problems with redeployment of staff and concerns over funding. However, the parties did not set out why and how the merger would address these issues.

#### *Improve career structure and training opportunities to improve staff morale*

111. Buckinghamshire Hospitals in its proposal to merge with Community Health Buckinghamshire states that 'staff morale, retention and further education have been a problem in community hospitals and this exciting model delivers a more interesting career structure. Training opportunities are also broadened for acute staff.'<sup>30</sup> Although the parties told us that the merger would allow for staff transfers between Community Healthcare Buckinghamshire and Buckinghamshire Hospitals, giving greater variation of roles, there was no evidence to suggest that a lack of different career opportunities was one of the causes of problem with staff morale and training. The parties said that they take career structure and training seriously, but it was not clear how these issues would be improved by the merger. There is also clear recognition within the documentation that "*the merger in and of itself will not address this issue ...*".<sup>31</sup>

#### *Bring about efficiencies by reducing duplication and wasted clinical time*

112. The parties provided examples of where service duplication currently exists and where the parties consider it would be reduced by the merger. One example was that of reduced duplication in the services provided by midwives and health visitors. It is not clear from the documentation how this duplication would be reduced by the merger. Appropriate commissioning of services could prevent such duplication, rather than merging the organisations.

#### *Alternative models of care provision*

113. The parties said that there would be a change in clinical working to facilitate alternative models of care provision. They told us: "*Our clinical teams will need to learn to work differently*

---

<sup>29</sup> This is included in the Buckinghamshire Economy IV Service Handover Document Version: 1.3 Final.

<sup>30</sup> This is stated in the "Buckinghamshire Hospitals Community health services Proposal Integrated, efficient and patient centred care in Bucks January 2010".

<sup>31</sup> This is stated in Buckinghamshire Hospital entitled 'Clinical response to the CCP' and dated 17 June 2010.

*to support community colleagues, e.g. this may mean our consultants hosting local clinics with GPs to meet admission avoidance targets and GP education programmes to support GPs with a special interest”.*

114. The CCP recognises that patients may benefit if the merger improves community training for GPs, allows clinics to be held closer to patients’ homes and reduces unnecessary acute admissions. However, the parties did not provide evidence of how these goals would be achieved (eg through plans for a change in consultants’ working patterns), or of how such working prevents unnecessary admissions, or how resources would be found to facilitate educational programs.

#### *Improved prescribing*

115. The parties said that the merger would lead to a reduced number of errors in drug prescribing and administration and a costs saving due to improved governance and unified prescribing protocols. The CCP agrees that the merger could make it easier to realise such benefits, but the parties did not set out how this potential benefit would be achieved in practice.

#### *Greater utilisation of telemedicine*

116. The parties also considered that there would be greater utilisation of telemedicine which would benefit patients. However, there is no evidence that the merged organisation has plans as to how this would be done and why this benefit could not arise without the merger.

### **TAXPAYER BENEFITS**

117. Buckinghamshire Hospitals’ proposal to merge with Community Health Buckinghamshire forecast an externally imposed savings requirement of £31 million by 2011/12, requiring £17 million in annual savings to be achieved in 2010/11 and an additional £14 million in annual savings to be achieved in 2011/12.<sup>32</sup> The parties have submitted that the savings identified in this proposal should be accepted as benefits to taxpayers arising from this merger.

118. The extent to which these savings can be accepted by the CCP as a benefit to taxpayers arising from the merger depends on whether the savings: (1) are attributable to the merger (or are cost reductions that could be implemented without the merger); and (2) are likely to be achieved in practice.

119. The merger parties have identified the source of the £17 million in annual savings to be achieved in 2010/11. These are as follows:

- £1.95 million from corporate and back office workforce;
- £1.88 million from estates costs;
- £0.03 million from Information Management & Technology;
- £7.48 million from reductions in length of stay;
- £1.30 million from a skill-mix review;
- £1.98 million from procurement;

---

<sup>32</sup> “Buckinghamshire Hospitals Community health services Proposal” Buckinghamshire Hospitals NHS Trust, January 2010, page 117, paragraph 3.

- £0.06 million from diabetes;
- £0.89 million from community beds and premises;
- £0.90 million from therapies; and
- £0.25 million from sexual health services.

We discuss below whether these cost savings meet the two criteria set out in the previous paragraph.

120. The parties are yet to identify the source of the additional £14 million in savings. As a result, the CCP is unable to accept these savings as a benefit to taxpayers arising from the merger. This is because there is no evidence as to how these savings will be achieved and whether they can be regarded as savings that arise from the merger or are cost savings that could be achieved without the merger.

#### *Corporate and back office workforce savings*

121. Buckinghamshire Hospitals told us that it considers the savings target of £1.95 million from corporate and back office workforce as reasonable, but that detailed restructuring plans are still being made. It told us that each corporate department will be assessed individually with a starting target of an overall 10 per cent reduction in cost. Buckinghamshire Hospitals also told us that as there is no spare capacity in either Buckinghamshire Hospitals or Community Health Buckinghamshire, and the saving is based on the opportunity to adopt more efficient systems across different departments.

122. In the absence of specific plans, it is unclear whether these savings are a result of the merger or could be realised without the merger. Given this, and in the absence of any further detail, we cannot conclude that this saving is a benefit to taxpayers arising from the merger.

#### *Estate costs*

123. The parties have established a target of £1.88 million in annual savings from estate costs. Of these, Buckinghamshire Hospitals considers that a saving of £1.73 million per annum can be realised from bringing the cost per square metre of estate at Community Healthcare Buckinghamshire in line with that at Buckinghamshire Hospitals. However, as Community Healthcare Buckinghamshire manages a larger number of small estates compared with Buckinghamshire Hospitals this is not a like-for-like comparison, and it is unclear whether estate costs can be equalised across estates with different characteristics.

124. Further, Buckinghamshire Hospitals was unable to identify differences in its estate costs across the three sites it currently operates. As a result, it is not clear that Buckinghamshire Hospitals has access to management information that would allow it to identify where savings might be made in the management of the Community Health Buckinghamshire estate.

125. Buckinghamshire Hospitals also told us that part of these savings arise from savings in facilities management, but that it contracts out its soft facilities management. To the extent that there are savings in this area that are merger specific, this implies a combined management across the entire estate. It is not clear to us how this would be achieved given the existing soft

facilities management contract and whether this would require this contract to be re-tendered, and thus delay the realisation of these benefits. If the cost savings could be achieved solely through competitively tendering facilities management at Community Healthcare Buckinghamshire, then this could be achieved without the merger.

#### *Information Management & Technology*

126. Buckinghamshire Hospitals submitted that following the merger it would implement a new IT infrastructure. Most of the £0.03 million saving in this area is expected to arise as a result of having “a more efficient and integrated IT infrastructure that will provide a comprehensive, single patient record and easy access to organisational information and statistics to support operational management”. In the absence of any specific plans in this area, the CCP cannot take this into account in its analysis of the effects of the merger.

#### *Reductions in length of stay*

127. Buckinghamshire Hospitals submitted that reductions in length of stay will result in a reduction of approximately 20,000 bed-days across the Trust, giving rise to a cost saving of £7.48 million per annum. We discuss this in paragraphs 108-110, and conclude that there is insufficient evidence to accept that this benefit will arise from the merger.

#### *Skill-mix review*

128. Buckinghamshire Hospitals did not submit the internal benchmarking comparisons upon which it based its expectation that efficiencies from a skill-mix review (aimed at increasing staff training and improving professional supervision) would save £1.3 million, but said it was based upon estimates of possible future improvements in clinical productivity. Given the lack of supporting evidence the CCP is unable to take this benefit into account in its assessment.

#### *Procurement*

129. Buckinghamshire Hospitals considers that joint procurement with Community Health Buckinghamshire would not be as beneficial as “having a single entity to drive forwards the rationalisation programme” and that £1.98 million cost savings could be made as a result of the merger. For example, it suggested that delivery costs for suppliers might be reduced post-merger. It seems likely, however, that these supplies would still need to be distributed to the different sites within the merged organisation. Buckinghamshire Hospitals also submitted that at this stage it was not possible to allocate the savings to specific procurements in a meaningful way.

130. Based on the evidence submitted, the CCP was not persuaded that there were procurement cost savings of the order of magnitude put forward by Buckinghamshire Hospitals arising from the merger.

#### *Diabetes*

131. This planned benefit of £0.06 million in annual cost savings in the diabetes services is based on Buckinghamshire Hospitals achieving the national quartile target for the ‘average spend per

admission with a primary diagnosis of diabetes'. Twenty-five per cent of Trusts in England (40 in number) have achieved this target.

132. As all of these Trusts are not integrated community and acute elective care providers, it indicates that this benefit is achievable without the merger. Since this benefit is not merger specific the CCP cannot take it into account in its analysis of the effects of the merger.

#### *Community beds and premises*

133. Buckinghamshire Hospitals told us that detailed plans and timelines for achieving cost savings of £0.89 million per annum from community beds and premises in the first year were not available at this stage. Buckinghamshire Hospitals told us that: *“Whole system pathway redesign and integration of services will allow for staff rotation across the acute and community setting, making the best use of staff rotas and leading to development of skills and enabling care of a more acute nature to be provided in a community setting.”* Given the lack of supporting evidence, the CCP cannot take it into account in its analysis of the effects of the merger.

#### *Therapies and Sexual health services*

134. Buckinghamshire Hospitals told us that changes to patient pathways for therapy and a review of sexual health services aimed at achieving a cost saving of £0.25 million per annum in the first year will begin in the first three months following the merger. On the basis that the method by which these benefits will accrue has not yet been planned, we consider that there is insufficient evidence that these benefits will accrue in a reasonable timeframe and are merger specific. Therefore the CCP cannot take them into account in its analysis of the effects of the merger.

### **CONCLUSION – ASSESSMENT OF BENEFITS**

135. The parties submitted that a significant number of benefits to patients and taxpayers would arise from the merger between Community Health Buckinghamshire and Buckinghamshire Hospitals. We are unable to accept that the various benefits put to us either exist, arise as a result of the merger, or are likely to be realised within a reasonable timeframe following the merger.

### **ADVICE AND RECOMMENDATIONS**

136. We find that the merger gives rise to a material adverse effect due to the impact of vertical integration on the primacy of the GP gatekeeper function for patients being referred from community to acute elective services, and in particular, the incentives that the merged organisation would have to refer its community services patients to its own acute elective care services.
137. We considered whether there were benefits to patients and taxpayers arising from this transaction that would offset the cost to patients associated with the merger's impact on the GP gatekeeper function. We conclude that there is insufficient evidence that the merger would give rise to benefits to patients and taxpayers that could be balanced against this cost. However, as

we discuss below, we have identified a set of remedies that we believe will address the concerns that we have identified.

138. We do not conclude that vertical integration between the parties will affect patient choice and competition in community services in the future under an AWP model. However, this finding is primarily a result of this policy still being in the early stages of development. We recognise the possibility that, under certain circumstances, vertical integration could have an adverse effect on patient choice and competition in community services under AWP. As a result, we recommend that the Government in developing this policy design appropriate safeguards so that patient choice and competition are not unintentionally undermined.

139. Given that we have found that the merger is likely to give rise to a material net adverse effect on patients and taxpayers, we have identified a set of remedies to address the concerns we have identified about the impact of the merger on patients' ability to choose between providers of acute elective care. In particular, Buckinghamshire Hospitals, on behalf of itself and Community Health Buckinghamshire, agreed to implement the following remedies, set out in full at Appendix 5, concerning:

- i. compliance with all current and future legislation or Department of Health guidance regarding patient choice of acute elective care provider;
- ii. use of the Choose and Book system;
- iii. the provision of an appointment letter when an employee of the merged entity refers a patient for acute elective care, setting out the patient's right to a choice of provider, together with an explanation of the contents of the letter;
- iv. training for all those referring patients for acute elective care;
- v. compliance with any written directions the CCP may from time to time give for the purpose of securing compliance with the remedies; and
- vi. the provision of information to Buckinghamshire PCT to enable it to monitor the remedies.

140. Buckinghamshire PCT also agreed to implement the following remedies, set out in full at Appendix 6, concerning:

- i. the monitoring of referral patterns;
- ii. the monitoring of the quality and impartiality of advice being offered on choice;
- iii. choice specifications built into new integrated pathways;
- iv. compliance with any written directions the CCP may from time to time give for the purpose of securing compliance with the remedies; and
- v. cooperation with South Central SHA and/or Buckinghamshire PCT in respect of monitoring compliance with, and/or investigation into potential breaches, of the remedies.

141. The remedies set out above require that patient choice is offered by the merged entity to those patients who require acute elective care. The remedies also require that Buckinghamshire PCT will monitor referral patterns. We consider that the remedies will address the adverse effects in a timely manner and are practical to implement, monitor and enforce. We also consider that there is a high degree of certainty that the remedies will achieve their intended

effect. Accordingly, we believe that the remedies are effective in addressing the reduction in patient choice of acute elective care that we have identified.

142. We believe that the effect of the remedies is to reflect existing good practice and legal obligations in respect of choice in acute care services. The remedies therefore do not therefore impose additional cost or burden on the parties. Further, we consider the remedies necessary to preserve the principle of patient choice in acute elective care. We therefore believe that the remedies are proportionate in addressing the effect on patient choice of acute elective care that we have identified.

143. Finally, the analysis, advice and recommendations set out in this report are 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 changes to the terms of the proposed merger, we expect the parties to re-refer the matter to us for further consideration.

**APPENDIX 1 - COMMUNITY HEALTH SERVICES PROVIDED BY COMMUNITY HEALTH BUCKINGHAMSHIRE**

<i>Service</i>	<i>Value (£)</i>
Integrated Care Teams	20,078,860
Children & Young People's Therapy	2,718,770
Specialist Community Public Health Nursing	7,696,330
Complex care	1,280,919
Contraceptive & Sexual Health Services	1,326,711
Specialist Palliative Care	2,235,798
Stop Smoking Services	382,215
Wheelchair Services	1,377,563
Musculo-skeletal and Chronic Pain/Fatigue	2,300,797
Podiatry	2,033,930
Back Care	142,326
Falls	295,744
Dieticians	525,002

## APPENDIX 2 - MARKET DEFINITION

### INTRODUCTION

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<sup>33</sup>) and the geographic area in which competition between Community Healthcare Buckinghamshire and Buckinghamshire Hospitals 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<sup>34</sup>) 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

---

<sup>33</sup> We use the terms 'product' and 'service' interchangeably in this document.

<sup>34</sup> Most services in the NHS are subject to fixed prices in the form of a tariff. In community health services, however, there is no fixed tariff for services, the cost of which (or price) is the subject of negotiation with the PCT.

taxpayers regardless of how it defined the markets affected by the merger. In these latter cases, 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 community health services supplied by Community Healthcare Buckinghamshire and Buckinghamshire Hospitals are set out at Appendix 1 and Appendix 2 respectively.
7. In principle, the relevant product market(s) for our analysis might be:
  - separate product markets for each community and acute service; or
  - a product market for sets of community health services and acute care services; or
  - a separate product market for (i) all community health services and (ii) all acute care services; or
  - a product market that includes community health services, acute care services and other health services such as primary care.
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 and acute care services or a single market for the supply of all community and acute care services. That is primarily due to the number of actual and possible community and acute care services providers in the area capable of providing the services provided by Community Healthcare Buckinghamshire and Buckinghamshire Hospitals, either as a whole or individually.
9. We also considered the extent to which community service providers and acute elective care services providers face competition from care provided in other settings (e.g. providers of primary care), and as a result, whether these services should also be included in the same market 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 and one acute elective provider was available to them.
10. The product component of each community and each acute elective 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, at a community health facility or in an acute setting). If, for example, there is only one primary care 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 (e.g. in an acute setting) if this was available.<sup>35</sup> 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 alternative service should be included in the same product market as the community service(s) in question.<sup>36</sup>

---

<sup>35</sup> For simplicity this assumes that patients would not stop treatment altogether if they were dissatisfied with the quality of service in a particular setting.

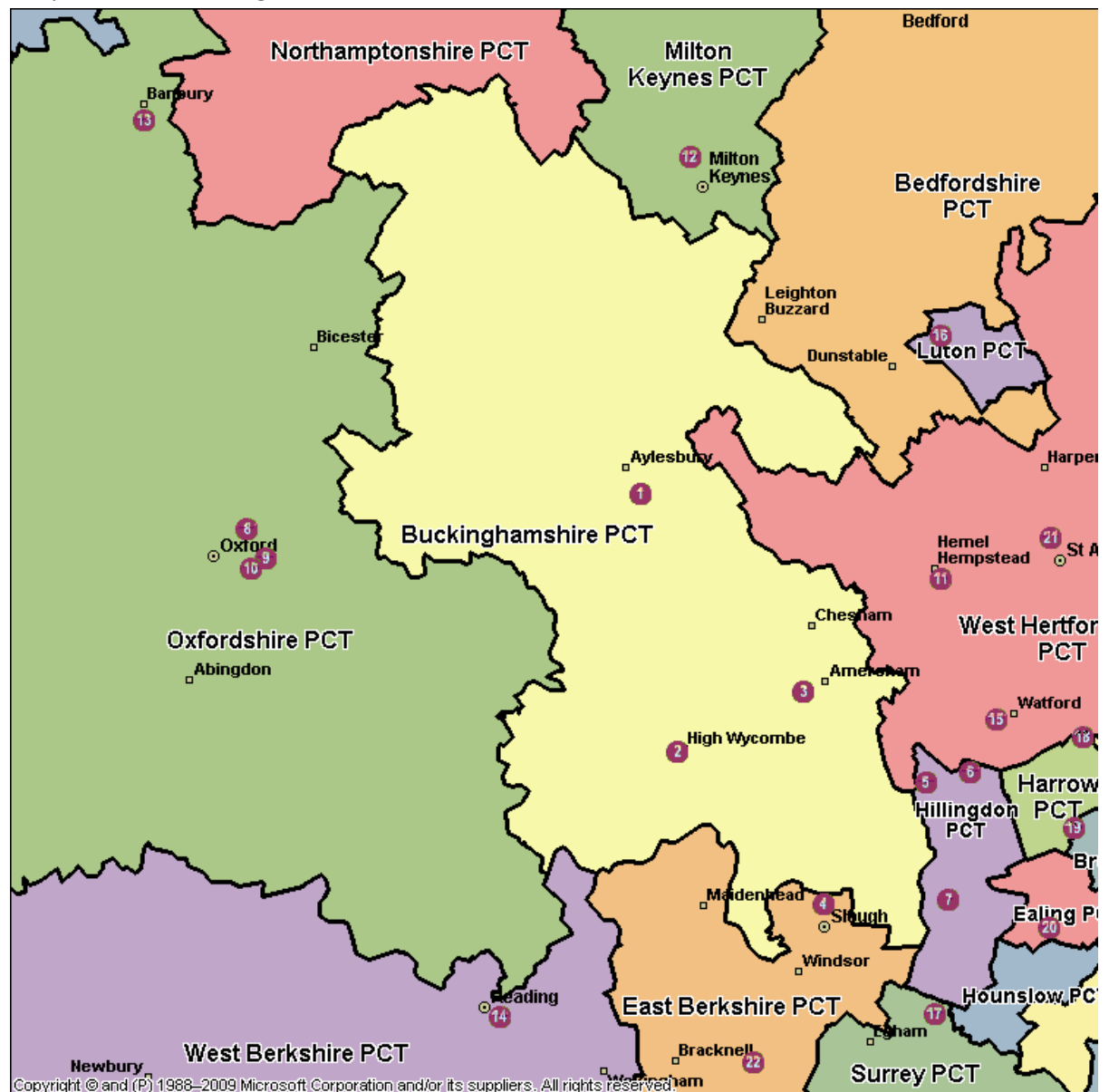
<sup>36</sup> This, in essence, is the 'hypothetical monopolist' test.

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 their use of the service in response to a small but significant reduction in the quality. 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 health services or community health 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 is: (i) the supply of individual community health services and individual acute care services; *or* (ii) community health services as a whole and acute care services as a whole. At this stage we consider it unlikely that the relevant product market(s) also includes other healthcare services, such as primary care services.

### **GEOGRAPHIC MARKET**

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;
  - 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.

FIGURE 1:  
Hospitals in the Buckinghamshire area





Key:

No.	Hospital	Trust	Specialism
1	Stoke Mandeville Hospital, Aylesbury	BUCKINGHAMSHIRE HOSPITALS NHS TRUST	
2	Wycombe Hospital, High Wycombe	BUCKINGHAMSHIRE HOSPITALS NHS TRUST	
3	Amersham Hospital, Amersham	BUCKINGHAMSHIRE HOSPITALS NHS TRUST	
4	Wexham Park Hospital, Slough	HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST	
5	Harefield Hospital, Harefield	ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	Heart & lung
6	Mount Vernon Hospital, Northwood	THE HILLINGDON HOSPITAL NHS TRUST	
7	Hillingdon Hospital, Uxbridge	THE HILLINGDON HOSPITAL NHS TRUST	
8	John Radcliffe Hospital, Oxford	OXFORD RADCLIFFE HOSPITALS NHS TRUST	

Source: CCP

14. For the majority of community health services in Buckinghamshire the PCT has agreed a single contract to supply the county. In a small number of service lines it has agreed contracts with two providers, one covering the south of the county and one covering the north of the county. Therefore for those services in which the commissioner has split the county into northern and southern contracts we identify two relevant geographic markets. Between them these two markets cover Buckinghamshire PCT. However for those services in which the commissioner has contracted a single provider we identify the relevant geographic market for analysing the effects of this merger on community services as the Buckinghamshire PCT area.
15. In contrast, for acute elective care services provided by Buckinghamshire Hospitals residents are able to choose from a range of alternative providers of elective treatment. The closest of these providers are:
- Oxford Radcliffe Hospitals NHS Trust and Nuffield Orthopaedic Centre NHS Trust in Oxford to the west of Buckinghamshire;
  - Milton Keynes Hospital NHS Foundation Trust to the North of Buckinghamshire; and
  - Heatherwood & Wexham Park NHS Foundation Trust, Royal Berkshire NHS Foundation Trust, and Royal Brompton and Harefield NHS Foundation Trust to the South of Buckinghamshire.
16. If there were to be a reduction in the quality of service that is provided by Buckinghamshire Hospitals, patients would therefore have the ability to choose to be treated at one of these nearby alternatives. For some patients this choice will remain hypothetical since these alternatives would be inconvenient and so they would be unlikely to choose an alternative provider in response to a small reduction in quality.
17. We have not considered the precise boundaries of the market for elective acute healthcare in Buckinghamshire. However it would seem likely that the relevant geographic market would extend to both Oxford Radcliffe and Heatherwood & Wexham Park since:

- i. both Oxford Radcliffe and Heatherwood & Wexham Park each treat nearly 10 percent of Buckinghamshire residents; and
- ii. these 20 percent of patients are referred from GP practices that also refer a large proportion of their patients to Buckinghamshire Hospitals. These patterns suggest that patients and GPs at these practices choose between alternative providers and so might be expected to respond to a small change in quality by selecting an alternative acute provider.

18. Given these considerations, we believe that the relevant geographic market for acute elective care will include Oxford Radcliffe and Heatherwood and Wexham Park in addition to Buckinghamshire Hospitals.

#### **FINDINGS ON MARKET DEFINITION**

19. In summary, the relevant product market for analysing this merger may be: (i) individual community health services and individual acute care services; or (ii) community health services as a whole and acute care services as a whole. The relevant geographic market for analysing the effects of this merger on community health services maybe: (i) the Buckinghamshire PCT area, or, (ii) the north of Buckinghamshire and the south of Buckinghamshire (where the commissioner chooses to tender separate contracts for the two). The relevant geographic market for analysing the effects of this merger on acute elective care services is likely to include at least Buckinghamshire Hospitals, Oxford Radcliffe Hospitals and Heatherwood and Wexham Park.

20. 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 market for community health services in the Buckinghamshire PCT area and the market for elective acute services in the Buckinghamshire PCT area as the markets affected by this merger.

## APPENDIX 3 - REMEDIES OFFERED BY BUCKINGHAMSHIRE HOSPITALS

### INTRODUCTION

1. The Merger falls within the scope of Principles 9 and 10 of the Principles and Rules. The CCP has examined the Merger during Phase 1 and Phase 2 Inquiries.
2. The CCP decided during its Phase 1 Inquiry that there was a realistic prospect of material adverse effects on patients and/or taxpayers. This is because patients receiving community health services after the Merger may be referred exclusively, or to a larger extent than they would have been absent the Merger, to Buckinghamshire Hospitals for Acute Treatment.
3. We therefore investigated this issue further during our Phase 2 Inquiry. During our Phase 2 Inquiry, we concluded that, for the reasons above, the merger would be likely to give rise to a material adverse effect on patients and/or taxpayers. The CCP therefore decided the merger would be compliant with the Principles and Rules if the parties agreed to provide remedies to address its concern. Buckinghamshire PCT and Buckinghamshire Hospitals have agreed to the remedies put forward by the CCP. Buckinghamshire PCT and NHS South Central will monitor compliance with the remedies agreed by Buckinghamshire Hospitals. The remedies put forward by Buckinghamshire PCT also form part of this Report.
4. The CCP considers that the Remedies along with the additional remedies provided by Buckinghamshire PCT are appropriate to mitigate the potential loss of patient choice and competition identified in the Report.

### REMEDIES

5. Buckinghamshire Hospitals, on behalf of itself and Community Health Buckinghamshire (together, the merged organisation), now provides the CCP with the Remedies for the purpose of mitigating the adverse effects on patients and taxpayers set out in the Report.
6. The Remedies shall take effect from the date that the Department of Health (DH) accepts the advice and recommendations of the CCP.
7. In respect of referrals for Acute Treatment:
  - i. The merged organisation will comply with the *NHS Constitution December 2009*, and any superseding legislation or Department of Health guidance, which enshrines the rights of a patient to choose his/her provider of acute elective care.
  - ii. The merged organisation will ensure that it implements the Choose and Book System effectively.
  - iii. When a patient in the care of a Healthcare Professional requires Acute Treatment, that Healthcare Professional will, if referring the patient on for the Acute Treatment, provide the patient with an appointment letter which:
    - a) informs the patient that he/she has the right to choose the hospital where he/she will receive the Treatment;

- b) informs the patient that he/she does not have to choose to receive the Acute Treatment at the merged entity;
  - c) informs the patient that he/she can make an appointment with his/her GP in order to receive advice and assistance on making arrangements for the Acute Treatment;
  - d) informs the patient about the NHS Choices website;
  - e) offers to assist the patient to make the appointment for the Treatment using the Choose and Book System; and
  - f) provides the patient with an appointment reference number and a password so that the patient can use Choose and Book his/herself if he/she choose to do so.
- iv. Upon providing the patient with the appointment letter referred to in paragraph (iii) above, the Healthcare Professional will explain the contents of that letter so that the patient understands that he or she has a choice of date, time and hospital for the Acute Treatment.
- v. All Healthcare Professionals referring patients for acute elective care will receive training on NHS Choices and how to use the Choose and Book system. Buckinghamshire Hospitals will keep records of which Healthcare Professionals have received training and the date(s) on which this has been provided. Healthcare Professionals who have not received appropriate training will not be permitted to refer patients for Acute Treatment.

#### **COMPLIANCE**

8. In the event of a suspected breach of the Remedies, any interested party may ask the CCP to investigate. If the CCP finds that there has been a breach of the Remedies, it may advise NHS South Central to require Buckinghamshire Hospitals to comply with the Remedies. Buckinghamshire Hospitals will comply with such directions as NHS South Central and/or Buckinghamshire PCT may from time to time give for the purpose of securing compliance with the Remedies.
9. Buckinghamshire Hospitals shall cooperate fully with NHS South Central, Buckinghamshire PCT and the CCP when any of these organisations is either monitoring compliance with the provisions of the Remedies or investigating potential breaches of the provisions of the Remedies.

#### **PROVISION OF INFORMATION**

10. Buckinghamshire Hospitals will furnish promptly to the CCP, Buckinghamshire PCT or NHS South Central such information as any of these organisations consider necessary to enable them to monitor the Remedies.

#### **MATERIAL CHANGE OF CIRCUMSTANCES**

11. In the event of a material change of circumstances, Buckinghamshire Hospitals may ask the CCP to vary these Remedies. The CCP may make any variations which it considers appropriate following a request from Buckinghamshire Hospitals.

#### **INTERPRETATION**

12. For the purposes of the Remedies:

“Buckinghamshire Hospitals” means Buckinghamshire Hospitals NHS Trust or a successor body;

“Acute Treatment” means elective treatment in an acute setting;

“CCP” means Cooperation and Competition Panel;

“Choose and Book System” means a system offering a service that allows patients to choose their hospital or clinic and book an appointment with a specialist;

“Healthcare Professional” means any member of staff employed by the merged organisation, who refers a patient for Treatment;

“Merger” means the proposed transfer of Community Health Buckinghamshire to Buckinghamshire Hospitals;

“Phase 1 Inquiry” means an initial assessment into a case, as described in the CCP’s draft rules of procedure;

“Phase 2 Inquiry” means an in-depth assessment into a case, as described in the CCP’s draft rules of procedure;

“Principles and Rules” means the Principles and Rules for Cooperation and Competition and a reference to a Principle means any one of the ten Principles contained in the Principles and Rules;

“Remedies” means the remedies contained in this document; and

“Report” means the CCP’s advice to the Department of Health on the Merger, set out in a report dated 13 August 2010.

**Signed:**

**Chief Executive, Anne Eden**

A handwritten signature in blue ink, appearing to read 'Anne Eden', is positioned below the printed name.

## APPENDIX 4 - REMEDIES OFFERED BY BUCKINGHAMSHIRE PCT

### INTRODUCTION

1. The Merger falls within the scope of Principles 9 and 10 of the Principles and Rules. The CCP has examined the Merger during Phase 1 and Phase 2 Inquiries.
2. The CCP decided during its Phase 1 Inquiry that there was a realistic prospect of material adverse effects on patients and/or taxpayers. This is because patients receiving community health services after the Merger may be referred exclusively, or to a larger extent than they would have been absent the Merger, to Buckinghamshire Hospitals for Acute Treatment.
3. We therefore investigated this issue further during our Phase 2 Inquiry. During our Phase 2 Inquiry, we concluded that, for the reasons above, the merger would be likely to give rise to a material adverse effect on patients and/or taxpayers. The CCP therefore decided the merger would be compliant with the Principles and Rules if the parties agreed to provide remedies to address its concerns. Buckinghamshire PCT and Buckinghamshire Hospitals have agreed to the remedies put forward by the CCP. Buckinghamshire PCT and NHS South Central will monitor compliance with the remedies agreed by Buckinghamshire Hospitals. The remedies put forward by Buckinghamshire PCT also form part of this Report.
4. The CCP considers that the Remedies along with the remedies provided by Buckinghamshire Hospitals are appropriate to mitigate the loss of patient choice and competition identified in the Report.
5. The Remedies shall take effect from the date that the Department of Health (DH) or the South Central Strategic Health Authority (South Central SHA) accepts the advice and recommendations of the CCP.

### REMEDIES

6. Buckinghamshire PCT now provides the CCP with the Remedies for the purpose of mitigating the adverse effects on patients and/or taxpayers set out in the Report.
  - i. Buckinghamshire PCT will monitor and analyse actual attendances by specialty, trust, GP practice and category of referrer, compared with previous time periods, examining changes in patterns accordingly.
  - ii. Buckinghamshire PCT will also monitor the referrals flowing through the Choose and Book system.
  - iii. Buckinghamshire PCT will use patient experience information from patient surveys, both national and local, and information from their Patient Advice and Liaison Service and Local Involvement Networks as further sources of information about the quality of choice being offered.
  - iv. As new integrated pathways are developed, Buckinghamshire PCT will include in its specification the point at which choice must be offered and who will offer the choice. This will almost always be through the GP. If pathways do arise which do not use the GP, then special monitoring arrangements will be put in place, including

monitoring data from Choose and Book, and specific patient surveys of patients' perception of the choices they were offered.

- v. If there is any indication that the merged entity is not offering choice appropriately, then there will be a further investigation, which can include a specific patient survey, and further analysis of the data. Mechanisms are in place through the contract to ensure that performance improves, including the issue of a performance notice and ultimately the termination of the contract.
7. Buckinghamshire PCT will store this information in such a way as to ensure it can be provided to the CCP and/or NHS South Central in a timely and clear manner and will provide such information upon request from either organisation.

#### **COMPLIANCE**

8. In the event of a suspected breach of the Remedies, any interested party may ask the CCP to investigate. If the CCP finds that there has been a breach of the Remedies, it may advise NHS South Central to require Buckinghamshire PCT to comply with the Remedies. Buckinghamshire PCT will comply with such written directions as NHS South Central may from time to time give for the purpose of securing compliance with the Remedies.
9. Buckinghamshire PCT shall cooperate fully with NHS South Central and the CCP when either of these organisations is either monitoring compliance with the provisions of the Remedies or investigating potential breaches of the provisions of the Remedies.
10. Buckinghamshire PCT shall cooperate fully with Buckinghamshire Hospitals, the CCP and NHS South Central when any of these organisations is either monitoring compliance with the provisions of the Remedies or investigating potential breaches of the provisions of the Remedies.

#### **PROVISION OF INFORMATION**

11. Buckinghamshire PCT will furnish promptly to the CCP, Buckinghamshire Hospitals or NHS South Central such information as any of these organisations consider necessary to enable them to monitor the Remedies.

#### **MATERIAL CHANGE OF CIRCUMSTANCES**

12. In the event of a material change of circumstances, Buckinghamshire PCT may ask the CCP to vary these Remedies. The CCP may make any variations which it considers appropriate following a request from Buckinghamshire PCT.

#### **INTERPRETATION**

13. For the purposes of the Remedies:

“Acute Treatment” means elective treatment in an acute setting;

“CCP” means Cooperation and Competition Panel;

“Choose and Book System” means a system offering a service that allows patients to choose their hospital or clinic and book an appointment with a specialist;

“Buckinghamshire Hospitals” means Buckinghamshire Hospitals NHS Trust or a successor body;

“Merger” means the proposed transfer of Community Health Buckinghamshire to Buckinghamshire Hospitals;

“Phase 1 Inquiry” means an initial assessment into a case, as described in the CCP’s draft rules of procedure;

“Phase 2 Inquiry” means an in-depth assessment into a case, as described in the CCP’s draft rules of procedure;

“Principles and Rules” means the Principles and Rules for Cooperation and Competition and a reference to a Principle means any one of the ten Principles contained in the Principles and Rules;

“Remedies” means the remedies contained in this document; and

“Report” means the CCP’s advice to the Department of Health on the Merger, set out in a report dated 13 August 2010.

**Signed:**

**Chief Executive, Ed Macalister-Smith**

A handwritten signature in black ink, appearing to read 'Ed Macalister-Smith', with a period at the end. The signature is written in a cursive style.

## APPENDIX 5 - COOPERATION ARRANGEMENTS WITH GP BUSINESSES

1. Buckinghamshire Hospitals' bid for Community Health Buckinghamshire was supported by a partnership with primary care providers in Buckinghamshire: Chiltern Health (2007) Limited, Vale Health Limited and The Practice PLC (together the GP Businesses), which provide GP services in the Buckinghamshire PCT area.<sup>37</sup> Together, they represent 59 of 60 GP practices within the PCT area. In Buckinghamshire Hospitals' bid, the involvement of the GP Businesses was referred to as a 'partnership'.
2. In the course of the CCP's review, the parties continued to negotiate their proposed arrangements. The Guiding Principles document that sets out the current arrangements with the GP Businesses and is included at the end of this Appendix. It should be noted that The Practice delegated its role in the negotiations to the other GP Businesses, but this is not reflected in the attached Guiding Principles document.
3. If a full partnership had been pursued this may, in certain circumstances, have constituted a merger between the GP Businesses and Buckinghamshire Hospitals/Buckingham Community Health under the Principles and Rules. However, we did not consider that the involvement of the GP Businesses with the merged organisation as presented to us at the date of this report constituted a merger because the GP Businesses remain independent from the merged organisation. However, cooperation arrangements between an acute provider (or, as is the case here, a merger acute/community services provider) and GPs may be inconsistent with the Principles and Rules, for example in one of the following ways:
  - i. Where the GPs and the acute provider agree (expressly or tacitly) to refer patients to the acute provider this may limit patient choice contrary to Principle 4.
  - ii. Where GPs coordinate their conduct (expressly or tacitly) so that patients' choice of GP provider is eliminated or restricted is likely to limit patient choice contrary to Principle 4.
  - iii. Where GPs coordinate bids for community services that are competitively tendered either by the acute provider or the PCT commissioner, this may limit commissioner choice contrary to Principles 1 and 4.
  - iv. Where GPs are involved in the design of care pathways but there are conflicts of interest (for example because a GP practice is involved in the design of a care pathway that is subsequently put out to competitive tender and the same GP practice bids for this contract), this may be contrary to Principles 1 and 3.
  - v. Where the acute provider agrees to subcontract community services to GPs instead of holding a competitive tender, this may be contrary to Principles 1 and 3.

---

<sup>37</sup> Chiltern Health (2007) Limited is a provider organisation established by 34 GP practices within the Buckinghamshire Primary Care Collaborative, a practice based commissioning group for the south of Buckinghamshire. The Practice PLC is a primary care company providing community healthcare for the NHS with three GP practices located in Buckinghamshire. Vale Health Limited is a primary care provider organisation for the 22 GP practices in the north of Buckinghamshire.

4. In terms of consistency with the Principles and Rules, each of these scenarios is explored in more detail below. Moreover, it is important to note that cooperation arrangements between GPs (and between GPs and an acute provider) may breach provisions of the Competition Act 1998 (the Act). The Act is enforced by the Office of Fair Trading and significant fines may be imposed on undertakings that have agreed to restrict competition to an appreciable extent.

*References from GPs to acute provider*

5. Principle 4 states that commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare. Principle 4 Rule 2 states that providers, referrers to and commissioners of NHS services must not restrict choice via collusive behaviour or any other action.
6. As part of cooperation arrangements between GPs and an acute provider (or, in this case, a merged acute and community services provider) GPs may have the ability and incentive to refer a greater proportion of patients to the acute provider, thereby reducing patients' ability to choose their acute provider, as they are entitled to do in certain circumstances. This could also have an adverse effect on competition if the GPs in question refer a significant proportion of patients in a particular area to the acute with which they have entered into a cooperation arrangement and this affects the intensity of competition between that acute provider and other rival acute providers.

*Coordination of conduct to limit choice of GP provider*

7. Cooperation arrangements between GPs may result in GPs agreeing (either expressly or tacitly) not to "poach" each other's patients. This could limit patients' choice of GP provider and impact on their ability to switch GP if they are unhappy with the service provided by their current GP. This in turn could have an impact on quality of GP services because GPs will no longer have an incentive to compete for patients. This type of conduct is likely to be inconsistent with Principle 4 and Principle 4, Rule 2 (see paragraph x).

*Coordination of bids for contracts*

8. Principle 1 provides that commissioners should commission services from providers who are best placed to deliver the needs of patients and populations. Cooperation arrangements between GPs may result in GPs coordinating bids for community services contracts that are competitively tendered in their area. Where GPs would have been able to bid for contracts independently, coordination of bids may be contrary to Principle 1 because it means that services are not commissioned from those best placed to provide the needs of patients and populations. It may also limit commissioner choice contrary to Principle 4.

*Conflicts of interest*

9. Where GPs are involved in the design of community services or the design of care pathways, and they are subsequently also involved in bidding for these services, there may be a risk of conflict of interest because there is an incentive to design services and pathways so that the GP will be in a good position to bid for the services in question. This may mean that services and pathways are not designed in patients' best interests and that services are not commissioned from providers who are best placed to deliver the needs of patients and populations, contrary to Principle 1.
10. The risk of conflict is augmented where the GPs have a cooperation agreement with an acute provider and both the acute provider and the GPs have an interest in designing care pathways.
11. Principle 3 provides that commissioning and procurement should be transparent and fair. Where the PCT does not manage possible conflicts of interest appropriately, this may also be inconsistent with the obligation to commission and procure services in a transparent and fair manner. Transparency requires that conflicts are declared and known to all parties involved in the design and procurement process. Fairness requires that organisations involved in service design do not have an advantage as a result of their involvement, compared to organisations that were not involved in this way.

#### *Agreements to subcontract*

12. Where GPs and a merged acute/community provider agree that some community services that are contracted to the acute provider will be subcontracted to the GPs (i.e. by way of an uncontested procurement) , this may be inconsistent with Principles 1 and 3. In addition, Principle 3 rule 1 provides the commissioners must follow the guidelines set out in the Procurement Guide. The Procurement Guide also applies to subcontracting for NHS services.<sup>38</sup> It guide does not introduce a general policy requirement that all NHS services should be subject to competitive tendering, but it does provide guidance on the circumstances when Single Tender Actions (uncontested procurements) may be appropriate. In particular, commissioners are expected to comply with principles of transparency, proportionality, non-discrimination and equality of treatment. In certain circumstances these requirements may mean that awarding a community services contract to GPs pursuant to a cooperation arrangement will be inconsistent with the Principles and Rules and the PCT procurement guide.

---

<sup>38</sup> DH, *PCT Procurement Guide* (25 March 2010), paragraph 1.10.

**DRAFT**  
**GUIDING PRINCIPLES (this “Agreement”)**  
**BETWEEN**  
**BUCKINGHAMSHIRE HOSPITALS NHS TRUST (BHT)**  
**VALE HEALTH LIMITED**  
**CHILTERN HEALTH (2007) LIMITED**  
**(Together the GP Provider Companies)**

**(Together “the Parties” and individually a “Party”)**

**1 Background**

- 1.1. The 2008/2009 Operating Framework requires all Primary Care Trusts to create internal separation of operational provider services and agree service contracts for these services based on the same business financial rules as apply to all other external service providers. In January 2009, the Department of Health issued Best Practice Guidance “Transforming Community Services: Enabling New Patterns of Provisions” setting out detailed requirements for achieving “hard” separation provider functions by Primary Care Trusts.
- 1.2. As part of this Transforming Community Services agenda, the Parties have bid together in relation to the provision by BHT of certain community services (the “**Community Services**”) (previously provided by Community Healthcare Buckinghamshire (“**CHB**”)) to NHS Buckinghamshire (the “**PCT**”).
- 1.3. The transfer of the Community Services by the PCT to BHT will require a recommendation by The Co-operation and Competition Panel (**CCP**) to the Department of Health (under CCP merger rules). This recommendation has not yet been given by the CCP. However, due to urgent patient care reasons and with Strategic Health Authority approval, BHT is currently working with the PCT on a transitional basis on the terms of a Memorandum of Understanding (“**MOU**”) in relation to the provision of Community Services. The intention of BHT and PCT is to enter into permanent arrangements in relation to the transfer of Community Services on the terms of agreements, which are yet to be agreed (such agreements together the “**Transfer Agreements**”).
- 1.4. This Agreement sets out the terms on which BHT and the GP Provider Companies will work together

## 2. Commencement and Duration

2.1. This Agreement will begin on the commencement date and will continue until on the terms of the Agreement unless or until terminated in accordance with Clause 11 of this Agreement. The commencement date will be agreed post recommendation from the CCP and once the Transfer Agreements are signed.

## 3. Aims of the Parties

3.1. The Parties agree that it is the purpose of this Agreement to establish a partnering and collaborative relationship between BHT, Vale Health Limited and Chiltern Health (2007) Limited (the “**GP Provider Companies**”) with respect to the provision of the Community Services. Subject to the terms of this Agreement, this relationship is intended to last for the duration of this Agreement.

3.2. The GP Provider Companies shall be involved in developing patient pathways. The parties shall collaborate and combine their expertise and workforce to achieve the transformation of the Community Services.

3.3. The Parties shall work together to achieve:

3.3.1. patient-centred services which will provide care closer to the patient's home;

3.3.2. better value for money; and

3.3.3. Prevention of illness in order to avoid unnecessary hospital admissions and to reduce rates of re-admission.

## 4. Principles

4.1. The following are the high-level principles which underpin the delivery of the Parties' obligations under this Agreement and set out key factors for a successful relationship between the parties: :

- a) to develop close and productive working relationships between BHT and the GP Provider Companies, and through them to enable closer working with GP practices within Buckinghamshire;
- b) to achieve patient benefits and best value for money through system transformation by the development of clinically-focused patient pathways;
- c) to identify, by regular monitoring, weaknesses and strengths in the relationship between BHT and the GP Provider Companies and to work together to overcome the weaknesses and to build on the strengths;

- d) to commit to the early recognition and resolution of differences, conflicts and disputes between BHT and the GP Provider Companies; and
- e) To appoint within each of the Parties, co-ordinators at senior level who will support and promote the relationship between them.

## 5. Binding Effect of Clauses 3 and 4

- 5.1. The Parties recognise and agree that the aims and principles described in Clause 3 and 4 above are aspirational and not intended to give rise to legally binding rights and obligations between the Parties.
- 5.2. Nothing in Clause 5.1 shall affect the interpretation or effect of any other provision of this Agreement, including any provision which makes reference to (or incorporates by reference) any part of the above Clauses.

## 6. Process for Clinical Service Transformation

- 6.1. The commissioning process will identify services to be transformed. The Programme Board will then set out an implementation framework and timetable. The GP Provider Companies and, if appropriate, primary care managers identified by the GP Provider Companies will collaborate with BHT clinicians and managers to develop models for service transformation.
- 6.2. The Parties may support the PCT in developing specifications for new services that are to be tendered. In order to ensure that the Parties do not have an unfair advantage over other potential bidders, strict procurement and contestability guidelines will be adhered to, including the use of “chinese wall” processes where necessary.
- 6.3. Any services that BHT may intend to sub-contract may be subject to competitive tender in line with the PCT procurement and contestability guidance and clause 48 of the Integrated Acute and Community Services Contract (*Assignments and Subcontracting*).
- 6.4. The Parties acknowledge and agree that the PCT may carry out a procurement exercise in relation to some or all of the services and, if that shall occur, the Parties will consider whether it might be appropriate to submit a joint bid.
- 6.5. The Parties agree that if a Party does not wish to, or that it is not appropriate, for the Parties to submit a joint bid for such services, nothing shall preclude any or all of the GP Provider Companies and/or BHT from submitting a separate bid for such services.
- 6.6. The Parties agree that there is no intention to not bid against one another which may give rise to unfair advantage. In situation where a joint bid is not considered appropriate the Parties will work independently of one another adhering to strict procurement and contestability guidelines.

6.7. The Programme Board will approve new models and patient pathways for service delivery and will oversee the implementation of change to ensure transformation is achieved within the agreed timescales.

## 7. The Transition Board

7.1. This is a commissioning led multi-agency board to oversee the commissioning process. Terms of reference will be established by the PCT.

## 8. The Programme Board

8.1. Terms of reference attached

8.2. GPs with special skills identified by the Programme Board for service pathway delivery and service transformation will be remunerated by BHT on the terms as set out in clause 12.

## 9. Division of Community and Integrated Care

9.1. The parties acknowledge and agree that the intention of BHT is to establish a sixth division of community and integrated care (the **Division**). The Division will initially encompass all clinical services previously provided by CHB with the exception of Child and Family Services and Sexual Health and Family Planning Services, which have been integrated into the appropriate division within BHT.

9.2. The GP Provider Companies (acting jointly) will work with BHT to recruit to the position of Divisional Chair.

9.3. In addition to the Divisional Chair a primary care manager will also be recruited by BHT to the board of the Division. This role will be similar to that of an SDU lead and will report to the board on primary care involvement in the integration and re-design.

9.4. The effectiveness of this agreement will be reviewed every 6 months via the Programme Board or sooner should operational issues arise.

## 10. Disputes

10.1. In the event of a dispute or disagreement the Parties agree to use their reasonable endeavours to negotiate in good faith a settlement of the dispute.

10.2. If the Parties are unable to resolve the dispute they shall attempt to settle it by mediation using an external body as agreed.

## 11. Termination

- 11.1. This Agreement shall terminate automatically upon termination of the Integrated Acute and Community Services Contract.
- 11.2. Either Party may terminate this Agreement by giving not less than six months written notice.
- 11.3. The Parties may terminate this Agreement in whole or in part (including terminating this agreement with one or more of the GP Provider Companies).
- 11.4. Termination of this Agreement for any reason shall not affect any rights or liabilities which have accrued prior to the date of termination.

**12. Remuneration**

- 12.1. BHT shall pay any person, appointed as a Divisional chair a management allowance in line with all other BHT divisional chairs, circa £20k.
- 12.2. All other remuneration paid by BHT to any GP for regular involvement in Programme Board or additional specific project work shall be agreed between the Parties.

**IN WITNESS WHEREOF the Parties have signed this Agreement on the date shown below**

**1. SIGNED by**

**for and on behalf of the  
Buckinghamshire Hospitals NHS Trust**

}  
-----  
}

Date:

-----

**2. SIGNED by**

**for and on behalf of  
Chiltern Health (2007) Limited**

}  
-----  
}

Date:

-----

**3. SIGNED by**

**for and on behalf of the  
Vale Health Limited**

}  
-----  
}

Date:

-----