CO·OPERATION & COMPETITION PANEL
FOR NHS-FUNDED SERVICES

Cooperation and Competition Panel

Merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust

15 December 2011

Contents

EXECUTIVE SUMMARY

1. The Cooperation and Competition Panel (CCP) has reviewed the proposed merger of Barts and The London NHS Trust (Barts and The London), Newham University Hospital NHS Trust (Newham Trust) and Whipps Cross University Hospital NHS Trust (Whipps Cross Trust). We have found that the proposed merger will give rise to a material cost for patients and taxpayers as a result of a loss in patient choice and competition in respect of routine elective and non-elective care provided from Newham Trust. However, we considered that it is unlikely that the proposed merger would result in a reduction in, or removal of, competition in respect of the services provided from Barts and The London or Whipps Cross Trust.

2. We accepted that the merger is likely to benefit patients and taxpayers by facilitating the reconfiguration of pathology and accelerating the reduction of length of stay care for elderly patients at Barts and The London and Whipps Cross. However, we did not consider that these benefits are significant. We concluded that the benefits that we have identified do not outweigh the costs in this case. Accordingly we decided that this merger is inconsistent with Principle 10 of the Principles and Rules.

3. In reaching our findings we considered the effect of the merger on choice and competition in routine elective and non-elective services, specialist tertiary services, outpatient, and community services provided by the merging organisations in the wider north-east London area.

4. For individual specialist tertiary services, outpatient services and community services we concluded that it was likely that there would be sufficient choice and competition following the merger. We also concluded that adverse effects from the merger arising from the referral relationship between the merger parties and others were unlikely to arise.

5. For routine elective services we concluded that there is likely to be sufficient patient choice and competition following the merger in respect of services provided at Barts and The London and Whipps Cross hospitals. However, we also concluded that Barts and The London and Whipps Cross hospitals impose an important competitive constraint on the services provided from Newham hospital. We concluded that although there are a number of other providers of these services in the north-east London area, Barts and The London and Whipps Cross hospitals are the next best alternatives for people that are likely to access services provided at Newham hospital (with the exception of ophthalmology services). The merger removes important competitive constraints for routine elective services and accordingly significantly reduces choice of hospital provider for people living in Newham.

6. For routine non-elective services we concluded that in the foreseeable future, but not for at least two years, commissioners would be likely to review whether these services should be provided from Newham hospital, Whipps Cross hospital and Homerton hospital. We concluded that this creates an incentive for the management of Newham hospital, Whipps Cross hospital and Homerton hospital to invest in maintaining and improving services to increase the likelihood of being permitted to continue to provide these services. We concluded the merger would significantly reduce this incentive at Newham hospital because if

commissioners decided not to commission these services from Newham most of Newham's patients would be treated instead at Barts and The London or Whipps Cross hospital, as the next closest hospitals. This would mean that the merged organisation would still be paid for treating these patients. Accordingly, we found that the merger would reduce competition for non-elective services at Newham Trust.

7. We were told that commissioners and NHS London support the proposed merger and we note that considerable financial support is being made available to the merged organisation. We acknowledge that there are a number of difficult challenges relating to the provision of healthcare services in north-east London. It is not clear how the merger will help overcome those challenges and indeed in our view a merger of this complexity will present challenges of its own. We note that the CQC has some concerns in relation to services provided by each of the merger parties. In our view this means it is all the more important that the benefits of choice and competition should continue to be made available to patients in north-east London so that they can access the best possible healthcare.

8. Having concluded that the merger is likely adversely to affect the provision of routine elective care and routine non-elective care to patients in Newham, the CCP is now seeking views from interested parties on appropriate remedies. Following consideration of any submissions, the CCP will decide which remedy or remedies to recommend to the Secretary of State for Health. A statement of possible remedies is available on the CCP's website at www.ccpanel.org.uk. Interested parties are invited to submit written observations on suitable remedies by close of business on 6 January 2012 to cases@ccpanel.gsi.gov.uk. The CCP will finalise its recommendations to the Secretary of State for Health in January 2012.

PARTIES

BARTS AND THE LONDON

9. Barts and The London is a large teaching NHS trust based on three hospital sites located in north-east London (the Royal London hospital in Whitechapel, St Bartholomew's in the City of London and The London Chest hospital in Bethnal Green were all merged together in 1994).[1] Barts and The London was awarded a 'Fair' rating for financial management in 2009/10. In the financial year 2010/11 it provided routine acute and specialist (including tertiary) services worth around £707 million.[2] Since July 2011, when it acquired the provider services arm of Tower Hamlets PCT, Barts and The London has also provided a wide range of community health services in Tower Hamlets worth around £70 million per year.

10. The Royal London hospital is the Trust's main site and is used for providing accident and emergency, maternity, adult and paediatric acute and specialist services. It is one of London's

[1] Barts and The London also provides renal, dermatology and rheumatology services at Newham General Hospital, a range of outpatient clinics from a number of health centres/community hospitals and also provides renal services at Whipps Cross Trust.

[2] Local acute hospital services refer to those services that are routinely available in the majority of hospitals with an A&E Department, or in elective treatment centres. Patients are treated without the need for a tertiary referral or transfer to a specialist centre. Specialist hospital services refer to those services not routinely offered in local acute hospitals or treatment centres. In addition, specialist units will treat patients whose conditions have added complexities or where it is determined that the patient is higher than normal risk. A unit can be specialist because it has access to specialist equipment, skills or expertise, or links with academic institutions. Some specialist services are exclusively tertiary services meaning that they only accept referrals from another consultant whereas others are open to secondary referrals from GPs.

four major trauma centres and is the inner north-east London Hyper-Acute Stroke Centre.[3] The St Bartholomew's site provides specialist cancer and cardiac services and The London Chest hospital provides cardiothoracic services and houses the north-east London Heart Attack Centre.[4]

11. Barts and The London is registered without conditions by the Care Quality Commission (CQC). We contacted the CQC to learn if there were any other issues relating to its assessment of Barts and The London that we should be aware of. The CQC told us that it had some concerns relating to elderly care services provided by The Royal London hospital.

12. The Trust is mid-way through a £1.15 billion Private Finance Initiative (PFI) redevelopment of the majority of its estate that will establish St Bartholomew's as a major cancer and cardiac centre (bringing together cardiac services from the two current sites) and redevelop The Royal London as inner north-east London's major trauma, acute and specialist teaching hospital. The new Cancer Centre at St Bartholomew's opened in March 2010 and will be followed by a new Cardiac centre in 2014. The new Royal London Hospital will open in early 2012.

NEWHAM TRUST

13. Newham Trust is also located in north-east London and provides a range of routine acute hospital services from a single hospital site in Plaistow (which comprises Newham General hospital which was built in 1987 and expanded in 2004 with a £30 million PFI contract to accommodate outpatients, rehabilitation services and more recently a new maternity suite and the Gateway Surgical Centre for elective care which opened in 2005). It provides accident and emergency and maternity services, as well as some specialist community nursing services.[5] Newham Trust has had a very strong financial performance in previous years, although a £1 million deficit is forecast for 2011/12. In the financial year 2010/11 Newham Trust provided services worth around £170 million.

14. Newham Trust is registered without conditions by the CQC. We contacted the CQC to learn if there were any other issues relating to its assessment of Newham Trust that we should be aware of. The CQC told us that it had some concerns relating to a number of clinical areas (for example, emergency caesareans; urinary tract infections; patient safety reporting; emergency consultants).

[3] In 2009 a joint committee of PCTs across London approved plans for eight hyper-acute stroke centres and four major trauma centres. The centres operate 24 hours a day, seven days a week and are staffed by consultant-led specialist teams with access to the best facilities. The specialist centres are linked to local units delivering high quality general and rehabilitation care. The new services are expected to save around 500 lives a year and reduce long-term disability for thousands. The four major trauma centres treat the most seriously injured patients, such as those with multiple injuries including head injury, life-threatening wounds and multiple fractures. Teams of specialists including trauma surgeons, orthopaedic surgeons and neurosurgeons are on hand to care for these patients. The major trauma centres are located at: The Royal London Hospital (Whitechapel), St George's Hospital (Tooting), King's College Hospital (Denmark Hill) and St Mary's Hospital (Paddington). The Royal London, which was already close to operating as a major trauma centre, took a leading role in establishing London's major trauma system. Patients with less serious injuries continue to be treated by their local A&E trauma centres. Each local trauma service will be linked to a specialist centre as part of a network designed to share expertise and resources.

[4] The eight hyper-acute stroke centres provide specialist care to patients following a stroke, after which they are transferred to one of 24 local stroke units to continue their recovery. The new hyper-acute stroke centres are located at: Northwick Park Hospital (Harrow), Charing Cross Hospital (Hammersmith), University College Hospital (Euston), St George's Hospital (Tooting), King's College Hospital (Denmark Hill), The Royal London Hospital (Whitechapel), The Princess Royal University Hospital (Orpington) and Queen's Hospital (Romford). Within 24 local hospitals there is also a TIA services for people who have had a transient ischaemic attack (or mini-stroke). People attending a TIA service will be rapidly assessed and treated, to reduce their chance of having a full stroke in future. Barts and the London opened their heart attack centre in 2006. The parties told us that it serves two million people in North East London.

[5] Newham Trust also provides a range of outpatient clinics in nine health centres in the local area.

WHIPPS CROSS TRUST

15. Whipps Cross Trust is located in north-east London at a single hospital site in Leytonstone. It provides a wide range of routine acute hospital services, including accident and emergency, maternity services, and some specialist acute and community health services.[6] The trust has relatively run-down estate and is developing a new £23 million accident and emergency and co-located emergency assessment centre, which is due to be completed in the summer 2013. The Challenged Trust Board intends to provide £25.5m to the merged trust to assist in addressing historical financial debt of Whipps Cross Trust. In the financial year 2010/11 Whipps Cross Trust provided services worth around £233 million.

16. Whipps Cross Trust is registered without conditions by the CQC. We contacted the CQC to learn if there were any other issues relating to its assessment of Whipps Cross Trust that we should be aware of. The CQC told us that it had concerns in relation to infection control and cleanliness, staffing levels in maternity, patient records, Criminal Records Bureau checks of staff, safeguarding children training and staffing concerns / delivery of care at two community service rehabilitation units.

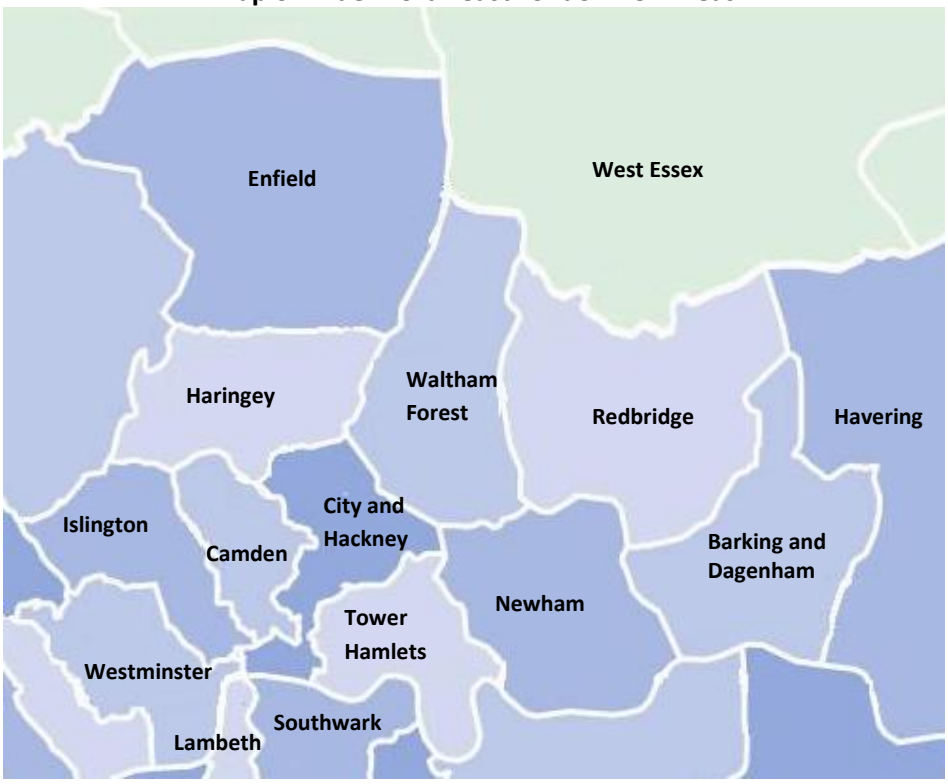
Area affected by the merger

17. A map of the PCT areas in wider north-east London is shown in Figure 1 (inner north-east London includes the PCT areas of City and Hackney, Tower Hamlets and Newham. Outer north-east London includes the PCT areas of Waltham Forest, Redbridge, Barking and Dagenham and Havering).

[6] Whipps Cross Trust also provides Ear Nose and Throat, audiology and ophthalmology services at Newham General Hospital and various outpatient services from six Health Centres in the local area.

FIGURE 1

Map of wider north-east London PCT Areas



BACKGROUND TO THE TRANSACTION

18. The transaction under review by the CCP is the proposed merger of Barts and The London, Newham Trust and Whipps Cross Trust. We were told that this transaction is undertaken within the broader policy context that requires the majority of NHS trusts to become NHS foundation trusts by April 2014.[7]

19. The National Audit Office has determined that a number of hospital trusts in England are not sustainable in their current form with concerns raised in respect of finance, quality and performance, and governance and leadership.[8] It is unlikely these organisations will be able to achieve NHS Foundation Trust status in their current form. The Government has explained that it is for individual NHS trusts to demonstrate how the quality and sustainability of services will be improved in order to achieve NHS foundation trust status. To bring about the necessary change it was suggested by the Government that a trust may take steps such as replacing the senior management teams; introducing turnaround teams to improve the efficiency and quality of existing service delivery; reviewing the scope of existing service delivery (including exploring options to establish service level agreements with other providers where it would be more cost effective and clinically appropriate to do so); and working to ensure costs efficiently incurred in healthcare delivery – either currently or in the past – are appropriately reimbursed

[7] The strong expectation is that the vast majority of NHS trusts will achieve FT status by 2014, on their own, as part of an existing FT or in another organisational form. A small minority of NHS trusts will continue beyond this date by exceptional agreement, with a specifically agreed later date to move to FT status.

[8] Of the 113 NHS trusts aspiring to obtain NHS Foundation Trusts Status 80 per cent face financial issues; 65 per cent face quality and performance issues; 39 per cent face governance and leadership issues. See 'Achievement of foundation trust status by NHS hospital trusts', National Audit Office, 11 October 2011.

(e.g. PFI costs). Structural change in the market has also been proposed. For example, managerial/operational franchise arrangements with a more efficient provider or merging with another provider.

20. The Government has also announced that under certain circumstances it will provide loans to trusts that need them and meet certain criteria.[9] The merger parties told us that the merged organisation would require significant financial support. In particular, they told us that it would require £86.5m to address historic funding shortfalls and investment requirements (including the costs of integrating the three trusts) over the period 2012/13 to 2015/16.[10] In addition, in 2006/07 Barts and The London received approval for a £1.15 billion redevelopment of its hospital estate through a Private Finance Initiative (PFI). At the same time Barts and The London received a £58.6 million loan (for the period 2011/12 to 2015/16) from the NHS Bank to cover running costs incurred from operating multiple sites and other costs incurred when transferring services to the new PFI estate.[11]

21. Each of the three merging trusts undertook separate options appraisals to decide on a preferred approach to achieve NHS foundation trust status (for a detailed review see Appendix 1).
    - In 2010 Whipps Cross Trust decided to merge with Newham Trust and Barts and The London. Other options were mergers with nearby NHS trusts and/or NHS foundation trusts and a franchise model of service provision.
    - Newham Trust decided to merge with Whipps Cross Trust and Barts and The London but also considered other options ((acquisition by Homerton University Hospital NHS Foundation Trust, Whipps Cross Trust and another NHS Trust or NHS foundation trust, or a franchise model of service provision).
    - Barts and The London told us that it has previously made an unsuccessful application to become an NHS foundation trust in 2007. At that time the application was considered to have unrealistic financial planning assumptions. In 2010 Barts and The London considered whether to make another application to become an NHS foundation trust in its current form or whether to first merge with Whipps Cross Trust and Newham Trust. We understand that both options had the support of local commissioners and London SHA and on balance it was decided to first merge with the other two trusts.

[9] These trusts will only be able to access this support once they have met four key tests: (i) the problems they face must be exceptional and beyond those faced by other organisations; (ii) they must show that the problems are historic and that they have a clear plan to manage their resources in the future; (iii) they must show that they are delivering high levels of annual productivity savings; and (iv) they must deliver clinically viable, high quality services – including delivering low waiting times and other performance measures. Speech by Andrew Lansley, 26 October 2011, 'Rooting Out Poor Performance', Reform.

[10] The Challenged Trust Board will provide £26.5m, sector commissioners will provide £40.3m with Public Dividend Capital making up the remainder of £19.7m.

[11] The NHS Bank is an arms-length body of the Department of Health that is managed by the all of the SHA's.

JURISDICTION

22. The proposed merger of Barts and The London, Newham Trust and Whipps Cross Trust is a transaction requiring review Principle 10 of the Principles and Rules as it will result in Barts and The London, Newham Trust and Whipps Cross Trust which were previously independent of each other coming under common management and control.
23. We have not reviewed for consistency with the Principles and Rules the process by which Barts and The London, Newham Trust and Whipps Cross Trust were selected as merger partners. 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 relevant 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. Responsibility for monitoring the ongoing provision of high quality secondary care services from the merging organisations remains with the East London and City PCT cluster, the Outer north-east London PCT cluster (and their successor bodies), London SHA and the CQC (responsible for continuously monitoring health care providers to make sure they are meeting essential standards).

CCP PROCESS

24. Following notification of the transaction to the CCP, we decided that it met our acceptance criteria for a merger case. Specifically:
    i. the proposed arrangement falls within the scope of Principle 10 of the Principles and Rules;
    ii. the CCP is the most appropriate body to consider this matter;
    iii. Barts and The London, Newham Trust and Whipps Cross Trust made available sufficient relevant and applicable information on the case to the CCP; and
    iv. the combined turnover of merger of Barts and The London, Newham Trust and Whipps Cross Trust exceeds the relevant threshold of £70 million.

25. As a result, we accepted the case on 1 June 2011, published a notice to that effect on our website on that date and invited submissions by interested individuals and organisations. Consistent with our *Draft Rules of Procedure* we were required to complete our Phase I review by 27 July 2011.[12] At the end of Phase I the CCP concluded that there was a realistic prospect that the merger may result in a material adverse effect on patients and taxpayers and decided to proceed to Phase II.

26. During Phase II the CCP continued to assess costs to patients and taxpayers resulting from the transaction as well as expected benefits. On 8 August 2011 the parties met with the CCP and made representations about the benefits that are expected to arise from the merger. Further detailed submissions on the benefits were received on 31 August 2011. The CCP's Clinical Reference Group reviewed the parties' benefits submissions and offered a clinical insight into the submissions.[13] The CCP provided working papers on its analysis of the costs and benefits of

[12] The CCP's Merger Guidelines are available at www.ccpanel.org.uk.
[13] The CCP's Clinical Reference Group's role is to provide clinical expertise in order to support Panel's understanding of the possible merits of any clinical benefits, submitted by the parties, in support of a proposed merger. Group members collectively assess the benefits submitted and reach an agreed view which is presented to Panel for their deliberation.

the case to the parties during September and October 2011. The parties provided additional submissions in response to these working papers during October. The parties met CCP staff on 2 November 2011 to discuss staff concerns in relation to the merger and further written submissions were received by the CCP in respect of part of the analysis. The CCP suspended its review of the case on 14 November 2011, at the request of the merger parties, to allow further submissions on the costs and benefits of the case to be made. Following receipt of a further comprehensive submission of the costs and benefits of the merger, the CCP restarted its review of the case on 8 December 2011. All submissions received by the parties have been reviewed carefully and our analysis in this report has been revised and updated in light of all the submissions that have been received.

27. 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 NHS foundation trusts. As this is a merger of NHS trusts, the Secretary of State for Health will consider our advice and recommendations in relation to the proposed merger.

THIRD PARTY SUBMISSIONS

28. The parties told us that they had engaged with a wide range of stakeholders since July 2011 (including the public, staff, GPs, MPs, LINk representatives, local authorities, patients and media) that might potentially be affected by the merger. We were told that public engagement was undertaken using widely distributed published materials explaining the merger, numerous meetings and road-show events (with a video presentation available) and website feedback. In total, by 28 November 2011, 217 submissions were received by the parties and the parties told us that 75 responses supported the merger, 44 responses were unclear in supporting or being against the merger, 90 responses had questions about the merger (often specific questions about what it meant), and eight responses did not support the merger.[14]

29. We also received a number of submissions from third parties in respect of the merger.
    - East London Integrated Care (ELIC) pathfinder GP commissioning consortium, representing 45 GP practices in City and Hackney, expressed a number of concerns about the merger including how the creation of the merged organisation might impact on patient choice, how marginal existing administrative functions might be improved rather than allowed to deteriorate following the merger and how the merged organisation planned to mitigate any effect the size of the merged organisation might have on clinical service delivery and engagement with local GPs.
    - Klear pathfinder GP commissioning consortium, representing ten GP practices in Hackney expressed concerns that the creation of the merged organisation could lead to services being centralised around Barts and The London instead of being maintained from the Newham Trust hospital site, which would lead to longer travel times for patients in its areas. It also told us that Barts and The London did not have a good history of listening to the GPs represented by Klear. KIear also submitted that it was likely to be

[14] The CCP has not reviewed the approach used to gather these views nor the categorisation of responses.

more difficult to commission services within limited financial budgets from an even larger trust. During the course of the CCP merger review ELIC and Klear are working toward becoming a single commissioning structure.

- East London and the City (ELC) commissioners told us that they supported the merger. They were not concerned by the reduction of choice of provider for elective activity for the residents of Newham and considered that sufficient competition would continue to exist. We were told that they recognised that the new merged organisation would become a monopoly provider of non-elective care in Newham but as commissioners they will ensure there were mechanisms to ensure quality did not deteriorate. It was also submitted that the clinical benefits that are expected to accrue from the merger should be reviewed in the context of the consequences of not proceeding.
- Geoffrey Rivett, a member of the public, submitted to us that documentation supporting the merger had missed a number of important issues that should be addressed before proceeding. One of the key concerns raised by Mr Rivett was that supporters of the merger seemed to assume that existing difficulties being experienced by the three individual trusts would be resolved by merging and had not discussed or consulted on the likelihood that the merged organisation will need to relocate or remove some service provision (with a likely impact on patient choice and competition) after the merger was completed.

30. We contacted the local LINk representatives, as we do for all merger cases that we review, and received two submissions from the Hackney LINk. They told us that in their view a merger that brings together three local providers is likely to materially reduce patient choice when the structure of acute care in the area was being reduced from five to three acute care providers. In this context the LINk told us that in its view the benefits of the merger that had been put forward by the merger parties were unlikely to outweigh the negative impacts and potential harm to patients in east London. It also told us that in its view the recent mergers in London leading to the creation of Barking, Havering and Redbridge University Hospitals NHS Trust and the South London Healthcare NHS Trust had both experienced clinical and financial issues and contradicted any argument that economies of scale will necessarily lead to improved standards of care or financial performance. The Hackney LINk did not support the merger and was concerned that it may lead to greater financial pressure on the services that are provided from the hospital sites of each of the three trusts.

FRAMEWORK FOR MERGER ASSESSMENT

31. The framework that we use to assess mergers between healthcare providers is set out in the Principles and Rules and our *Merger Guidelines*. The relevant provision of the Principles and Rules is Principle 10, which provides:

Principle 10: Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interests, for example because they will deliver significant improvements in the quality of care.

32. Our *Merger Guidelines* set out a cost-benefit framework for the assessment of mergers under this Principle.[15] Where a merger may give rise to costs to patients or taxpayers as a result of a loss of choice or competition, these will be weighed up against any benefits to patients and taxpayers that may arise from the merger. From this analysis the CCP will determine whether the proposed transaction is likely to result in a material net cost to patients and taxpayers.[16] The CCP may determine that the merger is inconsistent with Principle 10 of the Principles and Rules if costs to patients and taxpayers arise with respect to part of the services included in the merger. For example, if costs to patients and taxpayers arise with respect to a single service, or a group of services, provided by just one of the merger parties.

33. Consistent with this framework, this report provides an assessment of the costs as well as benefits to patients and taxpayers that arise from the merger. At the outset of our analysis we noted the potential for the activities and capabilities of the parties to overlap in respect of routine elective and routine non-elective services and accordingly in this report we focus on the effects of the merger in respect of those services (see paragraphs 53 to 123). Prior to assessing the costs and benefits likely to arise from this merger we explain the background context of patient choice and competition in the provision of acute services (see paragraphs 34 to 39).

BACKGROUND TO PATIENT CHOICE AND COMPETITION IN ACUTE SERVICES

34. The merger takes place in a broader policy context of patient choice and competition that exists in the provision of acute health services. This context forms the background to our assessment of how patient choice and competition are likely to be affected by the merger. In the paragraphs below we explain the potential models of competition relevant to this market and national policy supporting patient choice and plurality of providers.

MODELS OF COMPETITION

35. In general there are two models of competition in healthcare services. First, there is competition for the market, where service providers compete for the right to provide services across a PCT area or other locality, generally on an exclusive basis. Prices are agreed between the commissioner and the provider (either on the basis of a competitive procurement exercise or by way of bi-lateral negotiation). Payment may be based on cost/volume contracts, where the provider pays for treatment on a per patient/per episode of care basis and does not pay for treatments not provided, or on block contracts, where the provider pays a lump sum for the provision of a particular category of treatments. Competition for the market occurs in community services, mental health services and tertiary acute services (which may be competitively tendered by specialist commissioning groups at the regional or national level).

[15] 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.

[16] 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.

36. Second, there is competition in the market, where patients (with advice from clinicians) can choose between competing providers of the same service. The 'Any Qualified Provider' (AQP) model is an example of where competition occurs in the market, where patients may choose between any NHS or independent sector provider in England is registered with the CQC, has a PCT or nationally let contract and is willing to provide care at the NHS tariff.[17] Within the NHS, remuneration under an AQP model is often based on national or local tariffs for the relevant services. Competition in the market and competition for the market are not necessarily mutually exclusive. For example, commissioners may hold a competitive process to select a range of providers with whom they wish to contract; patients may then be able to choose which of these providers they wish to use.

NATIONAL POLICY OF CHOICE AND COMPETITION

37. Since 2000 a series of reforms to the NHS have aimed to strengthen patient choice, particularly in relation to acute elective care, with the aim of creating stronger incentives for acute care providers to improve access to services and the quality of care they provide. The policy of patient choice was first announced in the NHS Plan in 2000 with the aim of providing patients with the opportunity to book every hospital appointment and elective admission with a choice of a date and time.[18] Delivering the NHS Plan (2002) set out a series of further initiatives that emphasised patient choice. In particular, it committed to providing patients with information on alternative providers, and reinforcing their ability to choose providers so as to benefit from shorter waiting times. Consequently, a number of pilot programmes ran between 2002 and 2004 where patients were able to choose their provider of acute elective care for some procedures.

38. Choice on referral to hospital was formally introduced on 1 January 2006. Patients requiring an elective referral could expect to be offered a choice of at least four hospitals (or suitable alternative providers) and a choice of time and date for their booked appointment. This choice would be provided following referral from a GP or primary care professional using the Choose and Book system and NHS Choices (a website providing information on local services, conditions and treatment) to guide their decisions. From July 2007, patients were able to choose any provider on the ECN in respect of routine elective orthopaedic care. This ability to choose was expanded beyond routine elective orthopaedic care to all patients requiring an elective referral in April 2008 with ECN providers supplemented through the development of the Free Choice Network (FCN) which included NHS acute trusts, newly appointed NHS foundation trusts, and further independent sector providers. A patient's right to choose was formally enshrined in the NHS Constitution, which was adopted in January 2009.

39. Under the AQP model patients can now select from any NHS or independent sector provider of acute elective care in England that is registered with the CQC, has a local commissioner or nationally-let contract, and is willing to provide services at the NHS tariff. Even when there is competition in the market (e.g. for acute elective care) commissioners have obligations and responsibilities in relation to the supply of services in their local area and have considerable influence over the pattern of local service provision.

[17] The 'Any Qualified Provider' model was previously known as the 'Any Willing Provider' model.
[18] The NHS Plan: A time for investment, a time for reform (July 2000).

ASSESSMENT OF MERGER COSTS

40. This section sets out our assessment of whether the proposed merger between Barts and The London, Newham Trust and Whipps Cross Trust can be expected to impose costs on patients and taxpayers as a result of a loss of patient or commissioner choice and competition. In this section we:
    i. explain the counterfactual for the merger;
    ii. define the relevant markets within which to assess the proposed merger; and
    iii. consider the potential competitive effects, or costs, of the proposed merger in the relevant markets by reviewing the extent of competitive interactions between the merging parties and the competitive constraints from other providers.[19]

41. In carrying out our assessment, we considered a range of information. This included internal documents, as well as submissions and other evidence provided by the merger parties and third parties (both providers and commissioners).[20] We analysed travel times to alternative NHS-funded healthcare providers and GP referral patterns.[21]

COUNTERFACTUAL

42. To reach a conclusion on the effect of the merger on patient choice and competition, it is necessary to have a benchmark against which to compare the effect of the merger. This is known as the counterfactual to the merger, and is the situation that would be expected to prevail if the proposed merger does not take place. The counterfactual enables us to compare the extent of patient choice and competition after the merger with the likely extent of patient choice and competition if the merger did not proceed. This enables us to form a judgement about whether the merger would be likely to reduce the extent of patient choice and competition.

43. In many merger cases the most appropriate counterfactual is the situation that existed before the merger. However, in this particular case the three trusts and local commissioners have decided that this merger is the best solution to addressing the particular financial sustainability challenges faced by each of the trusts (see paragraph 21). We therefore considered whether each of the three trusts was sustainable and therefore likely to achieve NHS Foundation Trust status, and, if not, the most likely situation in the absence of the merger.[22]

44. The merger parties told us in the absence of the merger Barts and The London Trust would most likely continue as a standalone organisation and apply for NHS Foundation Trust status for a second time. However, Newham Trust and Whipps Cross Trust told us that the financial situation of each trust meant that the pre-merger situation was not sustainable and those Trusts would not apply for NHS Foundation Trust status as standalone organisations.

[19] This includes, where appropriate, an assessment of barriers to entry and the extent of any countervailing commissioning buying power.
[20] As part of our assessment we reviewed a wide range of documents and evidence provided by the merger parties. These included documents produced prior to the proposed merger (for example minutes from Board meetings, strategy documents and market analysis reports), documents produced as part of the work stream to develop the merger proposals (for example option appraisal exercises, the Outline Business Case and submission to the CCP) as well as evidence provided as part of our merger inquiry.
[21] See Appendices 3 and 4 for further details of this analysis.
[22] See the CCP Merger guidelines, paragraph 6.42.

Accordingly the most likely alternative situation for Newham Trust Whipps Cross Trust would be that each trust would merge with another provider.

45. Various solutions have been proposed (see paragraph 19) to ensure that these currently unsustainable trusts continue to provide healthcare services from their existing locations. We have been told by the merging parties they have no plans to close these hospitals. Therefore, it is not a realistic counterfactual for the CCP to assume that either of Newham Trust or Whipps Cross Trust will cease to provide healthcare services. In this scenario, where the pre-merger situation is not sustainable but the trusts are to continue providing healthcare services, the CCP considers the most likely alternative to the merger is that: either an alternative solution would be found (see paragraph 19);[23] or that each of the unsustainable trusts would merge with a provider that raises no competition concerns (or any competition concerns that were raised by the transaction would be successfully remedied).[24] The choice between these alternatives does not make a material difference to our assessment since services would continue to be provided by separate and independent organisations from the sites currently operated by Newham Trust and Whipps Cross Trust.[25] Therefore, for the purpose of analysing the effects of the proposed merger on patient choice and competition, we take the appropriate counterfactual scenario to be one in which each of the merger parties continue to operate independently of one other.

MARKET DEFINITION

46. The purpose of a market definition exercise is the identification of those other services, and the locations from which they are provided, that constrain the ability of the merged organisation to increase the price or reduce quality of the services it offers following a merger. This can provide a framework for analysing the competitive effects of a merger through identifying providers of competing services. Appendix 2 sets out our analysis of the relevant product and geographic markets in this case.

47. The activities of the three merging organisations overlap in the supply of a wide range of routine acute hospital services (which include elective and non-elective services), one specialist acute hospital service (cardiac catheterisation), and a small number of community health services.

48. We defined separate product markets for each acute speciality (e.g. ophthalmology, gastroenterology, cancer treatment). However, for the purpose of assessing the merger, specialties which face similar constraints and which are provided by the same set of

[23] Whipps Cross Trust and Newham Trust each considered various alternatives to the proposed merger, including a franchise model of service provision and mergers with alternative providers. Each of the trusts considered the following alternative merger parties: Homerton University Hospital NHS Foundation Trust, Barking, Havering and Redbridge University Hospitals NHS Trust, North Middlesex University Hospital NHS Trust, 'other London district general hospitals', University College London Hospitals NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust, East London NHS Foundation Trust, North East London NHS Foundation Trust.

[24] See CCP Merger guidelines, paragraph 6.43.

[25] The counterfactual would only lead us to conclude that an otherwise problematic merger was not considered to be problematic when absent the merger the assets used to deliver NHS-funded healthcare services would cease to play a role in the market (the definition of a failing firm).

competitors were analysed together in a cluster.[26] We considered the following service clusters:

i. Routine elective services for admitted patients cluster (referred to as the 'routine elective cluster'). These services are provided by a wide range of providers in England, including NHS acute trusts, Independent Sector Treatment Centres and private hospitals holding an NHS Standard Acute Contract. Competitors to services in the routine elective cluster include all providers of NHS-funded elective and non-elective healthcare services (see Appendix 2 for a description of elective and non-elective services);
ii. Routine non-elective services cluster (i.e. accident and emergency and maternity services). These services are mainly provided by NHS acute trusts although some private providers operate Urgent Care Centres.[27] Competitors to services in the non-elective services cluster include all providers of NHS-funded non-elective healthcare services;
iii. Community health services cluster. These services are provided around England by NHS, independent and third sector providers with backgrounds in different areas of health and social care.[28] Competitors to services in this cluster include all providers of NHS-funded community, primary and acute (including both elective and non-elective routine and specialist) healthcare services;
iv. Outpatient services cluster. This cluster only includes outpatient services which are not linked to an admitted patient episode.[29] This cluster reflects the growing trend towards medical care that can be provided on an outpatient basis (with no requirement to admit the patient for treatment). Competitors to services in this cluster include all providers of NHS-funded elective and non-elective routine and specialist healthcare services.

49. Note that where one service in a cluster might be facing a different set of competitors from other services in the cluster (for example ophthalmology) we analysed that service separately in more detail. The strength of the competitive constraints from providers of other services in each cluster may vary and will be taken into account, where relevant, in our competitive assessment.

50. For specialist/tertiary healthcare services we did not adopt a clustering approach and analysed each specialist/tertiary service separately.[30] Competitors will include all actual and potential providers of each specialist service.

51. We have not found it necessary to precisely define the relevant geographic market as it is not material to our findings.[31] However, for the purposes of explaining our competitive

[26] In some cases a provider of a range of specialities may not face similar constraints and the same set of competitors across all of its specialties. Some of its specialties may face greater or lesser constraints, for example as a result of the additional independent sector capacity funded by commissioners in certain specialities. In that case we may examine the speciality outside the clusters that we define below.
[27] Urgent Care Centre's (UCC's) offer ambulatory care in a facility dedicated to the delivery of medical care outside of a hospital accident and emergency department, usually on an unscheduled, walk-in basis. UCC's are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an accident and emergency department.
[28] Third sector providers include social enterprises, not-for-profit, charities and voluntary organisations.
[29] Outpatient services which are provided in conjunction with an admitted patient episode (i.e. pre-operative assessments and follow up appointments) are considered as forming part of the routine elective and non-elective service clusters and each individual specialist service.
[30] Specialist services include tertiary services. The difference between the two is that only hospital consultants can refer a patient to tertiary services while GPs are able to refer patients to non-tertiary specialist services.

assessment we refer to a market we have termed 'the wider north-east London area' (see Figure 2). The wider north-east London area includes providers located in north-east London, as well those located in immediate surrounding areas, including providers located to the north (e.g. The Princess Alexandra Hospital NHS Trust in Harlow), to the south (e.g. South London Healthcare NHS Trust in Woolwich), to the west (e.g. University College London Hospitals NHS Foundation Trust and Imperial College Healthcare NHS Trust) and further to the east (e.g. Basildon and Thurrock University Hospitals NHS Foundation Trust).[32]

52. As location is important to patients/GPs when they choose a hospital, those hospitals providing the same services in different locations are not perfect substitutes for one another and hospitals that are near one another will tend to be more important competitors than those that are not. We assess the relative strength of competitive constraints between providers in the wider north-east London area in the next section.

COMPETITION FOR ROUTINE ELECTIVE SERVICES FOR IN WIDER NORTH EAST LONDON

53. In considering the competitive effects of the proposed merger, we analysed whether the merger would be likely to reduce choice and competition in routine elective services in the wider north-east London area. For a merger to reduce competition for routine elective services we must first expect that the merging organisations impose a competitive constraint on each other. If we find they do so we next review the strength of the competitive constraint that would remain from other providers that we have identified as operating within the relevant market.[33] This means that although a merger may reduce competition, whether this reduction is material depends on whether there are alternative effective providers that might provide sufficient competitive constraint following the merger. In this case we have undertaken this assessment from the perspective of each of the three merging parties.

[31] This is because we have within our competitive effects analysis considered the strength of the competitive constraints posed by all relevant potential rivals. Given the nature of the identified product markets and the importance of convenience to patients we are able in this case to identify the potentially relevant rivals based on the proximity of the facilities of those rivals. We have also considered the possibility of a competitive threat from more distant rivals moving into the area, and we treat these as potential new entrants to the market.

[32] In one of the product markets described above (tertiary cardiac catheterisation service) we also considered the role of specialist providers from further afield such as the Royal Brompton which is located outside the wider north-east London area.

[33] We note that the competitive constraints faced from competitors located within the wider north-east London area by each of the hospitals of the merger parties will not be equal and will depend on factors such as the preferences of GP's/patients and commissioners. It will also vary depending on whether the services provided are routine or more specialist.

54. We assessed the competitive effects of the proposed merger on each of the three hospital sites separately rather than the competitive constraints upon the merged organisation as a whole because as a merged organisation its management can decide how to maintain or improve quality and/or efficiency at each hospital site (depending on the competitive constraint a hospital site faces). Where there is a material reduction in the competitive constraint a hospital site faces there is less likelihood of patients switching to an alternative hospital and management of the merged organisation may take decisions that impact on the quality of services offered to patients, or the efficiency with which they are provided, without the fear of losing a significant number of patients (and revenue). Services might be varied in a number of ways including:[34]

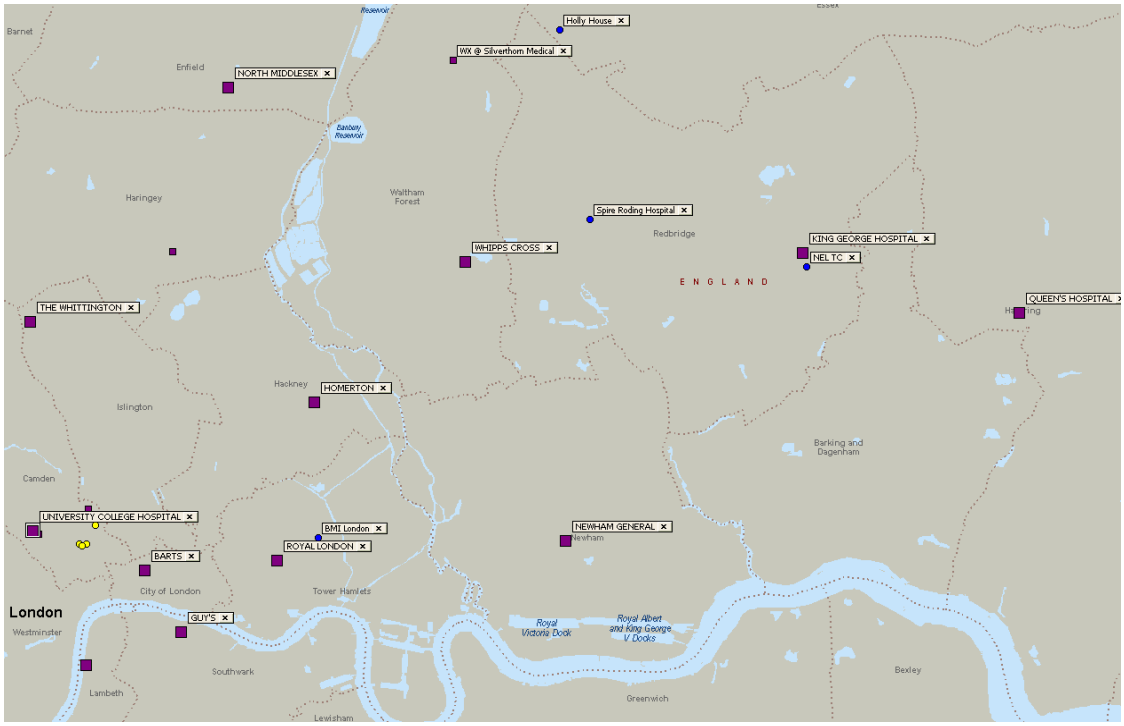
- Reducing the range of procedures or treatments routinely offered on a site which would result in patients having to travel further for treatment at another site of the merged organisation than the patient would have travelled prior to the merger.
- Changing existing staffing levels at a site, for example reducing the level of consultant-delivered services or out-of-hours cover, and/or changing the skill mix requirements for designated staff groups (such as nurses and other health professionals).
- Reducing or not extending the operating hours of elective services at a site (or the services that support their delivery such as diagnostics or anaesthetists). This would restrict the availability of appointment times and may lead to increases in waiting times.
- Reducing or delaying the level of capital expenditure on existing assets at a site (such as equipment, accommodation or hospital buildings) and/or investing in new assets.
- Focusing less time and effort on ensuring high quality services are delivered at the lowest cost possible at a site. This may, for example, result in longer length of stays for patients. Over time the provision of inefficient services may require additional taxpayer funding for services delivered from the site.

55. As we explained in paragraphs nine to 16), Barts and The London, Whipps Cross Trust and Newham Trust each provide a range of routine elective care from a number of sites to patients from the wider north-east London area. Barts and The London provides the majority of its routine elective services from the Royal London hospital site which is located in Whitechapel.[35] It also provides the elective dermatology and rheumatology service on the Newham hospital site. Whipps Cross Trust provides the majority of its routine elective services from Whipps Cross hospital which is located in Leytonstone.[36] It also provides elective Ear, Nose and Throat and ophthalmology services on the Newham hospital site. Newham Trust provides the majority of its routine elective services from the Newham hospital site, which comprises Newham General hospital and the Gateway Surgical Centre.[37] Figure 2 shows the location of hospitals that provide routine elective care in wider north-east London.

[34] Some of these are illustrated in recent media coverage of services provided at the Royal London: http://www.bbc.co.uk/news/uk-england-london-15983985.
[35] They also provide some routine elective services from St Bartholomew Hospital, The London Chest Hospital and various community locations in Tower Hamlets.
[36] Whipps Cross Trust also delivers some routine elective services from community locations across Waltham Forest, including the Silverthorn Medical Centre.
[37] Newham Trust also provides some routine elective services in community settings across Newham.

FIGURE 2

Providers of Routine Elective Care in the wider north-east London area



Note: The map is focused on providers of routine elective care in the north east London area. However, as discussed in paragraph 51 the wider north east London area extends to providers located beyond the immediate surrounding areas.

56. In the following paragraphs we explain our assessment of the effect of the merger on the strength of the competitive constraint on the routine elective services provided from; (i) The Royal London hospital; (ii) Whipps Cross hospital; and (iii) Newham hospital. When assessing the competitive constraint on each of these hospital sites we evaluate a range of different information sources.

57. We first consider the range of potential providers of the services that patients can access within different travel times (see Appendix 3 for our analysis of patient travel times to alternative providers).[38] This information, in conjunction with submissions by the merger parties, helps us to ascertain the choices available to patients and GPs in the wider north east London area. We then consider which of these hospital sites within the choice set provides a competitive constraint on the routine elective services provided from Royal London hospital, Whipps Cross hospital and Newham hospital sites. This assessment takes account of which hospital sites patients choose to attend by identifying the catchment area for each hospital site from patient flow information (see Appendix 4 our analysis of GP referral patterns).[39] We also consider the extent of any overlap in these catchment areas. This information helps us to understand whether patients would consider switching between one of the hospital sites (for

[38] The parties provided us with submissions on this analysis. We do not consider that the submissions that were provided impact upon the value of the analysis. In Appendix 3 we describe in detail the analysis, the various submissions that we have received on this analysis, and our evaluation of those views.

[39] The GP referral analysis provides an insight into which provider patients/GPs are likely to switch to in response to a deterioration of quality at each of the hospital sites that would be operated by the merged organisation, if they decide to switch at all. The parties provided us with submissions on this analysis. We do not consider that the submissions that were provided impact upon the value of the analysis. In Appendix 4 we describe in detail the analysis, the various submissions that we have received on this analysis, and our evaluation of those views.

example Newham hospital) and a potential competing hospital site (for example, Homerton hospital) in response to changes in quality and, where this happens, how many patients do this (i.e. the more patients that consider switching between these hospitals the greater the competitive constraint provided by the competitor). To inform this assessment we also review internal documents and other submissions (see paragraph 41) to understand whether the provider considered a potential competitor to have the potential to reduce the volume of referrals that it receives and if there has been any action taken to prevent referrals from being lost. All of the information that we consider is evaluated together to reach a conclusion on the competitive constraint provided by each provider in the choice set upon each hospital site.

58. Where the merging parties are found to be close competitors, we consider whether there are sufficient other strong competitors that can offset the loss of this competition.

The Royal London Hospital Site

59. Barts and The London provides the majority of its routine elective services from The Royal London hospital.[40] They told us these services attract patients from Tower Hamlets (around 50 per cent of its elective services depending on the specific elective service) and surrounding PCTs, with substantial flows from Newham (17 per cent), City and Hackney (11 per cent), Waltham Forest (six per cent) and Redbridge (six per cent).[41] Barts and The London sends information on referral protocols and service developments (which we collectively refer to as 'marketing material') to GP's located across these areas (as well as Havering and South East Essex).[42]

60. We found that Newham Trust competes with the routine elective services provided from The Royal London hospital site.[43] Newham Trust is located around seven kilometres to the east of The Royal London hospital and provides the majority of its routine elective services to patients from the Newham PCT area. Newham Trust and Barts and The London also both send marketing material to GPs in the Newham area. This indicates its catchment area overlaps with The Royal London hospital site's catchment area. Our analysis of GP referrals suggests Newham Trust is considered an important alternative to Barts and The London (Newham Trust was the most popular alternative to Barts and The London for approximately 20 per cent of Barts and The London's routine elective referrals).[44] Internal documents provided by Barts and The London also identify Newham Trust as a competitor which (along with Homerton University Hospital NHS Foundation Trust, Whipps Cross Trust and Barking, Havering and Redbridge University Hospitals NHS Trust) 'pose a threat to the Trust's existing referral patterns and provide possible obstacles to the expansion of the Trust's services'.[45] Responding to this threat, Barts and The London focused their efforts on improving aspects of their service

[40] For the purpose of our analysis we considered the competitive constraint faced by the Royal London Hospital site only, given that the majority of routine elective services are provided from this hospital site. In our competitive effects analysis Barts and The London refers to the Royal London Hospital site only.
[41] Barts and The London told us that its central location and designation as specialist provider for many services means that it has relationships with GPs across a wide geographic area and attracts patients from across north-east London and Greater London.
[42] We considered whether Barts and The London's marketing information might relate to specialist services, which attract patients from a wider geographic area. However, we note that many of these services are likely to require a tertiary referral from a hospital consultant rather than a GP and in any case all marketing information will help build the reputation of a hospital amongst GP's and aide the development of a relationship between them.
[43] Newham Trust does not provide ENT, ophthalmology, dermatology or rheumatology and so does not compete in these specialities.
[44] See Appendix 4 for further details of our GP referral analysis.
[45] See Chapter 4, Barts and The London Integrated Business Plan.

which GPs consider to be important when evaluating a hospitals performance.[46] As part of this exercise they benchmarked their clinical performance against other providers (including Newham Trust), focused on improving their communication with GPs and monitored their reputation with key stakeholder groups.[47]

61. We found that Whipps Cross Trust competes with the routine elective services provided from The Royal London hospital site. Whipps Cross is located around eight kilometres to the north-east of The Royal London hospital and provides the majority of its routine elective services to patients from Waltham Forest and Redbridge. Whipps Cross Trust and Barts and The London also both send marketing material to GPs in Waltham Forest and Redbridge. This indicates its catchment area overlaps with Barts and The London. Our analysis of GP referrals suggests Whipps Cross Trust is considered an important alternative to Barts and The London (Whipps Cross Trust was the most popular alternative to Barts and The London for approximately 10 per cent of Barts and The London's routine elective referrals). The internal documents provided by Barts and The London referred to above also identify Whipps Cross Trust as a threat to Barts and The London's existing referral patterns and an obstacle to its future expansion.

62. We next considered the extent to which other providers are likely to compete with the routine elective services provided from the Royal London hospital site following the merger and found they would face a range of competitors which together are likely to represent a strong competitive constraint. Our finding was based on an analysis of catchment areas, travel times and GP referral patterns, along with evidence from the merger parties' internal documents and submissions to us. In particular, we identified that Homerton University Hospital NHS Foundation Trust, University College London Hospitals NHS Foundation Trust, Royal Free Hampstead NHS Trust, and Guy's and St Thomas' NHS Foundation Trust would be competitors across a wide range of routine elective services. We also found BMI Healthcare and Moorfields Eye Hospital NHS Foundation Trust to be competitors across a narrower range of elective services.[48] Appendix 5 provides further details of our competitive assessment of each of these providers.

63. In conclusion, we found that Whipps Cross Trust and Newham Trust would be competitors to the routine elective services provided from the Royal London hospital site. However, there would remain sufficient choice and competition from a range of alternative providers post-merger to ensure that the loss of Newham Trust and Whipps Cross Trust as competitors is unlikely to significantly reduce the competitive constraint on the routine elective services provided from the Royal London site.

[46] Barts and The London undertook a survey of GPs to identify the factors that are most important to GPs when evaluating the Trust's performance.
[47] They benchmarked their clinical performance in terms of safety ratings, waiting lists, average length of stay, and infection rates and sought to improve communication with GP's through marketing newsletters, a GP section of the website, establishing referral guides, clinical events and features in GP trade media. This marketing strategy also targeted patients and the public.
[48] Moorfields Eye Hospital NHS Foundation Trust would represent a strong competitor for routine elective ophthalmology services and BMI Healthcare would represent a competitor for day case ophthalmology services.

Whipps Cross Hospital Site

64. We next considered the effect of the merger on the competitive constraints upon the routine elective referrals provided from the Whipps Cross hospital site. Whipps Cross Trust provides routine elective services from the Whipps Cross hospital site.[49] It provides the majority of its routine elective services to patients from Waltham Forest (56 per cent) but also provides these services to patients from the western part of Redbridge (23 per cent), the northern part of Newham (eight per cent)[50] and the Epping Forest area of West Essex (seven per cent). Whipps Cross Trust sends marketing material to GP's in each of these areas which together form its catchment area.

65. We found that Barts and The London competes with the routine elective services provided from Whipps Cross hospital. As discussed above, Barts and The London provides routine elective services to patients from Waltham Forest, Newham and Redbridge and sends marketing material to GP's in these areas. This indicates its catchment area for routine elective services overlaps with Whipps Cross Trust. We found that almost all patients in the catchment area of Whipps Cross Trust could reach Royal London hospital within a 60 minute travel time (see Appendix 3 for further details).[51] Our analysis of GP referrals suggests Barts and The London is considered an important alternative to Whipps Cross Trust (Barts and The London was the most popular alternative to Whipps Cross Trust for approximately 40 per cent of Whipps Cross Trust's routine elective referrals). Internal documents provided to us by Whipps Cross Trust also identified Barts and The London as a competitor (along with Newham Trust and seven other local NHS providers).

66. We found that Newham Trust competes with the routine elective services provided from Whipps Cross hospital.[52] Newham Trust provides more than 90 per cent of its routine elective services to patients from the Newham area, but also provides some of its routine elective services to patients from Redbridge (one per cent) and Waltham Forest (one per cent).[53] Consistent with these referral flows, Newham Trust only sends marketing material to GPs in the Newham area (Whipps Cross Trust also sends marketing material to these GPs). This indicates Newham Trust's catchment area for routine elective services overlaps to some extent with the catchment area of Whipps Cross Trust. We found that many patients in the catchment area of Whipps Cross Trust could reach Newham hospital within a 60 minute travel time. Our analysis of GP referrals suggests Newham Trust is considered an important alternative to Whipps Cross Trust for a small share of referrals (Newham Trust was the most popular alternative to Whipps Cross Trust for fewer than five per cent of Whipps Cross Trust's referrals). Internal documents provided to us by Whipps Cross Trust identified Newham Trust as a competitor (along with Barts and The London and seven other local NHS providers).

[49] Whipps Cross Trust also provides some elective ENT and ophthalmology services from the Newham Hospital site. We considered the effect of the merger on these services in the next section.
[50] The merger parties told us Whipps Cross Trust's share from Newham reflects the fact that Whipps Cross Trust runs the Ear Nose and Throat and Ophthalmology services on the Newham Hospital site. These services account for half of Whipps Cross Trust's routine elective referrals from Newham.
[51] The use of a 60 minute travel time does not represent patients' willingness to travel for routine elective healthcare but rather a fixed travel time with which to consider aspects of accessibility.
[52] Newham Trust does not provide ENT, ophthalmology, dermatology or rheumatology and so does not compete in these specialities
[53] Newham Trust also treats some patients from a number of other areas, including Tower Hamlets (one per cent).

67. We next considered the extent to which other providers are likely to compete with the routine elective services provided from Whipps Cross hospital following the merger and found that they would face a range of competitors which together are likely to represent a strong competitive constraint. Our finding was based on an analysis of catchment areas, travel times and GP referral patterns, along with evidence from the merger parties' internal documents and submissions to us. In particular, we found that Barking, Havering and Redbridge University Hospitals NHS Trust, University College London Hospitals NHS Foundation Trust, Princess Alexandra Hospital NHS Trust, North Middlesex University Hospital NHS Trust, Homerton University Hospital NHS Foundation Trust and Care UK are likely to compete with Whipps Cross Trust for routine elective referrals. We note, however, that Homerton University Hospital NHS Foundation Trust does not send marketing material to GPs in the catchment area of Whipps Cross Trust and currently receives few patients from the area. This suggests the competitive constraint provided by Homerton University Hospital NHS Foundation Trust is currently less than its relatively close geographic proximity would suggest. Appendix 5 provides further details of our competitive assessment of each of these providers.

68. In conclusion, we found that Barts and The London and Newham Trust are competitors to the routine elective services provided from Whipps Cross hospital. However, there would remain sufficient choice and competition from a range of alternative providers post-merger to ensure that the loss of Barts and The London and Newham Trust as competitors is unlikely to significantly reduce the competitive constraint on the routine elective services provided from the Whipps Cross hospital site.

Newham Hospital Site

69. We considered the effect of the merger on the competitive constraints upon the elective services provided from the Newham hospital site. The Newham hospital site comprises Newham General hospital and a recently built standalone elective surgical centre (The Gateway Surgical Centre). Newham Trust provides the majority of the routine elective services from the site. However, as explained in paragraph 55, Whipps Cross Trust and Barts and The London both provide some routine elective services, which followed Newham Trust's decision to cease providing some specialties. In particular, Whipps Cross Trust provides Ear, Nose and Throat and ophthalmology services while Barts and The London provide dermatology and rheumatology services.[54]

70. Reflecting these arrangements we structured our analysis as follows. We first assessed the extent to which Barts and The London and Whipps Cross Trust compete with the routine elective services provided by Newham Trust from the Newham hospital site. We then assessed the extent of competition between Barts and The London and Whipps Cross Trust for the routine elective services they provide from the Newham hospital site. Finally, we assessed the extent to which other providers are likely to compete with providers of elective services on the Newham hospital site following the merger.

[54] These providers offer day case surgery and outpatient services on the Newham Hospital site but patients requiring inpatient care would have treatment on their main hospital sites as inpatient care in these routine elective services is not provided on the Newham hospital site.

Competition between merger parties for routine elective services provided by Newham Trust on the Newham hospital site

71. Newham Trust provides a broad range of routine elective services (except ENT, ophthalmology, rheumatology and dermatology) from the Newham hospital site. The merger parties told us that Newham Trust provides over 90 per cent of its routine elective services to patients from the Newham PCT area, with only small flows from surrounding areas.[55] Newham Trust only sends marketing material to GPs in the Newham area.

72. We found that The Royal London hospital (operated by Barts and The London) is Newham Trust's closest competitor for routine elective services. Barts and The London is located around six kilometres to the west of the Newham hospital site and many patients in the catchment area of Newham Trust can access services at The Royal London hospital within a 60 minute travel time. As explained in paragraph 59, Barts and The London provides routine elective services to patients from Tower Hamlets (around 50 per cent of its patients are from this area), Newham (17 per cent) and a number of other PCT areas. Barts and The London sends marketing material to GPs in all of these areas, including Newham. We therefore found the catchment areas of Newham Trust and Barts and The London to overlap. Our analysis of GP routine elective referral patterns in Newham indicates that the vast majority of patients/GPs in the catchment area of Newham Trust consider Barts and The London to be the most important alternative to Newham Trust (Barts and The London is the most popular alternative to Newham Trust for approximately 70 per cent of Newham Trust's routine elective referrals). Newham Trust's 2010 Annual Plan indicates Newham Trust considers its closest rivals to be local NHS trusts, in particular Barts and The London.[56]

73. We found that Whipps Cross hospital competes with the routine elective services provided by Newham Trust. Whipps Cross hospital is located around six kilometres to the north of the Newham hospital site and many patients in the catchment area of Newham Trust can access services at Whipps Cross hospital within a 60 minute travel time. As explained in paragraph 64, Whipps Cross Trust mainly provides routine elective services to patients from Waltham Forest (56 per cent) but also provides services to patients from Newham (eight per cent). Whipps Cross Trust sends marketing material to the same GPs as Newham Trust. We therefore found the catchment areas of Newham Trust and Whipps Cross Trust to overlap. Our analysis of GP routine elective referral patterns in Newham indicates that the vast majority of patients/GPs in the catchment area of Newham Trust consider Whipps Cross to be an important alternative to Newham Trust (Whipps Cross Trust is the most popular alternative to Newham Trust for approximately 15 per cent of Newham Trust's routine elective referrals).

[55] Tower Hamlets (one per cent of patients), Redbridge (one per cent of patients) and Waltham Forest (one per cent of patients).
[56] The Annual Plan states 'the Trust is actively marketing its services to local GPs predominately in an effort ensure referrals are not lost to other local trusts. In the main our competitors for local services [routine elective care] are Barts and The London who across most specialities provide the second largest proportion of healthcare activity for Newham residents. The Trust recognises the potential for losing market share as the development of the Royal London Hospital continues'.

74. We estimated that the merged organisation would have a combined share of around 80 per cent of all routine elective referrals made by GPs in Newham (an increment of around 35 per cent).[57]

75. Based on this evidence, we found that Barts and The London is the most important competitor to the routine elective services provided by Newham Trust from the Newham hospital site and Whipps Cross Trust is also an important competitor.

Competition between merger parties for routine elective services provided by Barts and The London and Whipps Cross Trust on the Newham hospital site

76. We next considered the extent of competition between Barts and The London and Whipps Cross Trust for the routine elective services they provide from the Newham hospital site. We found that the competitive constraint imposed by Barts and The London on the routine elective services (ear, nose and throat and ophthalmology) provided by Whipps Cross Trust at the Newham hospital site is similar to the constraint Barts and The London imposes on the routine elective services provided from Newham hospital by Newham Trust (see paragraph 72 above).[58] We also found the competitive constraint provided by Whipps Cross Trust on the services provided by Barts and The London Trust at the Newham hospital site is similar to the constraint Whipps Cross Trust imposes on the routine elective services provided from Newham hospital by Newham Trust (see paragraph 73 above).

77. Given that we consider Barts and The London and Whipps Cross Trust are the two most important local providers that impose a competitive constraint on the routine elective services provided from the Newham hospital site, we next considered the extent to which other providers are likely to impose a competitive constraint on these services.

Competition from other providers

78. We identified a number of providers of routine elective care services from a list of competing providers that the parties gave to us. We expect that patients using routine elective services provided from the Newham hospital site could access these providers if they wished to do so. These providers include Homerton University Hospital NHS Foundation Trust, Barking, Havering and Redbridge University Hospitals NHS Trust, University College London Hospitals NHS Foundation Trust, North Middlesex University Hospital NHS Trust, Guy's and St Thomas' NHS Foundation Trust, Moorfields Eye Hospital NHS Foundation Trust, Lewisham Hospital NHS Trust, South London Healthcare NHS Trust, Care UK, BMI Healthcare and Spire Healthcare.[59] In Appendix 5 we consider in detail the competitive constraint that each of these organisations imposes on the providers offering routine elective services from the Newham hospital site (i.e. Newham Trust, Whipps Cross Trust and Barts and The London). In the following paragraphs we summarise the constraint that each of these organisations impose on routine elective services provided from the Newham hospital site.

[57] Newham Trust has a 41 per cent share of all elective referrals from Newham, with Barts and The London and Whipps Cross Trust having a share of 25 and 13 per cent respectively.
[58] In the case of ophthalmology, while Barts and The London may not provide the most important competitive constraint, they still impose a strong competitive constraint.
[59] The merger parties also identified Princess Alexandra hospital (Harlow) as a moderate competitor for routine elective patients in the northern part of Waltham Forest and West Essex.

79. There are five large NHS or NHS foundation trust competitors that we evaluated in order to ascertain the competitive constraint they impose on services provided at the Newham hospital site. Homerton University Hospital NHS Foundation Trust is a well performing and highly regarded NHS foundation trust located near the Newham hospital site. We found that although many patients from the Newham area could travel to the Homerton hospital, very few patients choose to do so and our analysis suggests that few GPs consider Homerton hospital to be an important alternative to services provided at Newham hospital. For these reasons we consider that Homerton hospital does not currently impose a significant competitive constraint on services provided at Newham hospital. We considered whether this constraint would increase in the future but concluded it was unlikely to change materially in the foreseeable future. This is consistent with evidence from a range of internal strategy documents provided by Homerton University Hospital NHS Foundation Trust and the merger parties.

80. Barking, Havering and Redbridge University Hospitals NHS Trust is a similar distance away from Newham hospital as the Homerton hospital and it also receives very few patients from the Newham area. However, our analysis suggests it is an alternative for some GPs. Our assessment of strategy plans and growth plans, together with the clinical and financial performance of Barking, Havering and Redbridge University Hospitals NHS Trust, suggests that this assessment is not likely to change significantly in the foreseeable future. We consider that Barking, Havering and Redbridge University Hospitals NHS Trust imposes some competitive constraint on services provided from Newham hospital.

81. We also considered the competitive constraint imposed by University College London Hospitals NHS Foundation Trust, North Middlesex University Hospital NHS Trust, and Guy's and St Thomas' NHS Foundation Trust. Although these are all strong performing organisations, none of them attracts many patients or GP referrals from the Newham area. Internal strategy documents from each of these organisations, and the merger parties, supports a view that patients are unlikely to consider these trusts are important alternative to services provided from the Newham hospital site and this is unlikely to change in the foreseeable future. We consider that these three organisations impose little competitive constraint on services provided from Newham hospital.

82. There are also three independent sector providers and one specialist NHS foundation trust in wider north-east London that we evaluated in order to ascertain the competitive constraint they impose on services provided at the Newham hospital site. Our analysis shows that each of Care UK, BMI Healthcare and Spire Healthcare receive very few patients from the Newham area (each receives less than one per cent of all patients from the Newham area) and few GPs consider that these organisations are an important alternative to services provided at Newham hospital. Based on internal strategy documents from all of these organisations and the merger parties we do not consider that patients are likely to consider these organisations to be important alternative to services provided from the Newham hospital site and we found this is unlikely to change in the foreseeable future. We consider that Care UK and BMI Healthcare impose little competitive constraint and Spire Healthcare provides no competitive

constraint on services provided from the Newham hospital site.[60] We therefore found none of these providers would provide a sufficient competitive constraint to prevent a reduction in quality on the Newham hospital site following the merger. Moorfields Eye Hospital NHS Foundation Trust provides specialist ophthalmology services from its hospital in wider north-east London and receives a large number of elective referrals for this speciality from the Newham area. We consider that it provides a significant competitive constraint – in this speciality only – for services provided from the Newham hospital site.

83. We also considered whether any other providers identified by the merger parties located further away (for example Princess Alexandra Hospital NHS Trust, South London Healthcare NHS Trust and Lewisham Hospital NHS Trust) imposed a competitive constraint on services provided from Newham hospital and found that they did not. The merger parties did not consider Princess Alexandra Hospital NHS Trust to be a competitor for patients in the Newham area and told us that South London Healthcare NHS Trust and Lewisham Hospital NHS Trust were weak competitors. We also found that collectively these other providers had a very small share of referrals from the Newham area (0.2 per cent of all elective referrals from the Newham area) and we saw no evidence to indicate that this would change in the foreseeable future. We therefore found none of these providers would provide a sufficient competitive constraint to prevent a reduction in quality on the Newham hospital site following the merger.[61]

84. We considered whether the referral patterns we observe in the Newham area reflect the current preferences of patients and GPs and whether these are likely to change significantly in the foreseeable future as patients and their GPs become more accustomed to exercising choice. We looked at a range of potential factors, including whether patients are likely to consider choosing between a wider set of hospitals in the future, whether potential conduct by local commissioners may have distorted referrals and whether new entry (which we discuss in the next section) or expansion by existing providers is likely. As part of this analysis we extrapolated recent trends in referral shares from the Newham area. We found no evidence to suggest that rival providers in the wider north east London area are likely to substantially increase their small share of referrals from the Newham area.

85. In summary, we found that across routine elective services (except ophthalmology) provided from the Newham hospital site there would remain a fringe of alternative providers that would offer some competition following the merger, including: Homerton University Hospital NHS Foundation Trust, Barking, Havering and Redbridge University Hospitals NHS Trust and Care UK. However, we do not consider these providers would impose a significant competitive constraint on the routine elective services provided from the site. For routine elective ophthalmology services, however, we consider Moorfields Trust to be a strong competitor

[60] NHS East London & City also told us that a GP provider company (Patient First) provides hospital equivalent outpatient care in the community to patients in the Newham area. Patient First provides these services for a limited number of specialities and plays a very small role in the Newham health economy (it currently receives less than 0.5 per cent of total expenditure on elective and outpatient services in Newham per year) and so we consider it imposes little competitive constraint on the routine elective services provided from the Newham hospital site.

[61] We assessed the extent of the competitive constraint that each potential competitor identified by the merger parties imposed on the routine elective services provided from the Newham hospital site. However, we also considered the competitive constraint from a wider range of potential competitors. For example, our analysis of GP referral patterns considered the potential constraint from over20 different providers.

which would impose a significant competitive constraint on upon the provider of ophthalmology services at Newham hospital.

Barriers to Entry

86. In this section we consider the scope for new providers to enter into the wider north-east London area and begin to provide routine elective care services in competition with the routine elective services provided from Newham hospital.[62] We found that barriers to entry include:
    - the cost of building a new facility from which to provide routine elective services (for example, Care UK built its north-east London treatment centre);
    - the need to locate the facility near to a hospital with emergency back-up facilities (for example, Care UK built its north-east London treatment centre on the site of King George hospital which provides access to the support facilities of the main hospital)

87. The entry by Care UK in 2006 shows entry is possible. However, it also demonstrates that it needs to be sponsored at some cost by commissioners (or the Department for Health).[63] Given the current financial challenges facing commissioners throughout the NHS it appears unlikely that the investment required to sponsor additional entry would be forthcoming in the short to medium term. We therefore conclude that there are significant barriers to entry for the supply of routine elective services in the wider north east London area.

Buyer Power

88. We considered the extent to which commissioners would be likely to counter the reduction in competition that the merger would otherwise create. We expect that the commissioners may be able to exert buyer power if the merger parties are largely dependent on the volumes that the purchaser buys from them. We concluded that even a strong buyer will still find that a reduction in competition between providers reduces its bargaining strength (as its dependence on a single provider increases) and therefore reduces its ability to achieve its desired outcomes. We conclude that commissioners would not be in a position to counter any reduction in competition that the merger would otherwise be likely to create.

Submissions from the parties

89. The parties made a number of points in relation to our analysis of the effects of the merger on patient choice and competition in routine elective services in the wider north east London area. They told us that the reduction in choice as a result of the merger would be marginal and so the physical accessibility of a range of providers would not be affected. In particular, they told us that patients in the Newham area would still be able to choose between many high quality providers. As set out above in paragraph 78, we found there are a number of other providers that might be accessed by patients that use the routine elective services provided from Newham hospital if they wished to do so. However, our analysis looked beyond a theoretical assessment of where patients could be treated and has focused on the reality of where GPs and patients have actually chosen to be treated and included insights gained from

[62] We considered scope for expansion by existing providers in our competitive effects analysis.
[63] We use the term 'sponsorship' to refer to broad set of behaviours which seek to encourage new entry into an area. This may range from simply identifying need to offering subsidies (or other forms of income support).

the parties internal strategic documents. This analysis indicates that Barts and The London and Whipps Cross Trust are the closest competitors to the elective services provided the Newham hospital site.

90. The parties also told us that they believe current choices are not a good indicator of future potential referral patterns. For example, the parties told us that GPs and patients may be relying on past experience to inform choice. We agree that GPs and patients are likely to rely on past experience to inform their choice of provider, and will continue to do so, and this is what we expect creates the incentive for hospitals to improve their service and gain a good reputation. The parties expect that this reliance on past experience and knowledge will change in future if awareness of choice and utilisation of choose and book by patients increases. We disagree and expect that the decisions made by GPs and patients will continue to be based on past experience and knowledge. The parties also made a number of additional points on our analysis and we consider each of these in turn in appendices 3 and 4.

Conclusion on Competition for Routine Elective Services

91. For the reasons outlined above, we conclude there is likely to be sufficient patient choice and competition following the merger in respect of routine elective services provided from the Whipps Cross hospital and Royal London hospital sites. We also found this to be the case in relation to the ophthalmology services provided by Whipps Cross Trust from the Newham hospital site.

92. However, we conclude there is unlikely to be sufficient patient choice and competition following the merger in respect of routine elective services (with the exception of ophthalmology) provided from the Newham hospital site. In respect of those elective services provided by Newham Trust we found that Barts and The London and Whipps Cross Trust impose a significant competitive constraint on the routine elective services provided from the Newham hospital site. In particular, we found Barts and The London to be Newham Trust's closest competitor and Whipps Cross Trust to be an important competitor. In respect of those elective services provided on the Newham hospital site by Whipps Cross Trust and Barts and The London we found each to be the others closest competitor. While there are nine other providers of these services in the north-east London area that patients could in theory choose from (as well as others in the wider north east London area), we conclude that these other providers exert a relatively weak competitive constraint on the routine elective services (except ophthalmology) provided from Newham hospital for a number of reasons explained above and we do not expect this to significantly change in the foreseeable future. We conclude that new entry is unlikely and that commissioners would not be in a position to counter the reduction in competition likely to arise from the merger.

93. We consider that the merger would enable the merged organisation to reduce the level of expenditure on maintaining or improving the quality or efficiency of routine elective services (except ophthalmology) provided from Newham hospital. The merged organisation could do this because any patients who may consider choosing services from a provider other than those based at Newham hospital would most likely switch to The Royal London hospital or, to a lesser extent, Whipps Cross hospital. The merged organisation would therefore retain the

revenue associated with those patients but would save any expenditure that it avoided maintaining or improving the quality or efficiency of services provided from Newham hospital.

COMPETITION FOR ROUTINE NON-ELECTIVE SERVICES IN THE WIDER NORTH-EAST LONDON AREA

94. We next considered the effect of the merger on commissioner choice and competition for routine non-elective services in the wider north-east London area. In particular, we considered whether it would reduce the merged organisation's incentive to maintain and improve the quality and/or efficiency of the non-elective services provided at each of its acute hospital sites.

95. Routine non-elective care services are non-specialist healthcare services provided in unplanned circumstances, and include consultant-led maternity and accident and emergency services (but exclude major trauma which is a specialist service).[64] Barts and The London, Whipps Cross Trust and Newham Trust each provide these services in the wider north-east London area from The Royal London, Whipps Cross and Newham hospital sites respectively.[65]

96. Our analysis focused on the effect of the merger on commissioner choice and competition. This is because the nature of non-elective services means that many patients are unable to choose which provider they use and commissioners choose which hospital sites provide these services on their behalf.[66] Under current commissioning arrangements, routine non-elective services (as well as routine elective services) across north east London are commissioned by two Acute Commissioning Units which comprise the seven PCTs in north-east London.[67] Competition between providers of routine non-elective services arises from the threat that commissioners could change which providers deliver these services in the future. There have been a number of examples of commissioners switching providers of non-elective services. For example, commissioners in north-east London recently reviewed the provision of accident and emergency services in the area and decided which hospital sites should continue providing these services and which should stop providing these services (we discuss this reconfiguration in more detail in paragraphs 102 to 103).

97. We expect that a provider of routine elective services will calculate how much money to spend on maintaining and improving the quality of its non-elective services by taking the following three factors into consideration: (i) achieving the highest standards of patient care, (ii) minimising costs so as to ensure as far as possible that the costs of providing services are recovered by the revenue generated from them, and (iii) making every effort to ensure the commissioner will continue to purchase these services from them in the future. A provider faces different incentives when deciding how much money to spend on maintaining and improving the quality of its non-elective services. On the one hand it will want to increase

[64] With the exception of pre-planned caesarean sections, consultant-led maternity services are non-elective services. We do not draw a distinction between accident and emergency and consultant-led maternity services in our competitive assessment as at the moment providers of accident and emergency services in north east London also provide consultant-led maternity services and so both services would face the same set of potential competitors.

[65] We note that Newham Trust does not provide emergency Ear, Nose and Throat services, rheumatology, ophthalmology or dermatology services. Barts and The London also provides a number of more specialist non-elective services, and is designated as a Major Trauma Centre, Hyper-Acute Stroke Centre and Heart Attack Centre.

[66] We note that some patients, in particular those who do not have life threatening injuries, will have a degree of choice as to which hospital they seek non-elective treatment.

[67] There are two Acute Commissioning Units covering north east London: NHS East London & City and NHS Outer North East London.

expenditure to achieve the highest standards of patient care and increase the probability that the commissioner will continue to purchase these services. On the other hand, it needs to minimise its costs to ensure the provider does not lose money and so remain financially viable.[68]

98. We assume that all providers will try and meet the CQC's quality and financial standards.[69] A merger between providers of non-elective services may reduce the merged organisation's incentive to maintain and improve the quality of its non-elective services at each of its sites above CQC minimum standards. This is because before the merger, each provider would take account of the revenue it would lose if commissioners decided to stop purchasing non-elective services from it. However, following the merger the merged organisation has the incentive to consider revenue on an organisation-wide basis rather than a site-level basis.[70] For example, if the merged organisation can expect to retain a high proportion of revenues associated with non-elective services overall even if it stops providing those services from a particular site, then the incentive to retain non-elective services from that site would be lower after the merger than it was prior to the merger.[71] Therefore it may not be prepared to incur the same level of expenditure on maintaining and improving the quality of non-elective services at this site as it would have done prior to the merger (we discuss possible ways through which adjustments to expenditure can affect the quality and efficiency of service delivery in paragraph 54). We therefore expect that the greater the proportion of revenue that would be captured by the merged organisation, the more likely it is that there will be a reduction in competition to provide non-elective services.

99. In order to assess the effect of the proposed merger on competition between providers of routine non-elective services, we considered:
    - Whether there is a realistic threat that in the foreseeable future commissioners would stop commissioning these services from any of the main hospital sites operated by the merger parties; and
    - What proportion of revenue (using patient numbers as a proxy) the merger parties could expect to gain in the hypothetical event of each of the merging trusts, in turn, losing the contract to provide non-elective services from their main hospital site.

Threat of switching non-elective services away from a provider

100. In the following paragraphs we set out our assessment of whether there is a realistic threat that commissioners in north east London would be likely to consider changing the way in which they purchase routine non-elective services from any one of the main hospital sites operated by the merger parties in the future.

[68] Acute trust managers are under an obligation to ensure that they earn sufficient revenue to cover their costs, and in the case of Foundation Trusts, there is an incentive to earn surplus revenue as this can be retained and invested in new services.
[6969] Registration to provide NHS services is dependent on meeting all the essential standards of care as assessed by the CQC
[70] For example, we note that in the financial appraisal of options to reconfigure accident and emergency services in north-east London the effect of King George hospital losing its accident and emergency services was reported at the level of the provider rather than the individual hospital site.
[71] We note that on balance the merged organisation may still prefer to retain non-elective services at each of its sites although its incentive to do so would be reduced.

101. Changes to the way commissioners purchase non-elective services could involve varying degrees of service reconfiguration which could take various forms, including decisions to redistribute services between hospital sites or decisions to reduce the number of hospital sites offering full 24 hour accident and emergency services. The commissioner may decide to make such changes in order to increase clinical quality, patient accessibility, or efficiency of service delivery.

102. Commissioners in north-east London have recently completed a consultation on proposed changes to the way in which routine non-elective services will be provided in the future.[72] Once implemented, these changes will reduce the number of hospitals providing a full non-elective service (including accident and emergency and consultant-led maternity) across north-east London from six to five, with the non-elective services at King George hospital (which is operated by Barking, Havering and Redbridge University Hospitals NHS Trust) being closed and replaced with an Urgent Care Centre.[73] In October 2011, the Government announced its support for the proposed changes.

103. The development of these changes was led by the Acute Commissioning Units in north-east London, with support from a Clinical Reference Group.[74] A range of reconfiguration options for non-elective provision in north-east London were considered and assessed in terms of: (i) clinical quality, safety and workforce; (ii) capacity; (iii) accessibility; and (iv) deliverability. The financial impact of each option on both the north-east London sector as a whole, as well as each individual provider, was considered alongside the clinical benefits. The strength of the case for retaining service provision at each provider's site depended on its ability to score strongly against these assessment criteria.[75]

104. We considered whether commissioners in north-east London would seek to implement further changes to the way in which routine non-elective services are provided across the north-east London area. Commissioners told us they may conceivably consider further changes to non-elective services in the future but major strategic decisions take a significant amount of work over a long period and at this time there is no strong pressure to begin this process again. The merger parties told us that in their view the commissioner would continue to commission these services at Newham and Whipps Cross (we respond to the merger parties' submission on this point in paragraphs 116 to 118). We note that any further change would require extensive public consultation. [✂] We concluded that it is unlikely that there will be another major reconfiguration of routine non-elective services in north east London within the next two years.

105. We went on to consider whether commissioners in north-east London would seek to implement further changes to how routine non-elective services are provided across the north-east London area in the foreseeable future beyond two years. We reviewed the pre-

[72] These proposals were developed as part of the *Health for North East London* programme. See www.healthfornel.nhs.uk for further details.
[73] These proposals would see routine non-elective services maintained on the following hospital sites: The Royal London (Barts and The London), Queens hospital (Barking, Havering and Redbridge University Hospitals NHS Trust), Newham hospital (Newham Trust), Whipps Cross hospital (Whipps Cross Trust) and Homerton hospital (Homerton University Hospital NHS Foundation Trust).
[74] The Clinical Reference Group comprised medical directors from each provider in the north-east London area (as well as some located outside the area), along with senior representatives of the Acute Commissioning Units, PCTs and various external advisors.
[75] See page 11 of the Executive summary of the 'Health for North East London decision making business case'.

consultation business case (dated November 2009) for the recent reconfiguration of routine non-elective services in north-east London.[76] The recommendation of the Clinical Reference Group was that the best option was a configuration of accident and emergency and supporting services on either four or five hospital sites, with a preference for four in the longer term and an interim stage of five in the medium term.[77] The Clinical Reference Group concluded that closing non-elective services on two sites (i.e. retaining the services on four sites) scored highest for clinical quality and safety although closing three (i.e. retaining the services on three sites) would leave insufficient capacity in the area (which was not a direct consideration of the Clinical Reference Group which focused on clinical issues only). They noted that it was not possible to rule out the closure of non-elective services at any of the hospitals in north-east London on the grounds of accessibility (due to the relative proximity of the hospitals to each other). They also concluded that routine non-elective services at the two major acute hospitals in the area (The Royal London and Queens hospital) should not be considered for closure. This means that any further reduction in sites providing non-elective services would involve a decision between closing the services at one of the following remaining hospital sites: Newham hospital, Whipps Cross hospital or Homerton hospital. We note that the commissioners only consulted on a configuration of routine non-elective services on five sites.

106. As noted above, the business case also assessed the financial case for reconfiguration. This identified that the savings to be made from closing services at Newham General hospital (either instead of King Georges hospital or in addition to it) would be significantly larger than the savings from closing services at other sites. We note that since the earlier consultation public finances have come under additional pressures. We also note that commissioning arrangements for non-elective services are expected to change with the two PCTs expected to be replaced by GP-led Clinical Commissioning Groups. We recognise that future commissioners may attach different weights to the financial/clinical benefits of different configurations and their ability to deliver them. We have taken this into consideration in reaching our conclusions set out in paragraphs 121 to 123 below.

107. We also found evidence from providers in the area which shows they consider there to be scope for further change beyond two years. [✂][78] This indicates Barts and The London consider there is scope for further reconfiguration of emergency services in the future.

108. On the basis of this evidence, and taking into consideration the proposed changes to commissioning arrangements, we concluded that it was more likely than not that providers of non-elective services in north-east London would perceive there to be a realistic threat that future commissioners may decide that further consolidation of non-elective services is beneficial and trigger a further review of the provision of non-elective services in the area. We consider this review would be unlikely to commence in the next two years but would be likely

[76] See www.healthfornel.nhs.uk/consultation/pre-consultation-business-case
[77] The Clinical Reference Group was undertaking its work in 2009 and considered the medium term to be within five years (i.e. by 2014) and the longer term to be within ten years (i.e. by 2019). The report also states that 'the Clinical Reference Group endorsed a recommendation of five sites on the basis that it would allow clinical and financial benefits to be delivered in the short to medium term. However, there was a strong view from the Clinical Reference Group that further consolidation of hospital provision may be required to support clinical and financial sustainability of north-east London health services in the longer term.' p123
[78] [✂]

to involve deciding whether to continue purchasing routine non-elective service from Newham hospital, Whipps Cross hospital and Homerton hospital (and so we focus on these providers). We do not consider it likely that commissioners would stop purchasing these services from either The Royal London or Queens hospital in the future.[79]

109. We next considered whether the threat of commissioners seeking to review provision of non-elective services in the foreseeable future (but not for at least two years) would affect the behaviour of Newham, Whipps Cross and Homerton hospitals. In particular, we considered whether it would affect their decisions to maintain and improve the quality and efficiency of their non-elective services over the next five years in the absence of the merger. We would expect that it is in the interests of each provider (absent the merger) to maintain these services in the future. We expect that it is in the interests of each provider (absent the merger) for commissioners to continue purchasing these services from them. For example, we understand that both Newham Trust and Whipps Cross Trust earn a positive surplus from operating their accident and emergency services, therefore absent the merger they will do everything possible to retain the service.[80]

110. As discussed in paragraph 101, the strength of the case for retaining routine non-elective services at each provider's site would depend on the provider's ability to score highly against the assessment criteria used (see paragraph 103 for a description of the criteria used in the recent reconfiguration in north east London). The location of a hospital is fixed and so a hospital cannot improve its accessibility. However, expenditure decisions on the level and quality of inputs used to deliver non-elective services (for example, equipment, buildings, and staff) as well decisions on the level of resource devoted to improving the efficiency of service delivery (re-designing services etc) will impact on the clinical quality and efficiency of a provider's routine non-elective services and hence its reputation with commissioners, patients and GPs. Based on the planning and implementation assumptions used in the recently agreed service reconfiguration in north east London, we would expect the threat of further

[79] This is because they are designated major acute hospitals, providing a range of specialist non-elective care, for example major trauma services and hyper-acute stroke services.

[80] We consider this to be the case for a number of reasons. First, they both have below average costs and the tariff is designed to reflect the average cost of a given HRG (Newham Trust's reference costs for accident and emergency services was 94 against an index of 100 in 2010/11, similarly Whipps Cross Trust's reference costs were 99). Second, we understand that a reduction in accident and emergency activity at Whipps Cross Trust would allow it to reduce its costs by only around 60 per cent of that reduction. Similarly, reductions in accident and emergency activity at Newham Trust would allow it to reduce its costs by 50 per cent (Source: page 33, Appendices to the Decision Making Business Case for Health for NEL consultation). This means that if either Trust loses accident and emergency activity they will be unable to reduce their costs in line with the associated revenue they would lose. In effect this means that absent the merger it would be important for both trusts to retain accident and emergency activity since losing it would have a significant negative impact on their balance sheet.

consolidation in the foreseeable future (but not for at least two years) to affect expenditure decisions from now until 2016.[81]

Expected diversion of patients from Newham Hospital and Whipps Cross Hospital

111. In the following paragraphs we set out our assessment of where we would expect patients to receive routine non-elective care if routine non-elective care services were no longer commissioned from Newham hospital or Whipps Cross hospital. This shows the number of patients that would be treated by the merged organisation in the event that either site lost its non-elective services. It therefore informs our view of the effect of the merger on the merged organisation's incentives to maintain expenditure at those sites.

112. Patients requiring non-elective services need to be treated urgently. We therefore assume that patients requiring such services would attend their nearest hospital providing these services, both before and after the merger. This assumption is consistent with modelling assumptions made in the recent Health for NEL reconfiguration proposals described above (see paragraphs 102 to 103). Therefore, if the commissioner were to stop commissioning non-elective services from either Newham hospital or Whipps Cross hospital, we assume patients would travel to the next nearest hospital providing these services. Using the location and size of GP practices (in terms of registered patients) as a proxy for the local population, we first identified those providers closest to Newham hospital and Whipps Cross hospital in terms of private transport travel time;[82] and then identified which provider of non-elective services was the next closest.[83] Appendix 3 describes the approach we took in more detail.

113. The analysis indicates that approximately 80 per cent of the population which is closest to Newham hospital would seek non-elective treatment at one of the other sites that would be under the control of the merged organisation (i.e. Royal London hospital or Whipps Cross hospital) if Newham hospital was no longer providing non-elective services.[84] This suggests that the merged organisation could expect to retain a significant proportion of patients (and

[81] When the Health for north-east London project began in 2009, its Clinical Reference Group expected that its final proposal (closure of non-elective services at one hospital) would be deliverable within three to five years (i.e. by 2012-2014). Following an extensive consultation exercise the final proposal was agreed in October 2011. We estimate that the implementation phase is expected within one to three years of agreement being reached (in order to allow delivery by 2012-2014). The Clinical Reference Group considered that its preferred proposal (closure of non-elective services at two hospitals) was deliverable within ten years (i.e. by 2019). We used this information to estimate when the consultation on a second closure would be expected to begin. For example, if implementation takes one to three years then there would need to be agreement on the proposal at some point over the period 2016-2018. Since undertaking public consultation and reaching agreement can be expected to take at least two years this means the consultation would need to be launched at some point over the period 2014-2016. A provider seeking to influence the decision taken in that consultation would need to be performing strongly in the two years prior to the launch of the consultation (i.e. over the period 2012-2014 or 2014-2016). This means that the three non-major acute hospitals with non-elective services in north-east London (Homerton hospital, Whipps Cross hospital, and Newham hospital), might be able to delay investing to maintain/improve the quality and efficiency of their non-elective services for the next two years. However, given the uncertainty of a future review on non-elective service provision in the area they would need to be investing in their non-elective services from 2012 onwards to ensure they are in the best possible position to retain their non-elective services.

[82] We assume in line with the modelling assumptions made in the recent Health for North East London reconfiguration proposals that patients requiring non-elective treatment will travel by ambulance or private transport to the nearest accident and emergency department (the department with the shortest drive-time), rather than use public transport.

[83] Given the decision to close the accident and emergency and consultant-led maternity services on the King George hospital site we exclude the site from our analysis.

[84] In response to this analysis the parties told us that we have only undertaken a partial analysis that does not consider the potential competitive constraint from patients who might switch from one non-elective site to another. As noted in paragraph 112, we have adopted the same modelling assumptions that were made in the recent Healthcare for north-east London reconfiguration proposals. We expect these assumptions are reasonable since, whether it is the patient or the ambulance driver that decides which Accident and Emergency site to travel to, the need for urgent care will mean that the most convenient Accident and Emergency site will usually be selected.

accordingly a significant proportion of non-elective revenue), even if the commissioner were to stop commissioning non-elective services from Newham hospital.

114. We repeated this analysis for Whipps Cross hospital. We found that only 20 per cent of the population which is closest to Whipps Cross hospital would seek non-elective treatment at one of the other sites that would be under the control of the merged organisation (i.e. Royal London hospital or Newham hospital) if Whipps Cross hospital was no longer providing non-elective services. This suggests that the merged organisation would expect to lose a very significant proportion of patients (and accordingly a significant proportion of non-elective revenue) if the commissioner were to stop commissioning non-elective services from Whipps Cross hospital.

Submissions from the Parties on routine non-elective services

115. The parties disagreed with our analysis of the effect of the proposed merger on routine non-elective services. A summary of the issues and our response to them is set out below. The parties told us that the CCP should either discount both costs and benefits in the medium to longer term in the analysis or include them both. They told us that they do not believe it is valid to include costs but exclude benefits occurring in the medium to longer term. We are in agreement that it is important to use the same timeframe for assessing costs and benefits. The CCP considers that this is precisely the approach that has been adopted. In particular, we found that the threat of further consolidation of routine elective services in the north east London area in the foreseeable future (but not for at least two years) is likely to affect expenditure decisions taken from now until 2016.

116. The parties also told us that in their view the commissioners would continue to commission both accident and emergency services and maternity services at Newham and Whipps Cross.[85] They told us this is because other providers in the area do not have capacity to treat the patient volumes (100,000 accident and emergency attendances and 7,000 to 9,000 births) that would be lost from Newham if it stopped providing routine non-elective services. In particular they noted the high birth rate in east London, which in their view will require consultant-led maternity services at Newham or Whipps Cross hospital, and will in turn necessitate retaining accident and emergency services at both hospitals.

117. However, in our view this is not consistent with the evidence we have seen. First, the recommendations in the Health for NEL consultation are based on an assumption that east London will experience high growth in births and accident and emergency attendances.[86] The consultation proposed that some of this additional demand for maternity services should be met by a number of new midwife-led birth units. The consultation considered that closing accident and emergency services and maternity services on three sites would leave insufficient capacity in the area, however closing two sites scored highest for clinical quality and safety and offered the largest savings of the options considered. We note that the decision to close non-elective services on the King George hospital site was based on an

[85] The parties submitted that a more likely scenario would be a tender for a third party to provide routine non-elective services on the Newham site or developing alternatives (such as an urgent care centre).
[86] For example, in relation to Newham the analysis took into account a 34 per cent increase in the number of births over a ten year period and a 20 per cent growth in accident and emergency attendances.

assumption that surrounding hospitals would increase their capacity to accommodate the additional demand. Notably, the consultation also ruled out the continuation of small obstetric units with less than 4,000 births per annum since they were becoming clinically and economically sub-optimal, and also ruled out very large maternity units (12,000 births or more per year) since they felt these were undesirable.

118. Secondly we found that even if commissioners were to decide that on balance Newham hospital should continue to provide a consultant-led maternity service it does not follow that accident and emergency would necessarily remain as well. For example, the analysis in the Health for North East London consultation explicitly considered the option of closing an accident and emergency service whilst continuing the maternity service on that site. It noted that such a 'standalone' maternity unit would be able to sustain a full range of clinical support services if it delivered a minimum 8,000 births per year. We note that Newham hospital is forecast to deliver around 8,250 babies per year by 2016/17.[87] The CCP's clinical reference group confirmed that co-location is not always necessary. The commissioners told us that the closure of a further accident and emergency service is not inevitable however they acknowledged that it is conceivable that they will consider further changes to non-elective services in the future. This scope for further changes is reflected in the strong view of the Health for NEL clinical reference group that further consolidation of hospital provision may be required to support clinical and financial sustainability of north east London in the longer term.[88]

119. The parties told us that patients with less urgent conditions are able to choose which accident and emergency department to attend and so there is potentially an additional competitive constraint upon the merged organisation if these patients would consider attending a different accident and emergency department if the quality of service were to deteriorate. As noted we adopted the same modelling assumptions that were made in the recent Health for north-east London reconfiguration proposals. We expect these assumptions to be reasonable since patients that take themselves to an accident and emergency department (rather than arriving by ambulance) will still require urgent treatment and are therefore unlikely to travel to more distant hospitals

120. Finally the parties told us that the CCP has disregarded the significant scope that exists in this market for commissioners to take contractual steps to ensure the quality of the hospital does not decline. They also told us that competitive tendering can be a poor mechanism for maintaining or improving service quality. We agree that contractual arrangements are one tool available to commissioners to protect the quality of the service. However, these are better placed to protect a minimum level of quality than to drive providers to improve the quality of their service. This is because the bargaining strength of the commissioner relative to the provider depends on its ability to credibly commission the service from another provider. If there are no or only a few alternative providers, the commissioners bargaining power is very limited.

[87] Health for North East London Pre-consultation business case, p159

[88] The Clinical Reference Group comprised medical directors from each provider in the north-east London area (as well as some located outside the area), along with senior representatives of the Acute Commissioning Units, PCTs and various external advisors.

Conclusion

121. We concluded that it was more likely than not that the operators of Newham and Whipps Cross hospitals would perceive there to be a realistic threat that commissioners may decide that further consolidation of non-elective services is beneficial and trigger a further review of the provision of non-elective services in the north east London area in the foreseeable future (but not for at least two years). We found this threat acts as a competitive constraint on the behaviour of the operators of Newham and Whipps Cross hospital in the absence of the merger. In particular it creates incentives to invest in maintaining and improving their non-elective services above CQC minimum standards so as to improve the likelihood of retaining these services.

122. We found that if the commissioner stopped commissioning non-elective services from Whipps Cross hospital the merged organisation could expect to lose the vast majority of patients and revenue associated with these services. This is because on the basis of travel time to alternative sites patients would most likely attend a site not operated by the merged organisation for treatment. On this basis, we found that the proposed merger would not reduce the strong existing competitive constraint on non-elective services at Whipps Cross hospital.

123. We also found that if the commissioner stopped commissioning non-elective services from Newham hospital the merged organisation could expect to retain the vast majority of patients and revenue associated with these services. This is because on the basis of travel time to alternative sites, patients would most likely attend another site operated by the merged organisation. On this basis, we found that the proposed merger would reduce the existing competitive constraint and reduce the incentive on the merged organisation to maintain and improve the quality of non-elective services on the Newham hospital site above minimum CQC standards.

INDIVIDUAL SPECIALIST SERVICE PROVISION

124. We next considered whether the proposed merger would be likely to reduce choice and competition for individual specialist services in the wider north-east London area. Barts and The London provides a comprehensive range of specialist services. With the exception of one specialist cardiac service which is provided by Whipps Cross Trust (cardiac catheterisation), Whipps Cross Trust and Newham Trust do not provide specialist services. We therefore focused our analysis on the effects of the proposed merger on choice and competition in cardiac catheterisation services only in the wider north-east London area.

Cardiac Catheterisation Services

125. Cardiac catheterisation (also known as coronary angiogram) services are generally elective diagnostic procedures, although some patients may be admitted through accident and emergency. The parties explained that the service is operated as a day unit which undertake angiography, pacemaker implant, angioplasty, cardio version, and temporary pacing wire insertion procedures. Barts and The London currently provides the service from two sites (St Bartholomew's hospital and The London Chest hospital) where it forms part of its specialist

service for adult cardiology and cardiothoracic surgery.[89] The service at Whipps Cross Trust forms part of its acute cardiology service and is provided from Whipps Cross hospital.

126. The parties told us that the number and location of cardiac units has been planned by the Cardiac Network for London with capital investment controlled by the London SHA. The merger parties identified Barking, Havering and Redbridge University Hospitals NHS Trust as the alternative specialist provider of cardiac services in the wider north-east London area, and a further six specialist providers across London who all provide cardiac catheterisation services.[90] In addition, the merger parties identified four providers who provide the service as part of their routine acute cardiology service.[91] The merger parties told us that cardiac units are capital intensive to establish and so new entry would be difficult.[92]

127. When considering the competitive effects of the proposed merger, we analysed whether it would be likely to reduce patient choice and competition in the cardiac catheterisation service across the wider north-east London area. When reaching a view on the costs that are likely to arise from a merger we review the current degree of competition between the merging parties and the strength of the competitive constraints that would remain post-merger from the other providers that we have identified as operating within the relevant market.

128. We undertook our competitive assessment separately for the service provided on sites operated by Barts and The London and Whipps Cross Trust because the merged organisation would be in a position to set different levels of expenditure to ensure or improve quality and efficiency at each of its hospital sites.

Whipps Cross Hospital

129. The catchment area for Whipps Cross hospital's cardiac catheterisation service corresponds closely with its catchment area for routine elective services. Patients from Waltham Forest account for around 65 per cent of Whipps Cross hospital's total cardiac catheterisation referrals, with substantial patient flows also from Redbridge (around 20 per cent) and West Essex (around ten per cent).

130. We first considered the extent to which Barts and The London competes with Whipps Cross Trust for cardiac catheterisation referrals. We found Barts and The London to be the most easily accessible alternative provider to Whipps Cross hospital for patients using public transport located in the south and east of Whipps Cross hospital's catchment area, although a number of other providers were more easily accessible for patients located in the north-west of its catchment area. We note that patients using private transport have access to a number of alternative providers of cardiac catheterisation services closer than Barts and The London. Barts and The London sends general marketing material to GP's located across Whipps Cross Trust's catchment area and internal documents provided by Whipps Cross Trust identify Barts

[89] We note that The London Chest Hospital is due to close with services transferred to other sites operated by Barts and The London.
[90] These other six providers are University College London Hospitals NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust, Imperial College Healthcare NHS Trust, Royal Brompton and Harefield NHS Foundation Trust, Royal Free Hampstead NHS Trust, and Kings College Hospital NHS Foundation Trust.
[91] These four providers are Barnet and Chase Farm Hospitals NHS Trust, The Princess Alexandra Hospital NHS Trust, North Middlesex University Hospital NHS Trust and Whittington Health NHS Trust.
[92] The Health for North East London Pre-consultation business case assumed the construction of a new cardiac catheter laboratory on an existing acute hospital site would cost between £2.3 and £3.4 million.

and The London as a competitor across a wide range of acute hospital services. We identified that Barts and The London has a 20 per cent share of referrals from Whipps Cross Trust's principal catchment area for cardiac catheterisation services and found that around 70 per cent of patients who had treatment at Whipps Cross Trust were from GPs who consider Whipps Cross Trust and Barts and The London Trust to be important alternatives (see Appendix 4 for further details). Taken together, this evidence indicates Barts and The London is an important competitor to Whipps Cross Trust for cardiac catheterisation services.

131. We next assessed the extent to which other providers are likely to compete with Whipps Cross Trust for cardiac catheterisation referrals. We note that the specialist nature of the service means that the number of competitors providing the service is lower than for routine elective services. In particular, we found that neither Homerton University Hospital NHS Foundation Trust nor Newham Trust provide the service and independent sector providers treat almost no NHS patients from the catchment area of Whipps Cross Trust needing this service. However, on the basis of our analysis of catchment areas, travel times and GP referral patterns, we found that Whipps Cross Trust will continue to face a range of competing providers which together are likely to represent a significant competitive constraint on its cardiac catheterisation service. As one of two providers of specialist cardiac services in north-east London, and with around a third of referrals from Whipps Cross catchment area for cardiac catheterisation services, we consider Barking, Havering and Redbridge University Hospitals NHS Trust to be the most important competitor. We also found a number of other providers, including Royal Free Hampstead NHS Trust, The Princess Alexandra Hospital NHS Trust, North Middlesex University Hospital NHS Trust, University College London Hospitals NHS Foundation Trust and Royal Brompton and Harefield NHS Foundation Trust to be important competitors for referrals with Whipps Cross for cardiac catheterisation services.[93]

132. We conclude that Barts and The London would be a competitor to Whipps Cross Trust for cardiac catheterisation referrals in the absence of the merger. However, we also conclude that there would remain a range of competitors which together are likely to provide an effective competitive constraint to the Whipps Cross hospital site.

Barts and The London

133. We next assessed the effect of the merger on cardiac catheterisation services provided by Barts and The London. Barts and The London told us that its specialist services attract referrals from a wider geographic area than its routine elective services, with referrals from across north-east London and beyond. We assessed the extent to which Whipps Cross Trust competes with Barts and The London for cardiac catheterisation referrals noting that although Whipps Cross Trust faces competition from Barts and The London the converse might not necessarily be true. We found that Whipps Cross Trust sends general marketing material to GP's within the catchment area for Barts and The London and internal documents from Barts and The London identify Whipps Cross Trust as a competitor across a wide range of acute services. We found that Whipps Cross Trust received a small share of referrals from the Barts

[93] This competitor set differs from the competitor set for Whipps Cross Trust that was identified for routine elective services in paragraphs 65 to 67. For example, as noted above Homerton University Hospital NHS Foundation Trust and Newham Trust do not provide the service and so they are not in this competitor set. Our analysis also shows patients more willing to travel further to more specialist providers such as the Royal Brompton and so we include them in the competitor set.

and The London catchment area for cardiac catheterisation services. We also found that around 10 per cent of patients who had treatment at Barts and The London were from GPs who consider Barts and The London and Whipps Cross Trust to be important alternatives (see Appendix 4 for further details). Taken together, this evidence indicates that Whipps Cross Trust is a competitor to Barts and The London for cardiac catheterisation services.

134. We next considered the extent to which other providers are likely to compete for cardiac catheterisation referrals with Barts and The London. We found that the most important competitors to Barts and The London were Barking, Havering and Redbridge University Hospitals NHS Trust and University College London Hospitals NHS Foundation Trust. We also identified Royal Free Hampstead NHS Trust, and Royal Brompton and Harefield NHS Foundation Trust as competitors to Barts and The London for cardiac catheterisation services. We therefore concluded that following the merger there would remain a range of competitors which together would form an effective competitive constraint on the cardiac catheterisation service provided by Barts and The London

135. In summary, the CCP found that Whipps Cross Trust would be a competitor to Barts and The London for cardiac catheterisation referrals in the absence of the merger. However, we also found there would remain a range of competitors which together are likely to provide an effective competitive constraint on the site that Barts and The London provides these services from.

Conclusion

136. As explained in paragraph 124 above, the CCP identified cardiac catheterisation services as the only specialist service in respect of which the proposed merger may reduce patient choice and competition in the wider north-east London area. The CCP, however, concluded that while Barts and The London and Whipps Cross Trust would impose a competitive constraint on each other in the absence of the merger, there would, after the proposed merger, remain a range of competitors which together would be likely to provide an effective competitive constraint on the cardiac catheterisation services provided by the merged organisation. We therefore concluded that the proposed merger was unlikely to reduce patient choice and competition in the provision of specialist services in the wider north-east London area.

OUTPATIENTS SERVICES CLUSTER

137. We also assessed whether the proposed merger would be likely to reduce choice and competition for outpatient services in the wider north-east London area. There are two types of outpatient services: those which form part of a pathway for a specific admitted patient episode (i.e. first and follow-up appointments);[94] and those standalone outpatient services which do not form part of a specific admitted patient pathway. This second category reflects the growing demand from commissioners for medical care that can be provided on an outpatient basis (with no requirement to admit the patient for treatment).

[94] As these outpatient appointments are only provided in conjunction with the admitted service we considered them in our analysis of the effects of the merger on routine elective care in the wider north-east London area. See paragraphs 91 to 93 for our findings in relation to the effect of the merger on these services.

138. The merger parties each provide a range of outpatient services in community settings across their respective catchment areas. These services are provided from a range of premises including GP practices, health centres and community hospitals. We consider that the merger parties are likely to be competitors for the provision of outpatient services in the wider north-east London area. However, we also consider that the provision of stand-alone outpatient services is likely to be more competitive than routine elective services. This is because the provision of outpatient services has lower barriers to entry than the provision of routine acute services because less significant capital investment is required. This means that a wider range of providers is likely to be able to start providing outpatient services. For example, we note that Care UK has recently established a network of four outpatient clinics across Waltham Forest, Redbridge, Barking and Dagenham and Havering areas.[95] We consider that the threat of entry by new providers will ensure that the merged organisation is unable to allow the quality of its standalone outpatient services to deteriorate without the threat of patients switching to an alternative provider. In conclusion we conclude that for outpatient services, the proposed merger is unlikely to result in a material adverse effect on patient choice and competition.

COMMUNITY SERVICES CLUSTER

139. We next considered whether the proposed merger would be likely to reduce patient choice and competition in community health services in the wider north-east London area. The main form of competition in community services to date has been competitive tendering, or the threat of competitive tendering by commissioners of these services. This involves commissioners selecting a provider to provide a defined service across a particular geographic area and patients from within that area using the service provided. However, in July 2011 the Government announced that patient choice would be extended into community (and mental health) services. A phased approach was proposed, with local commissioners being expected to identify three or more community or mental health services in which to implement patient choice of Any Qualified Provider during 2012/13.[96]

140. East London and the City PCT cluster, in conjunction with its local pathfinder clinical commissioning groups and local patients and clinicians, has identified the following services in which to implement patient choice of AQP in 2012/13:[97]
    - Wheelchair services for children (cluster-wide);
    - Diagnostic services closer to home (cluster-wide);
    - Venous leg ulcers (Newham only);
    - Incontinence (Newham only); and
    - Adult hearing (City & Hackney only).

141. Detail on how patient choice will be implemented across the full range of community services in future continues to remain unclear at this stage. Accordingly for these other community

[95] Setting up these clinics requires a provider to rent space within existing healthcare facilities (e.g. a community hospital or a local GP) or rent alternative appropriate accommodation. The provider must also be able to provide consultants, nurses, and administrative staff. Consultant staff will rotate between the provider's hospital site and its consultant clinics.
[96] See www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128462.pdf.
[97] pathfinder clinical commissioning groups are the local groups of GPs and other clinicians that are due to take responsibility for the commissioning of NHS services in April 2013

services we consider competitive tendering to be the predominate form of competition in community services in the short term.

142. With these policy developments in mind, we assessed the impact of the proposed merger on community services from the perspective of commissioner choice and competition and then, for those services where patient choice is expected to be introduced in 2012/13, we assessed the impact of the proposed merger from the perspective of patient choice and competition.

Impact on commissioner choice

143. We assessed the extent to which the merger parties might in future compete for community service contracts in the absence of the merger. Barts and The London provides a comprehensive range of community health services from locations across the Tower Hamlets area.[98] We therefore expect Barts and The London to be an important competitor for contracts tendered in north-east London area. Newham Trust does not provide community services and has not bid for contracts to provide individual community services over the last three years, although it does have a service level agreement (SLA) to provide some specialist nurses to the local community service provider in Newham (East London NHS Foundation Trust).[99]

144. Whipps Cross Trust provides a number of community health services in Waltham Forest and has bid for individual community health service contracts in the north-east London area over the last three years.[100] Whipps Cross Trust told us they would focus on community services linked to acute services and their recent bidding behaviour is consistent with this approach.[101]

145. Taken together, this evidence suggests the proposed merger may remove at least one effective bidder for community service contracts tendered in the Tower Hamlets, Newham or Waltham Forest areas, particularly for those community services formerly provided by acute hospitals.

146. We next assessed the extent to which other providers would represent an effective competitive constraint to the merged organisation across the full range of community services should contracts be tendered for community services provided in Tower Hamlets, Newham or Waltham Forest in the future.[102] We found there would remain a range of credible and effective bidders for these contracts. In particular, East London NHS Foundation Trust, Homerton University Hospital NHS Foundation Trust and North East London Foundation Trust would be credible and effective competitors to the merged organisation across the full range of community services. Depending on the community service tendered, we also expect there to be a range of other potential effective bidders, including other large NHS providers

[98] Barts and The London won the contract to provide the community services formerly provided by the Tower Hamlets PCT provider arm.
[99] Newham Trust bid to provide the community services formerly provided by the Newham PCT provider arm but was not awarded the contract.
[100] Whipps Cross Trust told us that they currently provide community occupational therapy and physiotherapy, community beds for rehabilitation and community multi-disciplinary team for admission avoidance and early discharge, community-based musculoskeletal physiotherapy assessment service and inpatient rehabilitation unit.
[101] See www.ccpanel.org.uk/cases/East-London-NHS-Foundation-Trust-aquisition-of-Newham.html.
[102] East London NHS Foundation Trust currently provides community services in Newham PCT area. Homerton University Hospital NHS Foundation Trust currently provides community services in City and Hackney PCT area. North East London NHS Foundation Trust provides community services across Waltham Forest, Redbridge, Havering and Barking and Dagenham.

providing acute services in the wider north-east London area, local primary care provider groups and other Independent Sector providers. We therefore concluded that the proposed merger is unlikely to result in a substantial lessening of competition for these community service contracts.

Impact on patient choice

147. We next considered the impact of the proposed merger on patient choice and competition in those community services described above where patient choice is expected to be implemented during 2012/13.

148. We found that Newham Trust and Whipps Cross Trust do not currently provide these services. We also found there would be a range of other providers who could start providing these services on an AQP basis, including the current incumbent providers of these services who have experience of providing these services in the area (including East London NHS Foundation Trust, Homerton University Hospital NHS Foundation Trust and North East London Foundation Trust).

149. We therefore do not consider the merger would lead to a material reduction in patient choice and competition in those community services identified above where AQP is expected to be introduced in the near future.

Conclusion

150. In summary, the CCP concluded that for community services, the proposed merger is unlikely to result in material adverse effects on choice and competition.

VERTICAL EFFECTS OF THE MERGER

151. In this section we assess whether the proposed merger would be likely to have an impact on the relationship between the merger parties and those providers who refer patients to them, or to whom they refer patients. In particular, we assessed whether the merged organisation would have the ability and incentive to direct or otherwise influence patient referrals to the services it provides rather than to alternative providers and thus reduce competition for those referrals.

152. There are two main patient flows which give rise to referrals to and from the merger parties and which could be influenced by the merged organisation. The first is the flow of patients between community service providers and providers of acute services. The second is the flow of patients between providers of routine acute services and providers of specialist acute services.

Referrals between providers of community and acute hospital services

153. We assessed the effect of the proposed merger on the flow of patients between community service providers and acute service providers.

154. Patients of community services are entitled to choose their provider of acute elective services. We assessed whether the merged organisation would be able to direct (or otherwise

influence) patients receiving community services but requiring acute treatment to have routine elective treatment provided by the merged organisation. Barts and The London currently provides a broad range of community services in Tower Hamlets, Whipps Cross Trust provides a number of community services in Waltham Forest whereas Newham Trust does not generally provide community services (see paragraph 143 for further details).[103] We identified that these community service providers already had the ability and incentive to direct patients towards the acute services operated by their organisation.[104] The proposed merger will therefore have little or no additional impact and so we do not find that it is likely to adversely affect patient choice and competition or undermine the GP gatekeeper function.

155. We also assessed the potential impact of the proposed merger on patient choice and competition in community services i.e. referrals from acute providers to community service providers. As discussed in paragraphs 139 to 143, patient choice is only being extended into a limited number of community services. For those community services where patient choice is being introduced in the near future, the three merger parties already each have the ability and incentive to refer patients to any community services that they choose to enter into providing under the AQP model of service provision and so we do not expect that the proposed merger will change the existing incentive. We note that Barts and The London provided the CCP with assurances in respect of preserving patient choice at the time it acquired the Tower Hamlets PCT provider arm. We consider that it will be important when commissioners extend patient choice into community services in future that the potential for some providers to influence patient choice is considered and adequate safeguards implemented by commissioners.

Referrals between providers of routine and specialist acute hospital services

156. We assessed the effect of the proposed merger on the flow of patients from providers of routine acute services to providers of specialist acute services. We note that patients are not able to choose their provider at this stage of the patient pathway and so we focus on the impact on competition. With respect to referrals into specialist services, we find that referrals from Newham Trust and Whipps Cross Trust would represent a small proportion of the total number of patients requiring specialist treatment that are referred to Barts and The London or other providers for specialist care.[105] Therefore, after the merger Barts and The London and other providers of specialist care would continue to have a strong incentive to invest in quality and/or efficiency in order to attract patients. We therefore do not expect that any changes in the flow of patients to providers of specialist acute services as a result of the merger are likely to adversely affect competition between providers of specialist services.

157. We also assessed the effect of the proposed merger on the flow of patients from providers of specialist acute services to providers of routine acute services. Such referrals are a small proportion of the provider's total routine acute activity. Therefore, the small volume of referrals will be unlikely to change the merging parties' incentive to invest in quality and/or efficiency in order to attract patients. Therefore we do not expect that changes in the flow of

[103] East London NHS Foundation Trust provides the full range of community services in the Newham area and North East London NHS Foundation Trust provides these services in the Waltham Forest area.
[104] Subject to assurances they provided to commissioners upon acquiring these community services.
[105] This would be the case for Barts and The London if *all* referrals for specialist care were internalised within the merged organisation.

patients between providers of routine acute services and providers of specialist acute services are likely to adversely affect competition between providers of routine acute services.

CONCLUSION ON THE ASSESSMENT OF MERGER COSTS

158. For the reasons outlined above, the CCP has concluded that the proposed merger between Barts and The London, Whipps Cross Trust and Newham Trust can be expected to result in material costs to patients and taxpayers. In particular, we find that the merger removes important competitive constraints for routine elective services (except ophthalmology) provided from the Newham hospital site and accordingly significantly reduces choice of hospital provider in Newham. We also find that it would reduce competition for non-elective services provided from the Newham hospital site. In the following section we consider whether there are benefits to patients and taxpayers arising from the merger, which would be likely to offset these costs.

FRAMEWORK FOR ASSESSING MERGER BENEFITS

159. We first set out the framework that the CCP uses when assessing merger benefits which is consistent with the CCP's Merger Guidelines. We then apply this framework to the merger benefits that the parties have described to us.

160. Patients may benefit from a merger through higher quality service, a greater choice of services, or greater innovation by the merged organisation in the provision of services. Taxpayers may also benefit from a merger if it leads to a lower cost (or price) for commissioners for services from the merged organisation.[106]

161. In assessing whether a merger is likely to give rise to benefits to patients and taxpayers, the CCP relies on submissions from the merging parties as a means of identifying the benefits that potentially arise from a merger and the evidence in support of these claims. This approach reflects the position of the merging parties as the proponents of the transaction and the organisations responsible for ensuring that the intended benefits are realised.

162. The following paragraphs discuss four factors that the CCP takes into account in considering the weight that should be placed on the benefits that the merging organisations attribute to a merger.[107] These primarily relate to:
    - whether the benefit attributed to the merger represents a real improvement in services to patients or better value for money for taxpayers;
    - whether the CCP considers it likely that a benefit will, in practice, be realised;
    - whether the benefit will be realised within a reasonable period following the merger; and whether the benefit has a degree of longevity (rather than being a temporary or one-off gain); and
    - whether the benefit is dependent on the merger (i.e. whether or not it is merger specific).

[106] This could be a result of, for example: (i) a smaller number of referrals; (ii) reduced services utilisation; or (iii) lower cost of block contracts.
[107] In undertaking its analysis, the CCP called on the expert opinion and advice of its Clinical Reference Group.

163. For the CCP to believe that a benefit attributed to a merger represents a real improvement in services to patients or value for money for taxpayers, the parties to the merger should – where relevant – be able to describe in sufficient detail the pre-existing situation which the merger will improve. For example, if it is suggested that a merger will improve staffing and provide better coverage of staff absences, then the extent to which existing services suffer from staffing problems should be set out. In the absence of this information, the CCP will find it difficult to form a judgement as to the existence or size of the benefit in question.

164. In relation to clinical benefits arising from a merger, the CCP will seek to evaluate the extent to which the benefit in question results in an improvement in the health outcomes or experience of patients. For example, if it is suggested that a merger will allow a particular type of care or treatment to be carried out at home rather than in hospital, then evidence from the parties would need to explain why this is clinically better for patients, which outcomes this will positively affect, the number of patients this will affect (and which patient groups this improvement might not apply to) as well as the rationale for why this service improvement is not being delivered currently, but will be delivered as a result of the merger.

165. The CCP will have greater confidence that a particular merger benefit is likely to be realised where the parties to a merger have a clear and detailed post-merger integration plan that sets out how the merging organisations' existing structures, processes and practices will be modified to realise the benefits in question. The CCP is likely to place greater weight on the credibility of post-merger integration plans where these have been scrutinised by independent third party experts, and where these plans have not been developed specifically for the purpose of obtaining CCP approval for the merger.

166. In assessing the credibility of any plans to realise merger benefits the CCP may also look to the experience of the merging parties in previous transactions and their success in realising benefits from those mergers. The CCP may also look at other similar transactions and consider whether the parties to those transactions have been successful in realising similar benefits. The CCP will also consider the incentives that the merged organisation has to carry out the implementation plans that are presented to it.

167. In terms of timing, the CCP will generally place greater weight on benefits that will be realised in the short-, rather than medium- or long-term, particularly where a merger is expected to give rise to costs to patients and taxpayers in the short-term as a result of a diminution in patient choice and competition.

168. Finally, the CCP will consider whether any particular benefit is more likely to be realised through the merger (i.e. is merger specific) than would otherwise be the case. To some extent, this requires the CCP to consider the actions that might potentially have been taken, in the absence of the merger, and is analogous to the CCP's consideration of the counterfactual when analysing the costs of a merger (see paragraphs 42 to 45).

169. Having assessed the benefits to patients and taxpayers that the parties ascribe to a merger, the CCP will reach a view on the scale of these benefits (and, ultimately, their size relative to the costs associated with the merger). While it may be possible to measure some benefits in

terms of monetary values or, for example, improvements in quality adjusted life years (QALYs) for patients, it is unlikely that the CCP will be in a position to place a specific overall value on benefits in either monetary or other terms. Rather, the Panel will in most cases exercise its judgement in reaching a view as to the scale of benefits in either absolute terms or relative to the costs of the merger. Where this is the case, the Panel's findings and supporting reasoning will be set out as transparently as possible in the CCP's report on the merger.

170. In some cases, it is possible that the costs and benefits of a merger may fall on different groups. For example, it may be that one group of patients is expected to benefit from a merger, while another group has been identified as likely to bear the expected costs. In these circumstances, it is open to the CCP to recommend that conditions be placed on a merger, even where the overall benefits outweigh the costs, so as to ensure that the adverse consequences of a merger for any particular group of patients or taxpayers are minimised or that particular benefits are realised.

ASSESSMENT OF MERGER BENEFITS

171. This section sets out the CCP's assessment of benefits submitted by Barts and The London, Whipps Cross and Newham. The merger parties tended to describe a benefit and provided specific examples to illustrate the benefit in question. As we explain in more detail below we were sometimes unable to take the benefit into consideration in our assessment if the example was not sufficiently well evidenced. The following paragraphs describe the benefits submitted by the parties and assess in detail the examples provided by way of illustration. They also outline the CCP's findings and views.

BENEFITS FROM REMOVAL OF ORGANISATIONAL BOUNDARIES AND CULTURAL BARRIERS

172. The parties told us that the merger would remove the organisational boundaries and cultural barriers that currently exist. This would improve the adoption of best practice and the development of seamless pathways of care. The parties told us that clinical staff in individual trusts can be resistant to changing the way services are provided after being involved in developing the existing model of provision over time. The parties encountered difficulties, for example, when attempting to roll out Newham's length of stay (LOS) best practice model at Whipps Cross. We refer to this in more detail in paragraph 193.

173. The parties also submitted that organisational boundaries can lead to fragmented care. By way of an example, the parties referred to cancer services and identified problems around consultant to consultant referrals for cancer patients requiring tertiary care. We refer to this in more detail in paragraph 180. The parties also referred to a single specialist team providing services to vulnerable adults and children would lead to improvements in service levels. Very little detail was provided on how these improvements would materialise and accordingly we are not able to take this into consideration in our assessment.

174. The parties told us that strong clinical and managerial leadership under one organisation would help to remove organisational barriers and allow new service models to be adopted.

The parties said that Barts and The London had such leadership and would therefore be able to overcome any challenges associated with the delivery of this type of benefit.

175. The CCP accepts the merged organisation may reduce some of the cultural and organisational barriers by for example mixing up clinical teams across the different sites. However, the CCP notes that the merger will not in itself address these differences as the merged organisation will continue to have the same staff. It will require strong clinical leadership and managerial stewardship and the complexity of the merger may in fact mean that management time is taken up with other matters. In the following sections we assess examples of specific services the parties expect to benefit from the removal of organisational boundaries and cultural barriers.

Shared staff

176. The parties provided three main examples in relation to improved specialist care services (neurosurgical patients and cardiac patients in particular), another to cancer care and another to diabetes care. The parties submitted that as a result of the merger specialist care services would be delivered seamlessly and more locally with consultants from Barts and The London working on the Whipps Cross and Newham hospital sites and clinicians from Whipps Cross and Newham hospitals working on the Barts and The London hospital site. The parties did not expect significant staff resistance as staff would be likely to see these types of rotational arrangements as yielding professional benefits. In our view, there may be staff resistance to such changes. In addition, such changes might diffuse expertise at the Barts and The London and increase the costs of providing care at the other sites. In response, the parties told us that the services in question have sufficient scale that delivering outpatient (rather than inpatient) services would not undermine the provision of existing services and would benefit those patients that require occasional specialist long-term or follow-up care but do not live close to Barts and The London.

177. The parties told us that the merged organisation may provide transport between hospital sites, reimburse staff travel costs and provide parking facilities and would aim to design a staff rota that minimised the need for travel between the sites (i.e. ensuring that staff spend whole days at a single site). The parties did not provide enough detail to enable us to take this benefit into consideration in our assessment. Nor did they assess the costs of implementing the proposal.

178. The parties referred to delays in the transfer of neurosurgical patients from Newham Trust and Whipps Cross Trust to Barts and The London and submitted that the merger would alleviate this problem. The CCP notes that it is common in specialist areas such as neurosurgery for trusts with multiple sites to be unable to accommodate all patients requiring specialist care all of the time and it is normal practice to then apply triage policies to best utilise limited resources. In the absence of capacity being increased at Barts and The London as a result of the merger we do not expect neurosurgical capacity issues to be resolved. The parties have not explained how the merger would increase capacity at the neurosurgical specialist unit. The parties also submitted that the merger would enable clinicians to assess organisational risk differently and would therefore result in patients being transferred sooner.

The CCP would expect clinicians to assess the merits of a transfer of a patient against an agreed protocol of clinical risk and accepted triage best practice. The CCP does not accept that this clinical practice and decision making would be altered as a result of the three individual trusts becoming one entity. We therefore do not take this benefit into consideration in our assessment.

179. The parties told us that the merger would improve diabetes care and ensure patients are treated in an appropriate setting. We were told this would primarily occur through improved communication between primary and secondary providers of diabetes care. The parties were not able to explain how they would deliver this benefit and had not developed an agreed implementation model. We therefore do not take this benefit into consideration in our assessment. We consider below the parties' submissions relating to the ways in which the removal the organisational boundaries and cultural barriers would benefit cancer services.

Improvements to cancer care

180. The parties told us that the merger provides an opportunity to bring together secondary and specialist providers of cancer services and remove traditional organisational boundaries. The parties submitted that this would allow clinical teams to be integrated and clinical pathways redesigned. The parties also told us that patients being treated for cancer by the merger parties currently experience fragmented care. The parties submitted that this is due to organisational boundaries between the merger parties and delays in treatments being made accessible to patients. The parties told us that the merger will allow them to:
    i. change the way in which they provide cancer services and enable them to comply with the Integrated Cancer Systems (ICS) improvement programme;[108]
    ii. provide a new acute oncology service;
    iii. improve the availability of local provision for chemotherapy care; and
    iv. link IT systems so that patients records are easier to share and harder to lose.

181. We assessed whether the benefits described in paragraph 180 above were likely to lead to real improvements for patients or better value for money for taxpayers. The parties told us that they have, from time to time, breached the 62-day cancer treatment target.[109] They told us this was because of delays when making referrals from secondary to specialist care. Reasons for the delay might include poor patient transfer processes and/or lack of capacity at the specialist trust receiving the patient. We were told the merger could improve this situation because a single trust providing both secondary and tertiary services have responsibility for all patients requiring treatment by it. The parties also told us that a failure to set up local chemotherapy services was due to organisational barriers that exist between the three trusts, for example due to Barts and The London being reluctant to send patients back to Newham Trust or Whipps Cross Trust. The CCP considers that the improvements articulated in paragraph 180, would be likely to lead to improvements in patient care.

[108] The ICS work-stream is the implementation of the published and agreed case for change and proposed model of care for cancer services in London, developed by clinical experts and cancer patients at the request of London's health commissioners and NHS London. It proposes a new model of cancer care in London through: earlier diagnosis, care closer to home, improved access to specialist centres and delivery of cancer services through provider networks so patients receive seamless care from diagnosis to treatment to follow up.
[109] The 62-day cancer treatment target is the maximum two month wait from urgent GP referral for suspected cancer to first definitive treatment for all cancers by 2005. This target is one of a number of commitments and targets relating to waiting times for treatment contained within The National Cancer Plan, published in September 2000.

182. We assessed whether the benefits described in paragraph 180 above were likely to be realised. We consider that these benefits are likely to be realised as there is a great deal of support and effort from across the London network to improve cancer care in the ways proposed by the ICS work programme. The CCP considers that the clinical benefits listed in paragraph 180 are part of the proposed model and changes contained within the ICS implementation programme. The CCP notes that linking IT systems, required to share patient records, would be a separate work programme and a lack of detail around how this would be delivered or the cost implications make it difficult to assess this benefit.

183. We assessed whether the benefits described in paragraph 180 above were likely to be realised within a reasonable period following the merger; and whether the benefit has a degree of longevity. We are aware that work has been undertaken for many years by London's cancer networks to deliver seamless pathways of cancer care but issues around patients moving across organisational boundaries remain. We note that the changes arising from the ICS work program are due to be implemented by the trusts during February 2012.

184. We assessed whether the benefits described in paragraph 180 above were merger specific. As we explain in paragraph 180, many of the benefits relating to improved cancer services are part of a wider London program to improve cancer care in London. For this reason the CCP expects that improvements in cancer care are likely to be achieved regardless of whether or not the proposed merger proceeds.

Conclusion on improvements to cancer care

185. We accepted that the benefits described in paragraphs 180 would be likely to lead to improvements in patient care and would be likely to be realised with a reasonable period. We did not consider these benefits to be dependent on the proposed merger. Accordingly we did not weigh these benefits against the expected costs from the merger in our conclusion in paragraphs 221 to 225 below.

BENEFITS FROM STANDARDISATION AND ROLL OUT OF BEST PRACTICE

186. In previous cases we have explained that there tend to be two particular areas of focus when assessing benefits relating to roll out of best practice:[110]
    - whether this type of benefit in each merger can be regarded as uniquely arising from the merger; and
    - the longevity of these benefits taking into account the pace of innovation.

187. The parties told us that agreements to collaborate to achieve a given aim often do not work in the absence of a merger as organisations in the NHS are often slow to share good practice for two reasons:
    - The incentives available for a trust to help another trust are often minimal; and

[110] See for example the CCP's review of the merger of Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership NHS Trust (www.ccpanel.org.uk/cases/Merger_of_Norfolk_and_Waveney_Mental_Health_NHS_Foundation_Trust_and_Suffolk_Mental_Health_Partnership_NHS_Trust.html) where we refer to the diffusion of well-known best practice and the department of health publication available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131687.pdf.

- A trust that might benefit from assistance will often struggle to understand the complexities and nuances of how improvements can be made if expertise and dedicated resources are not made available from the donor trust.

188. The merger parties provided several examples of how they would roll out best practice across the merged organisation, for example by sharing innovative specialist care expertise and knowledge in trauma care or reducing variation in new to follow up ratios for outpatient appointments or reducing the variation of cancelled elective operations on the day of surgery. One example described to us is using the work undertaken at Newham Trust to reduce length of stay (LOS) in acute non-elective services and care of the elderly. This was the most clearly articulated and evidenced example and the following paragraphs outline our assessment of this benefit.

Reducing length of stay in acute non-elective services and care of the elderly

189. The parties explained that Newham Trust has implemented a best practice model and has been ranked as the most efficient for acute elective and non-elective admitted LOS in England by a University of York study. The parties also submitted that annual savings of around £7.2m will be achieved across the merged organisation by reducing LOS to the standard achieved by Newham Trust.

190. The parties explained that the Newham Trust LOS model delivers a much earlier senior physician assessment in the patient's pathway. The parties explained that based on evidence from internal audits all patients cared for under the Newham LOS model went home on average two days earlier and patients who are reviewed within four hours of their initial assessment receive more timely diagnostics and earlier discharge. We assessed whether roll out of LOS best practice is likely to lead to real improvements in services to patients or better value for money to taxpayers.

191. The parties provided evidence around the LOS measures at Newham Trust compared to Whipps Cross Trust and Barts and The London. This showed that patients are discharged in 2.7 days at Newham Trust (with no evidence of any increase in readmission rates) compared to 4.5 days at Whipps Cross Trust and 4.7 days at Barts and The London. Further evidence was provided showing that Newham Trust has a reduced Hospital Standard Mortality Rate and Hospital Acquired Infection rate compared to the other two trusts.

192. The CCP accepts that Newham Trust has lead to real improvement for patients admitted for acute non-elective care and elderly care. The CCP accepts as reasonable the conclusion that the improvements to the clinical model of service delivery has reduced LOS for patients and therefore reduced Hospital Standard Mortality Rate and Hospital Acquired Infection rates. The CCP accepts that reducing LOS therefore allows for a more efficient usage of trust beds and that this can lead to cost savings which can be re-invested in patient care or passed on to the commissioner.

193. We assessed whether the roll out of LOS best practice across the merged organisation was likely to be realised in practice. The parties told us that for cultural reasons making changes to

services was sometimes challenging and that the removal of organisational boundaries would assist with these challenges (see paragraph 172).

194. The CCP considers that the merger will not address the cultural barriers that exist and notes that management at Whipps Cross Trust and Barts and The London has not implemented these changes to service delivery to date, despite the proven benefits to patients. In addition the CCP notes that a loss of competition may have an adverse effect on the improvement gains achieved by Newham Trust. The CCP accepts that revised staff rotas, integrating clinical teams and the application of change management techniques are together likely to facilitate the delivery of the LOS model at Whipps Cross Trust and Barts and The London and on balance considers it likely that this benefit will be delivered.

195. We assessed whether the roll out of Newham's best practice LOS model is likely to be delivered within a reasonable time frame. We were also told by the parties that this benefit would be realised in one or two years as the merger will integrate the services provided by each of the teams at each of the three trusts and address the challenges that have already been experienced when implementing the Newham Trust LOS model at Whipps Cross Trust. We therefore concluded that this benefit was likely to be achieved within a reasonable timeframe following the merger.

196. We assessed whether the Newham LOS best practice model benefit, described in paragraphs 189 and 190 was merger specific. We accept that the implementation of the Newham Trust LOS model by Whipps Cross Trust and Barts and The London could be dependent, at least to some extent, on overcoming cultural differences and staff resistance to change. We refer to this in paragraphs 172 to 174. The parties told us that in the absence of the merger Newham Trust would not have any financial incentive to release clinician time to support Whipps Cross Trust or Barts and The London implementing an improved LOS model. The parties submitted that the merger would remove the need for Newham Trust to receive a financial incentive given that the merged organisation would benefit overall from the Newham Trust clinicians assisting the other hospital sites to implement the improved LOS model.[111]

197. The CCP accepts that in the absence of a financial incentive or the merger Newham is unlikely to assist the other trusts to improve each trust's respective LOS model for non-elective acute care or care for the elderly services. However, given the scale of the savings that could be achieved from implementing the improved LOS model at either Whipps Cross Trust or Barts and The London it seems likely that a financial incentive could be provided by either of these trusts for Newham Trust to lead on implementing its LOS model at each trust's location. The CCP notes that a service level agreement or a staff back-fill arrangement might also be possible to reimburse Newham Trust's financial costs. We have decided that in light of the merger facilitating the ability to overcome cultural differences and staff resistance to change,

[111] The parties' told us that although the clinical lead for the development and implementation of the model at Newham is currently supporting Whipps Cross in the implementation of the LOS model in the care of the elderly ward, this has only been able to take place following the parties' discussions and proposals to merge.

the Newham Trust LOS model is likely to be implemented more quickly than would be the case in the absence of this merger.[112]

Conclusion on reducing length of stay in acute non-elective services and care of the elderly

198. The CCP accepts that the Newham Trust LOS model leads to improved patient outcomes and efficiency savings in the provision of acute non-elective care and elderly care and that the proposed merger facilitates the roll out of this benefit more quickly than would otherwise be the case. We consider that the benefit of facilitating the role out of the Newham Trust LOS model is that Whipps Cross Trust and Barts and The London avoid the cost of having to agree a service level agreement (including a financial incentive to ensure participation) with Newham Trust. We consider that this benefit is facilitated rather than created by the merger and take this into consideration by reducing the weight attributable to this benefit when weighing up this and other benefits against the costs of the proposed merger.

BENEFITS FROM INCREASED SIZE OF THE MERGED ORGANSISATION

199. The merger parties submitted that the merged organisation will be able to deliver benefits to patients and taxpayers as a result of its larger size. Key examples are:
    - Cost savings;
    - Improved staffing arrangements;
    - Better use of estate capacity;
    - Better use of IT required to deliver services;
    - New services; and
    - Improvements to diagnostic services.

200. Many of these size-related benefits relate to economies of scale. We have considered economies of scale in other merger cases.[113] Economies of scale arise when an organisation is able to reduce its average (or unit) costs as a result of increased scale. For example, when providing acute health services, economies of scale would arise if the average cost per patient were to fall when the number of patients increased. This will typically come about if the costs of the inputs needed to provide a service (for example, buildings or staff) do not increase in proportion to the number of patients.[114] We review each of these examples below.

Cost savings

201. The merger parties told us that the merger will generate net cumulative operational savings in the region of £31.8 million over the first five years following the merger as follows: £13 million from staff pay, £12.7 million from clinical standardisation (e.g. LOS best practice) across the

[112] We note that if Newham Trust were to merge with another partner, then another organisation might also be expected to benefit in the same way.

[113] For example, see the CCP's reports for the merger of Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership NHS Trust and the merger of Nuffield Orthopaedic Centre NHS Trust and Oxford Radcliffe Hospitals NHS Trust at www.ccpanel.org.uk.

[114] We also note that the studies of economies of scale, that we are aware of, suggest that economies of scale appear to be fully exploited in hospitals with 200 beds and diseconomies of scale are likely to apply beyond 300 beds ('Is bigger better? Concentration in the provision of secondary care' Posnett, BMJ, 1999; and 'A comparison of hospital scale effects in short run and long run cost functions', Aletras, Health Economics, 1999). We note that each of the merging hospitals sites is currently larger than 350 beds and the proposed merger does not increase the size of any of these hospitals, only the size of the Trust. Working across multiple sites is, if anything, likely to create additional logistical difficulties for the merger parties as is evident in the research on the impact of past mergers. ('Process and impact of mergers of NHS Trusts' Fulop et al, BMJ, 2002; and 'Merger Mania and Hospital Outcomes in the English NHS' Gaynor, Laudicella, and Propper, 2011).

merged organisation, £4.1 million from corporate non-pay savings and £2 million from decreased management cost of Clinical Academic Groups. We were told that these savings could not be made in the absence of the merger by the three trusts individually. None of these figures were supported by any modelling provided to us or sensitivity analysis that we might use to assess their reliability. We were not told how these savings would be achieved. For these reasons we cannot take this benefit into consideration in our assessment.

Improved staffing arrangements

202. The parties submitted that the proposed merger would enable the merged organisation to use existing staff more efficiently and effectively and to recruit new staff more easily. Examples included the establishment of an on-call rota for colorectal surgery and an interventional radiology service. The parties told us that the merger would allow improvements in local access to a number of other specialist services such as cardiac services. We focus on improvements to paediatric services below since this example was best illustrated. We assessed whether improved paediatric staffing arrangements was likely to lead to real improvements in services to patients or better value for money to taxpayers.

203. The parties told us that post-merger the paediatric teams would work across all sites of the merged organisation and this would improve quality by providing additional scheduled consultant sessions. We accept that more efficient and effective use of staff can lead to real improvements to patients.

204. We were told that none of the merging parties are compliant with the standards set by the Royal College of Paediatrics and Child Health (RCPCH). The parties told us that to become compliant they would need to recruit new paediatric consultants and that the merger would enable them to do so.[115] The CCP accepts that compliance with the RCPCH's standards would lead to real improvements to patients.

205. We assessed whether the benefits described in paragraphs 202 to 204 above were likely to be realised. We were told that there were no plans to stop or reduce the provision of paediatric services from any of the merger parties' sites. The merger parties did not provide details of how the consultant rota might be expected to change, or increase capacity, as a result of the merger. We therefore concluded it was unlikely that existing paediatric clinicians would be able to work additional sessions.

206. We then assessed whether the merged organisation would be likely to recruit staff more easily. The parties told us that the ability to rotate staff at different hospital sites, without the need for complex contracting arrangements or travel between sites, would make staff recruitment easier, but did not provide any evidence to substantiate this. We consider that

[115] The parties told us that the review by the RCPCH, published in April 2011, states that a consultant-delivered model of care is the best way to improve paediatric services, as consultants (as the most senior clinicians) make better decisions about appropriate care more quickly. We were also told by the parties that the review sets out ambitious aims for paediatric care which partly relies on recruiting an adequate work force. The parties submit that trusts are being encouraged to increase the number of paediatric consultants to ensure they provide improved out-of-hours on-site presence. Of the ten standards set out in the RCPCH review (which describe the level of paediatric specialist clinical input every child or young person admitted to a paediatric department with an acute medical problem should receive) the parties emphasise that standard number eight best illustrates how paediatric rotas might be improved by the merger. This standard recommends that paediatric rotas should be made up of at least ten whole time equivalent consultant staff, in order to provide the staffing levels required to achieve the remaining standards.

recruitment of UK-based staff would necessarily come at the expense of other NHS organisations and therefore is unlikely to be a net benefit to patients or taxpayers. We note that there are also other factors which are relevant to recruitment (for example, the reputation of the hospital, terms and conditions, and skill-mix of the staff). We therefore concluded that it was unlikely that the merger would make staff recruitment easier.

Better use of estate capacity

207. The parties told us that the merger would allow the merged organisation to better manage surgery lists by utilising theatre capacity across the three major sites so that elective surgery theatres are protected from interruption from emergency surgery (and vice versa). The parties also told us that the Gateway Centre in Newham has the capacity to treat more patients. By treating patients at the Gateway Centre in Newham the merger parties expected capacity would be released for emergency surgery at the Barts and The London hospital sites.

208. We agree that better use of estate capacity could lead to real improvements for patients or better value for money for taxpayers. Unfortunately the parties did not provide evidence to enable to us to assess the likelihood of these changes being implemented. We were not told how this benefit would be implemented and accordingly cannot take it into consideration in our assessment.

Better use of IT to deliver services

209. The parties told us that a shared IT system would enable the multiple hospital sites to access the details of each patient in a consistent way which means that the patient could receive a similar experience when presenting for treatment at any of the hospital sites and reduces the need for duplicate tests. Unfortunately the parties did not provide any details on how or when this IT investment is likely to be undertaken or why this investment is created or facilitated by the merger. Accordingly we cannot take this benefit into consideration in our assessment.

New services

210. The parties told us that they proposed to develop new services, for example centralised acute oncology unit, breast and colorectal chemotherapy and a cancer treatment centre at Whipps Cross hospital, and a number of chemotherapy treatments at Newham hospital. They also said they proposed to develop a step-down service for neuro-rehabilitation patients. The parties told us that access to a greater critical mass of patients makes development of this care more viable. The parties also told us that the critical mass of population that the merged organisation would become responsible for might enable the appointment of a Hepatitis C specialist. The parties also told us that they planned to manage and improve services across eight clinical academic groups (these are the proposed groupings of clinical services post merger). These services are Ambulatory Care (including Tower Hamlets Community Health Services, Dental Hospital, and Renal Services), Cardiovascular Services, ECAM (Emergency Care and Acute Medicine), Children's services; Cancer; Women's services, Surgery, Clinical Support services – pharmacy, pathology, imaging and therapies (CSS).

211. Although new or improved services seem likely to improve care for some patients, they would all require commissioner support and funding and no evidence has been provided that this is

likely, or even been discussed. Also no evidence on planning for developing these services has been provided to the CCP.

212. The parties also told us that the merged organisation would be able to pool resources to undertake social marketing campaigns to improve the health of the population and research to tackle local health problems. We were also told that the experience of Tower Hamlets Community Health Services (part of Barts and The London) could be shared amongst Whipps Cross Trust and Newham Trust to improve services in the community. The CCP is unable to take the benefits set out above relating to new services into consideration in our assessment due to a lack of evidence to demonstrate a real improvement to services for patients as well as a lack of detail about their likely implementation and realisation.

Improvements to diagnostic services

213. The parties submitted that the merged organisation would be able to reconfigure some services which would lead to more efficient and effective service provision. They illustrated this by reference to planned improvements in pathology services which can be summarised as follows:
    i. Reconfiguration of pathology services which were recommended by the Carter Review (Report of the second phase of the Review of Pathology Service in England, 2008) and The NHS London Clinical Expert Panel and implementing efficiencies identified in a report provided by consultants to NHS London through a reorganisation of service provision;
    ii. the merged organisation could do more pathology tests in-house and negotiate a better price for those tests that had to be outsourced because of increased volumes (estimated saving £200,000 per annum);
    iii. one-off savings from avoiding procurement costs for out-sourced pathology services;
    iv. reducing staff numbers for histopathology due to staff restructuring and centralising the service on one site; and
    v. removing the cost paid to the Homerton University Hospital NHS Foundation by Whipps Cross Trust for the provision of consultant cover as Barts and The London have the capacity to provide this cover immediately.

214. We considered whether the benefits described in paragraph 213 above were likely to lead to real improvements for patients or better value for money for taxpayers. The parties submitted that a reconfiguration of pathology services would be likely to reduce errors and increase the speed of results being returned. We agreed that these were real improvements to patients. We also decided that more efficient service provision would lead to better value for money for taxpayers. However, we note that that there will be costs incurred from reconfiguring the pathology services as new IT systems and transport logistics (to move pathology specimens between the core and local sites) will have to be developed. These costs have been estimated by the parties to be £2.1 million for IT system development. No costs have been provided for transport logistics, although we note that Barts and The London are in the process of tendering for the service. We also note that Barts and The London already provides the pathology services for itself and Newham Trust and so these improvements would be focused on Whipps Cross Trust.

215. We considered whether the benefits described in paragraph 213 above were likely to be realised. The parties told us that previous attempts to improve pathology services and networks over the last ten years have failed to deliver improvements in quality or cost of providing the pathology services. We note the strong support for the rationalisation of pathology services across London by the London SHA and we consider that at least some of the benefits anticipated by the parties are likely to be realised, although we have not been provided with any evidence on the likely scale of those benefits.

216. We assessed whether the benefits described would be delivered within a realistic time frame. We were told that the initial organisation of pathology services to concentrate volumes and reconfigure rotations could be expected to be delivered within two years of the merger, along with cost reductions and service improvements. We note the past difficulties in implementing improvements to pathology services over the last decade. However, we also note the support from NHS London to the current work programme and accept that the merger may facilitate the benefits described more quickly and within a reasonable time frame.

217. We considered whether the benefits described in paragraph 213 above were merger specific. The parties told us that only the merger would create the scale required to realise the benefits that have been described. The parties conceded that it might be possible to coordinate and develop an agreement for a single core lab with local sites, but this has not been achieved, despite the intention to do so, at any time in the past ten years. London SHA told us that the work programme for pathology services in north-east London is further advanced than other areas of London, in the view of London SHA this was due to the parties working more closely together, in discussion with other north-east London providers, as part of considering the case for a potential merger. The CCP considers that the rationalisation of pathology services is likely to be facilitated by the merger and to be achieved more quickly.

Conclusion on improvements to diagnostic services

218. The CCP accepts that reconfiguring pathology services is a benefit that is likely to lead to a real improvement in services to patients and better value for taxpayers. We conclude that this benefit is likely to arise within a reasonable time frame. We consider that this benefit is facilitated rather than created by the merger and take this into consideration by reducing the weight attributable to this benefit when weighing up this and other benefits against the costs of the proposed merger.

RESEARCH AND DEVELOPMENT BENEFITS

219. The parties told us that the merger, which brings together a major acute hospital with a broader community population available from the local hospitals, would improve the opportunities for research. However, the parties did not explain what might be expected to improve, advance more quickly or benefit patients or taxpayers as a result of having a broader population base. In this context the CCP notes that many research collaborations have been advanced in the absence of a merger of organisations. For these reasons we did not take this benefit into consideration in our assessment.

SUMMARY OF CONCLUSIONS ON MERGER BENEFITS

220. The parties told us that they expected the merger to result in a large number of wide ranging benefits. We assessed all of these benefits and decided to take two into consideration when weighing up the costs and benefits of the proposed merger. Those were rolling out the Newham Trust LOS model in Whipps Cross and Barts and The London which we accepted was likely to be facilitated by the proposed merger; and reconfiguring pathology services which we also accepted was likely to be facilitated by the transaction.

CONCLUSIONS – COSTS AND BENEFITS

221. In the preceding sections we concluded that there are two benefits that, to varying degrees, we can take into account in our assessment of the effects of the merger relating to the provision of pathology services and length of stay for elderly patients. In this section we weigh these benefits against the adverse effects identified in our assessment of merger costs.

222. We found that the merger led to costs to patients and taxpayers through the removal of a competitive constraint in respect of the provision of both routine elective and non-elective services at Newham Trust. For routine elective services we concluded that Barts and The London and Whipps Cross hospitals impose an important competitive constraint on the services provided from Newham hospital. We concluded that although there are a number of other providers of these services in the north-east London area, Barts and The London and Whipps Cross hospitals are the next best alternatives for people that are likely to access services provided at Newham hospital (with the exception of ophthalmology services). The merger removes important competitive constraints for routine elective services and accordingly significantly reduces choice of hospital provider for people living in Newham.

223. For routine non-elective services we concluded that in the foreseeable future, but not for at least two years, commissioners would be likely to review whether these services should be provided from Newham hospital, Whipps Cross hospital and Homerton hospital. We concluded this creates an incentive for the management of Newham hospital, Whipps Cross hospital and Homerton hospital to invest in maintaining and improving services to improve the likelihood of being permitted to continue to provide these services. We concluded the merger would significantly reduce this incentive at Newham hospital because if commissioners decided not to commission these services from Newham hospital most of Newham hospital's patients would be treated instead at Barts and The London or Whipps Cross, as the next closest hospitals. This would mean that the merged organisation would still be paid for treating these patients. Accordingly, we found that the merger would reduce competition for non-elective services at Newham Trust.

224. The parties told us that they expected the merger to result in a large number of wide ranging benefits. We assessed all of these benefits and decided to take two into consideration when weighing up the costs and benefits of the proposed merger. Those were rolling out the Newham Trust LOS model in Whipps Cross Trust and Barts and The London which we accepted was likely to be facilitated by the merger; and reconfiguring pathology services which we also accepted was likely to be facilitated by the transaction. The CCP's merger guidelines explain

that weighing of costs and benefits is not a mathematical exercise, but rather an assessment to which the Panel brings its expert judgement.[116]

225. In the current case we consider that the benefits we have identified are not material and do not outweigh the costs. In particular, we note that although the merger may to some extent facilitate the reconfiguration of pathology services and the rolling out of the LOS model in Barts and The London and Whipps Cross, these benefits are not significant and do not outweigh the costs for patients and taxpayers in Newham. Accordingly we conclude that this merger is inconsistent with Principle 10 of the Principles and Rules.

ADVICE AND RECOMMENDATIONS

226. We have found that the proposed merger will give rise to a material cost for patients and taxpayers as a result of a loss in patient choice and competition in respect of routine elective and non-elective care provided from Newham Trust. However, we considered that it is unlikely that the proposed merger would result in a reduction in, or removal of, competition in respect of the services provided from Barts and The London or Whipps Cross Trust.

227. We accepted that the merger is likely to benefit patients and taxpayers by facilitating the reconfiguration of pathology and accelerating the reduction of length of stay care for elderly patients at Barts and The London and Whipps Cross. However, we did not consider that these benefits are significant. We concluded that the benefits that we have identified do not outweigh the costs in this case. Accordingly we decided that this merger is inconsistent with Principle 10 of the Principles and Rules.

228. The analysis, advice and recommendations set out in this report have been given by the CCP on the basis of information it has received to date. Should there be any material change to the terms of the transaction we expect the change to be referred back to us for consideration.

Cooperation and Competition Panel
15 December 2011

[116] See paragraph 6.111 of the CCP's merger guidelines.

APPENDIX 1: BACKGROUND TO THE MERGER PARTIES

1. In this Appendix we explain the current and expected financial positions of each of the merging Trusts and the options each Trust considered to improve their future financial sustainability.

WHIPPS CROSS TRUST

2. Whipps Cross Trust had an income of £232.7 million in 2009/10 and delivered a surplus of £0.23million although it was expected to operate a deficit of £5.2 million in 2010/11, £3.9 million in 2011/12 and £4.1 million in 2012/13. As part of its Cost Improvement Programme (CIP) Whipps Cross Trust is aiming to deliver cost savings of around 12.5 per cent in 2011/12, and further cost savings of between 4 and 6 per cent each year going forward.

3. Over the period 2005/06 to 2006/07, Whipps Cross Trust incurred a total deficit of £26.7m.[1] This deficit led to cash shortfalls within the Trust which led to the Department for Health granting a loan of £26.3m with a term of 12 years. Since then the Trust has not been able to deliver sufficient cash surpluses to offset the value of annual interest and capital repayments on the loan. The repayment schedule generated further cash short falls which Whipps Cross Trust told us were being overcome by management of working capital, short term cash advances from PCTs and under spending against the planned capital programme.

4. To address these longstanding funding issues, in 2008/09 NHS London identified Whipps Cross Trust as one of ten financially Challenged Trusts. As part of these arrangements, an agreement was reached to clear Whipps Cross Trust's historic deficit. The allocation of these funds was overseen by the Challenged Trust Board (CTB) which was tasked with ensuring recipient Challenged Trusts had credible plans for the future so as to avoid the need for recurrent funding support. As discussed below, the financial sustainability issues identified by the CTB were such that funding support was not agreed quickly. In the meantime Whipps Cross Trust continued to experience cash shortfalls culminating in the Department for Health granting Whipps Cross a further loan of £16.2m in March 2011. The Trust was awarded a 'Weak' rating for financial management in 2009-10.

5. In addition to these on-going cash shortfalls, Whipps Cross Trust needs to undertake a significant capital investment programme estimated at around £50m, both to correct for previous underinvestment and also to respond to the projected increased patient volumes due to the planned service reconfigurations of maternity and emergency services in NE London.

6. Whipps Cross Trust has not made an application to be a NHS Foundation Trust. They told us that they have not progressed an application because based on financial analysis undertaken

[1] WCUHT told us this was due to their MFF being 'too low', various operational budget overruns, impairment charges and contributions to risk pooling schemes to support the local health economy.

internally they did not consider the trust would be able to meet Monitor's financial standards.[2]

7. As discussed above, Whipps Cross Trust is part of the Challenged Trust programme. The CTB funding allocation process involved a two stage assessment. During stage 1 the CTB sought to establish whether a Trust, its existing governance structures and future plans had the capability to address the underlying problems. The second stage involved a detailed assessment of the financial position of the Trust with a view to agreeing a cost-effective funding settlement. In July 2009 WCUHT was told that it had not passed the first stage of the CTB process as it did not have a credible plan for its future. In particular, WCUHT was told to resubmit a revised solution which included changes to existing governance arrangements and service strategy. Since that decision it remains unclear at this stage the discussions between WCUHT and the CTB. However, WCUHT told us that CTB funding of £26.3m (to write off outstanding debt) has been agreed, but is contingent on successful organisational reconfiguration. The CTB agreed on 8 December 2011 that the merger business case meets the criteria set for the release of this funding.

8. To improve their financial sustainability, Whipps Cross Trust has considered a number of alternative merger options. These were considered in two jointly commissioned options appraisal exercises. The first was undertaken in conjunction with Homerton University Hospital NHS Foundation Trust and Newham Trust in late 2009, and the second undertaken with Barts and The London and Newham Trust in late 2010. Each exercise consisted of a high level analysis of the pros and cons of different options undertaken at Board Level (with no detailed financial/clinical analysis undertaken to aide decision making). Detailed financial/clinical analysis was only undertaken on the preferred option to see if it was a viable option.

9. In the first options analysis, Whipps Cross Trust considered the following options in their short list:
    - Three-way merger with Homerton University Hospital NHS Foundation Trust and Newham Trust. This was the preferred option at the time although the deal collapsed because Homerton University Hospital NHS Foundation Trust wanted to acquire the Trusts (in order to minimise risks to its FT status) whereas Whipps Cross Trust and Newham Trust were seeking a 'merger of equals' and assurances that key services would be secured and capital investment forthcoming.
    - Merge with another acute Trust: Homerton University Hospital NHS Foundation Trust, Newham Trust, Barts and the London or Barking, Havering and Redbridge University Hospitals NHS Trust.

10. In the second exercise, Whipps Cross Trust considered the following options:
    - Merge with Barts and the London.

[2] To be an NHS Foundation Trust an organisation has to have a minimum financial risk rating of 3 or more at authorisation and in the first full year of projections unless exceptional circumstances exist. Whipps Cross Trust considered that it could only achieve a risk rating of 2, over a three year period.

- Merge with Newham Trust, and then merge with another acute NHS Trust, with the following identified: Barking, Havering and Redbridge University Hospitals NHS Trust, North Middlesex University Hospital NHS Trust, 'other London district general hospitals'
- Merge with Newham Trust, and then be acquired by an NHS Foundation Trust, with the following identified:, UCLH (acute), Guys and St Thomas' (acute), East London FT (mental health), North East London FT (mental health)
- Franchise model of service provision (e.g. Hinchingbrooke)

NEWHAM TRUST

11. Newham Trust had income of £169.7 million during 2009/10 and made a surplus of £0.058m. However, in 2010/11 forecast income was expected to decline to £163.7m and costs were not reduced sufficiently resulting in a forecast deficit of £7.5m (actual income and deficit in 2010/11 were £166.7 million and £7.9 million respectively). Current forecasts are for a surplus of £0.1m in 2011/12 and a deficit of £4.3 million in 2012/13. In addition, Newham Trust told us that it has a historic deficit[3], has poor liquidity and has reached its Tier 2 borrowing limit. The Trust was awarded a 'Fair' rating for financial management in 2009-10.

12. Newham Trust constructed a new maternity unit in 2009/10 utilising £6.5m of Public Dividend Capital and a £9.25m capital investment loan from Department for Health payable over 10 years. They also have a £2m capital investment loan from Department for Health repayable over 5yrs which was approved in 2009/10 for their general capital programme. In terms of revenue (rather than capital programme) support, Newham Trust obtained a working capital loan of £5m repayable over five years in 2010/11 and received a £1m advance from PCTs in north-east London.

13. The Department for Health required Newham Trust to take part in national turnaround programme in 2006/07 and 2007/08[4] which resulted in £19m of savings in 2006/07 (against £20.1m target). As part of its Cost Improvement Programme, Newham Trust delivered cost savings of £12m in 2009/10, although a significant part of the 2010/11 CIP programme was undelivered in that year. Despite some progress in addressing long-standing deficit issues, from 2008/09 NUHT has been part of the CTB arrangements discussed above in relation to Whipps Cross Trust.

14. Newham Trust has not made an application for NHS foundation trust status. They told us that they have not progressed an application because based on financial analysis undertaken internally they did not consider the trust would be able to meet Monitor's financial standards.[5]

15. Based on internal financial analysis they took the view that, based on analysis of key financial metrics, it would not be in a position to achieve NHS Foundation Trust status as standalone entity because it would not achieve a risk rating above 2 each year over a three year period

[3] This was due to a number of factors including: changes to commissioning which reduced activity, tariff deflator, PFI costs and underutilisation of Gateway Surgical Centre, delays in delivering cost savings.
[4] This involved appointment of external advisors and a turnaround director.
[5] To be an NHS Foundation Trust, an organisation has to have a minimum financial risk rating of 3 or more at authorisation and in the first full year of projections unless exceptional circumstances exist. Whipps Cross Trust considered that it could only achieve a risk rating of 2 over a three year period.

for a number of reasons, including: underlying historic debt; failure to deliver target CIPs in 2010/11; PFI cost pressures (from 2009/10) and its poor cash position.

16. In terms of Newham Trust's progress through the CTB process, unlike Whipps Cross Trust they passed the first stage of the CTB's assessment in June 2009. This indicated the CTB thought NUHT had a 'viable future'. In explaining its decision and in setting up the second stage of the assessment, the CTB asked Newham Trust to 'consider a wider range of options for the future; in particular to consider options for merger as well as vertical integration'. However, in early 2010 the CTB announced that Newham Trust would not undergo the second stage of the assessment as planned (at that time other Challenged Trusts had funding allocated) 'pending the outcome of discussions within the sector.'[6] The CTB work stream was subsequently superseded by the initial three-way merger proposal with Homerton University Hospital NHS Foundation Trust and Whipps Cross Trust.

17. The merger parties told us that the CTB has allocated Newham Trust £1.5m to enable it to meet the cumulative break-even target by 31 March 2011. However, the release of funds is being delayed until a final decision has been made on the proposed merger with Barts and the London and Whipps Cross Trust (the CTB agreed on 8 December 2011 that the merger business case meets the criteria set for the release of this funding). It would appear the merger has delayed the release of CTB funds, although it remains unclear whether Newham Trust would have received funds in the absence of any merger or the value of these funds. Newham Trust told us that if the proposed merger does not take place it does not expect to be in position to resolve its accumulated deficit as stand-alone entity. However, they do not rule this out entirely as they go on to say that 'even if historic debt was cleared by CTB as standalone entity, Newham Trust does not expect to return to surplus within next three years.'

18. To improve their financial sustainability, Newham Trust has considered a number of alternative merger options. Newham Trust was part of the two option appraisal exercises discussed above in relation to Whipps Cross Trust. In the first exercise, Newham Trust considered the following options in their short list:
    - Three-way merger with Homerton University Hospital NHS Foundation Trust and Whipps Cross Trust. As discussed above, this was the preferred option at the time but has not progressed.[7]
    - Merge with another acute Trust: Homerton University Hospital NHS Foundation Trust, Whipps Cross Trust or Barts and the London.

19. In the second exercise, Newham Trust considered the following options:
    - Acquisition by Homerton University Hospital NHS Foundation Trust
    - Merge with Whipps Cross Trust, and then merge with another acute NHS Trust, with the following identified: Barking, Havering and Redbridge University Hospitals NHS Trust, North Middlesex University Hospital NHS Trust, 'other London district general hospitals'

[6] http://www.london.nhs.uk/webfiles/board/10 per cent20Meeting per cent2027 per cent20Jan/4.3 per cent20Enc per cent20M per cent20CTB per cent20update per cent20(2).doc

[7] The parties submitted that 'NUHT pursued initial merger conversations with the Homerton NHS FT. However, these negotiations broke down as it became apparent that the significant cultural differences between the trusts that would make developing the relationships necessary for a successful merger very difficult.

- Merge with Whipps Cross Trust, and then be acquired by a FT, with the following identified: UCL (acute), Guys and St Thomas' (acute), East London FT (mental health), North East London FT (mental health)

- Franchise model of service provision (e.g. Hinchingbrooke)

BARTS AND THE LONDON

20. Barts and the London had income of £707 million in 2009-10 and delivered a surplus of £11.4m. It is expecting to deliver a surplus of £6m in 2010-11 (excluding impairments), £2.6m in 2011/12 and £2.7m in 2012/13 on a (Department of Health basis). Barts and the London has not suffered from any financial problems in the last 5 years and has delivered on its financial targets for each of the past 5 years. It achieved efficiency savings (CIPs) of £37m (5.7 per cent of turnover) in 2010/11 but is forecasting CIPs of £41.2 million (5.5 per cent of turnover) in 2011/12 and £40.8 million (5.4 per cent) in 2012/13. The Trust was awarded a 'Fair' rating for financial management in 2009-10.

21. Barts and the London is nearing completion of a £1.15 billion PFI redevelopment of its estate. The first phase of the redevelopment (the cancer centre) opened in March 2010 and will be followed by the new Cardiac centre in 2014. The new Royal London Hospital will open in early 2012. PFI repayments will represent just below 15 per cent of Barts and the London's turnover when they commence in early 2012. This is higher than DH guidelines of 12 per cent. Barts and the London

22. Barts and the London has previously made an unsuccessful application to be considered a NHS Foundation Trust. It submitted an Integrated Business Plan to the Department for Health in April 2007 for approval to proceed with its application as part of Wave 5 but the Department for Health declined to support the application at that time (citing unrealistic financial planning assumptions). The application was not resubmitted.

23. As part of internal discussions to secure the financial sustainability of the Trust, Barts and the London undertook a separate options appraisal exercise from Newham Trust and Whipps Cross Trust. Barts and the London considered two options: continuing in its existing configuration or merging with Newham Trust and Whipps Cross Trust. Both options were supported by commissioners and NHS London and it was considered that both had risks attached to them in terms of securing financial sustainability. A Board paper identifies the options as fairly close alternatives and states 'a reasonably positive argument in favour of the merger option, albeit not an overwhelming one'.

APPENDIX 2: MARKET DEFINITION

1. In this Appendix we consider the appropriate product market definition to adopt in order to analyse the competitive effects of the merger. The outcome from a market definition exercise is an identification of those other services that constrain the ability of the merged entity to increase its prices or reduce quality following a merger. This can then provide a framework for analysing the competitive effects of a merger through identifying providers of competing services and, for example, examining the market shares of different providers of those services.

2. Whether other services constrain the ability of a merged entity to increase prices or reduce quality (and should thus be considered as belonging to the same market as services provided by the merging organisations) depends on whether they represent an effective alternative to which patients and/or commissioners could switch. The methodology that the CCP uses to define a market is the hypothetical monopolist test (see paragraphs four to seven below).

3. There are two dimensions to a market: a product dimension (which may, for example, correspond to a service (for example, hip replacement surgery) or a group of services (for example, acute inpatient services), and a geographic dimension (which may correspond to a specific area).

THE HYPOTHETICAL MONOPOLIST TEST

4. In line with best practice, and consistent with our 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.

5. The test begins by considering the substitute products or services supplied by the merging organisations. The following question is then asked: if there were only one supplier (a hypothetical monopolist) of the service in question, could the hypothetical monopolist raise prices or reduce service quality profitably, by a small but significant amount?[1] If this would not be profitable, because customers would switch to other services (demand-side substitution), or new providers would start to supply the service (supply-side substitution), then the closest substitute products or services are added to the group and the process is repeated. The product market is defined at the point at which a hypothetical monopolist is able to increase prices (or reduce quality) profitably for those services.

6. Similarly, in relation to the geographic market, the hypothetical monopolist test begins by considering the area where the merging organisations both supply products or services. The question is then asked: if there were only one supplier in the area in question, could the hypothetical monopolist maximise profit by raising prices or reducing service quality by a small but significant amount? If this would not maximise profits, because customers would

[1] We assume that it is costly to increase or maintain quality and so a hypothetical monopolist might be able to increase revenue if it can cut costs without losing too many patients. The loss of patients (and therefore of profitability) due to cutting costs will depend on both the availability of alternatives (in product and geographic space) to patients and/or commissioners, and their propensity to switch in response to a fall in quality. For example this threat of patients switching in response to a change in quality is consistent with the conclusions reached by Propper, Gaynor, and Moreno-Serra in 'Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service' July 2010.

switch to services provided in other areas, then the area is widened accordingly. The relevant geographic market is defined as the set of services in the smallest area that could, hypothetically be monopolised profitably. The scope of geographic markets often depends on transport costs and they are usually defined based on providers' locations. By 'profitably' we mean surplus generating and the key issue is whether the loss of sales would be sufficient to offset the increased profits that will be made from retained sales.

7. We note that there is not always an obvious starting point for the test. The competitive constraints between providers of different sizes, providing different services in different locations are likely to differ. Further, any two providers may not necessarily each impose an equal competitive constraint on the other. As such, the starting point for the test can affect the outcome and so we begin the test at different starting points to check for asymmetric constraints.

HEALTHCARE SPECIFIC CONSIDERATIONS

8. On the demand-side healthcare is different to other sectors as a result of the role played by both patients and commissioners, both of whom can be viewed as purchasers of healthcare services, 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.

9. The ability of patients or commissioners to access alternative service providers will be affected by whether, for example, patient choice or competitive tendering is used to select the provider that supplies services to patients. Our assessment of product market definition will deal with these two areas of competitive interaction.

PRODUCT MARKET

10. In order to define the relevant product market we need to consider substitution possibilities on both the demand side (i.e. substitution by patients/commissioner) and the supply side (i.e. substitution by providers) of the market. In addition, because the consumers (patients with advice from clinicians) and the purchaser of healthcare (commissioners) are split into two groups, we will also consider these two groups' behaviour separately when addressing demand side substitution.

11. We begin by considering demand side substitution, that is, whether patients/commissioners would choose to switch provider if the quality of the service declines.[2] We then consider the supply side, that is, whether other providers would choose to switch to providing the service if quality of services declines.

Demand side substitution in the product market

12. An analysis of the demand side should consider whether consumers (patients with advice from clinicians) or purchasers (commissioners) would choose to switch product or service if the quality of the product or service provided by the hypothetical monopolist declined.

[2] We refer to patients choosing a provider though we recognise that when a patient is offered a choice of provider their decision taken in consultation with their GP.

13. Given the nature of the requirements of a patient needing to be treated for a given condition, each individual healthcare service or procedure provided should be considered to constitute its own separate market. That is because a patient's diagnosis will determine the treatment that (s)he requires. For example the patient is unable to opt to have a replacement knee if (s)he is unsatisfied with the quality of the replacement hip surgery that a hypothetical monopolist provider is offering to treat a broken hip.

14. Similarly on the purchaser side, the commissioner, in fulfilling its duties to commission the health services that the local population needs, will not choose to commission more knee surgery as a result of a hypothetical monopolist provider of hip surgery providing a poor service.[3]

15. Therefore there is no scope for demand side substitution. In other words, from the patients' as well as from the Commissioners' perspective, each service or procedure provided by a hospital constitutes a separate relevant product market.

Supply side substitution in the product market

16. The analysis of the supply side considers whether an alternative supplier (a hospital) would have the ability and incentive to switch easily and in a timely fashion into the provision of a service or procedure in the event of a small but significant worsening in the quality of provision of the service in question by a hypothetical monopolist supplier.

17. Based on evidence from clinicians it is our view that supply-side substitution possibilities exist within each specialty. However these possibilities tend to be asymmetric ones. For example specialist/tertiary providers of a given specialty have the highly trained staff and necessary technology/equipment to also provide more routine services, even if doing so would be comfortably within their capability. In contrast, the opposite does not hold. Routine providers are unlikely to have the necessary staff and technology/equipment to be capable of quickly providing specialist/tertiary services.

18. Similarly non-elective providers have access to emergency department backup and intensive care units. They will therefore have the capability to provide non-emergency treatment of the same routine specialties that they provide under emergency conditions, even if doing so does not require the use of their emergency backup.[4] However, as above the opposite does not hold. Providers without emergency departments are unlikely to be able to quickly provide emergency services.

19. Therefore we asymmetrically expand the market to a specialty level. For example, a market:
    - for routine ophthalmology in which existing specialist/tertiary and routine ophthalmology providers compete;[5] or
    - for routine orthopaedics in which routine trauma orthopaedic providers and routine elective orthopaedic providers (and specialist/tertiary orthopaedic providers) compete.

[3] If the quality of the hip service provided by the hypothetical monopolist were to decline significantly the commissioner may choose to stop commissioning the service altogether (and may use these funds to commission other services). For a commissioner to refuse to fund a procedure is possible, however it is unlikely to result from a small reduction in quality, as postulated in the hypothetical monopolist test.
[4] For example, we note that consultant are trained and registered within a particular specialty and increasingly sub-specialty.
[5] As distinct from a market for tertiary ophthalmology in which only tertiary ophthalmology providers compete.

20. However, supply side substitution possibilities are less likely to occur between specialties since a provider of one specialty may not necessarily be in a position to provide another specialty. For example, a provider of routine elective orthopaedics would not be in a position to provide routine elective gastroenterology using its existing staff, facilities and equipment.[6] It might be able to purchase the new staff, facilities and equipment that it requires to provide the service relatively quickly at additional cost. However if these costs or liabilities are sunk then while the provider may still enter the relevant market relatively easily, this would not constitute supply side substitution. Similarly in order to establish that supply side substitution was likely to occur in a particular case we would need to consider whether the provider in question had the available spare capacity (e.g. beds, operating theatre slots) and the incentive (e.g. the ability to earn a higher margin than was possible from its current services) to substitute into providing the product. There may also be some minimum sufficient volume required to gain accreditation as a clinically safe provider of certain services.

21. The role of supply side substitution is therefore likely to vary on a case by case basis and therefore we would not rule out the possibility that each specialty constitutes a separate relevant product market.

Clustering

22. As a result of the product market definition consideration above, we treat each specialty as a separate relevant product market. However, for the purpose of assessing the merger, specialties which face similar constraints and which are provided by the same set of competitors are analysed together in a cluster.[7]

RELEVANT PRODUCT CLUSTERS FOR THE ASSESSMENT OF THE MERGER

23. For the purpose of our analysis we considered the following service clusters:
    i. A routine elective services for admitted patients cluster (referred to as the 'routine elective cluster'), the competitor set will include all providers of NHS-funded routine and specialist/tertiary elective and non-elective healthcare services;
    ii. A routine non-elective services cluster, the competitor set will include all providers of NHS-funded routine and specialist/tertiary non-elective healthcare services;
    iii. A community health services cluster, the competitor set will include all providers of NHS-funded community, primary, routine elective, routine non-elective and specialist/tertiary healthcare services;
    iv. An outpatient services cluster, the competitor set will include all providers of NHS-funded routine elective, routine non-elective and specialist/tertiary healthcare services.

24. For specialist/tertiary healthcare services we did not adopt a clustering approach and analysed each specialist/tertiary service separately.[8] Note that the service clusters identified above are

[6] See submission to NHS Wiltshire Conduct complaint.
[7] In some cases a provider of a range of specialities may not face similar constraints and the same set of competitors across all of its specialties. Some of its specialties may face greater or lesser constraints, for example as a result of the additional independent sector capacity funded by commissioners in certain specialities. In that case we may examine the speciality outside the clusters that we define below.
[8] Specialist services include tertiary services. The difference between the two is that only hospital consultants can refer a patients to tertiary services while GPs are able to refer patients to non-tertiary specialist services.

stratified across all specialties in order to allow us to consider the asymmetries discussed in paragraphs 16 to 21.[9] However, in some cases a provider might not face similar constraints and the same set of competitors across all of its specialties. For example some of its specialties may face greater or lesser constraints than others, perhaps as a result of the additional independent sector capacity funded by commissioners in certain specialities. In that case we may decide to examine the speciality outside the clusters that we define here.

Routine non-elective cluster

25. Routine non-elective healthcare services include accident & emergency and maternity services. They are provided by NHS hospitals (large and small). Private provision of these services is unusual for NHS patients.

26. Providers of one non-elective specialty often also provide other non-elective care specialties. For example, in this case the parties overlap in the provision of most non-elective care, which is also provided by neighbouring hospitals. Therefore, for the provision of each of these routine non-elective services, the parties and other hospitals face the same set of competitors. We will therefore analyse these services all together. However, where we expect that one service might be facing a different set of constraints from other services in this cluster, we will analyse the service separately

27. We also considered whether to include in this cluster providers who only provide routine elective services (but not non-elective services). However, we understand that to provide non-elective services a provider would need to have an accident and emergency department and an Intensive Care Unit. This might involve either building these facilities or having the chance to operate an existing facility. We understand the cost of building an accident and emergency department to be in the order of several million pounds.[10] In addition, an accident and emergency department would require a change in consultant types and other support services (such as putting aside theatre capacity for emergency lists and having diagnostic facilities) to provide non-elective services.[11] We are aware of one instance where a commissioner has granted a third party the right to operate an existing accident & emergency facility although we understand this model of provision is unlikely to be implemented across other NHS hospitals in the immediate future.[12] Therefore, while this might hypothetically be possible, it does not appear likely and so we did not include providers of only elective services in this cluster and we do not include providers of elective care in the markets that we refer to as the 'routine non-elective cluster'.

Routine elective cluster

28. Routine elective services are provided by NHS hospitals (large and small) across, Independent Sector Treatment Centres and by private hospitals that hold NHS Standard Acute Contracts. Providers of one elective care specialty often also provide other elective care specialties. For example, in this case the parties overlap in the provision of most elective care, which is also

[9] That is, routine/specialist, elective/non-elective for each different specialty.
[10] See CCP report on the merger between Nuffield Orthopaedic Centre NHS Trust and Oxford Radcliffe Hospitals NHS Trust.
[11] For example it would require consultants specialising in accident and emergency medicine.
[12] Circle Healthcare has been awarded a 10 year contract to manage the provision of all acute hospital services at Hinchingbrooke Hospital.

provided by neighbouring hospitals. Therefore, for the provision of each of these elective services, the parties and other hospitals face the same set of competitors. We will therefore analyse these services all together. However, as above, where we expect that one service might be facing a different set of constraints from other services in this cluster we will analyse the service separately.

29. We also considered whether to include in this cluster the providers of non-elective services. We understand that a range of staff, equipment and facilities are needed to provide routine elective services, these include consultants; nurses; radiologists; anaesthetists; operating theatres; equipment; wards; and an intensive care unit or a high dependency unit. We also understand that for any given specialty, there is a large overlap in the skills of the staff (and sometimes even the members of staff) that provide non-elective services, and the skills of the staff that provide elective services.[13]

30. We therefore expect that these providers will have the capability to provide elective treatment of the same routine specialties that they provide under emergency conditions, even if doing so does not require the use of their emergency backup. Research by the CCP suggests that NHS providers rarely have fixed capacity constraints and so are able to open additional beds where they are permitted and incentivised to do so. This means they are likely to have the capacity to substitute into provision of an elective service. Prices are currently set at average cost and so there is also a good chance that a given provider will have an incentive to substitute into provision of an elective service. Hence, we consider that providers of non-elective care are likely to operate some constraint on providers of elective care. We therefore include providers of non-elective care in the markets that we refer to as the 'routine elective cluster'. However, we note that in this case there are no organisations providing only non-elective services and so we have not considered this in greater detail.

Community service cluster

31. Community services are provided around England by a range of NHS, private and voluntary sector providers with backgrounds in different areas of health and social care. In the past, these services were typically provided by Primary Care Trust community services provider arms but these organisations have now become, or are part of standalone organisations as part of the policy to separate provision from commissioning. Their individual contracts are gradually being tendered.

32. Providers of one community service often also provide other community services. For example, East London NHS Foundation Trust provides a wide range of community health services, including district nurses, physiotherapy, podiatry and a diabetes service (it acquired the community services previously provided by NHS Newham). Therefore, for the provision of each of these community services, providers will face broadly the same set of competitors. We will therefore analyse these services all together. However, as above, where we expect one service might be facing a different set of constraints from other services in this cluster, we will analyse the service separately.

[13] For example consultants are trained and registered within a particular specialty.

33. We also considered whether to include in this cluster the providers of primary, routine elective, routine non-elective and specialist/tertiary services that do not currently provide community services. We understand that community services generally have low fixed costs and can therefore potentially be provided by providers from a range of backgrounds.[14]

34. We expect that these providers will have the capability to provide community services. Hence, we consider that providers of primary, routine non-elective, routine elective, and specialist/tertiary care operate some constraint on providers of community services. We therefore include providers of primary, routine non-elective, routine elective, and specialist/tertiary care in the markets that we refer to as the 'community services cluster'.

Outpatient service cluster

35. When considering providers in the outpatient services markets we draw a distinction between two types of outpatient service. The first type is those outpatient services provided as part of an admitted care pathway (for example pre-operative assessment or follow up appointments). Since the provider of the admitted component of the care pathway is likely to also need to provide the associated outpatient service, we consider these form part of the relevant routine/specialist elective/non-elective service that it is provided in conjunction with.

36. Since only the provider offering the admitted service would be able to provide the outpatient service routine elective/routine non-elective/spec cluster. The second type of outpatient service is those which do not form part of the specific admitted patient pathway. This second category reflects the growing trend towards medical care being provided in an outpatient setting, with no requirement to admit the patient for treatment and we refer to this latter category of outpatient service in the outpatient service provision cluster.

37. Providers of one outpatient specialty often also provide other outpatient specialties.[15] For example, Whipps Cross provides a full range of outpatient services. Therefore, for the provision of each of these outpatient services, the parties and other hospitals face the same set of competitors. We will therefore analyse these services all together. However, as above, where we expect that one service might be facing a different set of constraints from other services in this cluster, we will analyse the service separately.

38. We also considered whether to include in this cluster the providers of elective, non-elective, and specialist/tertiary services. We understand that out-patient services often require simply a consultation room and an hour or two of the time of a consultant. We expect that elective, non-elective, and specialist/tertiary service providers will have the capability to provide out-patient services of the same specialties that they provide for in-patient and day-case patients. Hence, we consider that providers of elective, non-elective, and specialist/tertiary care operate some constraint on providers of out-patient services.

39. We include providers of elective, non-elective, and specialist/tertiary care in the markets that we refer to as the 'out-patient cluster'. However we note that given the set of providers

[14] Although commissioners may not consider those without experience to be strong competitors for contracts this is a matter for a competitive effects analysis rather than market definition.

[15] By which we mean the provider that gets paid the tariff for that outpatient appointment.

included within this out-patient cluster of markets we can be confident that out-patient service markets are likely to be more competitive than the in-patient elective services.[16] Therefore if we do not identify a loss of choice and competition in the elective cluster then we can be confident that there is no loss of competition in this out-patient cluster. We therefore will not consider this cluster within our competitive effects analysis.

Individual specialist/tertiary service provision clusters

40. Specialist/tertiary services are provided to patients that require more specialist treatment than is available in a local acute hospital (i.e. a district general hospital). They typically include both elective and non-elective services (i.e. non-elective patients will be transferred from an accident and emergency department). Providers may focus on one specialty or provide specialist services across a number of specialities. For example, Moorfields Eye Hospital NHS Foundation Trust only provides specialist services in one specialty ophthalmology) while Barts and The London provide a range of specialist/tertiary services across a number of specialities.

41. In contrast with the provision of routine elective and routine non-elective care, we observe that providers of one specialist/tertiary specialty often do not provide the same range of specialist/tertiary specialties. As a result the set of specialist/tertiary services provided by each hospital can vary significantly from one provider to the next. Therefore, we consider that for the provision of each of the specialist/tertiary services, the parties and other hospitals are likely to face different sets of competitors. We will therefore analyse each specialist/tertiary service market separately.

GEOGRAPHIC MARKET DEFINITION

42. We have not found it necessary to precisely define the relevant geographic market as it is not material to our findings.[17] However, for the purposes of explaining our competitive assessment we refer to a market we have termed 'the wider north-east London area' (see Figure 2). The wider north-east London area includes providers located in north-east London, as well those located in immediate surrounding areas, including providers located to the north (e.g. The Princess Alexandra Hospital NHS Trust in Harlow), to the south (e.g. South London Healthcare NHS Trust in Woolwich), to the west (e.g. University College London Hospitals NHS Foundation Trust and Imperial College Healthcare NHS Trust) and further to the east (e.g. Basildon and Thurrock University Hospitals NHS Foundation Trust).[18]

43. As location is important to patients/GPs when they choose a hospital, those hospitals providing the same services in different locations are not perfect substitutes for one another and hospitals that are near one another will tend to be more important competitors than

[16] While the market is more local there are little or no barriers to any form of acute provider entering into the provision of out-patient services.

[17] This is because we have within our competitive effects analysis considered the strength of the competitive constraints posed by all relevant potential rivals. Given the nature of the identified product markets and the importance of convenience to patients we are able in this case to identify the potentially relevant rivals based on the proximity of the facilities of those rivals. We have also considered the possibility of a competitive threat from more distant rivals moving into the area, and we treat these as potential new entrants to the market.

[18] In one of the product markets described above (tertiary cardiac catheterisation service) we also considered the role of specialist providers from further afield such as the Royal Brompton which is located outside the wider north-east London area.

those that are not. We assess the relative strength of competitive constraints between providers in the wider north-east London area in the report and Appendix 5.

APPENDIX 3: TRAVEL TIME TO ALTERNATIVE HEALTHCARE PROVIDERS

1. In this Appendix we present findings from our analysis of travel times between patients located in the catchment areas of Newham Hospital and Whipps Cross Hospital and alternative providers of NHS-funded healthcare in the wider north-east London area.[1] We first present our findings on the average travel time between patients and alternative providers of routine elective care. This information formed part of the evidence-base used to assess the likely effects of the merger on choice and competition in routine elective services in the wider north-east London area.[2] Second, for those patients closest to Newham Hospital and Whipps Cross Hospital, we present our findings on which providers of NHS-funded non-elective services are the next closest. This information formed part of the evidence-base used to assess the likely effects of the merger on choice and competition in routine non-elective services in the wider north-east London area.

AVERAGE TRAVEL TIME BETWEEN PATIENTS AND ALTERNATIVE PROVIDERS

2. For the purpose of this analysis we used the location of GP practices within the catchment areas of Whipps Cross Trust and Newham Trust to proxy the location of patients and used data on the list size of each GP practice as a proxy for the population located in the local area around each GP practice.[3]

3. From each GP practice location, we estimated the travel time to providers offering a broad range of NHS-funded routine elective services. The analysis focused on 15 providers which together operated 16 hospital sites in the wider north-east London area (see Table 1).[4] We identified these providers using the NHS Choices website and selected them on the basis of geographic proximity to the main catchment areas of Whipps Cross Hospital and Newham General Hospital. We specifically excluded specialist providers, for example Moorfields Eye Hospital, and smaller private providers in the local area offering a narrow range of services to NHS patients, for example BMI, Spire and Aspen Healthcare.

4. We estimated travel time using public and private (car and taxi) transport. The merger parties were unable to tell us the proportion of patients who travelled to each site using public and private transport and so we present results separately for public and private transport rather than deriving a single travel time for each site (with weights based on the proportion using the different modes of transport).

[1] We focused our analysis on these areas as this was where the evidence indicated the merger had the potential to have the greatest effect on choice and competition.
[2] Distance (as measured by travel time) is one of a number of factors which influence the preferences of patients and GPs to have treatment at particular hospitals. See x for an empirical analysis of the factors which are considered important when choosing provider of routine elective care.
[3] We consider this to be a reasonable proxy for patient location because patients typically live close to their GP's, particularly in London. Analysis undertaken by the Department for Transport found that on average residents in London can access a GP within a six minute walk/PT and Transport for London found that walking was the quickest means of transport to reach a GP for more than 85 per cent of London population.
[4] We did not need to include all potential hospitals in our analysis since as distance increases the proportion of patients who can access a given number of providers will tend to 1. We did not include specialist providers who only focused on one speciality, for example Moorfields NHS FT who only undertakes ophthalmology. Guy's and St Thomas' NHS Foundation Trust has St Thomas' hospital. However, this is located further away from all GP's within the Newham catchment area than the Guy's Hospital site and so as we only count each provider once depending on the minimum distance from the catchment area to the hospital site we have not included this site in our analysis.

5. For NHS-providers in north-east London, we estimated public and private transport travel times using the Health Services Travel Analysis Tools (HSTAT).[5] For the two providers not included within the model, but who we were interested in understanding their proximity to patients in the Newham area (Guys Hospital and Queen Elizabeth Woolwich), we estimated public transport travel times using Transport for London (TfL) Journey Planner.[6] Health for North East London identified that travel times estimated using the TfL Journey Planner were around 15 per cent longer than the equivalent travel time estimated by the HSTAT model and so we adjusted the TfL travel times accordingly. We estimated private transport travel times for these providers using Google Travel Planner.[7] We found these travel times to be around 20 per cent shorter than the equivalent travel times estimated by the HSTAT model and so adjusted the Google travel times accordingly.

Table 1: List of providers and travel time model

Hospital site	***Provider***	***HSTAT travel times***	***TfL and Google travel times***
Basildon University Hospital	Basildon & Thurrock General Hospitals NHS Trust	•	
Broomfield Hospital	Mid Essex Hospital Services NHS Trust	•	
Guys Hospital	Guys & St Thomas' NHS FT		•
Homerton University Hospital	Homerton University Hospital NHS FT	•	
King George Hospital	Barking, Havering and Redbridge University Hospitals NHS Trust	•	
Newham General Hospital	Newham University Hospital NHS Trust	•	
North East London NHS ISTC	Care UK	•	
North Middlesex Hospital	North Middlesex University Hospital NHS Trust	•	
Princess Alexandra Hospital	Princess Alexandra Hospital NHS Trust	•	
Queen Elizabeth Woolwich	South London Healthcare NHS Trust		•
Queens Hospital	Barking, Havering & Redbridge University Hospitals NHS Trust	•	
Royal Free Hospital	Royal Free Hampstead NHS Trust	•	
Royal London Hospital	Barts& The London NHS Trust	•	
University College Hospital	University College London Hospitals NHS FT	•	
Whipps Cross Hospital	Whipps Cross University Hospital NHS Trust	•	
Whittington Hospital	Whittington Health NHS Trust	•	

6. We were interested in understanding the closeness of alternative providers from different parts of the catchment areas of Whipps Cross Hospital and Newham Hospital. We therefore split the respective catchment areas into sectors and calculated a weighted average travel time from all GP's within each sector.[8]

[5] The HSTAT model was commissioned by NHS London and Transport for London (TfL) and is based on TfL's CAPITAL model. All Primary Care Trusts in London are encouraged to use this model for consistency when analysing accessibility to NHS services. The Essex travel times within the model use the Accession model which was designed by the Department of Transport. The travel times were used by Health for North East London in their recent review of non-elective services across north-east London. The travel times can be accessed from the following website: http://www.healthfornel.nhs.uk/resources/evidence-sources/travel/journey-calculator/

[6] The Transport for London Journey Planner can be access from the following website: journeyplanner.tfl.gov.uk/user/XSLT_TRIP_REQUEST2?language=en.

[7] The Google Travel Planner can be accessed from the following website: maps.google.co.uk/maps?hl=en&tab=wl.

[8] For each GP within each sector we estimated the travel time to each provider. We then calculated a weighted average travel time to each provider from all GPs in the sector, using the number of registered patients as weights. For example, if there were two GPs with a list size of 1000 and 2000 and it took 20 minutes from one GP to a provider and 30 minutes from the other GP to the same provider, than the weighted average travel time from both GPs to the provider is around 26 minutes.

Newham Hospital

7. We first considered the effect of the merger on the number of alternative providers available to patients registered at GPs in the catchment area of Newham Hospital. Newham Hospital told us that more than 90 per cent of its patients requiring routine elective care are from Newham PCT, with small flows from surrounding areas. In addition, Newham Hospital only sends its bimonthly newsletter and other marketing material to GPs in Newham PCT. We consider GPs that are located within the area bounded by Newham PCT to be within the catchment area of NUHT. As Newham Hospital lies towards the centre of Newham PCT we split the catchment area into four sectors (see Figure 1). We found that around 80 per cent of the population registered with GP's lies in the northern part of the PCT (see Table 2).

FIGURE 1

GPs located within the catchment area of Newham Hospital

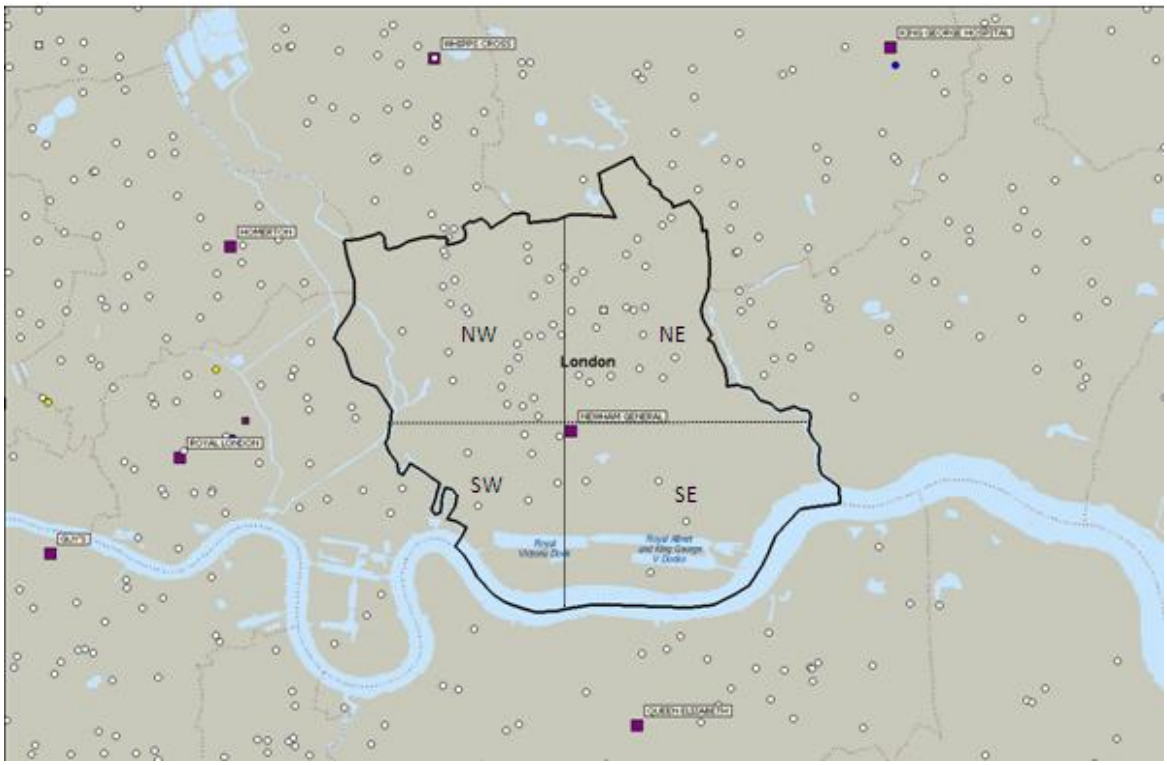


Table 2: GP's located within catchment area segments

Sector	*No. GPs*	*No. registered patients*	*patients in catchment area (per cent)*
NE	20	101,762	35
NW	27	125,773	43
SE	4	26,843	9
SW	7	39,867	13
Total	58	294,245	

8. Table 3 identifies providers located within a 60 and 45 minute travel time by public transport. We find the merger would reduce the number of different providers available to patients within 60 minutes but there would continue to be a wide range of alternative providers

available, except for the nine per cent of patients located in the south-east sector. When we consider a 45 minute travel time, we find the merger would reduce the number of providers from four to three across most sectors (with the exception of the SE sector). We note, however, that this result depends heavily on the inclusion of hospitals located south of the River Thames. If we exclude these providers, the merger will have a significant impact on the choices available at 45 minutes in each sector except the south-east.[9]

Table 3: Providers located within a 60 and 45 minute travel time by public transport

Sector of Newham	*Providers within a 60 minute travel time by public transport*	*Providers within a 45 minute travel time by public transport*	*Providers within a 45 minute travel time by public transport (north of the river only)*
North East	1. Guy's Hospital 2. Newham Hospital 3. Queen Elizabeth Hospital 4. Royal London Hospital 5. Queens/King George Hospital 6. Basildon Hospital 7. NE London NHS ISTC 8. Homerton Hospital 9. Whipps Cross Hospital 10.University College Hospital	1. Guy's Hospital 2. Newham Hospital 3. Queen Elizabeth Hospital 4. Royal London Hospital	1. Newham Hospital 2. Royal London Hospital
North West	1. Newham Hospital 2. Royal London Hospital 3. Guy's Hospital 4. Homerton Hospital 5. Queen Elizabeth Hospital 6. Whipps Cross Hospital 7. Queens/King George Hospital 8. University College Hospital 9. NE London NHS ISTC 10. Basildon Hospital	1. Newham Hospital 2. Royal London Hospital 3. Guy's Hospital 4. Homerton Hospital	1. Newham Hospital 2. Royal London Hospital 3. Homerton Hospital
South East	1. Guy's Hospital 2. Newham Hospital 3. Queen Elizabeth Hospital 4. Royal London Hospital	1. Guy's Hospital 2. Newham Hospital	1. Newham Hospital
South West	1. Newham Hospital 2. Guy's Hospital 3. Royal London Hospital 4. Queen Elizabeth Hospital 5. Homerton Hospital 6. Whipps Cross Hospital 7. University College Hospital 8. Queens/King George Hospital 9. Basildon Hospital	1. Newham Hospital 2. Royal London Hospital 3. Guy's Hospital 4. Queen Elizabeth Hospital	1. Newham Hospital 2. Royal London Hospital

[9] This is of interest because providers located south of the Thames told us they do not consider themselves to be competing for referrals from the Newham area and consistent with this receive few referrals from the area. We consider the competitive constraints imposed by each provider in the main report.

9. Table 4 shows the average travel time from each sector to each provider by public transport. We note that the average journey to work for people living in London is just over 41 minutes.

Table 4: Average travel time to alternative providers using public transport

Hospital site	*Provider*	*NE*	*NW*	*SE*	*SW*
Guys Hospital	Guy's and St Thomas' NHS FT	31	43	28	29
Newham General Hospital	Newham University Hospital NHS Trust	32	30	32	21
Queen Elizabeth Woolwich	South London Healthcare NHS Trust	39	46	48	39
Royal London Hospital	Barts& The London NHS Trust	42	37	56	43
Queens Hospital	Barking, Havering & Redbridge University Hospitals NHS Trust	52	48	69	58
Basildon University Hospital	Basildon & Thurrock General Hospitals NHS Trust	52	56	62	58
King George Hospital	Barking, Havering & Redbridge University Hospitals NHS Trust	53	52	72	63
North East London NHS ISTC	Care UK	53	52	72	63
Homerton University Hospital	Homerton University Hospital NHS FT	54	44	65	51
Whipps Cross Hospital	Whipps Cross University Hospital NHS Trust	55	46	69	55
University College Hospital	University College London Hospitals NHS FT	57	52	71	57
Whittington Hospital	Whittington Health NHS Trust	69	63	81	68
Royal Free Hospital	Royal Free Hampstead NHS Trust	69	63	82	68
Princess Alexandra Hospital	Princess Alexandra Hospital NHS Trust	76	71	85	77
Broomfield Hospital	Mid Essex Hospital Services NHS Trust	76	71	113	78
North Middlesex Hospital	North Middlesex University Hospital NHS Trust	79	69	90	77

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10. Table 5 identifies providers located within a 30 and 20 minute travel time of Newham by private transport. We find the merger would reduce the number of different providers available to patients within 30 minutes but there would continue to be a wide range of alternative providers available for patients to choose between. We note, however, that Newham Hospital and Whipps Cross Hospital are generally the closest providers. The number of alternative providers reduces significantly if we consider a 20 minute travel time by private transport.

Table 5: Providers located within a 30 and 20 minute travel time by private transport

Sector of Newham	*Providers within 30 minutes drive-time*	*Providers within 20 minutes drive-time*
North East	1. Newham Hospital	1. Newham Hospital
	2. Whipps Cross Hospital	2. Whipps Cross Hospital
	3. King George/Queens Hospital	
	4. NE London ISTC	
	5. Nth Middlesex Hospital	
	6. Queen Elizabeth Hospital	
	7. Homerton Hospital	
North West	1. Newham Hospital	1. Newham Hospital
	2. Whipps Cross Hospital	2. Whipps Cross
	3. Homerton Hospital	
	4. King George Hospital	
	5. NE London ISTC	
	6. Nth Middlesex Hospital	
	7. Guys Hospital	
	8. Royal London Hospital	
South East	1. Newham Hospital	1. Newham Hospital
	2. Whipps Cross Hospital	
	3. Queen Elizabeth Hospital	
	4. NE London ISTC	
	5. King George/Queens Hospital	
	6. Nth Middlesex Hospital	
	7. Homerton Hospital	
	8. Guys Hospital	
South West	1. Newham Hospital	1. Newham Hospital
	2. Queen Elizabeth Hospital	
	3. Whipps Cross Hospital	
	4. Homerton Hospital	
	5. Guys Hospital	
	6. Royal London Hospital	
	7. NE London ISTC	
	8. BH&R	
	9. Nth Middlesex Hospital	

11. Table 6 shows the average travel time from each sector to each provider by private transport.

Table 6: Average travel time to alternative providers using private transport

Site	*Provider*	*NE*	*NW*	*SE*	*SW*
Newham General Hospital	Newham University Hospital NHS Trust	11	12	10	12
Whipps Cross Hospital	Whipps Cross University Hospital NHS Trust	19	19	21	22
King George Hospital	Barking, Havering & Redbridge University Hospitals NHS Trust	22	21	23	26
North East London NHS ISTC	Care UK	22	25	23	26
North Middlesex Hospital	North Middlesex University Hospital NHS Trust	24	26	25	27
Queen Elizabeth Woolwich	South London Healthcare NHS Trust	25	22	22	18
Homerton University Hospital	Homerton University Hospital NHS FT	28	21	27	22
Queens Hospital	Barking, Havering & Redbridge University Hospitals NHS Trust	30	32	30	32
Guys Hospital	Guys & St Thomas' NHS FT	31	27	27	25
Princess Alexandra Hospital	Princess Alexandra Hospital NHS Trust	32	34	32	35
Royal London Hospital	Barts& The London NHS Trust	35	27	31	26
Basildon University Hospital	Basildon & Thurrock General Hospitals NHS Trust	44	45	38	40
Broomfield Hospital	Mid Essex Hospital Services NHS Trust	53	56	54	57
Whittington Hospital	Whittington Health NHS Trust	54	48	54	49
University College Hospital	University College London Hospitals NHS FT	62	55	58	53
Royal Free Hospital	Royal Free Hampstead NHS Trust	67	61	67	62

Whipps Cross Hospital

12. We next considered the effect of the merger on the number of alternative providers available to patients registered at GPs in the catchment area of Whipps Cross Hospital.

13. Whipps Cross Hospital told us that its catchment area for routine elective care covers Waltham Forest, the western part of Redbridge, the northern part of Newham and the Epping Forest area of West Essex. Reflecting the wide geographic area covered we split the catchment area into 6 sectors (see Figure 2). The majority of people live towards the southern part (sectors 2 -5) with fewer people in the northern part (see Table 7).

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FIGURE 2

GPs located within the catchment area of Whipps Cross Hospital

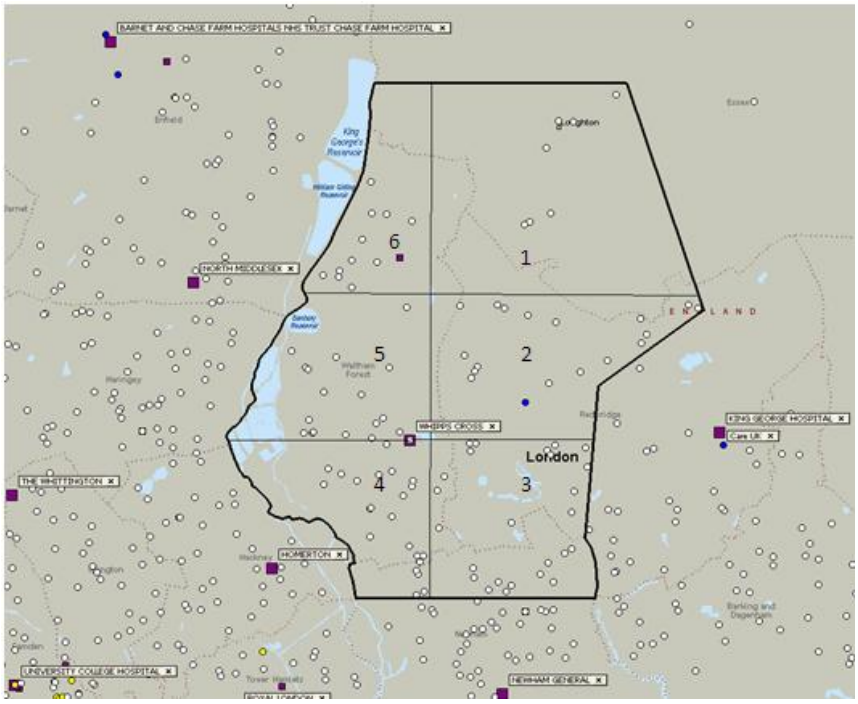

Table 7: GP's located within catchment area segments

Sector	*No. GPs*	*No. registered patients*	*patients in catchment area (per cent)*
1	7	46196	9 per cent
2	19	87122	17 per cent
3	29	129815	25 per cent
4	25	108621	21 per cent
5	18	110037	21 per cent
6	10	38980	7 per cent
Total	101	474575	

14. Table 8 identifies providers located within a 60 and 45 minute travel time by public transport. We find the merger would not reduce the number of alternative providers that patients located in Sector 6 could reach within 60 minutes travel time. The merger would reduce the number of alternative providers that patients located in other sectors could access within 60 minutes travel time by public transport but there would remain at least four alternative providers of routine elective services within that travel time. Within a 45 minute travel time by public transport, the merger would not reduce the number of alternative providers available to patients located in Sectors 2, 5 and 6; it would however reduce the number of alternative providers available to patients within Sectors 1, 3 and 4. We note that following the merger, patients located in Sectors 3 and 4 would have one or no other alternative providers to the merged organisation within a 45 minute travel time by public transport. Table 9 shows the average travel time from each sector to each provider by public transport.

15. Table 10 identifies providers located within a 30 and 20 minute travel time of patients in the catchment area of Whipps Cross Hospital by private transport. We find the merger would reduce the number of different providers available to patients within 30 minutes in Sectors 2 to 5 although there would remain at least 5 alternative NHS providers located within 30 minute travel time. The merger would have no effect on the alternatives available within 30 minutes to patients in Sectors 1 and 6. Within a 20 minute travel time by private transport, the merger would only reduce the alternatives available to patients located in Sector 3, with no affect in other sectors; there would be 2 alternative providers available. Table 11 shows the average travel time from each sector to each provider by private transport.

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Table 8: Providers located within a 60 and 45 minute travel time by public transport

Sector	*Providers within a 60 minute travel time by public transport*	*Providers within a 45 minute travel time by public transport*
1	Whipps Cross Hospital	Whipps Cross Hospital
	Royal London Hospital	Royal London Hospital
	Homerton University Hospital	Homerton University Hospital
	North East London NHS ISTC	North East London NHS ISTC
	King George Hospital	King George Hospital
	Newham General Hospital	
	Princess Alexandra Hospital	
	Queens Hospital	
	Guys Hospital	
	University College Hospital	
	North Middlesex Hospital	
2	Whipps Cross Hospital	Whipps Cross Hospital
	Royal London Hospital	
	Guys Hospital	
	North East London NHS ISTC	
	King George Hospital	
	Homerton University Hospital	
3	Whipps Cross Hospital	Whipps Cross Hospital
	Royal London Hospital	Royal London Hospital
	Newham General Hospital	
	North East London NHS ISTC	
	King George Hospital	
	Homerton University Hospital	
	Guys Hospital	
	Queen Elizabeth Woolwich	
	University College Hospital	
4	Whipps Cross Hospital	Whipps Cross Hospital
	Homerton University Hospital	Homerton University Hospital
	Royal London Hospital	Royal London Hospital
	Guys Hospital	
	Newham General Hospital	
	University College Hospital	
	Queens Hospital	
	North East London NHS ISTC	
	King George Hospital	
	Queen Elizabeth Woolwich	
	Whittington Hospital	
5	Whipps Cross Hospital	Whipps Cross Hospital
	Homerton University Hospital	
	University College Hospital	
	Guys Hospital	
	North Middlesex Hospital	
	Royal London Hospital	
	Whittington Hospital	
	Chase Farm	
6	Whipps Cross Hospital	
	North Middlesex Hospital	

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Table 9: Average travel time to alternative providers using public transport

		1	*2*	*3*	*4*	*5*	*6*
Whipps Cross Hospital	Whipps Cross University Hospital NHS Trust	30	45	44	26	28	49
Royal London Hospital	Barts& The London NHS Trust	42	52	44	40	55	71
Homerton University Hospital	Homerton University Hospital NHS FT	43	57	48	37	49	67
North East London NHS ISTC	Care UK	45	55	46	54	70	86
King George Hospital	Barking, Havering & Redbridge University Hospitals NHS Trust	45	55	46	54	70	86
Newham General Hospital	Newham University Hospital NHS Trust	51	62	45	49	66	81
Princess Alexandra Hospital	Princess Alexandra Hospital NHS Trust	52	62	70	65	62	62
Queens Hospital	Barking, Havering & Redbridge University Hospitals NHS Trust	53	60	46	52	68	83
Guys Hospital	Guys & St Thomas' NHS FT	54	54	49	47	52	68
University College Hospital	University College London Hospitals NHS FT	54	65	57	51	49	66
North Middlesex Hospital	North Middlesex University Hospital NHS Trust	54	79	73	63	54	50
Whittington Hospital	Whittington Health NHS Trust	63	76	67	58	57	73
Royal Free Hospital	Royal Free Hampstead NHS Trust	67	77	69	62	61	77
Queen Elizabeth Woolwich	South London Healthcare NHS Trust	67	67	54	55	78	90
Chase Farm Hospital	Barnet & Chase Farm Hospitals NHS Trust	82	76	76	70	61	48
Basildon University Hospital	Basildon & Thurrock General Hospitals NHS Trust	83	75	61	67	81	91
Broomfield Hospital	Mid Essex Hospital Services NHS Trust	92	85	78	75	92	99

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Table 10: Providers located within a 30 and 20 minute travel time by private transport

Sector	*Providers within a 30 minute travel time by private transport*	*Providers within a 20 minute travel time by private transport*
1	Whipps Cross Hospital	
	North Middlesex Hospital	
	King George Hospital	
	North East London NHS ISTC	
	Princess Alexandra Hospital	
2	Whipps Cross Hospital	Whipps Cross Hospital
	King George Hospital	King George Hospital
	North East London NHS ISTC	North East London NHS ISTC
	North Middlesex Hospital	
	Queens Hospital	
	Newham General Hospital	
	Homerton University Hospital	
	Princess Alexandra Hospital	
3	Whipps Cross Hospital	Whipps Cross Hospital
	Newham General Hospital	Newham General Hospital
	King George Hospital	King George Hospital
	North East London NHS ISTC	North East London NHS ISTC
	North Middlesex Hospital	
	Homerton University Hospital	
	Queens Hospital	
	Queen Elizabeth Woolwich	
	Princess Alexandra Hospital	
4	Whipps Cross Hospital	Whipps Cross Hospital
	Homerton University Hospital	Homerton University Hospital
	North Middlesex Hospital	
	King George Hospital	
	North East London NHS ISTC	
	Newham General Hospital	
	Queen Elizabeth Woolwich	
	Guys Hospital	
5	Whipps Cross Hospital	Whipps Cross Hospital
	North Middlesex Hospital	North Middlesex Hospital
	King George Hospital	
	North East London NHS ISTC	
	Homerton University Hospital	
	Newham General Hospital	
	Princess Alexandra Hospital	
6	North Middlesex Hospital	North Middlesex Hospital
	Whipps Cross Hospital	Whipps Cross Hospital
	Chase Farm Hospital	
	King George Hospital	
	North East London NHS ISTC	

APPENDIX 3

Table 11: Average travel time to alternative providers using private transport

Site	*Provider*	*1*	*2*	*3*	*4*	*5*	*6*
Whipps Cross Hospital	Whipps Cross University Hospital NHS Trust	23	17	14	10	9	19
North Middlesex Hospital	North Middlesex University Hospital NHS Trust	26	21	21	23	16	15
King George Hospital	Barking, Havering & Redbridge University Hospitals NHS Trust	27	18	19	23	24	27
North East London NHS ISTC	Care UK	27	18	19	23	24	27
Princess Alexandra Hospital	Princess Alexandra Hospital NHS Trust	29	30	29	32	28	31
Chase Farm Hospital	Barnet & Chase Farm Hospitals NHS Trust	30	35	38	37	30	25
Queens Hospital	Barking, Havering & Redbridge University Hospitals NHS Trust	32	25	26	31	31	34
Newham General Hospital	Newham University Hospital NHS Trust	33	28	17	24	27	31
Homerton University Hospital	Homerton University Hospital NHS FT	37	29	22	18	25	34
Queen Elizabeth Woolwich	South London Healthcare NHS Trust	40	34	27	27	32	38
Guys Hospital	Guys & St Thomas' NHS FT	45	40	32	29	34	42
Basildon University Hospital	Basildon & Thurrock General Hospitals NHS Trust	46	44	45	49	46	48
Broomfield Hospital	Mid Essex Hospital Services NHS Trust	48	48	51	54	50	53
Royal London Hospital	Barts& The London NHS Trust	49	42	32	31	40	46
Whittington Hospital	Whittington Health NHS Trust	56	51	49	45	41	45
Royal Free Hospital	Royal Free Hampstead NHS Trust	70	64	62	58	55	58
University College Hospital	University College London Hospitals NHS FT	72	65	58	54	56	63

SUBMISSIONS FROM THE MERGER PARTIES

16. The parties and their advisors responded to a working paper setting out this analysis. They made a number of points:[1]
    - The exclusion of independent sector providers and providers south of the river Thames will have had the effect of underestimating the number of alternative providers that patients can access within a given travel time
    - The use of a 45 minutes public transport and 20 minute private transport travel time as an approximate estimate of patient willingness to travel is artificially short and would not appear to be consistent with current referral patterns and will have the effect of underestimating the number of alternative providers that patients can access within an appropriate travel time. They also consider that the CCP places too much emphasis on public transport times rather than private travel times.
    - The segmentation approach that the CCP has used to identifying accessibility is invalid

17. We agree that the exclusion of independent sector providers from this access analysis may, depending on their location relative to patients, have the effect of underestimating the number of alternative providers that patients can access within a given travel time. However, as explained in paragraph 7 above, we specifically excluded smaller, private providers offering a limited range of routine elective services because for this aspect of our analysis we wanted to focus on large providers offering a wider range of routine elective services. For the same reason we excluded Moorfields Eye Hospital from the analysis. This does not mean that these providers have been excluded from the competitive analysis, as can be seen in the main report and Appendix 5. It is important to recognise that travel time is likely to be one of many factors which shape hospital preferences and our competitive assessment took full account of the strength of the competitive constraint offered by these smaller providers. We included providers south of the river in our analysis.

18. We agree with the parties that the patients have shown themselves willing to travel more than 45 minutes by public transport and 20 minutes by private transport to access routine elective care at certain providers. The use of these travel times was not to represent a willingness to travel but was to provide a time period against which to compare accessibility of different hospitals. We also looked at accessibility using a 60 minute public transport travel time and a 30 minute private transport travel time. Again, travel time is likely to be one of many factors which shape hospital preferences. We have considered accessibility in terms of both public and private transport travel times since we understand that different patients travel by different modes of transport.

19. The parties consider that a granular analysis of the data is preferable to the segmentation approach the CCP has presented. The parties analysed the data and found it to show that many patients could reach Guy's and St. Thomas', Homerton and UCLH within 51 minutes. They submitted that it seems implausible that these trusts would not offer a significant competitive constraint. As we have noted this analysis is of the accessibility of the various large hospital sites in the area and is not a competitive analysis, the competitive analysis is

[1] They also noted that while they understood why GP locations were used as a proxy for patient locations they did not consider it ideal for conducting this analysis as GP list sizes may not be reflective of actual list sizes.

contained in the main text and Appendix 5. The parties consider that looking at access within 51 minutes gives a very different picture from the picture at 45 minutes. On that basis we looked at both 45 and 60 minute public transport travel times in order to see which providers are closest, and which are accessible if patients travel a little further (we then repeated this analysis in relation to private travel times). We note that by aggregating up the GP practices to segments we provided a weighted average of travel times for people within each quadrant. It is clear that within this weighted average there will be some patients that have easier access to certain hospitals and others that have more difficulty in accessing the same hospital. We do not consider that the differences between these approaches alter the results that we take from this analysis.

CLOSEST ALTERNATIVE PROVIDER OF NON-ELECTIVE SERVICES

20. In this section we present results on patients' closest alternative provider of non-elective services, in particular accident and emergency services. We assume that patients attend their closest accident and emergency department. The merger parties considered this to be a reasonable assumption and we note this assumption is consistent with the modelling assumptions made in the recent Healthcare for North East London reconfiguration proposals.

21. For the purpose of this analysis we used the location and list size of GP practices as a proxy for the population located in the immediate area around each GP practice.[2] From each GP practice location, we then estimated the travel time to 13 hospital sites in the wider north-east London area that are likely to be providing a full range of accident and emergency services over the next few years (see Table 12).[3] We estimated travel time for private transport using the same approach as discussed above (see paragraph 9).

Table 12: Hospital sites included in the analysis

Hospital site	*Provider*	*HSTAT travel times*	*Google travel times*
Basildon University Hospital	Basildon & Thurrock General Hospitals NHS Trust	•	
Broomfield Hospital	Mid Essex Hospital Services NHS Trust	•	
Guys Hospital	Guys & St Thomas' NHS FT		•
Homerton University Hospital	Homerton University Hospital NHS FT	•	
Newham General Hospital	Newham University Hospital NHS Trust	•	
North Middlesex Hospital	North Middlesex University Hospital NHS Trust	•	
Princess Alexandra Hospital	Princess Alexandra Hospital NHS Trust	•	
Queens Hospital	Barking, Havering & Redbridge University Hospitals NHS Trust	•	
Royal Free Hospital	Royal Free Hampstead NHS Trust	•	
Royal London Hospital	Barts& The London NHS Trust	•	
University College Hospital	University College London Hospitals NHS FT	•	
Whipps Cross Hospital	Whipps Cross University Hospital NHS Trust	•	
Whittington Hospital	Whittington Health NHS Trust	•	

[2] We consider this to be a reasonable proxy for patient location because patients typically live close to their GP's, particularly in London. Analysis undertaken by the Department for Transport found that on average residents in London can access a GP within a 6 minute walk/PT and Transport for London found that walking was the quickest means of transport to reach a GP for more than 85 per cent of London population.

[3] Due to the recent decision to downgrade accident and emergency services on the King George Hospital site we have excluded this site from our analysis. It was not necessary to include all potential sites with accident and emergency services across a wider area since we are only calculating the distance to the next nearest accident and emergency department.

22. We then identified those GP's closest to Newham Hospital and Whipps Cross Hospital and for each of these GPs identified the next closest provider of accident and emergency services. We then calculated the proportion of patients registered with GP's closest to Newham Hospital and Whipps Cross Hospital that had different providers as their next nearest provider.

23. We found that for GP's closest to Whipps Cross Hospital, the North Middlesex Hospital was the next closest provider of non-elective services for 44 per cent of registered patients, Homerton University Hospital was next closest for 21 per cent of registered patients, Newham General Hospital was next closest for 20 per cent of registered patients, Queens Hospital was next closest for 11 per cent of registered patients and Princess Alexandra was closest for 3 per cent of registered patients (see Table 13).

Table 13: Next closest alternative provider of non-elective services to Whipps Cross Hospital

Hospital site	*No. of registered patients*	*registered patients (per cent)*
North Middlesex Hospital	222,959	44
Homerton University Hospital	109,017	21
Newham General Hospital	100,568	20
Queens Hospital	58,150	11
Princess Alexandra Hospital	17,795	3
Total	508,489	100

24. We found that for GP's closest to Newham General Hospital, Whipps Cross Hospital was the next closest provider of non-elective services for 80 per cent of registered patients, Homerton University Hospital was the next closest provider for 19 per cent of patients and Queens Hospital was the next nearest for just one per cent of registered patients.

Table 14: Next closest alternative provider of non-elective services to Newham General Hospital

Hospital site	*No. of registered patients*	*registered patients (per cent)*
Whipps Cross Hospital	259,992	80
Homerton University Hospital	60,857	19
Queens Hospital	4,435	1
Total	325,284	100

APPENDIX 4: GP REFERRAL ANALYSIS

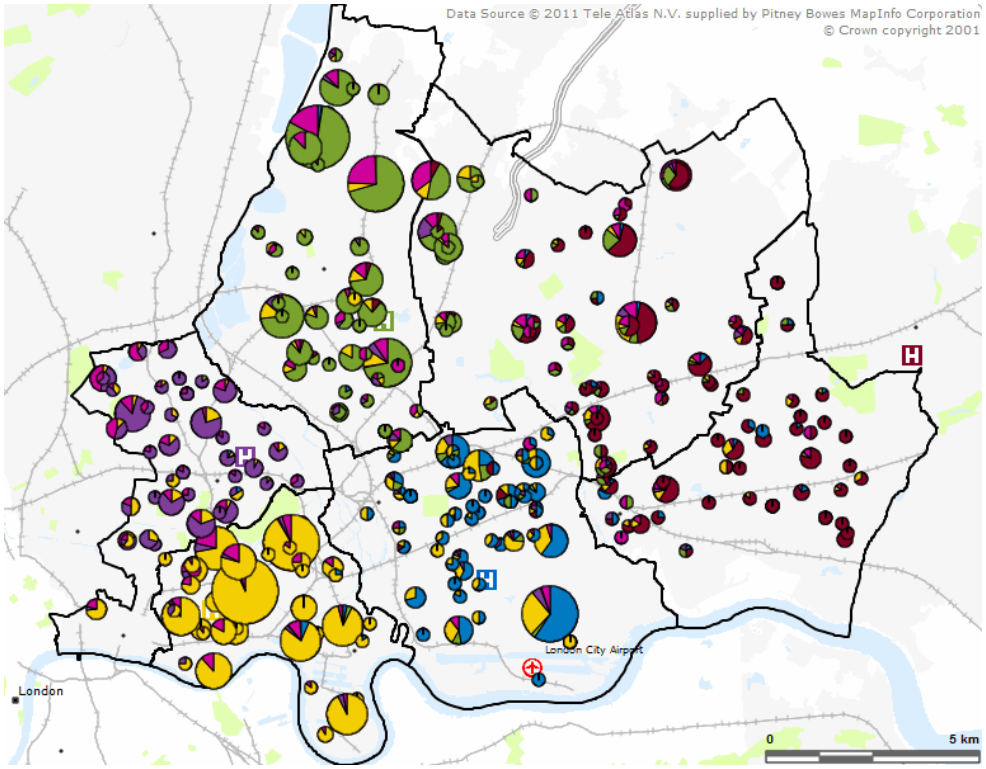
1. In this analysis we use GP referral patterns to gain an insight into the relative competitive constraints that different providers exert upon a particular site (which we label the 'anchor site'). For example we observe the competitive threat to a provider's volumes that is imposed by a rival, relative to the threat posed by a range of other potential rivals. This allows us to identify those rivals that appear likely to exert the greatest competitive effect by competing for a large volume of its current activity. We note however that this analysis is not informative on how likely it is that a referral will be switched. Research suggests that on average, a 10 per cent decrease in quality (such as mortality rate) is associated with an 11 per cent decrease in demand, though the responsiveness of demand to changes in relative quality will depend on a number of factors including the competitive environment in which the hospital operates.[1] We also note that the insights drawn from the analysis within this Appendix formed just one part of the full competitive effects analysis that is described in the report and Appendix 5.

ROUTINE SERVICES: MAPPING THE DATA

2. We begin by mapping the share of the referrals for a routine treatment that the parties receive from each GP practice in the area.[2] We consider more complex treatments in paragraphs 24 to 30.

FIGURE 1

Referrals for a routine treatment from GPs in East London



[1] See Choice of NHS-funded hospital services in England, Beckert, Walter. Christensen, Mette and Collyer, Kate, Economic Journal forthcoming

[2] In figure 1 this is for HRG F54: Inflammatory Bowel Disease - Endoscopic or Intermediate Procedures; aged under 70; without complications).

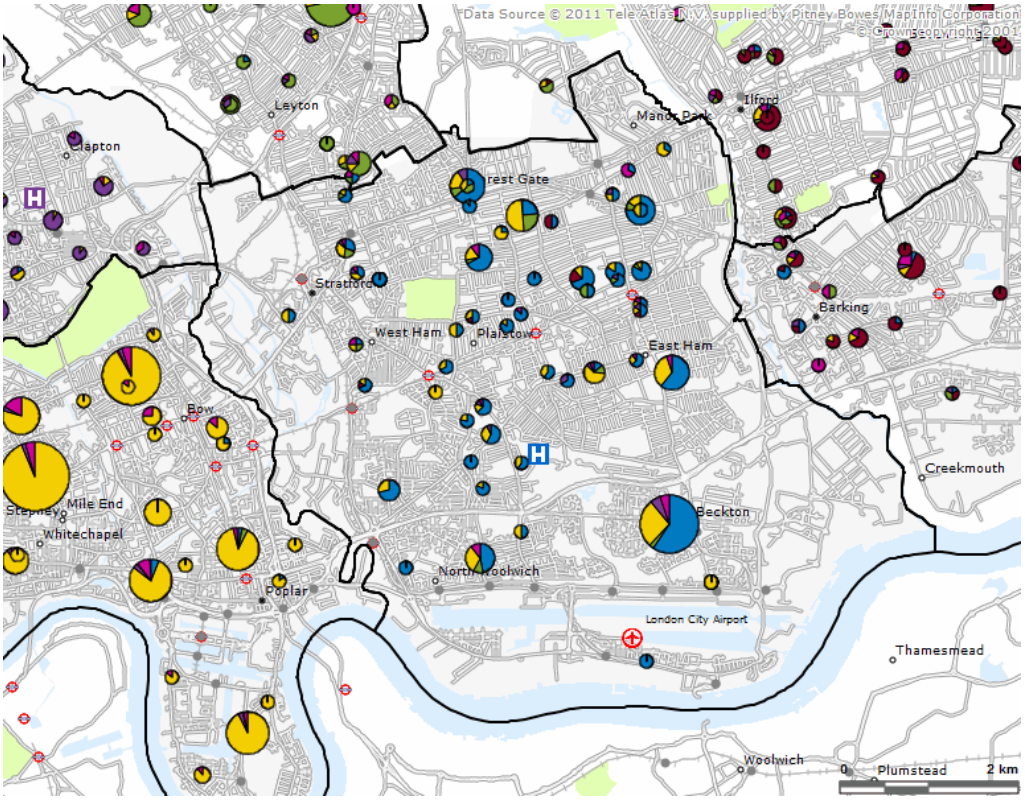
Hospitals

- Newham University Hospital NHS Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Whipps Cross University Hospital NHS Trust
- Barts and the London NHS Trust
- Homerton University Hospital NHS Foundation Trust
- Others

3. From Figure 1 we can see that all but a few of Newham Trust's referrals are from GP practices in Newham Trust PCT,[3] in contrast many of Whipps Cross Trust's referrals are from GP practices in Waltham Forest, but there are also significant proportions from GP practices in neighbouring Redbridge PCT. From Figure 2 we can see that GP practices that refer to Newham Trust (blue) also generally refer to Barts and The London Trust (yellow), or Whipps Cross Trust (green). Only a small number of these GP practices refer to BHRUT (red) or HUHT (purple), or others (pink).

FIGURE 2

Referrals from GPs in and around Newham Trust



ANALYSING THE DATA

4. In this section we first conduct a GP practice level analysis in which we take the mapped data and create a ranking of providers that are referred to by each GP practice in the area, this allows us to infer which provider each GP practice prefers. We take this preference to be demonstrated by the aggregated individual decisions of different pairs of GPs and patients within the GP practice.[4] We aggregate referrals to GP practice level because the characteristics of the different pairs of GPs and patients within a practice that make decisions

[3] Though some travel from Barking which is just to the east of Newham PCT

[4] Each referral from a GP practice can be seen as a decision made by a patient and their GP. A GP practice is therefore constituted of a large number of potential pairings of GP and patient.

are likely to be relatively homogenous given their common location and their need for the same treatment.[5]

5. Using these rankings we make the assumption that the first ranked provider is the favoured provider for that GP practice, and that the second ranked provider is, for that GP practice, the best alternative provider.

6. We next assume (assumption 1) that, if a GP practice were, following a change in the quality of service at its favoured provider, to decide against referring some patients to that provider, they would instead refer to the second ranked provider. Similarly if a GP practice were, following a change in the quality of service at the second ranked provider, to decide against referring some patients to that provider, they would instead refer to the first ranked provider.

7. We consider it reasonable to assume that GPs would switch to hospitals to which they already refer. This is because firstly hospital care is an experience good in the sense that patients and GPs cannot perfectly observe the quality of the service that they select but instead need to use the experience that they and others have had in order to inform their choice of provider. Therefore GPs and patients are more likely to have experience on which to base their decision if they have previously referred patients to a given hospital (e.g. they may know the consultants). Secondly we expect that the choices made by patients and GPs at a particular GP practice in the past will reveal something about the providers that they consider to offer the best combination of convenience and quality.

8. Since this is a key assumption within the analysis we also relax it and test a second assumption (assumption 2), that if a GP practice were, following a change in the quality of service at the first, second or third ranked provider, to decide against referring some patients to that provider, they would refer instead to either of the remaining providers ranked within the top three.

9. The value of this sensitivity test can be seen in Figure 2. For example the GP practice located beneath the label 'East Ham' in Figure 2 would, from its past behaviour, appear to favour Newham Trust, and to consider the second ranked Barts and The London Trust as the next best alternative provider. In contrast the GP practice located beneath the label 'Forest Gate' in figure 2 would appear to favour Barts and The London Trust, but to consider both Newham Trust and Whipps Cross Trust as alternative providers. In the case of this GP practice the relaxing of the assumption allows us to account for the possibility that the referrals to Barts and The London Trust might be expected, following a reduction in quality, to turn to either the second ranked provider (Newham Trust) or the third ranked (Whipps Cross Trust), rather than necessarily the second ranked provider (as is the case under assumption 1).

10. Taking an analysis of the relative competitive constraints upon Newham Trust as an example, we would calculate the proportion of Newham Trust's referrals that come from GP practices that would place Newham Trust and Barts and The London Trust as the first and second

[5] We control for possible differences in preference that are based on the type of treatment by examining referrals for the same treatment

ranked providers.[6] We also calculate the proportion of Newham Trust's referrals that come from GP practices that appear to consider Newham Trust and Barts and The London Trust within the first, second and third ranked providers. We then compare these proportions with those of Newham Trust and other potential rival providers in order to identify which providers Newham Trust is likely to consider as being its most important rivals for referrals.

11. In addition we also carry out a catchment area level analysis in which we aggregate all the referrals that are made by GP practices that refer to Newham Trust for a given treatment. The percentage share of referrals that each rival receives out of Newham Trust's catchment area can be taken to indicate the most important rivals to Newham Trust.[7]

RESULTS

Newham Trust

12. We begin by considering the competitive constraints upon Newham Trust. We first ran the GP practice level analysis on all adult elective treatments. Table 1 below shows the results. The key result is that Barts and The London Trust appears to be the most important competitor to Newham Trust. For example it appears that, following a change in the quality of service at Newham Trust, 86 per cent of the 22,601 adult elective patients treated at Newham Trust during the period January 2009 to December 2010, would, if they switch anywhere, be likely to switch to Barts and The London Trust. This suggests that Barts and The London Trust is Newham Trust's most important competitor, posing a threat to 86 per cent of its referrals. Whipps Cross Trust appears to be the next closest competitor. For example 5 per cent of GP practices appear to consider Newham Trust and Whipps Cross Trust as their first and second ranked providers.[8]

13. Under the more relaxed assumption, following a change in the quality of service at Newham Trust, 92 per cent of patients treated at Newham Trust might, if they switch anywhere, consider switching to Barts and The London Trust. However it is also notable that 86 per cent of patients treated at Newham Trust might, if they switch anywhere, consider switching to Whipps Cross Trust. These results suggest that Barts and The London Trust is likely to be the most important rival for Newham Trust (i.e. Barts and The London Trust is the first ranked when Newham Trust is second ranked, or the second ranked when Newham Trust is the first ranked), and that Whipps Cross Trust is generally the third ranked provider for the vast majority of GP practices in the area. In any case this suggests that the three providers that plan to merge are the three most important options for patients and GPs that refer to Newham Trust.[9]

[6] That is, Newham Trust is first and Barts and The London Trust is second or, Barts and The London Trust is first and Newham Trust is second.

[7] Note that this is calculated by aggregating the total volume of referrals from all GP practices within the catchment area of Newham Trust and identifying the most important rivals (eg table 4 below). This is in contrast to the approach of GP practice level analysis which observes the most important rival at an individual GP practice level and then aggregates these into a summary table (eg table 1, 2 or 3 below).

[8] In addition to 21 potential rivals (and others) the table also indicates where there is some duplication (eg where 2 providers have tied in second place), and where the anchor provider had only a peripheral ranking.

[9] In earlier analysis we also considered the full choice set of providers available to the GP practices that refer to Newham Trust. The results that we obtained reflected those that we set out in Appendix 3, which is that there are a number of rival providers that can be

APPENDIX 4

Table 1: GP level analysis for all elective spells at Newham Trust

	Assumption 1		*Assumption 2*	
No one	1	0%	1	0%
Barts and The London Trust	19546	86%	20868	92%
Whipps Cross Trust	1116	5%	19405	86%
Homerton	180	1%	184	1%
Imperial College	126	1%	126	1%
BHRUT	13	0%	180	1%
Care UK	1	0%	2	0%
UCL	1	0%	2	0%
Kings College	1	0%	1	0%
Royal Brompton	0	0%	70	0%
Royal Free	0	0%	1	0%
Whittington	0	0%	1	0%
BUPA	0	0%	0	0%
BMI	0	0%	0	0%
North Middlesex	0	0%	0	0%
Basildon & Thurrock	0	0%	0	0%
Guy's & St. Thomas'	0	0%	0	0%
Lewisham	0	0%	0	0%
Dartford & Gravesham	0	0%	0	0%
Chelsea & Westminster	0	0%	0	0%
Barnet & Chase Farm	0	0%	0	0%
South London Healthcare	0	0%	0	0%
Others	76	0%	1441	6%
Peripheral	1558	7%	1457	6%
Duplicates	-18	0%	-21138	-94%
Total	22601	100%	22601	100%

14. However we decided to sensitivity test these results to consider whether the results might be driven, not by GP practices choosing between alternative providers of the same procedure but by the fact that Newham Trust cannot provide the elective specialist/tertiary services that Barts and The London Trust has ability to provide. For example, if GP practices did not in fact choose between Barts and the London and Newham Trust when making a referral, but instead referred all their routine cases to Newham Trust and all their specialist/tertiary cases to Barts and The London Trust then we might see a similar looking pattern in our results. In their response to the analysis the parties endorsed our decision to focus on routine procedures rather than all elective procedures.

15. We tested the sensitivity of the results by selecting a high volume routine HRG (code F54: 'Inflammatory Bowel Disease - Endoscopic or Intermediate Procedures; aged under 70; without complications'). This is on the list of routine HRGs that providers on the extended choice or free choice network (now the regional AQP contracts) can provide subject to having CQC registration. We set out the results below in table 2.

accessed by patients within 60 minutes. However as we set out in the report, the competitive set differs from the choice set. This Appendix is therefore focused on identifying the competitive set rather than the full choice set.

APPENDIX 4

Table 2: GP level analysis for a routine service at Newham Trust (F54)

	Assumption 1:		*Assumption 2:*	
No-one	21	6.1%	21	6.1%
Barts and The London Trust	246	71.5%	262	76.2%
Whipps Cross Trust	46	13.4%	115	33.4%
BHRUT	42	12.2%	49	14.2%
Guy's & St. Thomas'	15	4.4%	16	4.7%
Homerton	14	4.1%	71	20.6%
Whittington	7	2.0%	7	2.0%
UCLH	4	1.2%	6	1.7%
Care UK	4	1.2%	4	1.2%
Royal Free	1	0.3%	28	8.1%
Imperial	1	0.3%	15	4.4%
Chelsea & Westminster	1	0.3%	4	1.2%
North Middlesex	0	0%	0	0%
Barnet & Chase Farm	0	0%	1	0.3%
Spire	0	0%	0	0%
Basildon & Thurrock	0	0%	0	0%
Kings College	0	0%	0	0%
Royal Brompton	0	0%	0	0%
South London Healthcare	0	0%	0	0%
BMI	0	0%	0	0%
Lewisham	0	0%	0	0%
Dartford & Gravesham	0	0%	0	0%
Others	8	2.3%	36	10.5%
Peripheral	16	4.7%	10	2.9%
Duplicates	-82	-23.8%	-301	-87.5%
Total	344	100%	344	100%

16. We can see that the percentage of patients registered with GPs that choose between Newham Trust and Barts and The London Trust is slightly smaller than in Table 1. However the key conclusion that Barts and The London Trust is the closest competitor to Newham Trust is robust.[10] Interestingly the role of BHRUT is more significant here in that it is almost as important a rival to Newham Trust as Whipps Cross Trust. Similarly under assumption 2, Homerton are the third ranked rival in a number of GP practices. However overall this analysis of routine treatment reinforces the conclusion that the majority of Newham Trust's patients (85 per cent) would, in response to a change in quality at Newham Trust, be likely to divert, *if anywhere*, to one of the other two merging parties.[11] This suggests that post-merger there is likely to be scope for the merged parties to reduce investment in quality or efficiency at the Newham Trust hospital site, knowing that those GP practices that, when quality changes, will redirect their patients to other sites are likely to redirect them towards Barts and The London Trust or Whipps Cross Trust, meaning that the merged trust will retain the revenue associated

[10] Note also that for non-ENT treatments Whipps Cross Trust remains the second closest competitor. Whipps Cross Trust operates the ENT and ophthalmology outpatient departments at Newham Trust Hospital. As a result a high proportion of patients requiring inpatient treatment for these specialties are referred to Whipps Cross Trust. However IBD treatment is not within the ENT or ophthalmology specialities and so is likely to provide a more reliable estimate of the typical proportion of referrals to Whipps Cross Trust.
[11] A further 6 per cent appear unlikely to divert anywhere since these GPs refer exclusively to Newham Trust.

with those referrals while saving the cost of investing in quality or efficiency at the Newham Trust site.

17. However a key caveat to again emphasise in this analysis is that it does not suggest how likely it is that these patients would go *anywhere* at all in response to the new trust reducing its investment in the quality or efficiency of services provided at its Newham Trust site. Similar results are obtained in three further routine treatments in which we sensitivity tested our results, see table 3 below.

Table 3: GP level analysis for other routine services at Newham Trust (M05, M06, and L21)

	Assumption 1:		*Assumption 2:*	
No-one	0	0.0%	0	0.0%
Barts and The London Trust	969	55.1%	1548	88.0%
Whipps Cross Trust	657	37.4%	1234	70.2%
Homerton	76	4.3%	207	11.8%
BHRUT	55	3.1%	313	17.8%
BMI	38	2.2%	251	14.3%
Whittington	12	0.7%	23	1.3%
Spire	7	0.4%	26	1.5%
Guy's & St. Thomas'	6	0.3%	93	5.3%
South London Healthcare	5	0.3%	52	3.0%
Imperial	4	0.2%	31	1.8%
Chelsea & Westminster	1	0.1%	33	1.9%
Basildon & Thurrock	1	0.1%	5	0.3%
Lewisham	1	0.1%	1	0.1%
UCLH	0	0.0%	118	6.7%
Royal Free	0	0.0%	19	1.1%
Kings College	0	0.0%	12	0.7%
Barnet & Chase Farm	0	0.0%	4	0.2%
Care UK	0	0.0%	0	0.0%
North Middlesex	0	0.0%	0	0.0%
Royal Brompton	0	0.0%	0	0.0%
Dartford & Gravesham	0	0.0%	0	0.0%
Others	12	0.7%	106	6.0%
Peripheral	87	4.9%	56	3.2%
Duplicates	-172	-9.8%	-2373	-134.9%
Total	1759	100.0%	1759	100.0%

18. In Table 4 below we conduct a catchment area level analysis of the data in table 2. We aggregate all the referrals from GP practices that refer patients to Newham Trust for a routine treatment (F54). This therefore represents the share of referrals that Newham Trust gets from its catchment area. The key figures here are the proportion of referrals that different rivals receive from Newham Trust's catchment area. In particular, of the potential rivals, Barts and The London Trust takes by far the most referrals and is therefore likely to be considered the most important rival. Furthermore, alongside Whipps Cross Trust, Barts and The London Trust

receives a combined 34.6 per cent of the referrals. Of the other rivals only BHRUT receives a significant proportion of referrals from Newham Trust's catchment area.[12]

Table 4: Catchment area analysis for a routine service at Newham Trust

	Referrals	*Percentage*
Newham Trust	344	37.7%
Barts and The London Trust	223	24.4%
BHRUT	151	16.5%
Whipps Cross Trust	93	10.2%
Homerton	33	3.6%
Royal Free	10	1.1%
UCLH	8	0.9%
Guy's & St. Thomas'	8	0.9%
Imperial	6	0.7%
Care UK	3	0.3%
Whittington	2	0.2%
Barnet & Chase Farm	2	0.2%
Chelsea & Westminster	2	0.2%
North Middlesex	0	0.0%
Spire	0	0.0%
Basildon & Thurrock	0	0.0%
Kings College	0	0.0%
Royal Brompton	0	0.0%
South London Healthcare	0	0.0%
BMI	0	0.0%
Lewisham	0	0.0%
Dartford & Gravesham	0	0.0%
Others	28	3.1%
Total	913	100.0%

Whipps Cross Trust

19. Next we considered the relative competitive constraints upon Whipps Cross Trust. We first ran the GP practice level analysis on all adult elective treatments. Table 5 below shows the results. Whipps Cross Trust treated a total of 69,765 adult elective patients during the period January 2009 to December 2010.

20. Barts and The London Trust appears to be Whipps Cross Trust' most important competitor, posing a threat to 58 per cent of its referrals. Notably UCLH, BHRUT and Princess Alexandra also appear to be competitors for a significant proportion of Whipps Cross Trust' referrals. Newham Trust does not appear to be a competitor.

[12] Notably this is higher than the proportion of Newham trust's patients for which BHRUT is ranked first or second against Newham trust. This suggests that there are not that many patients and GPs that choose between the two providers, but that BHRUT receives a good share of referrals of those that do. This might be taken to reflect the balance of defensive and aggressive strategies by the two providers, for example, it may reflect Newham trust making more small inroads into what has been traditionally BHRUT territory than BHRUT makes into areas that traditionally have predominantly referred to Newham. In contrast, Whipps Cross Trust has a smaller percentage in the catchment area analysis than it does in the GP practice level analysis. Again this might reflect Whipps Cross Trust making small inroads into geographic areas in which Newham trust is traditionally strong.

APPENDIX 4

Table 5: GP level analysis for all elective spells at Whipps Cross Trust

	Assumption 1		*Assumption 2*	
No-one	14	0%	14	0%
Barts and The London Trust	40311	57.8%	59582	85.4%
UCL	6991	10.0%	22428	32.1%
BHRUT	6092	8.7%	10273	14.7%
Princess Alexandra	4715	6.8%	5031	7.2%
Care UK	1197	1.7%	1870	2.7%
Newham Trust	319	0.5%	5152	7.4%
Whittington	241	0.3%	799	1.1%
Homerton	10	0.0%	3258	4.7%
Barnet & Chase Farm	6	0.0%	19	0.0%
North Middlesex	4	0.0%	1294	1.9%
Basildon & Thurrock	2	0.0%	20	0.0%
Imperial College	1	0.0%	1	0.0%
Kings College	0	0%	701	1.0%
Royal Free	0	0%	283	0.4%
Chelsea & Westminster	0	0%	3	0.0%
Royal Brompton	0	0%	3	0.0%
BMI	0	0%	0	0%
Guy's & St. Thomas'	0	0%	0	0%
Lewisham	0	0%	0	0%
Dartford & Gravesham	0	0%	0	0%
South London Healthcare	0	0%	0	0%
Spire	0	0%	512	0.7%
Others	2561	3.7%	30259	43.4%
Peripheral	7495	10.7%	2610	3.7%
Duplicates	-194	-0.3%	-60568	-86.8%
Total	69765	100%	69765	100%

21. As in the Newham Trust analysis we then ran the analysis using a routine treatment. Table 6 below shows the results. Notably while Barts and The London Trust remains the most important rival to Whipps Cross Trust it is less important than suggested in table 5 above (58 per cent as against 40 per cent). This suggests that some of these GP practices were not choosing between Barts and The London Trust and Whipps Cross Trust, but were instead sending specialist/tertiary referrals to Barts and The London Trust while they chose between Whipps Cross Trust and another provider for their routine referrals. For example from table 6 we can see that many of those GP practices appear to instead choose between Whipps Cross Trust and North Middlesex (or between Whipps Cross Trust and Homerton).

22. We also note that the analysis in table 6 suggests that Barts and The London Trust and Newham Trust are less important than the combination of competitive constraints from other providers. In particular the constraints from BHRUT, UCLH, Princess Alexandra, North Middlesex and Homerton appear to be important. Therefore it would appear that the majority of Whipps Cross Trust' patients would, in response to a change in quality at Whipps Cross Trust, be likely to divert, *if anywhere*, to someone other than the merging parties.

APPENDIX 4

Table 6: GP level analysis for a routine elective service at Whipps Cross Trust (F54)

	Assumption 1		*Assumption 2*	
No-one	61	8.6%	61	8.6%
Barts and The London Trust	284	40.2%	365	51.6%
BHRUT	99	14.0%	127	18.0%
UCLH	87	12.3%	92	13.0%
Princess Alexandra	58	8.2%	83	11.7%
North Middlesex	55	7.8%	55	7.8%
Homerton	54	7.6%	148	20.9%
Guy's & St. Thomas'	45	6.4%	50	7.1%
Royal Free	28	4.0%	102	14.4%
Newham Trust	26	3.7%	49	6.9%
Whittington	16	2.3%	47	6.6%
South London Healthcare	11	1.6%	11	1.6%
Care UK	10	1.4%	10	1.4%
Imperial	1	0.1%	11	1.6%
Basildon & Thurrock	1	0.1%	2	0.3%
Barnet & Chase Farm	0	0.0%	26	3.7%
Kings College	0	0.0%	2	0.3%
Spire	0	0.0%	0	0.0%
BMI	0	0.0%	0	0.0%
Lewisham	0	0.0%	0	0.0%
Dartford & Gravesham	0	0.0%	0	0.0%
Royal Brompton	0	0.0%	0	0.0%
Others	108	15.3%	224	31.7%
Peripheral	35	5.0%	6	0.8%
Duplicates	-272	-38.5%	-764	-108.1%
Total	707	100.0%	707	100.0%

23. In table 7 below we consider the catchment area level analysis. This involves aggregating all the referrals from GP practices that refer patients to Whipps Cross Trust for this routine treatment. This is therefore the share of referrals that Whipps Cross Trust gets from its catchment area. The analysis suggests that the most important competitor is BHRUT. Barts and The London Trust is less important as a rival than it was to Newham Trust in table 4 (24.4 per cent vs. 9.8 per cent). The analysis also suggests that currently Princess Alexandra, located to the north in Harlow, is also a relatively important rival. Notably the increment from the merger on the Whipps Cross Trust site is approximately half the increment that was identified in relation to the Newham Trust site (18.3 per cent as against 34.4 per cent). This suggests the loss of competitive constraint will be much more significant at the Newham Trust site and that post-merger the merged parties would be unlikely to able to significantly reduce investment in quality or efficiency at the Whipps Cross Trust Hospital site since they would be likely to lose the revenue associated with patients that switched to alternative providers.

Table 7: Catchment area analysis for a routine service at Whipps Cross Trust (F54)

	Referrals	*Percentage*
Whipps Cross Trust	707	40.5%
BHRUT	274	15.7%
Barts and The London Trust	172	9.8%
Newham Trust	149	8.5%
Princess Alexandra	147	8.4%
UCLH	61	3.5%
Homerton	46	2.6%
Whittington	24	1.4%
Royal Free	22	1.3%
North Middlesex	13	0.7%
Guy's & St. Thomas'	13	0.7%
Basildon & Thurrock	6	0.3%
Imperial	5	0.3%
Barnet & Chase Farm	4	0.2%
Care UK	3	0.2%
South London Healthcare	2	0.1%
Kings College	1	0.1%
Spire	0	0.0%
BMI	0	0.0%
Lewisham	0	0.0%
Dartford & Gravesham	0	0.0%
Royal Brompton	0	0.0%
Others	98	5.6%
Total	1747	100.0%

Barts and The London Trust

24. Finally we considered the relative competitive constraints upon Barts and The London Trust. We proceed directly to the analysis of routine elective treatments since we do not need to consider the specialist/tertiary referrals that Barts and The London Trust receives. Table 8 below shows the results.

25. The GP practice level analysis shows that Barts and The London Trust's most important rivals are Homerton and UCLH. Newham Trust and Whipps Cross Trust are also important as are Guy's & St. Thomas, the Royal Free and Chelsea & Westminster. Using the second assumption BHRUT and Whittington are also each a rival for nearly 10 per cent of Barts and The London Trust's referrals. The analysis suggests that Barts and The London Trust faces a large number of rivals each of which is an important rival for some proportion of Barts and The London Trust's referrals.

APPENDIX 4

Table 8: GP level analysis for a routine elective service at Barts and The London Trust (F54)

	Assumption 1		*Assumption 2*	
No-one	83	9.0%	83	9.0%
Homerton	309	33.7%	377	41.1%
UCLH	197	21.5%	297	32.4%
Newham Trust	190	20.7%	203	22.1%
Whipps Cross Trust	108	11.8%	157	17.1%
Guy's & St. Thomas'	102	11.1%	116	12.6%
Royal Free	98	10.7%	125	13.6%
Chelsea & Westminster	83	9.0%	163	17.8%
BHRUT	59	6.4%	84	9.2%
Imperial	19	2.1%	45	4.9%
North Middlesex	19	2.1%	25	2.7%
Whittington	8	0.9%	88	9.6%
Barnet & Chase Farm	4	0.4%	9	1.0%
Basildon & Thurrock	3	0.3%	4	0.4%
Care UK	3	0.3%	3	0.3%
South London Healthcare	0	0.0%	19	2.1%
Kings College	0	0.0%	1	0.1%
Spire	0	0.0%	0	0.0%
BMI	0	0.0%	0	0.0%
Lewisham	0	0.0%	0	0.0%
Dartford & Gravesham	0	0.0%	0	0.0%
Royal Brompton	0	0.0%	0	0.0%
Others	125	13.6%	195	21.2%
Peripheral	68	7.4%	19	2.1%
Duplicates	-560	-61.0%	-1095	-119.3%
Total	918	100.0%	918	100.0%

SPECIALIST SERVICES: MAPPING THE DATA

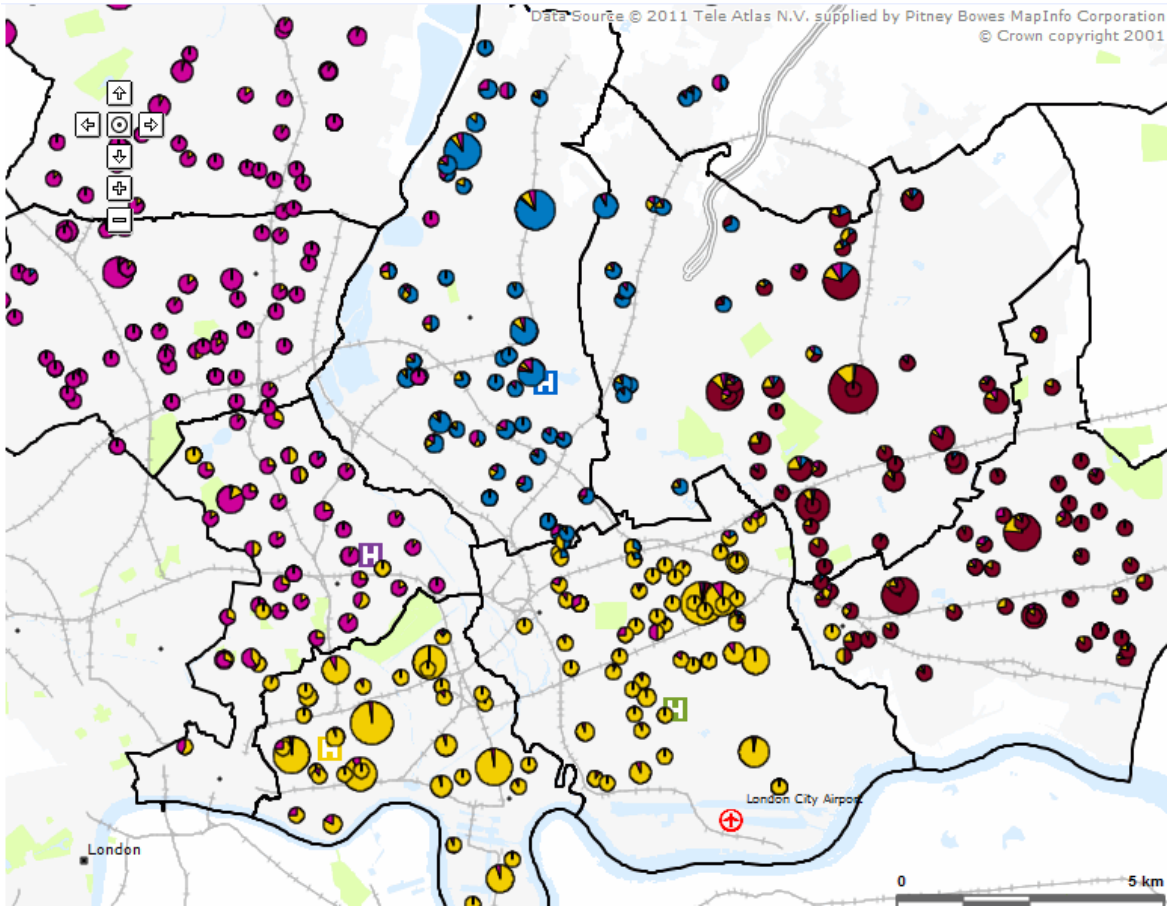
26. In this section we focus the analysis on elective cardiac catheterisation treatment. This is the one specialist service that is provided by more than one of the merging parties. In particular both Barts and The London Trust and Whipps Cross Trust provide this service (Newham Trust does not). We begin by mapping the share of the referrals for a routine treatment that the parties receive from each of the GP practices in the area.[13]

[13] This is for HRG E13 and E14

APPENDIX 4

FIGURE 3

Referrals for elective cardiac catheterisation from GPs in East London



27. From figure 3 we can see that Barts and The London Trust (yellow) provides this service throughout Tower Hamlets and Newham Trust. In contrast the referrals to Whipps Cross Trust (blue) are focused on Waltham Forest, the western half of Redbridge and the southern part of West Essex PCT. Since Homerton (purple) and Newham Trust (green) do not provide the service they do not appear on the map.

Whipps Cross Trust

28. We consider the relative competitive constraints upon Whipps Cross Trust in relation to this specialist service. The GP practice level analysis suggests that Whipps Cross Trust's most important rival is Barts and The London Trust. Between 5 and 10 per cent of GPs also choose between Whipps Cross Trust and each of the Royal Free, Princess Alexandra, Royal Brompton and BHRUT. Nevertheless this version of the analysis suggests that Barts and The London Trust is the most important of the rivals.

29. However, using the second assumption Royal Free, Royal Brompton, BHRUT, UCLH, North Middlesex and Imperial are also each a rival for more than 15 per cent of Whipps Cross Trust's referrals. This version of the analysis suggests that Whipps Cross trust faces a large number of rivals each of which is an important rival for some proportion of Whipps Cross Trust's referrals.

Table 9: GP level analysis for elective cardiac catheterisation at Whipps Cross Trust

	Assumption 1		*Assumption 2*	
No-one	69	6.4%	69	6.4%
Barts and The London Trust	749	69.8%	878	81.8%
Royal Free Hampstead	112	10.4%	165	15.4%
The Princess Alexandra	77	7.2%	82	7.6%
Royal Brompton & Harefield	73	6.8%	259	24.1%
BHRUT	59	5.5%	273	25.4%
UCLH	53	4.9%	289	26.9%
North Middlesex	45	4.2%	181	16.9%
Guy's & St Thomas'	37	3.4%	65	6.1%
Imperial	29	2.7%	185	17.2%
Kings College	28	2.6%	52	4.8%
Papworth	22	2.1%	102	9.5%
Barnet & Chase Farm	3	0.3%	25	2.3%
Basildon & Thurrock	1	0.1%	44	4.1%
Great Ormond Street Hospital	1	0.1%	84	7.8%
BMI	1	0.1%	1	0.1%
Southend University Hospital	1	0.1%	1	0.1%
Whittington	0	0.0%	16	1.5%
Mid Essex	0	0.0%	2	0.2%
St Georges	0	0.0%	0	0.0%
Others	0	0.0%	37	3.4%
Peripheral	59	5.5%	4	0.4%
Duplicates	-346	-32.2%	-1741	-162.3%
Total	1073	100.0%	1073	100.0%

30. Next we considered the aggregated referrals from GP practices that refer patients to Whipps Cross Trust for this specialist treatment (the catchment area level analysis). This gives us the share of referrals that Whipps Cross Trust gets from its catchment area. In this analysis BHRUT is a more important rival than Barts and The London Trust. We also note that the increment in this share that would occur as a result of the merger is 19.7 per cent which compares with an increment of 18.3 per cent for routine elective services at Whipps Cross Trust and a bigger increment of 34.7 per cent for routine elective services at Newham Trust.

Table 10: Catchment area analysis for cardiac catheterisation at Whipps Cross Trust

	Referrals	*Percentage*
Whipps Cross Trust	1039	35.9%
BHRUT	768	26.5%
Barts and The London Trust	571	19.7%
Princess Alexandra	206	7.1%
UCLH	87	3.0%
Barnet & Chase Farm	60	2.1%
Royal Free	38	1.3%
North Middlesex	33	1.1%
Imperial	20	0.7%
Royal Brompton	19	0.7%
Basildon & Thurrock	16	0.6%
Guy's & St. Thomas'	11	0.4%
Kings College	3	0.1%
BMI	1	0.0%
Whittington	1	0.0%
Dartford & Gravesham	1	0.0%
South London Healthcare	1	0.0%
Spire	0	0.0%
Care UK	0	0.0%
Lewisham	0	0.0%
Newham Trust	0	0.0%
Homerton	0	0.0%
Others	19	0.7%
Total	2894	100.0%

Barts and The London Trust

31. Next we consider the relative competitive constraints upon Barts and The London Trust. The GP practice level analysis suggests that Barts and The London Trust's most important rivals are BHRUT and UCLH. Whipps Cross Trust also appears to be important, as are Royal Free and Royal Brompton. The analysis under the second assumption reinforces this conclusion that there is a set of 5 important rivals for Barts and The London Trust's referrals. The analysis suggests that Barts and The London Trust faces a large number of rivals many of which are an important rival for some proportion of Barts and The London Trust's referrals.

Table 11: GP level analysis for elective cardiac catheterisation at Barts and The London Trust

	Assumption 1		*Assumption 2*	
No-one	552	22.6%	552	22.6%
BHRUT	524	21.4%	571	23.3%
UCLH	487	19.9%	573	23.4%
Whipps Cross Trust	425	17.4%	558	22.8%
Royal Free	400	16.4%	546	22.3%
Royal Brompton	217	8.9%	297	12.1%
Basildon & Thurrock	91	3.7%	148	6.1%
Imperial	72	2.9%	124	5.1%
North Middlesex	48	2.0%	96	3.9%
Guy's & St. Thomas'	42	1.7%	123	5.0%
Barnet & Chase Farm	23	0.9%	55	2.2%
BMI	22	0.9%	25	1.0%
Kings College	20	0.8%	26	1.1%
Whittington	4	0.2%	20	0.8%
Spire	0	0.0%	0	0.0%
Care UK	0	0.0%	0	0.0%
Lewisham	0	0.0%	0	0.0%
Dartford & Gravesham	0	0.0%	0	0.0%
Newham Trust	0	0.0%	0	0.0%
Chelsea & Westminster	0	0.0%	0	0.0%
Homerton	0	0.0%	0	0.0%
South London Healthcare	0	0.0%	5	0.2%
Others	176	7.2%	277	11.3%
Peripheral	67	2.7%	16	0.7%
Duplicates	-724	-29.6%	-1566	-64.0%
Total	2446	100.0%	2446	100.0%

32. We then considered the aggregated referrals from GP practices that refer patients to Barts and The London Trust for this specialist treatment (the catchment area level analysis). This gives us the share of referrals that Barts and The London Trust gets from its catchment area. In this analysis BHRUT is the most important rival, and UCLH, Barnet & Chase Farm and North Middlesex are all more important than Whipps Cross Trust. We also note that the increment in this share that would occur as a result of the merger is just 4.5 per cent which compares with an increment of 34.7 per cent for routine elective services at Newham Trust.

Table 12: Catchment area analysis for cardiac catheterisation service at Barts and The London Trust

	Referrals	*Percentage*
Barts and The London Trust	2376	37.1%
BHRUT	1735	27.1%
UCLH	531	8.3%
Barnet & Chase Farm	500	7.8%
North Middlesex	296	4.6%
Whipps Cross Trust	287	4.5%
Royal Free	121	1.9%
Royal Brompton	42	0.7%
Basildon & Thurrock	39	0.6%
Imperial	34	0.5%
Whittington	26	0.4%
Guy's & St. Thomas'	17	0.3%
Kings College	7	0.1%
BMI	4	0.1%
Dartford & Gravesham	1	0.0%
Spire	0	0.0%
Care UK	0	0.0%
Lewisham	0	0.0%
Newham Trust	0	0.0%
Chelsea & Westminster	0	0.0%
Homerton	0	0.0%
South London Healthcare	0	0.0%
Others	386	6.0%
Total	6402	100.0%

Submissions from the parties

33. The parties responded to a working paper setting out this analysis. The parties submitted that this is a static analysis that does not explain what is driving patient choice. We have noted above that this analysis looks at choices made by patients and GPs in the past. We have separately analysed how these decisions may change in future (for example by extrapolating existing trends and considering the evidence of competitor's future strategies), we also asked the parties how these decision can be expected to change in future. They told us that they are unaware of any work carried out internally by any of the parties that assesses the impact of changes in GP referral patterns. They said that based on their current understanding of the market, they would expect that the transferral of GP commissioning could result in some GPs changing their referral patterns. However, they said they cannot take a view as to possible

outcomes. In the absence of evidence to suggest that GP referral patterns will change significantly in future (nor on how they might change) we consider that this analysis is likely to continue to provide a useful insight on the competitive constraints between providers in the area.

34. They agreed with our view that this analysis does not necessarily inform a view as to how patients would respond to a reduction in quality at one of the trusts. They also agreed with our view that it is important to distinguish between routine and specialist treatments. They submitted that this is particularly important for Newham Trust and Whipps Cross Trust, both of which do not compete for specialist referrals (with the exception of cardiac catheterisation).

35. We agree that the set of competitors for specialist services is likely to differ from the set of competitors for routine services. This view has led us to focus the analysis on routine services in the first instance (see paragraphs 2 to 24 above), and in the second instance specialist services in which the parties overlap (see the cardiac catheterisation analysis in paragraphs 25 to 31 above). We also ran the analysis on a number of different treatment lines in order to sensitivity check our results, however we did not find it necessary to conduct an analysis for every routine treatment provided by the merging parties. Our approach to clustering markets is explained in our market definition Appendix (Appendix 2).

36. The parties also noted our analysis of the different options available to patients in east London (see Appendix 3). They submitted that the analysis in this Appendix of the choices that patients and GPs have actually made suggested that patients are willing to travel more than 45 minutes. They then drew the conclusion that we should consider all providers located within 55 minutes to be rivals to the merging parties.

37. Unfortunately this suggests a misunderstanding of the nature of these two analyses. Our analysis in Appendix 3 of the options available shows that there are a good number of providers that can be reached by patients in Newham within 60 minutes. However it is the analysis of the actual choices being made by patients and GPs (and the analysis of internal documents from the parties) which provide some insight on the preferences of patients and GPs and thereby inform a view on which other providers are offering a competitive constraint on the merging parties. The analysis of GP referrals suggests that while patients in Newham might be able to access a number of hospitals within 60 minutes, when faced with those options they appear to be actually choosing predominantly between their local hospital (Newham Trust) and a large teaching hospital (Barts and The London Trust). It is therefore not inconsistent for the competitor set to be smaller than the full choice set; rather it is to be expected where competition is local in its nature.

APPENDIX 5: COMPEITITON FOR ROUTINE ELECTIVE SERVICES IN WIDER NORTH EAST LONDON

1. In this Appendix we set out in more detail our assessment of the competitive constraint on the routine elective services provided at the Royal London, Whipps Cross and Newham hospital sites that would remain following the merger.

2. We identified a number of providers of routine elective care services from a list of competing providers that the parties gave to us. We expect that these providers could be accessed by patients if they wished to do so. These providers include: Homerton University Hospital NHS Foundation Trust, Barking, Havering and Redbridge University Hospitals NHS Trust, University College London Hospitals NHS Foundation Trust, North Middlesex University Hospital NHS Trust, Guy's and St Thomas' NHS Foundation Trust, Moorfields Eye Hospital NHS Foundation Trust, Lewisham Hospital NHS Trust, South London Healthcare NHS Trust, Princess Alexandra NHS Trust, Care UK, BMI Healthcare, Aspen Healthcare and Spire Healthcare. This information, in conjunction with our analysis of patient travel times, helps us to ascertain the choices available to patients and GPs in the wider north east London area.

3. We based our assessment on a range of evidence and information which we considered in the round. This evidence included internal documents provided by the merging parties as well as third parties, including alternative providers and commissioners. This evidence also included submissions by the merging parties and third parties as part of our merger review process and responses to various questions we asked. In addition, we analysed travel time to alternative providers and GP referral patterns.

BARTS AND THE LONDON

4. We first set out our assessment of the extent to which the providers identified above are likely to compete with the routine elective services provided from Barts and The London sites following the merger.

5. Following our assessment of Homerton University Hospital NHS Foundation Trust, University College London Hospitals NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust and Royal Free Trust - which we set out below - we concluded that the merger was unlikely to significantly reduce the competitive constraint on the routine elective services provided from Barts and The London sites. We therefore did not need to reach a view on the extent to which the other providers identified above would also compete.

Homerton University Hospital NHS Foundation Trust

6. We found that Homerton University Hospital NHS Foundation Trust would impose a significant competitive constraint on the routine elective services provided from Barts and The London sites.

7. Homerton University Hospital NHS Foundation Trust offers a broad range of routine elective care from a hospital site located around 4km to the north of the Royal London. It draws the majority of its patients from the area bounded by City & Hackney PCT (82 per cent), with small

flows from surrounding PCT areas. This indicates that the routine elective catchment areas of Homerton University Hospital NHS Foundation Trust and Barts and The London Trust overlap.

8. The merger parties identified Homerton University Hospital NHS Foundation Trust as a strong competitor for routine elective referrals from the Newham, Waltham Forest and Tower Hamlets PCT areas. They identified its high ratings from the CQC, strong financial performance and recent acquisition of a community services provider arm. Consistent with this Barts and The London Trust benchmark their performance against them. Homerton University Hospital NHS Foundation Trust told us they consider Barts and The London to be a strong competitor for routine elective referrals.

9. Our analysis of GP referrals indicates Homerton University Hospital NHS Foundation Trust is a very important competitor to Barts and The London Trust. In particular, Homerton University Hospital NHS Foundation Trust was the most popular alternative to Barts and The London Trust for around a third of Barts and The London's referrals (see Appendix 4 for further details). We found that Barts and The London Trust and Homerton both send marketing material to GP's in City & Hackney (which forms the main catchment area of Homerton University Hospital NHS Foundation Trust) and found evidence that Homerton University Hospital NHS Foundation Trust has been winning referrals from Barts and The London Trust in recent years.

University College London Hospitals NHS Foundation Trust

10. We found that University College London Hospitals NHS Foundation Trust would impose an important competitive constraint on the routine elective services provided from Barts and The London sites.

11. University College London Hospitals NHS Foundation Trust is a large specialist teaching hospital offering a broad range of routine elective care around 5 km to the west of Barts and The London Trust. The merger parties told us University College London Hospitals NHS Foundation Trust is a strong competitor for routine elective referrals. University College London Hospitals NHS Foundation Trust told us that most of their routine elective referrals come from Camden, Islington and Westminster although they increasingly receive referrals from north-east London, particularly from Tower Hamlets and Hackney where University College London Hospitals NHS Foundation Trust sends marketing material. These areas lie within the immediate catchment area of Barts and The London Trust.

12. Our analysis of GP referrals indicates University College London Hospitals NHS Foundation Trust is an important competitor to Barts and The London Trust. In particular, we found University College London Hospitals NHS Foundation Trust was the most popular alternative to Barts and The London Trust for around 20 per cent of Barts and The London Trust's referrals) (see Appendix 4 for further details). We found some evidence of University College London Hospitals NHS Foundation Trust winning referrals from Barts and The London Trust in recent years.

Guy's and St Thomas' NHS Foundation Trust

13. We found that Guy's and St Thomas' NHS Foundation Trust would impose some competitive constraint on the routine elective services provided from Barts and The London sites, although the constraint is unlikely to be as strong as that imposed by Homerton University Hospital NHS Foundation Trust or University College London Hospitals NHS Foundation Trust.

14. Guy's and St Thomas' NHS Foundation Trust is a large specialist teaching hospital offering a broad range of routine elective care from two sites; the closest of which is Guys Hospital located 3km to the south west of Barts and The London Trust. The merger parties consider Guy's and St Thomas' NHS Foundation Trust to be a weak competitor for routine elective referrals and Guys and St Thomas' told us that its local and secondary care service catchment area is focused on south-east and parts of inner south-west London and that they do not consider themselves to be competing for patients with hospitals in north-east London. Consistent with this, Guy's and St Thomas' NHS Foundation Trust explained that they do not send marketing material to GPs in north-east London as they are focused on building relationships with GP's in their main catchment area. Our analysis of GP referral patterns indicates Guy's and St Thomas' NHS Foundation Trust is a rival to Barts and The London Trust. In particular, we found that Guy's and St Thomas' NHS Foundation Trust was the most popular alternative to Barts and The London Trust for around 10 per cent of Barts and The London Trust's referrals (see Appendix 4 for further details).

Royal Free Trust

15. We found that Royal Free Trust imposes some competitive constraint on the routine elective services provided by Barts and The London, although the constraint is unlikely to be as strong as that imposed by Homerton University Hospital NHS Foundation Trust or University College London Hospitals NHS Foundation Trust

16. Royal Free Trust offers a broad range of routine elective services from its main site in Hampstead located around 8km to the north west of Barts and The London. It also provides elective ENT services from a site 4km to the north west of Barts and The London. Barts and The London did not identify Royal Free Trust as a competitor for routine elective services but it did identify the Royal Free Trust as a competitor for specialist services.[1]

17. Our analysis of GP referral patterns indicates Royal Free Trust is a competitor to Barts and The London Trust. In particular, we found Royal Free Trust was the most popular alternative to Barts and The London Trust for around 10 per cent of Barts and The London Trust's referrals (see Appendix 4 for further details).

WHIPPS CROSS HOSPITAL

18. We next set out our assessment of the extent to which the providers identified above are likely to compete with the routine elective services provided from Whipps Cross hospital following the merger.

[1] We note that the Royal Free Trust has previously provided ENT services from the Newham Hospital site and so has some relationship with GPs in the area although these services are now provided by Whipps Cross Trust.

19. Following our assessment of Barking, Havering and Redbridge University Hospitals NHS Trust, Homerton University Hospital NHS Foundation Trust, University College London Hospitals NHS Foundation Trust, Princess Alexandra NHS Trust, North Middlesex University Hospital NHS Trust and Care UK - which we set out below - we concluded that the merger was unlikely to significantly reduce the competitive constraint on the routine elective services provided from Whipps Cross hospital. We therefore did not need to consider the extent to which other providers would compete with the routine elective services provided from Whipps Cross hospital.

Barking, Havering and Redbridge University Hospitals NHS Trust

20. We found that Barking, Havering and Redbridge University Hospitals NHS Trust imposes an important competitive constraint on the routine elective services provided from Whipps Cross hospital although it is not currently a strong competitor.

21. Barking, Havering and Redbridge University Hospitals NHS Trust currently provides routine elective services from two sites located between 5 and 8km to the east of the Whipps Cross hospital site: King George hospital in Ilford and Queens hospital in Romford.[2] We found that many patients in the catchment area of Whipps Cross hospital could access elective services at Barking, Havering and Redbridge University Hospitals NHS Trust within a 60 minute travel time (see Appendix 3 for further details).

22. [✂]

23. The merger parties consider Barking, Havering and Redbridge University Hospitals NHS Trust is currently a moderate competitor to Whipps Cross hospital for patients in Newham, Waltham Forest and Redbridge but expect it to become stronger in future if its performance improves. Internal documents provided to us by Whipps Cross Trust also identify Barking, Havering and Redbridge University Hospitals NHS Trust as a competitor. Barking, Havering and Redbridge University Hospitals NHS Trust told us it competes with Whipps Cross hospital for routine elective referrals from GPs in Redbridge. Consistent with this, Barking, Havering and Redbridge University Hospitals NHS Trust sends marketing material to GP's in Redbridge and Waltham Forest which both lie within the main catchment area of Whipps Cross hospital.

24. Our analysis of GP referral patterns indicates Barking, Havering and Redbridge University Hospitals NHS Trust is a competitor to Whipps Cross hospital. In particular, we found Barking, Havering and Redbridge University Hospitals NHS Trust was the most popular alternative to Whipps Cross hospital for around 15 per cent of Whipps Cross hospital's referrals We also found Barking, Havering and Redbridge University Hospitals NHS Trust to have around a 15 per cent share of all routine elective referrals from the catchment area of Whipps Cross hospital; the highest of all rival providers. See Appendix 4 for further details.

[2] We understand that under the Healthcare for North East London reconfiguration proposals Barking Trust's routine elective services will be consolidated into a dedicated elective centre to be located on the King George Hospital site. We therefore focus our analysis on this site

Homerton University Hospital NHS Foundation Trust

25. We found that Homerton University Hospital NHS Foundation Trust imposes some competitive constraint on the routine elective services of Whipps Cross hospital although we consider it exerts less of a competitive constraint than we might expect given its proximity.

26. Homerton University Hospital NHS Foundation Trust offers a broad range of routine elective services from a hospital site located around 5km to the south west of Whipps Cross hospital. It draws the majority of its patients from the area bounded by City & Hackney PCT (82 per cent), with small flows from surrounding PCT areas. This indicates that the routine elective catchment areas of Homerton University Hospital NHS Foundation Trust and Whipps Cross overlap (to some degree). We found that many patients in the catchment area of Whipps Cross hospital could access routine elective services at Homerton University Hospital NHS Foundation Trust within 60 minute travel time (see Appendix 3 for further detail). However, we note NHS Waltham Forest consider that patients in their PCT area were more likely to travel for treatment at Barts and The London Trust rather than Homerton University Hospital NHS Foundation Trust even though it is located further away.[3]

27. The merger parties consider Homerton University Hospital NHS Foundation Trust to be a strong competitor for routine elective referrals from the Newham, Waltham Forest and Tower Hamlets PCT areas. They identified its high ratings from the CQC, strong financial performance and recent acquisition of a community services provider arm. Homerton University Hospital NHS Foundation Trust considers Whipps Cross Trust to be a competitor, albeit not a strong competitive constraint. Consistent with this, we found that Homerton University Hospital NHS Foundation Trust does not send marketing material to GP's in the catchment area of Whipps Cross Trust.[4]

28. Our analysis of GP referral patterns indicates Homerton University Hospital NHS Foundation Trust is a competitor to Whipps Cross Trust. In particular, we found Homerton University Hospital NHS Foundation Trust was the most popular alternative to Whipps Cross Trust for around 10 per cent of Whipps Cross Trust's referrals and we found Homerton University Hospital NHS Foundation Trust has less than 5 per cent share of all referrals from GP's in the catchment area of Whipps Cross Trust (see Appendix 4 for further details).

University College London Hospitals NHS Foundation Trust

29. We found that University College London Hospitals NHS Foundation Trust imposes some competitive constraint on the routine elective services provided from Whipps Cross Hospital.

30. University College London Hospitals NHS Foundation Trust provides a broad range of routine elective services from a site located around 11km to the south west of Whipps Cross Trust. While located in central London, we found that many patients in the catchment area of Whipps Cross hospital could access routine elective services at University College London Hospitals NHS Foundation Trust within a 60 minute travel time (see Appendix 3 for further details).

[3] NHS Waltham Forest Commissioning Strategic Plan 2009/10-2013/14, p27
[4] Homerton Trust only sends marketing material to GPs located in City and Hackney.

31. Internal documents provided by Whipps Cross Trust do not identify University College London Hospitals NHS Foundation Trust as a competitor (they identified a competitor set comprising of six large NHS Trusts in the north east London area). However, the merger parties submitted that University College London Hospitals NHS Foundation Trust is a strong competitor for patients in the catchment area of Whipps Cross Trust. University College London Hospitals NHS Foundation Trust told us they are experiencing an increase in referrals from GPs in north east London, although our analysis suggests these are mainly from Tower Hamlets or City & Hackney which do not form part of the principal catchment area of Whipps Cross Trust.

32. Our analysis of GP referral patterns indicates University College London Hospitals NHS Foundation Trust is a competitor to Whipps Cross Trust. In particular, University College London Hospitals NHS Foundation Trust was the most popular alternative to Whipps Cross Trust for around 10 per cent of Whipps Cross Trust's referrals and we found University College London Hospitals NHS Foundation Trust had less than 5 per cent share of all referrals from the catchment area of Whipps Cross Trust (See Appendix 4 for further details).

Princess Alexandra NHS Trust

33. We found that Princess Alexandra NHS Trust imposes some competitive constraint on the routine elective services provided from Whipps Cross Hospital, mainly for patients located in the north of its catchment area.

34. The Princess Alexandra NHS Trust provides a broad range of routine elective services from its hospital site located in Harlow which is around 22km to the north of Whipps Cross hospital. The merger parties told us that Princess Alexandra NHS Trust is not easily accessible for patients in inner north-east London and our analysis of travel times to alternative hospitals confirmed this. However, they explained Whipps Cross Trust's catchment area extends to parts of West Essex and that Princess Alexandra NHS Trust would be a moderate competitor for routine elective referrals from this part of its catchment area. We found that patients in this area would be able to access routine elective services at Princess Alexandra NHS Trust within a 60 minute travel time (see Appendix 3 for further details). Internal documents provided by Whipps Cross Trust identified Alexandra Trust as a competitor.

35. Our analysis of GP referral patterns indicates Princess Alexandra NHS Trust is a competitor to Whipps Cross Trust. In particular, we found Princess Alexandra NHS Trust was the most popular alternative to Whipps Cross Trust for around 10 per cent of Whipps Cross Trust's referrals and received around 4 per cent share of all referrals from GP's located within the catchment area of Whipps Cross Trust (see Appendix 4 for further details).

North Middlesex University Hospital NHS Trust

36. We found that North Middlesex University Hospital NHS Trust imposes some competitive constraint on the routine elective services provided from Whipps Cross Hospital, although the strength of this constraint is less than its proximity to Whipps Cross hospital would suggest.

37. North Middlesex University Hospital NHS Trust provides a broad range of routine elective services from a hospital site located around 6km to the north west of Whipps Cross hospital

on the Haringey/Enfield border. We found that many patients in the catchment area of Whipps Cross hospital could access routine elective services at North Middlesex University Hospital NHS Trust within a 60 minute travel time (see Appendix 3 for further details). However, we found that currently few of North Middlesex University Hospital NHS Trust's patients (2 per cent) are from Waltham Forest (which forms a large part of Whipps Cross hospital's catchment area), with around 90 per cent from Enfield and Haringey.

38. The merger parties considered North Middlesex University Hospital NHS Trust to be a moderate competitor to Whipps Cross hospital for patients in Waltham Forest. Internal documents provided by Whipps Cross Trust also identified North Middlesex University Hospital NHS Trust as a competitor.

39. Our analysis of GP referral patterns indicates North Middlesex University Hospital NHS Trust is a competitor to Whipps Cross Trust. In particular, North Middlesex University Hospital NHS Trust was the most popular alternative to Whipps Cross Trust for around 8 per cent of Whipps Cross Trust's referrals although we found North Middlesex University Hospital NHS Trust only received around 1 per cent share of all referrals from the catchment area of Whipps Cross Trust.

Care UK

40. We found that Care UK currently imposes little competitive constraint on the routine elective services of Whipps Cross hospital although we would expect this to increase in the future.

41. Care UK has provided a limited range of routine elective services from the North East London NHS Independent Sector Treatment Centre (NEL ISTC) since 2006.[5] The NEL ISTC is located on the King George hospital site which is around 5km to the east of Whipps Cross hospital. We found many patients in the catchment area of Whipps Cross hospital could access NEL ISTC within a 60 minute travel time (see Appendix 3).

42. Care UK previously held an ISTC contract which limited the range of routine elective services they have been able to provide. The contract also had a minimum income guarantee which will have dampened its incentive to compete for patients. This contract has now been replaced with a Standard Acute Contract (with no income guarantee) and so in the future Care UK will be free to offer a wider range of routine elective services. We discuss the likely impact of this below.

43. Care UK told us their catchment area includes Waltham Forest and Redbridge (which also form part of the catchment area of Whipps Cross Trust) and they operate an outpatient clinic in each area. We note, however, Care UK do not send marketing material to GP's in Waltham Forest. Care UK told us that Whipps Cross Trust is a close competitor for referrals from Waltham Forest and parts of Redbridge. Internal documents provided by Whipps Cross Trust did not identify Care UK as a competitor. However, the merger parties identify Care UK as a strong competitor for routine elective referrals from Newham, Redbridge and Waltham Forest.

[5] Care UK has previously been contracted to provide ENT, gastroenterology, general surgery, ophthalmology, oral, orthopaedics and pain management.

44. Our analysis of GP referral patterns indicates that Care UK currently imposes little competitive constraint on Whipps Cross Trust. In particular, Care UK was the most popular alternative to Whipps Cross Trust for fewer than 2 per cent of Whipps Cross Trust's referrals and had less than a 0.2 per cent share of all referrals from the catchment area of Whipps Cross Trust (see Appendix 4 for further details).

45. We considered whether the change in contracting arrangements described above will change the competitive constraint from Care UK in the future. Care UK won the tender to provide routine elective services from the NEL ISTC for a further 3 years. They told us the change in contracting arrangements is likely to initially lead to a decrease in referrals (which is consistent with commissioners which are liable to pay the minimum income guarantee influencing referral patterns) but plan to offset this initial decline by increasing their marketing to GP both within and outside their immediate catchment area and seeking to raise awareness of their services with patients.

NEWHAM HOSPITAL

46. We now set out our assessment of the extent to which the providers identified above are likely to compete with the routine elective services provided from the Newham hospital site following the merger.

47. As noted above, there are a range of providers in the wider north east London area, including: Homerton University Hospital NHS Foundation Trust, Barking, Havering and Redbridge University Hospitals NHS Trust, University College London Hospitals NHS Foundation Trust, North Middlesex University Hospital NHS Trust, Guy's and St Thomas' NHS Foundation Trust, Moorfields Eye Hospital NHS Foundation Trust, Lewisham Hospital NHS Trust, South London Healthcare NHS Trust, Princess Alexandra NHS Trust, Care UK, BMI Healthcare, Aspen Healthcare and Spire Healthcare

Homerton University Hospital NHS Foundation Trust

48. We found that Homerton University Hospital NHS Foundation Trust imposes some competitive constraint on the routine elective services provided from the Newham Hospital site, although it is not a significant competitor.

49. Homerton University Hospital NHS Foundation Trust operates from a single hospital site located around six kilometres to the north-west of the Newham Hospital site. We found that many patients in the catchment area of Newham Trust can access services at Homerton University Hospital NHS Foundation Trust within a 60 minute travel time (see Appendix 3 for further details). However, we found that very few patients from the Newham area currently choose to have routine elective treatment at Homerton University Hospital NHS Foundation Trust (around two per cent). Homerton University Hospital NHS Foundation Trust told us that the vast majority of its referrals for routine elective service are from City & Hackney (around 80 per cent), with small flows from Waltham Forest (five per cent) and Newham (three per cent). Homerton University Hospital NHS Foundation Trust told us that they only send marketing material to GP practices in City & Hackney. We therefore found a small overlap in

the respective catchment areas of Homerton University Hospital NHS Foundation Trust and Newham Trust.

50. Homerton University Hospital NHS Foundation Trust told us they consider Newham Trust to be a weak competitor, although we note that the competitive constraints of Newham Trust on Homerton University Hospital NHS Foundation Trust may not be the same as the constraint from Homerton University Hospital NHS Foundation Trust on Newham Trust. The merger parties told us that they consider Homerton University Hospital NHS Foundation Trust to be a strong competitor,[6] although we note that internal documents provided by Newham Trust prior to the merger being proposed did not identify Homerton University Hospital NHS Foundation Trust as a competitor, focusing instead on the threat posed by Barts and The London. However, these internal documents do show Newham Trust benchmarks its performance against Homerton University Hospital NHS Foundation Trust (as well as Barts and The London, Whipps Cross Trust and Barking, Havering and Redbridge University Hospitals NHS Trust).

51. Our analysis of GP referrals suggests Homerton University Hospital NHS Foundation Trust was considered an important alternative to Newham Trust for fewer than five per cent of Newham Trust's referrals and had a share of all referrals from GP's that referred to Newham Trust of less than 5 per cent.

52. We considered whether Homerton University Hospital NHS Foundation Trust would become a more important competitive constraint on the services provided from the Newham Hospital site in the foreseeable future and found that while they may become a more important competitor they would be unlikely to provide a significant competitive constraint. Homerton University Hospital NHS Foundation Trust has been increasing its share of referrals from GPs in the Newham area and when we applied these growth trends going forward we found Homerton University Hospital NHS Foundation Trust would have a projected share of around three per cent by 2015. We considered whether the growth rate may increase but found no evidence to support this. In particular, internal documents indicate their 'vision is to thrive and remain sustainable by retaining or increasing market share of the local population's referrals'. Consistent with this strategy, Homerton University Hospital NHS Foundation Trust has focused efforts on identifying those GPs in the City and Hackney areas which appear to be referring fewer than expected patients to Homerton University Hospital NHS Foundation Trust. We also note Homerton University Hospital NHS Foundation Trust do not send marketing material to GPs in Newham.

Barking, Havering and Redbridge University Hospitals NHS Trust

53. We found that Barking, Havering and Redbridge University Hospitals NHS Trust is likely to impose some competitive constraint on the routine elective services provided from the Newham Hospital site in the future although it is not currently a significant competitor.

54. Barking, Havering and Redbridge University Hospitals NHS Trust currently provides routine elective services from two sites located between 8 and 11km to the north-east of the Newham

[6] They identified its high ratings from the CQC, strong financial performance and recent acquisition of a community services provider arm

Hospital site: King George Hospital in Ilford and Queens Hospital in Romford.[7] We found that many patients in the Newham area could access services at Barking, Havering and Redbridge University Hospitals NHS Trust within a 60 minute travel time (see Appendix 3 for further details) although few of them currently do (less than two per cent).

55. Barking, Havering and Redbridge University Hospitals NHS Trust was registered by the CQC with a high number of conditions in April 2010. The CQC made a number of unannounced inspections following this which identified concerns and resulted in enforcement action being taken against the Trust. Although some improvements were noted, the Trust's capacity to respond adequately to the level of concern resulted in a formal investigation being launched by the CQC in April 2011. The full report, published in October 2011, identified serious problems in relation to the quality of care provided, particularly in maternity, Accident and Emergency and radiology services. The CQC reports that patients remain at risk of poor care at this Trust, and significant improvement action is now underway, supported by NHS London and commissioners. The CQC are continuing to monitor the Trust with unannounced inspections and will then review evidence in March 2012. Barking, Havering and Redbridge University Hospitals NHS Trust told us that there had been some adverse media coverage in relation to its maternity and accident and emergency services and that it had experienced a decline in elective and outpatient referrals (although it was unclear whether this was linked to care quality issues or referral management schemes being put in place by local commissioners).

56. The merger parties told us they consider Barking, Havering and Redbridge University Hospitals NHS Trust to be a moderate competitor, although they consider that over time the strength of the constraint may increase if its clinical and financial performance improves. Barking, Havering and Redbridge University Hospitals NHS Trust told us they compete with Newham Trust, although largely in Barking and Dagenham (which comprises only around two per cent of Newham Trust's referrals). Barking, Havering and Redbridge University Hospitals NHS Trust does not send marketing material to GP's in the Newham area which forms the main catchment area of Newham Trust. Internal documents provided to us by Newham Trust did not identify Barking, Havering and Redbridge University Hospitals NHS Trust as a competitor, focusing instead on the threat posed by Barts and The London. However, these documents did show Newham Trust benchmarked its performance against Barking, Havering and Redbridge University Hospitals NHS Trust (as well as Barts and The London, Whipps Cross Trust and Homerton University Hospital NHS Foundation Trust).

57. Our analysis of GP referrals indicates Barking, Havering and Redbridge University Hospitals NHS Trust is a rival to Newham Trust. In particular, we found Barking, Havering and Redbridge University Hospitals NHS Trust was the most popular alternative to Newham Trust for around 10 per cent of Newham Trust's referrals and had around a 15 per cent share of all referrals from GP's that referred to Newham Trust (see Appendix 4 for further details).

58. We considered whether Barking, Havering and Redbridge University Hospitals NHS Trust would become a more important competitor to Newham Trust in the future and concluded

[7] We understand that routine elective services are due to be consolidated onto the King George site as part of the Health for north-east London service reconfiguration proposals.

that while the strength of the competitive constraint may increase over the longer term it would be unlikely to become a significant competitive constraint in the foreseeable future. Barking, Havering and Redbridge University Hospitals NHS Trust currently has a very small share of routine elective referrals from GPs in the Newham area (less than two per cent) and we consider it unlikely that Barking, Havering and Redbridge University Hospitals NHS Trust will focus on gaining a larger share over the foreseeable future. First, the recently announced service reconfiguration in the north east London area will require significant change to the services (both routine elective and non-elective) provided across its two hospital sites.[8] Second, as discussed above, Barking, Havering and Redbridge University Hospitals NHS Trust has responded to concerns over its clinical quality and is having to focus on taking the required action to improve, under close scrutiny and monitoring by NHS London, commissioners and the CQC. The implementation of these changes is likely to distract efforts from growing referral volumes from the Newham area.

University College London Hospitals NHS Foundation Trust

59. We found that University College London Hospitals NHS Foundation Trust currently imposes little competitive constraint on the routine elective services provided from the Newham Hospital site and found this would be unlikely to change in the foreseeable future.

60. University College London Hospitals NHS Foundation Trust provides a broad range of routine elective services from a number of sites in central London which are located around 12 kilometres to the west of the Newham Hospital site. We found that many patients in Newham could access routine elective services at University College London Hospitals NHS Foundation Trust within a 60 minute travel time (see Appendix 3 for further details) although few of them currently do so (less than 3 per cent).

61. The merger parties told us they consider University College London Hospitals NHS Foundation Trust to be a strong competitor, although they did not identify which sites within the merged organisation this would be the case for. University College London Hospitals NHS Foundation Trust told us they do not compete with Newham Trust and while they have seen an increasing number of referrals from north-east London these have primarily been from the Tower Hamlets and Hackney areas which lie outside the principal catchment area of the Newham Hospital site. We note University College London Hospitals NHS Foundation Trust do not send marketing material to GPs in the Newham area. We also note that internal documents provided to us by Newham Trust that pre-date the proposed merger did not identify University College London Hospitals NHS Foundation Trust as a competitor, focusing instead on the threat posed by Barts and The London. We note that Newham Trust does not benchmark its performance against University College London Hospitals NHS Foundation Trust.

62. Our analysis of GP referral patterns indicates University College London Hospitals NHS Foundation Trust is not an important rival. In particular, we found University College London

[8] In particular, all routine elective care will transfer from Queens Hospital to King George Hospital where a standalone elective care centre will be developed and all accident and emergency and maternity services will transfer from King George Hospital to Queens Hospital.

Hospitals NHS Foundation Trust is the most popular alternative to Newham Trust for almost none of Newham Trust's referrals (one per cent).

63. We considered whether University College London Hospitals NHS Foundation Trust would become a more important competitor to Newham Trust in the future. We concluded that based on trends in the growth rate of referrals from the Newham area and the strategy of University College London Hospitals NHS Foundation Trust that it would be unlikely to provide a significant competitive constraint on the routine elective services provided from the Newham Hospital site in the foreseeable future.

Guy's and St Thomas' NHS Foundation Trust

64. We found that Guy's and St Thomas' NHS Foundation Trust imposes little competitive constraint on the routine elective services provided from the Newham Hospital site and found this would be unlikely to change in the foreseeable future.

65. Guy's and St Thomas' Trust provides a broad range of routine elective services from two hospital sites located between 9 and 11km to the south west of the Newham Hospital site: Guys Hospital and St Thomas' Hospital. We found that many patients in the Newham area could access routine elective services at Guy's and St Thomas' NHS Foundation Trust within a 60 minute travel time (see Appendix 3 for further details) although very few of them currently do (1 per cent).

66. Guy's and St Thomas' Trust told us their main catchment area for local and secondary care services is south east London and parts of inner south-west London and they do not consider themselves to compete for patients with hospitals in north-east London. Consistent with this, Guy's and St Thomas' Trust do not send marketing information to GP's in north-east London and instead focus on building relationships with GP practices in their main catchment area. [9] They have no plans to change this strategy in the immediate future.[10]

67. The merger parties told us that Guy's and St Thomas' NHS Foundation Trust was a weak competitor for routine elective services although they noted the Jubilee line provides good access to the trust's sites from the main population centre of Newham (Stratford). Internal documents from Newham Trust that pre-date this proposed merger do not identify Guy's and St Thomas' Trust as a competitor, focusing instead on the threat posed by Barts and The London. We note that Newham Trust does not benchmark its performance against Guy's and St Thomas' Trust.

68. Our analysis of GP referrals indicates Guy's and St Thomas' NHS Foundation Trust is not an important competitor. In particular, we found Guy's and St Thomas' NHS Foundation Trust was the most popular alternative to Newham Trust for around five per cent of Newham Trust's referrals (see Appendix 4 for further details).

[9] Guys and St Thomas' Trust explained that there are so few GP referrals from north of the river because of historical and habitual referral patterns and personal relationships that develop between GPs and local hospitals. Also, they said there is a public perception that South London is difficult to get to and the lack of public familiarity with the area reinforces behaviour. They consider that public transport links across the Thames are not as good as those north of the river, especially the underground system.
[10] They told us they could not rule out a change of strategy in the next 3 to 5 years.

69. We considered whether Guy's and St Thomas' NHS Foundation Trust would become a more important competitor to Newham Trust in the future and concluded based on observed trends in the growth rate of referrals from the Newham area that it would be unlikely to provide a significant competitive constraint on the routine elective services provided from the Newham Hospital site in the foreseeable future.

Care UK

70. We found that Care UK currently imposes little competitive constraint on the routine elective services provided from the Newham Hospital site and while this may increase in the future we found it is unlikely to change significantly in the foreseeable future.

71. Care UK has provided a limited range of routine elective services from the North East London NHS Independent Sector Treatment Centre (NEL ISTC) since 2006.[11] The NEL ISTC (located on the King George hospital site) is around 8km to the north east of the Newham hospital site. We found many patients in the catchment area of Newham hospital could access NEL ISTC within a 60 minute travel time (see Appendix 3). However, we found few of them currently choose to do so (less than 0.5 per cent).

72. The merger parties told us they consider Care UK to be a strong competitor, although Care UK was not referred to in Newham Trust's internal documents which pre-date the merger. Care UK told us they do compete with Newham Trust, although largely in Barking and Dagenham which accounts for a small share of Newham Trust's patients (around two per cent).

73. Our analysis of routine GP referrals suggests Care UK currently imposes little competitive constraint. In particular, Care UK was the most popular alternative to Newham Trust for only around one per cent of Newham Trust's routine elective referrals (around 1 per cent).

74. We noted above in our discussion of the competitive constraints on the Whipps Cross hospital site that Care UK has recently been awarded a contract to provide elective services from the site for a further three years and under the new contacting arrangements will not be paid a minimum income guarantee. We considered whether these contractual changes would increase the competitive constraint provided by Care UK on the services provided from the Newham hospital site. Care UK told us that these changes are likely to initially lead to a reduction in referrals but they plan to offset this through increasing their marketing and patient awareness activities both within and outside their immediate catchment area. We note that Care UK has recently established an outpatient clinic in Leytonstone which is easily accessible to patients located in the northern part of Newham. However, we also note that Newham was previously not responsible for funding the minimum income guarantee and so had no incentive to seek to increase the number of patients who have had treatment by care UK in the past.

75. Taking all this together, while we might expect the competitive constraint imposed on the Newham hospital site by Care UK is likely to increase, we do not consider it likely that they will become a significant competitive constraint in the foreseeable future.

[11] Care UK has previously been contracted to provide ENT, gastroenterology, general surgery, ophthalmology, oral, orthopaedics and pain management.

North Middlesex University Hospital NHS Trust

76. We found that North Middlesex University Hospital NHS Trust does not impose a competitive constraint on the routine elective services provided from the Newham Hospital site and found this would be unlikely to change in the foreseeable future.

77. North Middlesex University Hospital NHS Trust provides a broad range of routine elective services from its hospital site located around 12 kilometres to the north-west of the Newham hospital site on the Haringey/Enfield border. We found that while patients in the Newham area could use their routine elective services we found that few of them choose to do so (less than 0.5 per cent).

78. The merging parties did not identify North Middlesex University Hospital NHS Trust as a competitor for patients in the Newham area. Internal documents provided by Newham Trust that pre-date the proposed merger do not identify North Middlesex University Hospital NHS Trust as a competitor, focusing instead on the threat from Barts and The London.

79. Our analysis of GP referral patterns indicates North Middlesex University Hospital NHS Trust is not considered an important alternative to Newham Trust. In particular, we found North Middlesex University Hospital NHS Trust was the most popular alternative to Newham Trust for none of Newham Trust's routine elective referrals.

Moorfields Eye Hospital NHS Foundation Trust

80. We found that Moorfields Eye Hospital NHS Foundation Trust provides a significant competitive constraint on the ophthalmology services provided from the Newham Hospital site.

81. Moorfields Eye Hospital NHS Foundation Trust is a specialist hospital focusing on ophthalmology services and is located around nine kilometres to the west of the Newham hospital site. We consider Moorfields Eye Hospital NHS Foundation Trust to be a significant competitor to the Newham hospital site for routine elective referrals for this speciality due to their strong reputation. We note that they currently receive around 50 per cent of all elective ophthalmology referrals from the Newham area.

BMI Healthcare

82. We found that BMI Healthcare imposes little competitive constraint on the routine elective services provided from the Newham Hospital site. While this constraint may increase in the future, particularly for orthopaedic services where they are developing their service offer, we consider it unlikely to provide a significant competitive constraint in the foreseeable future.

83. BMI Healthcare provides routine elective services in the area from the London Independent Clinic which is located around five kilometres to the west of the Newham hospital site. We found that many patients in the Newham area could access BMI Healthcare within a 60 minute travel time (see Appendix 3). However, we found that few of them use BMI Healthcare (around 0.5 per cent).

84. Internal documents from Newham Trust do not identify BMI Healthcare as a competitor, focusing instead on the threat posed by Barts and The London. Newham Trust does not benchmark its performance against BMI Healthcare.

85. Our analysis of GP referral patterns indicates BMI Healthcare is not considered an important alternative to Newham Trust. In particular, we found BMI Healthcare was the most popular alternative to Newham Trust for few of Newham Trust's routine elective referrals.

86. We considered whether BMI Healthcare would become a more important competitor in the foreseeable future and found that while they may become more important they are unlikely to provide a significant competitive constraint on the routine elective services provided from the Newham hospital site. In particular, BMI Healthcare told us they recently opened a 20 bed elective day-case unit on the site which focuses on day-case orthopaedic procedures but explained that their marketing focus for this new service were GP's located within the western part of Tower Hamlets i.e. the area immediately surrounding their hospital and they find that GPs in the area are often not fully aware of the NHS services offered by private sector providers.

Spire Health Care

87. We found that Spire Healthcare does not impose a competitive constraint on the routine elective services provided from the Newham Hospital site and is unlikely to do in the foreseeable future.

88. Spire Healthcare (Roding site) is located around seven kilometres to the north of the Newham hospital site**.** We found that while patients from the Newham area could use Spire for their routine elective care few of them do so (less than 0.5 per cent).

89. Internal documents from Newham Trust do not identify Spire Healthcare as a competitor, focusing instead on the threat posed by Barts and The London. Newham Trust does not benchmark its performance against Spire Healthcare.

90. Our analysis of GP referral patterns indicates Spire Healthcare is not considered an important alternative to Newham Trust. In particular, we found Spire Healthcare was the most popular alternative to Newham Trust for none of Newham Trust's routine elective referrals.

91. The merger parties explained to us Spire Healthcare has demonstrated a willingness to treat patients at NHS tariff through their contract with Whipps Cross Trust. However, we do not consider that evidence of their willingness to undertake NHS work via a subcontracting arrangement provides evidence of their ability to compete effectively with Newham Trust for referrals from GP's in the Newham area.

92. We considered whether Spire Healthcare would become a more important competitor in the foreseeable future and found that while they may become more important there was no evidence to indicate that this was likely and so we expect that they are unlikely to provide a significant competitive constraint on the routine elective services provided from the Newham hospital site.

Other potential competitors

93. We also considered whether Princess Alexandra NHS Trust, Aspen Healthcare (Holly House), South London Healthcare NHS Trust and Lewisham Hospital NHS Trust would impose a competitive constraint on the routine elective services provided from Newham hospital. This is because combined they have a very small share (0.2 per cent) of elective referrals from the Newham area. Internal documents from Newham Trust also do not identify these providers as a competitor, focusing instead on the threat posed by Barts and The London