Anticipated acquisition by Chelsea and Westminster NHS Foundation Trust of West Middlesex University NHS Trust

ME/6481-14

Please note that [✂] indicates figures or text which have been deleted or replaced in ranges at the request of the parties for reasons of commercial confidentiality.

SUMMARY

1. Chelsea and Westminster NHS Foundation Trust (**CWFT**) and West Middlesex University NHS Trust (**WMUT**) (together **the Parties**) propose to merge their hospital based services (the **Merger**). These include elective and non-elective inpatient and outpatient services and specialised services to patients across West London. CWFT provides many more specialised services than WMUT.

2. The Competition and Markets Authority (**CMA**) considers that it has jurisdiction to assess the competitive impact of the Merger. The CMA believes that there are arrangements in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation according to the merger control provisions of the Enterprise Act 2002 (the **Act**). These arrangements will result in two or more enterprises ceasing to be distinct and the turnover test being met.

3. The CMA examined whether the Merger may be expected to result in a substantial lessening of competition in the provision of healthcare services leading to worse outcomes for patients and commissioners in West London.

4. With respect to product market definition, the CMA found that each specialty constitutes a separate market, consistent with previous decisions it has adopted in the context of mergers involving NHS providers.[1] Within each

[1] Also relevant case precedents from the CMA's predecessor organisations: the Competition Commission (**CC**) and the Office of Fair Trading (**OFT**). See for example, the CMA's decision of 14 May 2014 on the anticipated acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust by Frimley Park Hospital NHS Foundation Trust. (Frimley/Heatherwood); also CC, A report on the anticipated merger of The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17

specialty, the CMA treated (i) outpatient and inpatient activities as separate markets and (ii) non-elective and elective services as separate markets. The CMA considered that private services are separate markets from NHS services[2] and assessed the Merger on the basis of its impact on competition in the market and competition for the market, separately.

5. In relation to competition in the market, the CMA analysed competition for the provision of NHS elective inpatient and outpatient services and private services. In relation to competition for the market, the CMA analysed competition for winning contracts for commissioned NHS elective and non-elective inpatient services and outpatient services, including specialised services. The CMA did not, however, find it necessary to conclude on the precise scope of the relevant product market.

6. In relation to the geographic market, the CMA identified an overlap between the parties' catchment areas as a starting point. It then focused primarily on directly analysing the overlap in GP referral patterns rather than defining more precise geographic frames of reference for each specialty. This analysis takes into account how patient preferences are affected by location by focusing directly on the actual choices made by patients and GPs at each individual GP practice. The CMA did not therefore find it necessary to conclude on the precise scope of the relevant geographic market.

7. With regard to the relevant counterfactual against which the CMA should examine the impact of the Merger, it has taken account of the ongoing project known as Shaping a Healthier Future (**SaHF**)[3] which could result in material changes in the elective services supplied by some of the hospitals in North West London, most notably, at Ealing Hospital (part of London North West Healthcare NHS Trust) and Charing Cross NHS hospital (part of Imperial College Healthcare NHS Trust (**ICT**)). The CMA reviewed the SaHF report[4] and spoke to commissioners and providers directly involved in this project as part of its investigation. It also reviewed the procedural steps taken to date in relation to these possible service changes and understands that the majority of the obligatory public consultations have already taken place.[5] For the purposes of this assessment, the most relevant hospital controlled by a

---

October 2013 (Bournemouth/Poole). The CMA has also taken account of the substance of the CMA Guidance on the review of NHS mergers, 31 July 2014, CMA29 (NHS Mergers Guidance).

[2] Within private services, each specialty constitutes a separate market and within each specialty, markets can be defined along inpatient and outpatient lines (as with NHS services).

[3] See further at http://www.healthiernorthwestlondon.nhs.uk/.

[4] The SaHF report was produced by eight Clinical Commissioning Groups in North West London, including Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Central London, and West London CCG.

[5] The CMA understands that the required public consultations for the reconfiguration of these services have occurred. The CMA understands that legal challenges to this reconfiguration have been rejected. The Secretary of State for Health supported the proposals following a review by the Independent Reconfiguration Panel and the High Court found no grounds for a Judicial Review.

competitor that could be affected by the SaHF project is Charing Cross NHS hospital.

8. Having considered the evidence available to it, the CMA considers that it is reasonable to assume that at least some of the changes envisaged in the SaHF report will take place. It is, however, not possible for the CMA at this stage to determine with the necessary degree of certainty the scope and timing of any such changes. The prevailing degree of level of uncertainty prevents the CMA from departing from its standard approach to assess anticipated mergers, including this Merger, against the prevailing conditions of competition. However, for completeness the CMA has also considered the extreme hypothesis that all of the elective services of Charing Cross NHS hospital were terminated and has concluded that the competitive impact of this Merger would not be materially different.

Competition in the market

9. The CMA analysed overlaps between the Parties at specialty level. CWFT and WMUT both operate district general hospitals, leading to a significant overlap between their services.

Unilateral effects in relation to NHS services

10. With respect to non-elective services, the CMA followed the CMA's framework of its analysis in Frimley/Heatherwood[6] and found that the Merger does not raise a realistic prospect of a substantial lessening of competition (SLC) in relation to non-elective services.

11. The CMA assessed whether the Merger might lead to unilateral effects in relation to the provision of inpatient elective and outpatient services separately. The CMA notes that the analysis of GP referral data showed that in most specialties there are several other providers which patients consider to be close alternatives to the Parties' hospitals. Further, the analysis showed that CWFT is WMUT's closest competitor in Paediatric Surgery, Paediatric ENT, Paediatric Neurology and Respiratory Medicine. A review of the number of spells in each of these specialties showed that in all, with the exception of Paediatric Surgery, there were fewer than five spells. Given this low number, these specialties were not assessed any further.

12. As to Paediatric Surgery, CWFT ranks as a closer alternative to WMUT than vice-versa. A closer assessment showed that each Party offers differentiated

[6] This is also consistent with Bournemouth/Poole, paragraphs 5.44 ff.

services, reducing the closeness of competition between them. In addition, there are several other hospitals offering services similar to those the Parties offer in the areas from where the Parties draw most of their patients in this specialty. Consequently, the CMA does not believe that the Merger raises material competition concerns in the provision of inpatient services in Paediatric Surgery.

13. In relation to outpatient services, the Parties' data shows that WMUT is not the first alternative provider to CWFT in any specialty. Hospitals such as Imperial College NHS Healthcare Trust (**ICT**), Guy's and St Thomas NHS Foundation Trusts (**Guy's and St Thomas**), University College London Hospital NHS Foundation Trust (**UCLH**), and Great Ormond Street Hospital (**GOSH**) provide and will continue supplying similar services to the Parties and will confer sufficient competitive constraint on them. The level of constraint varies slightly per hospital depending on each specialty.

14. The CMA assessed five outpatient specialties where the Parties appeared to be particularly close competitors. These included General Surgery, Paediatric Surgery, General Paediatric services, Paediatric ENT and Paediatric Gastroenterology.

15. A closer assessment of these outpatient specialties showed that the Parties are differentiated either in terms of the scope and level of specialisation of each Party's their services or the geographic areas from where each Party draw its patients for different specialties. This assessment also showed that there are other providers which will continue providing sufficient competitive constraint on the merged organisation in relation to each of the five specialties listed in paragraph 14 above. These providers include, among others, ICT, Guy's and St Thomas, King's College Hospital NHS Foundation Trust (**King's College NHS Hospital**) and GOSH. Their constraint on the Parties varies depending on each specialty.

16. Accordingly, the CMA did not consider that the Merger would give rise to a realistic prospect of a substantial lessening of competition in the relevant markets for the provision of NHS elective, non-elective inpatient and outpatient services, and private services.

Unilateral effects in private services

17. The CMA has not found a realistic prospect of an SLC in relation to the provision of private services by the Parties. In particular, the CMA notes that the Parties provide a very small number of private services from their hospitals. In addition, there is a significant number of other providers of such

services, including private providers. Moreover, no third party raised significant competition concerns in relation to the provision of private services.

Competition for the market

18. The CMA considered whether the Merger might lead to reduced competition in relation to NHS (i) elective or non-elective services commissioned by CCGs and (ii) specialised services commissioned by NHS England Specialised Commissioning.

19. The tender data submitted by the Parties does not show any material overlap between the Parties in bidding for tender services. The CMA also notes that the relevant local CCGs replied to the CMA that the Parties do not compete with each other for tendered contracts. In addition, neither those CCGs nor NHS England raised significant concerns that the Merger would materially reduce their choice of provider.

20. With respect to specialised services, the CMA notes that CWFT has substantially more specialised services than WMUT and that the Parties do not significantly compete in any specialised services. Overall on the basis of the evidence available to the CMA, including the absence of material competition between the Parties, the presence of other credible NHS providers and the absence of substantial third parties concerns, the CMA does not consider that there is a realistic prospect that the Merger raises competition concerns in relation to the provision of elective and non-elective (including specialised) healthcare services commissioned by CCGs and NHS England Specialised Commissioning.

Monitor's advice

21. Monitor told the CMA that the Parties did not make any submissions on the subject to relevant customer benefits because the Parties were of the view that the Merger does not give rise to a substantial lessening of competition. As a result, Monitor's advice is that it is not able to take a view on whether any relevant customer benefits will arise as a result of this Merger.

Conclusion

22. On the basis of the evidence available, the CMA does not consider that there is a realistic prospect that the Merger will give rise to a substantial lessening of competition as a result of horizontal effects either in competition in the market or in competition for the market. Therefore, it does not consider that the Merger will give the merged entity the ability and/or incentive to decrease the quality of healthcare services or patient choice.

Decision

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

ASSESSMENT

Parties

24. CWFT is a single site foundation trust in North West London. It provides a full range of elective and non-elective inpatient services, outpatient services and many specialised services. In the financial year 2013/14, CWFT achieved a turnover of £343 million.

25. WMUT is a single site trust located at West Middlesex hospital. It provides a wide range of elective and non-elective inpatient and outpatient services, but only a small number of specialist services. In the financial year 2013/14, WHUT achieved a turnover of £155 million.

Transaction

26. The Parties expects to sign the Heads of terms in relation to the Merger on 22 January 2015. The Merger will be structured as a statutory acquisition under section 56A of the National Health Service Act 2006 (**NHS Act**).[7] The Parties plan to complete the proposed transaction, subject to satisfaction of the conditions precedent, including Monitor's approval, on 1 April 2015.

Jurisdiction

27. The Parties engage in activities which constitute 'enterprises' for the purposes of section 23 of the Act[8] and these enterprises will cease to be distinct as a result of the Merger. The UK turnover of WMUT exceeds £70 million and so the turnover test in section 23(1)(b) of the Act is satisfied.

28. The CMA gave notice to the Parties that their Merger Notice was satisfactory on 24 October 2014. The 40-working days deadline for the CMA to announce its decision on whether to refer the Merger for a Phase 2 investigation under section 34ZA(1) of the Act is 19 December 2014.

---

[7] As incorporated by section 169 of the Health and Social Care Act 2012 (**HSCA**).
[8] Section 79(1) of the HSCA states that where the activities of two or more NHS foundation trusts cease to be distinct activities, this is to be treated as a case in which two or more enterprises cease to be distinct enterprises for the purpose of Part 3 of the Act. The HSCA 2012 confirmed the CMA's role in assessing the competition aspects of mergers involving foundation trusts.

29. The CMA therefore believes that it is or may be the case that arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation.

Background

30. This section sets out:

    30.1. the Regulatory framework within which the Parties operate; and

    30.2. an overview of Competition in the provision of NHS-funded healthcare services.

Regulation of Foundation Trusts

31. In this case the Parties provide healthcare services in England. Therefore, in assessing the Merger, the CMA has taken account of the relevant healthcare regulatory framework in England.

32. CWFT has the status of a 'Foundation Trust'. Foundation trusts are public benefit corporations which are required to provide NHS services but are afforded a degree of operational autonomy. Their principal purpose is the provision of goods and services for the purposes of the health service in England. They can retain their surpluses and borrow to invest in new and improved services for patients and service users. This gives them an incentive to maximise their income by taking steps to attract patients.

33. The regulatory framework, which includes the payment by results (**PbR**) regime and the commissioning of services by CCGs, is designed to incentivise providers of acute services to attract additional patients, as this leads to additional income (that is, money follows the patient). The incentive to attract patients will be stronger for more profitable specialties and may lead to hospitals competing to offer the best quality service in their area. However, the CMA understands that tariffs do not always accurately reflect costs of provision and this may affect these incentives.

34. WMUT is an NHS Trust and is therefore regulated by the NHS Trust Development Authority.

Competition in the provision of NHS healthcare services

35. In line with the analysis of competition in the provision of NHS healthcare services by the CMA,[9] there are two different models of competition in the provision of NHS healthcare services:

35.1. Competition in the market (that is, competition for patients), which occurs where patients have a choice between providers of the same service. Payments for these services are commonly made according to the PbR tariffs that are nationally mandated prices. The initiatives related to patient choice are relevant to competition in the market, which occurs mainly in respect of routine elective (planned) services as well as maternity services. This incentivises hospitals to compete on quality in order to attract patient referrals and hence income. The CMA will assess the extent and nature of current (or pre-merger) competition.

In relation to competition to attract patients of NHS services, competition is mostly on quality, [10] rather than on price,[11] as the majority of services are covered by national prices and the PbR regime. The same applies to elective, non-elective, specialised, and community services.[12]

35.2. Competition for the market refers to competition to attract contracts from the commissioning entity to provide services. It occurs where providers are (or may be) competing to be one of a limited number of providers of a service (for instance for specialised services).[13] Providers may compete on quality and, in some cases, price.[14] The CMA will assess whether the merger will have any impact on:

35.2.1. a possible competitive tender, where the merger could lead to worse outcomes because there would be fewer bidders;[15] and

---

[9] Frimley/Heatherwood, paragraphs 18 and ff. See also Bournemouth/Poole, paragraphs 11 and 2.27.
[10] Bournemouth/Poole, paragraphs 6.72-77.
[11] However, it is possible for there to be variations from the national tariff.
[12] Different types of tariffs apply to different services. For example, national prices do not apply to some community services.
[13] This is often the case for specialised services, where there is an expectation of a small number of providers of services that are often costly to provide.
[14] Any Qualified Provider services do not typically restrict the number of providers, so these will not generally feature in an assessment of the effect of the merger on competition to attract contracts to provide services.
[15] This may be reflected in commissioners receiving reduced value for money, including lower quality services or higher prices where services are not subject to a national price.

35.2.2. providers on existing contracts might provide lower quality services, knowing that commissioners have fewer options to replace them post-merger than absent the merger.

Where there is competition to attract contracts to provide services, the CMA's assessment will consider whether the merging providers would be close competitors to supply these services and what other providers would constrain them.

Counterfactual

36. The CMA assesses the Merger's impact relative to the situation that would prevail absent the merger (that is, the counterfactual). In practice, the CMA generally adopts the pre-merger conditions of competition as the counterfactual against which to assess the impact of the merger. However, the CMA will assess the merger against an alternative counterfactual where, based on the evidence available to it, it considers that the prospect of prevailing conditions continuing is not realistic (for example because the CMA believes that one of the merger firms would inevitably have exited from the market) or where there is a realistic prospect of a different counterfactual that is more competitive than prevailing conditions.[16]

37. In this case the CMA has considered to what extent SaHF may be relevant to the counterfactual. As noted above, SaHF it is a programme to change certain aspects of NHS healthcare in North West London. It is driven by eight CCGs.[17] Under the recommended actions, Ealing and Charing Cross NHS hospitals will be reconfigured from acute hospitals to become local hospitals supplying a materially different type of services.[18] More specifically, maternity services, inpatient Paediatrics, A&E services and General Surgery are expected to close at Ealing NHS hospital, A&E services are expected to close at Hammersmith NHS hospital while A&E services are also expected to close at Charing Cross and Central Middlesex NHS hospitals. Many of the changes envisaged in the SaHF programme are interdependent as upgrades have to be made at other hospitals to absorb additional patients they would receive if Charing Cross and Ealing NHS hospitals would to materially change the scope of services they provide.

---

[16] Merger Assessment Guidelines, paragraph 4.3.5 ff.
[17] See footnote 4 above.
[18] Ealing NHS hospital is a part of the London North West Healthcare NHS Trust and Charing Cross NHS hospital is a part of Imperial College Healthcare NHS Trust.

38. Five CCGs in London are preparing the implementation business case (**ImBC**) to apply for funding for SaHF[19] which, the CMA understands that it will be discussed at board level during December 2014. The CMA understands that the expected funding requirement is approximately £1.2 billion and that the funding mechanism for the project has not yet been decided. If the ImBC were to be approved there would be at least 18 months of planning before any capital spend would be put out to tender.

39. The Parties submitted that there was still uncertainty about the exact extent of any changes that may materialise across the entire SaHF programme. They noted that discussions with the clinical lead of the SaHF programme team suggest that changes have not been agreed or indeed even proposed at this stage. They added that the Decision Making Business Case (**DMBC**) does not contain any decision on the scope of the reduction of any specific elective services and that any suggestion that elective services will be severely limited would be speculative. In their submission the Parties have only considered those changes that they consider should be taken into account for the assessment of the most appropriate counterfactual of this case.

40. The most relevant aspect of the SaHF programme for this case relates to possible changes in services at Charing Cross NHS hospital. Other changes recommended in SaHF – affecting primarily Ealing, Hammersmith and Central Middlesex NHS hospitals – do not have any material impact on the competitive assessment of this case. Ealing NHS hospital is not currently among the top three competitors to the Parties in any speciality (as measured by the CMA's indicators of closeness of competition).[20] As such the potential closure of Ealing NHS hospital would have little impact on the competitive analysis. In relation to Hammersmith NHS hospital, the present plans do not envisage a significant reduction in the services it provides.

41. As to Central Middlesex NHS hospital, its A&E has become an 'urgent care centre'. This hospital will retain its inpatient and outpatient services. In addition, it is not ranked as one of the top three competitors.

42. With regard to Charing Cross NHS hospital, the SaHF programme envisages that inpatient elective and non-elective services may be reduced, downgraded or closed. Outpatient services will continue, albeit on a projected smaller scale.

---

[19] These include: Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs. All share the same management team.
[20] See paragraphs 74 ff below.

43. The evidence available to the CMA related to the SaHF programme does not allow for the impact of any potential closure of Charing Cross NHS hospital to be assessed independently from that of other ICT's sites. However that data available to the CMA allowed it to conduct an analysis using the extreme assumption of ICT not operating. The outcome of that analysis does not differ materially from the assessment of the Merger against the prevailing conditions of competition.

44. Moreover, in conducting its assessment the CMA spoke to the joint CCGs leading the SaHF programme. These CCG told the CMA that the funding arrangements have not been finalised and that the closure of services at Charing Cross NHS hospital were not expected to occur until around 2022. In this context, the CMA notes that it will take into account in its counterfactual assessment those events which are foreseeable, enabling it to predict the competitive framework with some confidence.[21]

45. Having considered the evidence available to it, the CMA considers that it is reasonable to assume that at least some of the changes envisaged in the SaHF report will take place. It is, however, not possible for the CMA at this stage to determine with the necessary degree of certainty the scope and timing of any such changes. The prevailing degree of level of uncertainty prevents the CMA from departing from its standard approach to assess anticipated mergers, including this Merger, against the prevailing conditions of competition. However, for completeness the CMA has also considered the extreme hypothesis that all of the elective services of Charing Cross NHS hospital were terminated and has concluded that the competitive impact of this Merger would not be materially different.

Product frame of reference

46. The CMA considers that market definition provides a framework for assessing the competitive effects of the merger and involves an element of judgement. The boundaries of the market do not determine the outcome of the analysis of the competitive effects of the merger, as it is recognised that there can be constraints on merging parties from outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others.[22]

---

[21] Merger Assessment Guidelines, paragraph 4.3.2.
[22] CMA's Merger Assessment Guidance, a joint publication of the Competition Commission and the Office of Fair Trading, September 2010 adopted by the CMA (Merger Assessment Guidelines), paragraph 5.2.2.

47. In this case, the Parties overlap in the provision of both elective and non-elective inpatient care, specialised clinical services, and outpatient services. In addition, the Parties both provide some private (fee-paying) services to patients. This leads to a number of distinct segments of the market where the impact of the merger on competition may be assessed.

48. The CMA, and its predecessors the OFT and the CC, have previously considered mergers involving one or more NHS Foundation Trusts.[23] In line with those cases, the CMA has assessed the impact of the Merger by:

    48.1. each specialty as a separate product market;

    48.2. outpatient and inpatient services as separate product markets;[24] [25]

    48.3. elective[26] and non-elective[27] as separate product markets; and

    48.4. NHS and private patient services as separate product markets.

49. In line with previous cases,[28] the CMA has assessed the impact of the Merger on the basis of competition in the market and competition for the market.

    49.1. In relation to competition in the market, the CMA analysed competition for the provision of NHS elective inpatient and outpatient services respectively. It also assessed private patient services separately.

    49.2. As to competition for the market, the CMA analysed competition for winning commissioned elective and non-elective and outpatient (including specialised) services, each of these three categories assessed separately. NHS England commissions Specialised services. These includes the most complex and/or rare conditions which are best treated in specialised centres.

50. The CMA did not require to conclude on the exact product market definition in this case.

---

[23] For example, Frimley/Heatherwood (paragraph 38) and Bournemouth/Poole, Appendix F.
[24] The CC considered day cases as part of the relevant inpatient market in Bournemouth/Poole. In this case, the CMA has also taken note of the observations in that case that there is an asymmetric constraint between providers of inpatient and outpatient services, with inpatient providers being readily capable of providing outpatient services but not vice versa.
[25] Outpatient services are not separated any further. In other words, there is no further segmentation of community services. See Bournemouth/Poole paragraph 5.42.
[26] Elective clinical care is planned and typically requires a referral from a GP practitioners, a consultant or (in some cases) other clinical professionals.
[27] Non-elective clinical care is provided in unplanned and urgency circumstances. These may include A&E, emergency surgery, maternity services). It does not often require a referral.
[28] Bournemouth/Poole, paragraph 11 and Frimley/Heatherwood, paragraphs 15 ff and 51 ff.

Geographic frame of reference

51. This section sets out our approach to the geographic frame of reference for:

    51.1. competition in the market; and

    51.2. competition for the market.

Competition in the market

52. Location is important to patients and GPs when choosing the patients' preferred provider. When competing to attract patients (whether by specialty, outpatient services or inpatient services), hospitals that are near one another may be expected to exert a stronger competitive constraint than hospitals located further away.[29] Hospitals providing the same services in different locations are therefore not perfect substitutes for one another.

53. For NHS services, the CMA first identifies whether there is an overlap between the Parties' catchment areas. The CMA notes that a catchment area is typically narrower than a geographic market identified using the hypothetical monopolist test.

54. In this case, the CMA asked the Parties to calculate the drive-time from which they draw 80 per cent of their patients. The Parties concluded that 80 per cent of their patients come from within a 16 minute drive time of each of their sites, and 90 per cent of their patients come from within a 24-minute drive-time of each site. The exact drive time varied slightly by treatment specialty. The Parties' main hospital sites are located around 27 minutes apart by drive-time. Therefore, there is an overlap between each of the Parties' catchment areas.

55. The Parties provided Dr Foster data, for each specialty, on patient flows from local GP practices. This data enabled the CMA to identify to which hospitals patients are referred by their GPs, for each speciality. This provided a reasonable indication of the closeness of competition between the Parties and as such it was not necessary to conclude on the precise geographic markets for each specialty in this case.

56. The CMA also requested information on the Parties' outpatient and outreach clinics as well as each of the Parties' share of referrals in each overlapping clinical commissioning group (**CCG**) area. As discussed below the CMA has used this evidence to determine whether there are any specific geographic

[29] Bournemouth/Poole, paragraph 5.56 and Frimley/Heatherwood, paragraph 41.

areas where the Merger may change incentives to flex the Parties' competitive offering.

Competition for the market

57. With regard to competition for the market for inpatient (elective and non-elective) and outpatient services, including specialised services, the CMA reviewed the information provided by CCGs and NHS England (specialised services) on tenders to assess closeness of competition between the Parties and other providers for these services. This information also showed that catchment areas are wider for specialised services than other services. The CMA did not find it necessary to conclude on a precise geographic market in this case.

58. For private services, the CMA did not find it necessary to conclude on the precise scope of the geographic market given that on any possible geographic market, the [parties are not each other's closest competitor and] there are other providers of private services that compete with the Parties.

Competitive assessment

Horizontal unilateral effects

59. Unilateral effects are effects which may arise in horizontal mergers where the merger involves two competing entities and removes the rivalry between them. In this case, the CMA considered whether the Merger might result in a removal of rivalry which would allow the merged trust to reduce quality, as for the most part the Parties do not compete on price.

60. With respect to non-elective services, the CMA followed the CMA's framework of analysis in Frimley/Heatherwood and found that the Merger is not expected to result in an SLC in relation to non-elective services.[30]

61. The CMA considered whether the Merger would lead to a realistic prospect of an SLC in relation to (i) competition in the market for NHS elective inpatient and outpatient services, as well as private services and/or (ii) competition for the market for NHS elective and non-elective services and outpatient services, including specialised services.

[30] Paragraph 49. Also, it is consistent with the approach followed at Bournemouth/Poole, paragraphs 6.239 ff and paragraphs 6.273 ff.

Competition in the market

Data and methodology

62. Given the overlap between the Parties' catchment areas and the services that they offer, the CMA has assessed closeness of competition between the Parties. The CMA has thus analysed GP referral data, reviewed internal documents, and sought evidence from third parties, including relevant CCGs, NHS England and Monitor.

GP referral analysis

63. In line with CMA, OFT and CC case precedents, the CMA has carried out a ranking analysis of GP referral patterns.[31] GP referral patterns reflect the aggregated choices made by different pairs of GPs and patients within each GP practice. They provide an insight into the relative importance of the alternative providers of elective and outpatient services at each GP practice and therefore give some indication of where future patients may choose to go in the event that the merger will lead to a worsening of service levels.[32]

64. The Parties provided data on referral patterns for each speciality where both of the Parties are active in the five areas formerly comprising the relevant Primary Care Trusts (**PCT**) from where the Parties draw the majority (95%) of their patients. Although the CMA considers that this approach was appropriate in this case, it notes that it risks omitting areas near the edge of catchment areas where the Parties may compete strongly with another provider.

65. Within each GP practice the CMA ranked providers by the number of referrals that they received for a given specialty from April 2013 to March 2014.[33] It then used two different methods to produce measures that provide an indication of the closeness of competition between the Parties in each specialty:

Ordinal measure:

65.1. Using the rankings for each GP, the CMA made the assumption that the first ranked provider (that is, the provider a GP practice referred to

---

[31] Bournemouth/Poole, paragraphs 6.195 ff.
[32] In this case the CMA relied upon Dr Foster data provided by the Parties. It did not have access to the HES data from the Department for Health. Hospital Episode Statistics (HES) is a data warehouse containing details of all admissions, outpatient appointments, and A&E attendances at NHS hospitals in England. This data is collected during a patient's time at a hospital and is submitted to allow hospitals to be paid for the care they deliver. Dr Foster data is derived from the HES data, see http://drfosterintelligence.co.uk/solutions/nhs-hospitals/hospital-marketing-manager-hmm/.
[33] Extracted from Dr Foster in May 2014.

the most often for the set of services reviewed during the period of analysis) is the favoured provider for that GP practice (for the specified services), and that the second provider (that is, the provider a GP practice referred to the second most often for the set of services reviewed during in the period of analysis) was, for that GP practice, the best alternative provider.

65.2. Next, the CMA assumed that, following a change in the quality of service at its favoured provider (and assuming that all else remains equal), a GP practice would instead refer patients to its best alternative provider. In other words, if a GP practice were to decide against referring some patients to its favoured provider, it would instead refer to the second ranked provider. Similarly, following a change in the quality of service at its second ranked provider, if a GP practice were to decide against referring some patients to that provider, it is would instead refer to the first ranked provider.

65.3. To provide a measure of how close a competitor CWFT is to WMUT and vice-versa, the CMA aggregated the number of CWFT referrals for all GP practices where WMUT (or CWFT) was the best alternative provider. By dividing this by the total number of referrals made to CWFT, the CMA was able to produce a measure that provides an indication of closeness of competition. In this decision the outcome of the ordinal analysis and of the proportional analysis is described for ‘shorthand’ as a ‘diversion’ from one hospital trust to the other although the CMA is conscious that it is an indication how closely the hospitals compete and is not a measure of diversion in the usual sense.

Proportional measure:

65.4. Rather than assuming that all referrals would move to the best alternative provider at a GP (ordinal measure), the CMA assumes that referrals would be reallocated to all providers currently receiving referrals at that GP in proportion to the quantity of referrals that they currently receive from that GP practice.

65.5. To provide a measure of how close a competitor, WMUT is to CWFT, the CMA aggregated the number of referrals that would be reallocated to WMUT. By dividing this by the total number of referrals made to CWFT, the CMA produced measures that provide an indication of closeness of competition. Following this approach the CMA also produced measures that provide an indication of the closeness of competition of CWFT to WMUT and of other competitors to both of the Parties.

66. In line with Frimley/Heatherwood decision, the CMA considered it reasonable to assume that GPs would switch to hospitals to which they already refer for two reasons. First, both GPs and patients learn about the quality of a hospital when they experience its services. It seemed likely that GPs would switch to hospitals to which they have previously referred and for which they have gained some knowledge (as long as that experience has not been negative). Second, we expected that past choices of patients/GPs are likely to reflect (although imperfectly) their preferences over the best alternatives available.

67. The CMA notes that there are a number of different approaches which could be used to produce measures that provide an indication of closeness of competition. In this case for the ordinal method only, it has chosen to focus its analysis on competition between the top two providers. It notes that the evidence in this case suggests that most referrals are made to a limited number of hospitals, with a long tail receiving a limited number of referrals. In instances where there are a number of hospitals receiving a similar proportion of referrals from a GP, it may be appropriate for the CMA to look at lower ranked providers as well.

68. In the ranking analysis, the CMA has undertaken a closer analysis in relation to those specialties with diversion above 30% which the CMA considers to be a cautious approach.

69. The Parties have run a ranking analysis using an Ordinal and a Proportional methodology for elective inpatient services using Dr Foster data.[34]

70. The CMA is conscious that when there are relatively few patients in the data set regarding alternate hospitals (whether or not a hospital of the merger parties), the analysis may end up placing too much weight on those few observations. This data issue may arise if GP practices concentrate their referrals with relatively few providers. In such circumstances removing two providers which may be important to that GP practice, may leave the CMA assuming that patients would be 'diverted' to a provider who is rarely used by the GP at present. If a provider is rarely used currently, it is difficult to know if the GP would direct significant volumes of patients to them in the future.

71. The Parties have presented Dr Foster data based on all outpatient appointments. This includes both first outpatient appointments and onward referral. However, patients, in most cases do not have the right to choose between providers for follow on appointments. A patient will often be referred to a provider for an initial appointment and then require follow up treatment which may take the form of a further outpatient consultation. As such, data on

[34] As noted in the Counterfactual, the Parties expect that some reconfiguration of services will take place.

all outpatient appointments risks capturing pathways between hospitals which are offering a different degree of specialism. For instance, if one hospital specialises in more complex procedures it may receive referrals from other hospitals. This may make them look like close competitors when in fact they are offering a different and complementary or more specialised service.

72. To account for the fact that data on all outpatient appointments may overstate the closeness of competition between parties, the CMA has analysed whether the Parties are active in different specialisms or have a different focus the CMA has complemented the quantitative data with qualitative information and third parties' feedback. In addition, the CMA has analysed data on the source of referrals and the proportion of patients who attended an outpatient appointment who were admitted to the hospital for elective inpatient care. The CMA did not have data by subspecialties. Thus it was unable to undertake an analysis at subspecialty level.

73. The CMA's own ranking analysis based on all outpatient appointments produces very similar results to that the Parties undertook.

Overlap between the Parties and with third parties

74. CWFT and WMUT both operate district general hospitals, leading to a significant overlap between their services. In summary, the CMA notes that there is an overlap[35] between the Parties' activities in the following specialities.

    74.1. Elective inpatient: General Surgery, Urology, Trauma Orthopaedics, Paediatric Surgery, Paediatric ENT, Paediatric Endocrinology, Gastroenterology, Clinical Haematology, Cardiology, Dermatology, Respiratory Medicine, Medical Oncology, Rheumatology, Paediatrics and Gynaecology.

    74.2. Outpatient: General Surgery, Urology, Vascular Surgery, Trauma & Orthopaedics, Plastic surgery, Paediatric Surgery, Paediatric ENT, Paediatric Gastroenterology, Paediatric Endocrinology, Paediatric Respiratory Medicine, General Medicine, Gastroenterology, Endocrinology, Clinical Haematology, Diabetic Medicine, Cardiology, Paediatric Cardiology, Anticoagulant Service, Dermatology, Respiratory Medicine, Genitourinary Medicine, Medical Oncology, Neurology, Rheumatology, Paediatrics, Paediatric Neurology, Geriatric

[35] For the purpose of this analysis and overlap has been defined as where both trusts derive more than ten spells from a speciality.

Medicine, Obstetrics, Gynaecology, Chemical Pathology and Oral Surgery.

Inpatient elective services

Chelsea and Westminster NHS Foundation Trust

75. The analysis of GP referral data indicates that overall WMH is rarely a close competitor to CWFT at specialty level. This shows that WMH is amongst the top three alternative providers to CWFT in Paediatric Surgery, Paediatric Neurology and Respiratory Medicine. WMH is not a close competitor to CWFT in any of the other specialties. Referral data shows that a sufficiently large proportion of patients who could have chosen WMUT have instead chosen several other hospitals, including: ICT, King's College NHS hospital, St Georges' NHS Hospital, Guy's & St Thomas and Royal Marsden NHS hospital (depending on each specialty).

76. Diversion between the Parties is below [0–10]% in relation to Paediatric Neurology and Respiratory Medicine. For this reason, these specialties are not considered any further in this decision.

77. As to Inpatient Paediatric Surgery, WMUT is the best alternatives to CWFT under the proportional diversion assumption but even then the diversion is only [15–25]%.[36] However, the CMA notes that the Parties are materially different in size and level of specialisation. The parties submitted that CWFT handles more complex cases while WMUT is a relatively small provider of these services and instead concentrates on routine surgery.

78. In addition, post-Merger another provider, ICT would be expected to receive the same number of referrals than WMUT and the Royal National Orthopaedic NHS Hospital and St. Georges NHS Hospital would also receive a significant proportion of those referrals. As such, the total number of referrals 'diverting' between the Parties is similar to the number diverting to other providers.

West Middlesex University NHS Trust

79. CWFT ranks as a closer alternative to WMUT than vice versa. Patients seems to be drawn from a wider catchment area. This may be due to the slightly more specialist services CWFT offers. The parties' analysis shows that CWFT is amongst the top three alternatives to WMUT in Paediatric Surgery,

[36] Under the ordinal assumption, WMUT is amongst the top three alternatives.

Paediatric Ear, Nose and Throat (ENT), Paediatrics, Paediatric Neurology, and Respiratory Medicine.

80. Given the small absolute number of referrals (four) which could have diverted from WMUT to CWFT in Paediatric ENT, the CMA has not considered further this specialty. Also the CMA notes that the diversion from WMUT to CWFT is similarly low in Paediatric Neurology and Respiratory medicine (fewer than five referrals out of [0–100] and [100–200] respectively 'diverting' between the Parties. Thus, these specialties are not considered further in this decision.

81. As to Paediatric Surgery, the diversion ratio from WMUT to CWFT is around [65–75]%. However, as mentioned above, an assessment of the features in each hospital shows that CWFT performs substantially more complex procedures than WMUT, with CWFT holding an NHS England contract for specialist Paediatric Surgery services. For the provision of these services, CWFT employs eight specialist paediatric surgery consultants against none employed by WMUT.[37]

82. The differentiation is reflected in the substantially different turnover each hospital derives from this speciality. WMUT generates £83k which contrast with over £2 million generated by CWFT. The CMA also notes that the number of patients at CWFT is substantially larger (1109 patients) than at WMUT (71 patients).

83. For completeness, the CMA notes that there are several hospitals offering this specialty in the local area, in particular, the Royal National Orthopaedic Hospital NHS Trust and Hillingdon Hospital NHS Foundation Trust. Both hospitals receive similar number of referrals as WMUT does.[38]

84. In light of the above, due to the differentiation between the Parties, which reduces the closeness of competition between them, and the number of other hospitals attracting patients in the areas where WMUT is active, the CMA do not believe that this specialty raises a realistic prospect of a substantial lessening of competition. As a result, the CMA does not believe completion concerns arise in any elective specialty.

---

[37] All paediatric surgeons operating at WMUT are employed by CWFT. This existing cooperation occurs under an agreement between the Parties. As stated in Bournemouth/Poole (paragraphs 6.133 ff) a hospital contracting clinicians from other providers may still have the ability and incentive to compete if they retain the margin on the services undertaken at their site. In this case the parties acknowledge that WMUT retain the margin and have not submitted why they would not compete with CWFT. As such, the fact that WMUT's services are operated by CWFT clinicians does not mean that the hospitals do not compete with one another. However, it is reflective of the differences in specialism and levels of activity between the two hospitals, which mean that the ranking analysis is likely to be overstating the closeness of competition between the parties.
[38] These referrals come from the same postcodes as those areas from where WMUT draws its patients.

Outpatient elective services

85. The Parties have conducted an analysis of outpatient referral patterns using data on outpatient referrals. They have not used data that is restricted to first outpatient appointment.[39] They submit that this is due to the way they code outpatient appointments, with appointments coded based on the consultants specialism rather than symptoms of the patient.

Chelsea and Westminster NHS Foundation Trust

86. The Parties' analysis shows that WMUT is not the first alternative provider to CWFT in any specialty with ICT, Guy's and St. Thomas (**GST**), University College London Hospital (**UCLH**) and Great Ormond Street Hospital (**GOSH**) being the main alternatives depending on speciality. WMUT does rank as the second closest alternative in Paediatric Surgery and Paediatric Diabetic Medicine under both the ordinal and the proportional methodology, but in both cases the diversion is no more than [20–30]% and the third closest alternative attains a similar diversion. The CMA have run its own analysis of the Dr Foster data and this supports the parties' results. Therefore, the merger is unlikely to give the incentive to deteriorate quality at CWFT.

[39] Patients have a right to choose their provider for their first outpatient appointment, but do not have the right to choose between providers for follow on appointments, although they may be offered this choice. A patient will often be referred to a provider for an initially appointment and then require follow up treatment which may take the form of a further outpatient consultation. As such, data on all outpatient appointments risks capturing pathways between hospitals which are offering a different degree of specialism. For instance, if one hospital is a paediatric specialist more complex cases may be referred on to them from other hospitals. This may make them look like close competitors when in fact they are offering a different and more specialised service. However, data on all outpatients appointments does have an advantage in that appointments can be coded based on the consultant rather than the patient (the parties have indicated that this is the case in this investigation), and as such it is possible to miss overlaps when looking only at first outpatient appointments.

West Middlesex University NHS Trust

87. CWFT is the first alternative to WMUT in five specialities, the second preference in three and the third preference in one specialty under both the ordinal and the proportional methodology. These specialities are shown in the table below:

Speciality	Total referrals to WMUT	Ordinal (CWFT position)		Proportional (CWFT position)	
		Ranking	Diversion %	Ranking	Diversion %
General Surgery	[✂]	1	[30–40]	1	[20–30]
Paediatrics	[✂]	1	[20–30]	1	[20–30]
Paediatric Endocrinology	[✂]	2	[20–30]	2	[20–30]
Paediatric Diabetic Medicine	[✂]	2	[10–20]	2	[20–30]
Paediatric Neurology	[✂]	3	[0–10]	3	[0–10]
Plastic Surgery	[✂]	1	[65–75]	1	[35–45]
Paediatric Surgery	[✂]	1	[75–85]	1	[50–60]
Paediatric ENT	[✂]	2	[30–40]	2	[20–30]
Paediatric Gastroenterology	[✂]	1	[80–90]	1	[65–75]

Source: CMA's assessment based on Dr Foster data submitted by the Parties.

88. For the reasons set out in the paragraphs below, and because the measure of closeness of competition is below [30–40] per cent, the CMA does not believe that a more detailed analysis is required for Paediatrics, Paediatric Endocrinology, Paediatric Diabetic Medicine, or Paediatric Neurology:

88.1. Paediatrics – Although the CWFT is the first alternative to WMUT in Paediatrics there are a number of alternative hospitals who are similarly close competitors. In particular, Ashford's& St Peters NHS Foundation Trust ([10–20]%), Kingston Hospital NHS Foundation Trust ([10–20]%) and North West London NHS Trust ([10–20]%) are close alternatives to WMUT, and not significantly more distant that CWFT which attains [20–30]% of diversion under the proportional methodology.

88.2. Paediatric Endocrinology – CWFT is not the closest competitor to WMUT under either the ordinal or the proportional methodology, as GOSH receives around [50–60]% of diversion.

88.3. Paediatric Diabetic Medicine – CWFT is not the closest competitor to WMUT under either the ordinal or the proportional methodology, as UCLH receives around [60–70]% of diversion.

88.4 Paediatric Neurology – CWFT is not the closest competitor to WMUT under either the ordinal or the proportional methodology, as GOSH receives around [60–70]% of diversion and Guy's and St Thomas around [10–20]%.

Other specialties

89. In assessing the remaining elective outpatient services,[40] the CMA noted consistently across these specialties that the Parties have 'diversion ratios' over [30–40]% in all cases and the Parties rank as the first (or second) alternatives to each other.[41] However, they also have (relatively) low number of referrals, some level (to a greater or lesser) of existing co-operation between the Parties and the remaining presence of other providers post-merger. In addition, some specific notes applied to individual specialities. These will be noted, where appropriate, below.

General Surgery

90. In relation to outpatient General Surgery, the CMA notes that the Parties are geographically differentiated in terms of from where they draw patients.[42] It also notes that post-Merger, ICT will remain constraining sufficiently the merged organisation.

Plastic Surgery

91. As to Plastic Surgery, WMUT does not impose a meaningful constraint on CWFT at present. The WMUT site is a one-day a week clinic with a CWFT clinician. As such CWFT receives complex onward referrals from WMUT. Given this, and given WMUT earns comparatively little from this particular service (where CWFT is around ten times larger) the parties submitted that

[40] These are General Surgery, Plastic Surgery, Paediatrics, Paediatric ENT and Paediatric Gastroenterology.
[41] In most cases, in both, Proportional and Ordinal ranking.
[42] CWFT draws the majority of its patients from SW6 and SW11. WMUT draws its General Surgery patients primarily from TW3 and TW11.

the Merger will not introduce an incentive to worsen service levels in this specialty.

92. The data (described below) suggests that the ranking analysis is overstating the level of diversion between the Parties. Furthermore, the CMA notes that CWFT provides more complex procedures than WMUT. Differences in the composition of the source of referrals between different hospitals for the same specialty may provide an indication on the level of complexity of the procedures performed in those hospitals. In this case, CWFT's Plastic Surgery patients are primarily referred by consultants ([50–60]%) as opposed to GP practitioners ([10–20]%). The opposite applies at WMUT where [70–80]% of Plastic Surgery patients are referred by GP practitioners and [10–20]% by consultants. This suggests that the cases referred to CWFT are those more complex and consultants in other hospitals considers it appropriate to refer to a specialist centre.

93. The data on patient referrals also shows that there are several other hospitals active in Plastic Surgery to a significant degree in the same area as WMUT. These include The Royal Free, St George and ICT. They are active to a similar or greater degree to WMUT in the relevant geographic area and this is expected to continue post-Merger.

Paediatric services

94. For all Paediatric services, the CMA notes that there are two specialist centres for Paediatrics in London. CWFT is the specialist provider of surgery and ICT is the specialist provider for non-surgical Paediatrics. As a result, CWFT handles more complex paediatric procedures than WMUT.

Paediatric Surgery

95. Consistent with the above, the CMA notes that in relation to Paediatric Surgery, the proportion of patients who were actually treated and subsequently admitted at each trust is substantially higher at CWFT ([80–90]% of the referred patients were treated there) as opposed to [10–20]% of WMH's patients. The differences between both Parties' hospitals are noted when assessing the number of consultants. WMH only has a locum consultant. Set against this, CWFT has eight specialised paediatric surgeons. This difference between the parties in the level of complexity of the surgery that they perform is borne out in the referral data which show that a little over half of CWFT's referrals come from GPs whereas around three-quarters of WMUT do.

96. Other hospitals also provide (and will continue providing post-merger) similar Paediatric Surgery services than WMUT. These include UCLH, GOSH, ICT and RNO. They all receive a significant number of referrals from GP practitioners in the relevant areas.

Paediatric ENT

97. As to Paediatric ENT, WMUT obtained 1287 referrals. The provider receiving most referrals from patients registered at GPs who referred to WMUT was GOSH ([40–50]%), followed by CWFT ([25–35]%) and then ICT ([10–20]%). The CMA understands that neither party has consultants with a specialist in Paediatric ENT, with both Parties paediatric ENT requirements met by generalist paediatricians. The CMA notes that ICT provides paediatric ENT at CWFT under a service level agreement.

98. The data supplied by Monitor, based on first outpatient appointments, indicates that CWFT saw around three times the number of patients as WMUT. Although in both cases the majority of referrals originated from a GP, the figures do differ substantially between the Parties. [90–100]% of referrals to WMUT originated from GP practices, against [50–60]% for CWFT. Additionally WMUT only went on to treat [0–5]% as inpatients, against [30–40]% for CWFT. This indicates that WMUT handles less complex cases than CWFT.

99. The CMA also notes that other hospitals also provide Paediatric ENT services to patients who may be affected by the Merger (and will continue providing post-Merger). These include ICT and GOSH. They get similar number of referrals to CWFT from similar postcode areas.

Paediatric Gastroenterology

100. On Paediatric Gastroenterology, WMUT employs a single paediatrician with a special interest in haematology and gastroenterology, who runs a single clinic once a week, with CWFT providing an additional outpatient outreach clinic 4/5 times per year. The WMUT clinic covers routine gastro conditions whereas CWFT employs four specialist Paediatric Gastroenterologists, running a total of ten clinics per week. The CWFT clinics cover general Gastroenterology (although this tends to be specialist tertiary clinic with referrals from other providers). These may include inflammatory bowel disease, feeding clinic and PEG clinics[43] with training and education.

[43] Percurtanous Endoscopy Gastrotomy, a way to provide food, liquids and medications directly into the stomach to patients with difficulty swallowing.

101. Monitor supplied to the CMA patient referral data based on first outpatient appointments. This shows that CWFT attended around eight times the number of patients than WMUT did. WMUT received 2.5 times the number of referrals from a GP practitioners as from consultants. This compares to CWFT which received more referrals from consultants than from GP practitioners. Additionally WMUT did not treat any inpatients, whereas the data shows that slightly more patients were admitted to CWT for inpatient elective procedures than were seen as outpatients during the time period. This indicates that WMUT were seeing less complex cases than CWFT.

102. Other hospitals also provide Paediatric Gastroenterology services to patients who may be affected by the Merger and will continue providing post-Merger. Most notably, GOSH and at a lesser extent, St George's Hospital (part of St George's Healthcare NHS Trust) and King's College Hospital NHS Foundation Trust (among others).

103. In light of the evidence before the CMA as stated above, the CMA does not believe that a realistic prospect of a substantial lessening of competition arises as a result of the merger in relation to these other outpatients specialties.

Private services

104. As to private services the Parties overlap only in one inpatient specialty and six outpatient services, which are shown in the table below:

Specialty/ Service	CWFT Activity	CWFT Income	WMUT activity	WMUT Income
Inpatient				
General Surgery **Outpatient**	[✂]	£[✂]	[✂]	£[✂]
Trauma and Orthopaedics	[✂]	£[✂]	[✂]	£[✂]
General Medicine	[✂]	£[✂]	[✂]	£[✂]
Dermatology	[✂]	£[✂]	[✂]	£[✂]
Cardiology	[✂]	£[✂]	[✂]	£[✂]
Paediatrics	[✂]	£[✂]	[✂]	£[✂]
Ent	[✂]	£[✂]	[✂]	£[✂]

Source: The Parties.

105. The CMA notes that the data indicates that CWFT are active to a far greater extent in the provision of services to private patients than WMUT, with the parties submitting that WMUT are active in less complex procedures than CWFT. The differences in the level of activity undertaken by each party are reflected in their infrastructure, with CWFT having a dedicated Private Patient Unit (PPU) occupying three wings of their main hospital site, with a 15 room

inpatient wing and an additional four outpatient consultation rooms; in contrast WMUT does not have separate private patient facilities.

106. The Parties listed a number of competing providers that provide private care in addition to the main NHS hospitals. Other NHS hospitals include ICT, North West London and Guy's St Thomas's. Private providers include BMI, which has several sites, Spire and BUPA. These hospitals are active in the provision of the private services where the Parties overlap and in each instance more than three competitors to the Parties are active.

107. Third parties who replied to the CMA's market investigation did not express any concerns about the impact of the Merger on the provision of private services by the Parties.

108. The CMA notes that it has not found that the Merger would lead to a realistic prospect of a substantial lessening of competition in relation to the provision of private services by the Parties.

Competition for the market

109. In order to assess the effect of the Merger on competition for the market, the CMA considered whether or not potential reconfiguration of services by commissioners (including by tender) was likely to occur and, if so, whether the Merger was likely to create a loss of competition in relation to such reconfiguration.

Competition for the market for services commissioned by CCGs

110. The CMA considered whether the Merger might lead to reduced competition in relation to acute elective or non-elective services (including maternity services) and outpatient services which commissioners may change or reconfigure, because they have less choice of possible providers for these services.

111. The Parties told the CMA that they do not hold a central database of tenders and could only submit information on tenders based on its best recollection of events for the last five years. This data showed that WMUT had only participated in tenders in the Hounslow (former) PCT/CCG area in relation to services commissioned by the local CCGs. CWFT had not participated in any tenders in this PCT/CCG area during that period.[44] Therefore, based on the

[44] The CMA notes that in one occasion the Parties (together with ICT) bid jointly for a national commissioned contract for the provision of bowel screening services.

data available to it the CMA does not believe that there is an overlap between the Parties in bidding for tendered services.

112. As part of its sector enquiries, the CMA contacted CCGs that commission healthcare services from the Parties. The CMA note that the five North West London CCGs operate as a single Joint (London) CCG and as such one response covered, Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs, and acted as the host commissioner for both parties. This (Joint) London CCG indicated that it had not met the Parties competing with each other for its tendered contracts. Another third party stated that the two Parties were placed into different area categories when considering the SaHF restructuring. This suggests that the Parties are not each other's closest competitors.

113. The CMA notes that none of the CCGs raised concerns that the Merger would reduce their choice of provider for services.

Competition for the market for specialised services commissioned by NHS England

114. Specialised services as designated in the HSCA 2012 are commissioned by NHS England. Specialised services are those that either treat rare conditions or that require a specialised team working together at a centre. Some specialised services may be provided in relatively few specialist centres while other specialised services will be provided by most acute hospitals. Specialised services can be expensive to provide. On 1 April 2013, NHS England took over responsibility for commissioning specialised services.

115. The funding model differs between specialised and non-specialised services: whilst non-specialised services are funded by the CCG in which the patient lives, specialised services are commissioned and funded by the NHS England area in which the patient is treated. Each NHS England area team only commission from providers located in their allocated area. The Parties both fall within the London NHS England Specialised Commissioning team.

116. The Parties identified an overlap between their activities in four services: Chemotherapy, HIV, Orthopaedic Surgery, Paediatric Neuroscience and Neonatal Intensive Care.

117. The Parties presented data which suggested that in the majority of overlapping specialities WMUT undertakes more specialist work than CWFT. However, NHS England's financial data does not confirm this statement. It states that that NHS England has commissioned healthcare services for a value of £[✂] million from CWFT against £[✂] million of services commissioned from WMUT.

118. In NHS England's view, there is very little or no competition between the Parties as there is no real overlap between the services that they offer. NHS England indicated that for example in relation to the provision of Neonatal Intensive Care services, WMUT provides the lowest level of Intensive Care and CWFT provides the highest level.[45] NHS England also stated that it does not view WMUT as being capable of being a specialist provider as it lacks a rota of expertise and does not have a sufficient volume of work to build a critical base of expertise.

119. Overall, on the basis of the evidence, including the absence of material competition between the Parties, the presence of other credible NHS providers (and to a lesser degree of private providers for some services), and the absence of substantial third party concerns, the CMA does not consider that there is a realistic prospect that the Merger will give rise to a substantial lessening of competition as a result of horizontal effects in competition for the market.

120. Therefore, the CMA does not consider that the Merger will give the merged entity the ability and/or incentive to decrease quality or choice for services commissioned by CCGs and NHS England Specialised Commissioning teams.

Conclusion on horizontal unilateral effects

121. Accordingly, the CMA found that the Merger does not give rise to a realistic prospect of a substantial lessening of competition as a result of horizontal unilateral effects in relation to the supply of NHS-funded healthcare services to patients and commissioners.

Barriers to entry and expansion

122. The Parties told the CMA that the cost of entry into the provision of elective inpatient services is not negligible as any provider is likely to require trained staff (both medical and nursing), specialist equipment and commissioner support for expansion. A new entrant is therefore likely to be an existing elective inpatient care provider.

123. They stated that outpatient services are subject to lesser requirements in terms of medical expertise and equipment and the cost of entry is correspondingly lower. Moreover, some outpatient services can be provided by GPs with special interests (for example, pain management, cardiology,

[45] Intensive care services are classified in three levels.

dermatology, respiratory care). A likely entrant could be an existing secondary care provider (eg a general district hospital, like the Parties) but also a community provider and in some cases GPs with special interests. However, the identified cost of entry does not mean that barriers to entry themselves are high as there are providers able and willing to expand their service into new inpatient and outpatient services areas. They argued that some of the Parties' strongest competitors are already expanding their services in direct competition with the Parties.

124. The CMA notes that in the Bournemouth and Poole decision, the CC found that entry into inpatient services by any provider other than an existing acute hospital was unlikely. Many outpatient services are linked to inpatient services through the care pathway, which would prevent another provider from offering a comparable constraint into this part of the pathway.

125. In any event, on the basis that no competition concerns arise as a result of the Merger, the CMA does not consider it necessary to conclude on barriers to entry and expansion.

Monitor's advice

126. Section 79(5) of the Health and Social Care Act 2012 (**HSC Act**), requires Monitor to provide the CMA, with advice on the matters listed below. Such advice must be provided as soon as reasonably practicable after receiving a notification from the CMA under section 79(4) of the HSC Act.

    126.1. The effect of the matter under investigation on benefits (in the form of those within section 30(1)(a) of the Act (relevant customer benefits) for people who use health care services provided for the purposes of the NHS.

    126.2. Such other matters relating to the matter under investigation as Monitor considers appropriate.

127. Monitor provided the CMA with its advice pursuant to section 79(5) of the HSC Act on 5 December 2014.

128. Monitor told the CMA that the Parties were of the view that the Merger does not give rise to a SLC and did not make any submissions to Monitor on the subject of relevant customer benefits. As a result, Monitor's advice is that it is not able to take a view on whether any relevant customer benefits will arise as a result of this Merger.

Third party views

129. Third party comment has tended to refer to the general level of competition between the hospitals with no third party highlighting the hospitals as close competitors in any particular specialties.

130. The CMA refers to its competitive assessment of the Merger and notes that none of these concerns would arise due to an SLC as a result of the Merger.

Decision

131. Consequently, the CMA does not believe that it is or may be the case that the Merger may be expected to result in a substantial lessening of competition within a market or markets in the United Kingdom.

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

Nelson Jung
Director of Mergers
Competition and Markets Authority
19 December 2014