

Anticipated merger between Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust

Decision on relevant merger situation and substantial lessening of competition

ME/6653/16

The CMA's decision on reference under section 33(1) of the Enterprise Act 2002 given on 27 February 2017. Full text of the decision published on 9 March 2017.

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

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SUMMARY

1. Central Manchester University Hospitals NHS Foundation Trust (**CMFT**) and University Hospital of South Manchester NHS Foundation Trust (**UHSM**) plan to merge to form a single NHS Foundation Trust (the **Merger**). CMFT and UHSM are together referred to as the **Parties**.
2. The Competition and Markets Authority (**CMA**) believes that it is or may be the case that the Parties will cease to be distinct as a result of the Merger, that the turnover test is met and that accordingly arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation.
3. CMFT and UHSM are both NHS Foundation Trusts (**FT**) in central Manchester. CMFT includes Manchester Royal Eye Hospital, Manchester Royal Infirmary, Royal Manchester Children's Hospital, Altrincham Hospital, Saint Mary's Hospital, The University Dental Hospital and Trafford Hospital. UHSM includes Wythenshawe Hospital and Withington Community Hospital. The Parties are close to one another and overlap across a significant number of healthcare services commissioned by local clinical commissioning groups (**CCGs**) and NHS England which they provide to patients.
4. The Parties have requested a fast-track reference for an in-depth phase 2 investigation. They have therefore not made submissions on relevant customer benefits for the purposes of the CMA's phase 1 investigation, but the CMA expects the Parties to make such submissions at phase 2.
5. The CMA believes that the Merger gives rise to a realistic prospect of a substantial lessening of competition (**SLC**) as a result of horizontal unilateral effects in the supply of 25 specialties (24 acute elective services, and maternity services). The CMA also found concerns in relation to hospital-wide effects, as a result of its concerns in these acute elective services. The Parties accepted that there is sufficient evidence for the CMA to find a realistic prospect of a substantial lessening of competition in some elective acute services. It has not been necessary for the CMA at phase 1 to reach a conclusion in relation to other potential competition concerns.
6. The CMA believes that the criteria for a fast track reference are met. Third parties will have an opportunity to fully present their views during the in-depth phase 2 investigation, which is, for the avoidance of doubt, not restricted to investigating the issues that have been found to give rise to a realistic prospect of an SLC at phase 1.

7. As part of their request for a fast track, the Parties waived their procedural rights at phase 1, which included their right to receive an Issues Letter and attend an Issues Meeting or to submit potential UILs to address the concerns identified. As a result, the CMA has not considered UILs under section 73 of the Enterprise Act 2002 (**the Act**).
8. The CMA has therefore decided to refer the Merger pursuant to section 33(1) of the Act.

ASSESSMENT

Parties

9. CMFT is an acute hospital trust operating from seven hospitals in the Manchester and Trafford local authority areas. CMFT's main commissioners are NHS England and Central Manchester CCG. The turnover of CMFT in 2015-16 was around £967 million and it has around 1600 beds.
10. UHSM is an acute hospital trust operating from two hospitals in the Manchester local authority area. UHSM's main commissioners are NHS England, South Manchester CCG and Trafford CCG. The turnover of UHSM in 2015-16 was around £437 million and it has around 915 beds.

Jurisdiction

11. The Parties engage in activities which constitute 'enterprises' for the purposes of section 23 of the Act¹ and these enterprises will cease to be distinct as a result of the Merger. The Parties submitted that the proposed arrangements between their FTs create a qualifying merger reviewable by the CMA under the merger control provisions of the Act.
12. The UK turnover of each party exceeds £70 million, so the turnover test in section 23(1)(b) of the Act is satisfied.
13. 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.

¹ Section 79(1) of the Health and Social Care Act 2012 (HSCA) states that where the activities of two or more NHS FTs 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 FTs.

14. The initial period for consideration of the Merger under section 34ZA(1) read with 34ZA(3) of the Act started on 9 February 2017 and the statutory 40 working day deadline for a decision is therefore 6 April 2017.

Fast track reference

15. The Parties requested that the CMA make a fast track reference of the Merger for an in-depth investigation at phase 2 and gave their consent to use of the fast track procedure.
16. The Parties accepted that the conditions set out in paragraphs 6.61 to 6.65 of the CMA's guidance on jurisdiction and procedure (**CMA2**) are satisfied and that the CMA will find that the test for reference under section 33 of the Act is met (ie that there is a realistic prospect of an SLC).
17. As part of the request, the Parties waived their normal procedural rights during the phase 1 investigation and agreed that the CMA would not be required to undertake all of the procedural steps it normally follows in cases that are ultimately referred for a phase 2 investigation.²
18. For the CMA to make a fast track reference, it must have evidence in its possession at an early stage of the investigation that it believes objectively justifies a belief that the test for reference is met.³ In addition, fast track cases are likely to be cases where the competition concerns identified would impact on the whole or substantially all of the transaction, and not just one part (that could be resolved through structural UILs).⁴
19. The CMA has considered the Parties' request and concluded that the available evidence raises a realistic prospect of an SLC in one or more markets. The CMA notes that the identified SLCs impact on the whole or substantially all of the Merger and not just one part.⁵ The CMA has also had regard to its administrative resources and the efficient conduct of the case.⁶ In light of these considerations, the CMA decided that it was appropriate to proceed with a fast track reference of the Merger to phase 2.

Background

20. In November 2015 the Manchester Health and Wellbeing Board adopted the City of Manchester Locality Plan, in the context of the Greater Manchester

² **CMA2**, paragraphs 6.61, 6.62 and 6.64.

³ **CMA2**, paragraph 6.62.

⁴ **CMA2**, paragraph 6.62.

⁵ **CMA2**, paragraph 6.63.

⁶ **CMA2**, paragraph 6.65.

devolution process⁷ and the Healthier Together programme⁸, which included a proposal for a single Manchester hospital service to deliver acute services. The Manchester Single Hospital Service Review was commissioned to assess how this should be implemented, and it reported in April and June 2016. Following its recommendations on 22 July 2016 CMFT, UHSM and Pennine Acute Hospitals NHS Trust (**PAHT**) proposed a merger between CMFT, UHSM and North Manchester General Hospital (**NMGH**).⁹

21. The proposal of CMFT, UHSM and PAHT comprises two stages. The first stage involves bringing together CMFT and UHSM to form a new FT. This is the subject of the present merger inquiry. The CMA understands that the second stage involves transferring NMGH services and assets from PAHT into the new FT. The timetable for the second stage has not yet been agreed and therefore the CMA's review only relates to the merger between CMFT and UHSM.
22. In the Greater Manchester area, commissioning of healthcare services is carried out by 12 NHS CCGs and NHS England (for specialised services). In the City of Manchester local authority area, there are three CCGs (North Manchester, Central Manchester, and South Manchester CCGs), but the leaders of these three CCGs have committed to merge by April 2017.¹⁰
23. Both CMFT and UHSM are FTs, which are given more financial independence than NHS Trusts and can retain any surpluses and raise capital to invest in services.
24. For financial year 2016/17, both CMFT and UHSM are paid under the National Tariff (previously known as Payment by Results, or 'PbR'), with some minor exceptions in the case of CMFT. The National Tariff is an activity-based payment system, in which providers are paid for each episode of care that they deliver.
25. NHS patients in England have a right to choose the provider for their first outpatient appointment for elective care and this choice is driven by clinical need, location, waiting times, and quality of services.
26. Under the National Tariff, providers are incentivised to attract patients, as they are remunerated for additional activity by commissioners. As prices are fixed,

⁷ On 3 November 2014 the Chancellor of the Exchequer and leaders of the Greater Manchester Combined Authority signed an agreement devolving new powers and responsibilities to Greater Manchester. On 25 February 2015 the 37 NHS organisations and local authorities in Greater Manchester signed an agreement with the Government to devolve health and social care expenditure in Greater Manchester.

⁸ [Healthier Together](#) is a transformation programme of Greater Manchester CCGs.

⁹ [The report of CMFT, UHSM and PAHT on arrangements to implement the recommendations of the Single Hospital Service Review](#), 22 July 2016.

¹⁰ "[Leaders of CCG trio commit to merger by April](#)", Health Service Journal, 20 September 2016.

NHS trusts could attract patients by improving or maintaining quality, waiting times, and other aspects of their services that patients and GPs care about. Regulation sets a minimum standard, but competition can be used to drive quality above this minimum.

27. There are a number of factors other than competition which also influence providers' decision-making, such as regulation and public service objectives. In this regard the CMA notes the current challenges and pressures facing the NHS in England and the ongoing efforts to transform the delivery of healthcare in order to meet the challenges set out in the *NHS Five Year Forward View*.¹¹

Counterfactual

28. The CMA assesses a merger's impact relative to the situation that would prevail absent the merger (ie the counterfactual). For anticipated mergers the CMA generally adopts the prevailing 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 believes that, in the absence of the merger, the prospect of these conditions continuing is not realistic, or there is a realistic prospect of a counterfactual that is more competitive than these conditions.¹²
29. The Parties submitted that expected changes in the supply of NHS services in Manchester should be taken into account in the CMA's consideration of the counterfactual to the Merger. However, for the purposes of the CMA's phase 1 assessment of whether the Merger gives rise to a realistic prospect of a substantial lessening of competition, in particular given the uncertainty around the details of alternative counterfactuals, the Parties submitted that it may be more appropriate for the CMA to adopt the prevailing conditions of competition as the counterfactual.
30. The CMA has not found sufficient evidence from the Parties' internal documents and third parties' responses to confirm the expected changes and their effect on NHS services. As such, the CMA is not satisfied on the basis of the evidence available that continuation of the prevailing conditions of competition is not a realistic prospect, and the CMA does not believe that the impact of the expected changes to the supply of NHS services in Manchester

¹¹ [Five Year Forward View](#), NHS England, 23 October 2014.

¹² [Merger Assessment Guidelines](#) (OFT1254/CC2), September 2010, from paragraph 4.3.5. The [Merger Assessment Guidelines](#) have been adopted by the CMA (see [Mergers: Guidance on the CMA's jurisdiction and procedure](#) (CMA2), January 2014, Annex D).

outlined above would be more competitive than the prevailing conditions of competition. Therefore, for the purposes of its phase 1 assessment, the CMA has adopted the prevailing conditions as the counterfactual.

Frame of reference

31. Market definition provides a framework for assessing the competitive effects of a 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 merger parties from outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others. The CMA will take these factors into account in its competitive assessment.¹³

Product scope

32. In line with previous cases and guidance, the CMA adopted as a starting point the following segmentations:¹⁴
- (a) Each specialty is treated as a separate product market.¹⁵
 - (b) Within each specialty, further distinctions are made between:
 - (i) Elective and non-elective care;
 - (ii) Outpatient, day-case and inpatient care; and
 - (iii) Community and hospital-based care.
 - (c) Private and NHS-funded services are also distinguished from each other.
33. The CMA did not receive any evidence or submissions in the present case to suggest a different approach to that taken in previous cases would be appropriate with respect to the distinctions between elective and non-elective

¹³ [Merger Assessment Guidelines](#), paragraph 5.2.2.

¹⁴ See [Ashford St Peter's NHS Foundation Trust / Royal Surrey County NHS Foundation Trust merger inquiry final report \(ASP/RSC\)](#), paragraph 5.1 ff, [Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust / Poole Hospital NHS Foundation Trust merger inquiry final report \(Bournemouth/Poole\)](#), paragraph 5.1 ff, and [NHS Mergers Guidance \(CMA29\)](#), paragraphs 6.37 to 6.39.

¹⁵ Services can be classified according to the specialty within which the consultant with prime responsibility for the patient is recognized or contracted to the organization (main specialty) or the specialised service within which the patient is treated (treatment function). Although specialties do not always uniquely identify sets of distinct services, the classification of services by specialty is broadly used in the NHS and appeared to constitute a reasonable and practical approach to grouping services that have clinical commonalities.

care, community and hospital based care, and private and NHS-funded services, and these are not therefore discussed further.

34. As some parameters of competition may be set at a hospital level, the CMA also investigated whether the Merger could give rise to effects on a hospital-wide basis.

Parties' submissions on day-case and inpatient segmentation

35. The Parties submitted that it may be more appropriate to assess competition in routine elective care services on the basis of an overall 'treatment' product in each specialty (ie which includes the initial outpatient consultation and any inpatient or day case treatments that arise from that consultation) rather than treating the initial outpatient consultation and any follow-up day-case and inpatient treatments as separate markets. The Parties submitted that this would be more appropriate as patients exercise choice in relation to outpatient procedures only: patients who require inpatient care are either admitted at the hospital where they had their first outpatient appointment or they are referred onto another provider to receive that care (without further choice).
36. The Parties submitted that, at the point of referral in all cases, neither the patient nor their referring GP knows exactly what package of services will be needed by the patient, including whether or not the patient will be admitted for day-case or inpatient care. As a result of this uncertainty, patients will take into account the possibility that they will be admitted when making their initial choice of provider and so will assess the quality of both outpatient and inpatient services offered by each provider in taking their initial decision. If that is correct, then it is also possible that an analysis of the patterns of first outpatient referrals would already take into account patients' preferences across both outpatient and inpatient services in that specialty (discussed in the competitive assessment of elective services, below).
37. In some cases, patients may take into account the quality of a provider's inpatient and day-case services when deciding which provider to choose for the first outpatient appointment. However, in line with the *Ashford and St Peter's Hospitals NHS Foundation Trust / Royal Surrey County Hospital NHS Foundation Trust* phase 2 merger inquiry (**ASPIRSC**), and as a starting point in this case, the CMA distinguishes between outpatient, day-case, and inpatient services because, from a supply-side perspective, the conditions of competition may differ across these segments. This is because, generally, there are asymmetric constraints among different providers of inpatient, day-case and outpatient care for each specialty. Whilst inpatient providers are readily capable of providing both day-case and outpatient services, day-case-only providers are readily capable of providing outpatient services, but not

inpatient services because of the facilities and expertise required. Similarly, outpatient-only providers are not readily able to provide day-case or inpatient services.¹⁶

Parties' submissions on aggregation of specialities

38. The Parties also submitted that some specialties should not be assessed as separate product markets, because these services will be supplied to patients only as part of their treatment in another specialty (e.g. anaesthetics), or because patients receive these services as part of a broader treatment programme, or only having first received treatment in another specialty (e.g. speech and language therapy, cardiac surgery, and transplantation surgery).
39. Following the approach set out in ASP/RSC, the CMA accepts that where the conditions of competition are the same, it may be appropriate to group certain specialties together.¹⁷ The CMA also accepts that not all providers have the ability or incentive to offer all treatments within a specialty. The CMA has taken these factors into account in its competitive assessment.

Geographic scope

40. The CMA and its predecessor organisations have in the past used catchment area analysis¹⁸ to identify the area over which the parties are likely to be important alternatives and as such those where the merger is most likely to affect competitive conditions.¹⁹ Where catchment area analysis is used, the CMA generally considers the area from which 80% of patients travel.
41. The Parties submitted that they compete in Greater Manchester and Cheshire, and provided information on their 80% patient catchment areas by hospital site. However, the Parties' catchment areas overlap to a significant degree, which suggests that they are likely to be important alternatives for patients in the City of Manchester and the south of the Trafford CCG area.
42. Table 1 below sets out the 80% catchment area for CMFT and UHSM hospital sites.

Table 1: 80% catchment areas for CMFT and UHSM hospital sites

Acute Trust	Hospital	Catchment Area (drive-time)
CMFT	Oxford Road site	29 mins
CMFT	Trafford Hospital	14 mins
CMFT	Altrincham Hospital	14 mins

¹⁶ ASP/RSC, paragraphs 5.19-5.20.

¹⁷ ASP/RSC, paragraph 5.24.

¹⁸ Catchment area analysis considers where the parties draw the majority of their referral volumes from.

¹⁹ See for example [Bournemouth/Pooler](#), paragraphs 5.54-5.71.

UHSM	Wythenshawe Hospital	22 mins
UHSM	Withington Hospital	17 mins

43. The CMA has not found it necessary to conclude on the exact boundaries of the geographic market as it has assessed closeness of competition between the parties, using patient level data and using the location of the GP practice (as a proxy for patient location).

Competitive assessment

Background

44. As providers of publicly-funded NHS services for patients, FTs seek to deliver high-quality care for their patients. However, they must also ensure they receive sufficient revenue to cover the costs of such care and where possible retain surpluses to invest in new or improved services. As such, FTs may have an incentive to compete on quality (clinical and non-clinical) to attract patients to their hospitals and, in particular, to their profitable elective services. Some aspects of quality (such as mortality rates or waiting times) are directly observable. In other ways, quality can only be judged once the patient has received treatment. Patients and GPs will assess quality in a number of different ways, including by reference to the general reputation of a hospital.
45. Patient choice and the National Tariff payment system incentivise providers to make decisions that affect quality in a way that best reflects the factors that matter to patients and GPs. Mergers between providers of NHS services may dampen these incentives, if they serve to remove a significant alternative for patients and thereby significantly reduce the competitive constraints on the merging providers.²⁰ Thus a merger may harm competition if it removes an important current or potential provider, resulting in a reduced incentive for the merged provider to maintain and provide better quality services to patients and value for money for commissioners.²¹ This effect, in merger control terms, is known as a horizontal unilateral effect. The CMA has assessed whether it is or may be the case that the Merger may be expected to result in an SLC as a result of horizontal unilateral effects.
46. The Parties submitted that the role of competition in influencing providers' decision-making is limited. Providers are constrained by regulatory requirements controlling their services, including price, quality, inputs and processes, which limits the relevance of competitive pressures. Further, other

²⁰ [NHS Mergers Guidance](#) (CMA29), paragraph 1.5.

²¹ [NHS Mergers Guidance](#) (CMA29), paragraph 6.46.

factors such as public service objectives, government policy, and the constraints imposed by annual budgets are more important in motivating providers than profit-seeking behaviour. Finally, there is now an increased emphasis on centralised management, and a reduced emphasis on provider autonomy (for example, through the introduction of control totals, Sustainability and Transformation Plans, and a single oversight framework that does not distinguish between FTs and non-FTs).

47. To support their submission, the Parties submitted that a systematic review of 82 business cases at CMFT and UHSM found that only 7 business cases were motivated by competition-related considerations, with the remainder citing a range of other concerns including a need to respond to regulatory requirements (44 cases) and a need to invest in additional capacity to meet demand (15 cases).
48. The CMA recognises that factors other than competition also influence providers' behaviour, and has found in previous cases that intense regulation can reduce the impact of certain dimensions of competition.²² However the CMA has not accepted that these arguments in themselves negate a finding of a realistic prospect of an SLC in the relevant markets.

Theories of harm

49. There are, broadly speaking, two different models of competition in the provision of NHS healthcare services. These are competition to attract patients (that is, competition in the market) and competition to attract contracts to provide services (that is, competition for the market).²³
50. The CMA has considered a number of horizontal theories of harm and where appropriate has assessed both competition in and competition for the market, in relation to the following categories of services:
 - (a) unilateral effects in the provision of acute elective services (and maternity services);
 - (b) unilateral effects in the provision of acute non-elective services;
 - (c) unilateral effects in the provision of specialised services;

²² For previous hospital cases which have discussed the role of regulation in driving quality, see [ASP/RSC](#), paragraphs 6.68 ff, [Frimley Park/Heatherwood and Wexham Park](#), paragraph 18 ff, and [Bournemouth/Poole](#), paragraphs 2.22 to 2.24. For comparison, also see [Arriva Rail North/Northern rail franchise final report](#), paragraph 8.1 ff.

²³ [NHS Mergers Guidance](#) (CMA29), paragraph 6.5.

- (d) unilateral effects in the provision of community services;
- (e) unilateral effects in the provision of services to private patients; and
- (f) hospital-wide unilateral effects.

Horizontal unilateral effects in elective acute services (and maternity services)

51. For elective acute services (and maternity services), the CMA has focused its assessment on the impact of the Merger on competition for patients and referrals (ie competition in the market).

Overlaps

52. As a starting point for the identification of overlaps, the CMA used an extract of Hospital Episode Statistics (HES) data covering the four financial years from April 2012 to March 2016.²⁴ The CMA considered the Parties to overlap in all specialities where both Parties provided at least ten periods of care during this period. On this basis, the CMA found the Parties to overlap in at least one treatment setting for 48 specialities shown in Table 2 below.

53. Maternity services, whilst categorised as non-elective, are planned services. On this basis, the CMA has included maternity services as part of its assessment of elective acute services. In assessing maternity services, the CMA has combined obstetrics and midwifery services.

Table 2: The Parties' overlaps in routine elective services and maternity services, by treatment setting

	<i>Specialty</i>	<i>Inpatient</i>	<i>Day-case</i>	<i>Outpatient</i>
1	General surgery	X	X	X
2	Urology	X	X	X
3	Transplantation surgery	X		X
4	Vascular surgery	X	X	X
5	Trauma & orthopaedics	X	X	X
6	ENT	X	X	X
7	Oral surgery	X	X	X
8	Orthodontics			X
9	Plastic surgery			X

²⁴ The Hospital Episode Statistics dataset contains individual records for every NHS admitted acute, community or psychiatric hospital admission, outpatient appointment and A&E attendance in England. The CMA used an extract for outpatients and admitted patients covering the period 1 April 2012 to 31 March 2016. The extract includes episodes for patients who are registered with a GP practice located in a CCG area of any CCG included on either of the Parties' NHS Standard Contract. HES data are patient-level, and includes information about each patient's registered GP practice, information about their referrer, where they received treatment (provider and site), and what treatment they received (specialty and subspecialties).

10	Cardiothoracic surgery	X		X
11	Paediatric surgery	X	X	X
12	Cardiac surgery	X		X
13	Anaesthetics			X
14	Pain management	X	X	X
15	Paediatric urology	X	X	X
16	Paediatric plastic surgery			X
17	Paediatric diabetic medicine			X
18	General medicine	X	X	X
19	Gastroenterology	X	X	X
20	Endocrinology	X	X	X
21	Clinical haematology			X
22	Diabetic medicine			X
23	Palliative medicine			X
24	Cardiology	X	X	X
25	Paediatric cardiology			X
26	Anticoagulant service			X
27	Dermatology			X
28	Respiratory medicine	X	X	X
29	Infectious diseases			X
30	Nephrology	X	X	X
31	Medical oncology			X
32	Rheumatology	X	X	X
33	Paediatrics	X	X	X
34	Paediatric neurology		X	X
35	Neonatology			X
36	Geriatric medicine	X	X	X
37	Obstetrics and midwifery services	X		X
38	Gynaecology	X	X	X
39	Gynaecological oncology	X	X	X
40	Physiotherapy			X
41	Occupational therapy			X
42	Speech and language therapy			X
43	Podiatry			X
44	Dietetics			X
45	Clinical oncology			X
46	Interventional radiology			X
47	Chemical pathology			X
48	Audiology			X

54. The Parties' activities in the overlap specialties account for a large proportion of their total activity in the period 2012/13 to 2015/16.

Referral analysis

55. In line with previous decisional practice, the CMA carried out a ranking analysis of referral patterns for GP practices and other referrers.²⁵ Referral analysis is conducted at a referrer level (e.g. GP practices), and the CMA grouped patients by referring organisation, for those organisations that referred at least one patient to either one of the Parties in the period covered by the HES extract.
56. As a proxy for identifying which hospital patients of the Parties might switch to in response to a reduction in quality at the relevant Party, the CMA assumed that patients/referrers would switch providers in accordance with the share of patients/referrals received by the other providers at the referrer concerned. The output of the referral analysis is a list of providers by the numbers of patients that, we assume, would switch to each hospital at each referring organisation.
57. Historical referral patterns offer an insight into patient preferences and by implication the relative importance of the alternative providers of elective inpatient and outpatient services for each referring organisation. Therefore these offer an indication of likely responses by patients/referrers in the event of reduction in quality post-merger at the Parties' sites.

Competitive analysis

58. The CMA applied the threshold used in ASP/RSC to identify services which warranted further investigation:
 - (a) One of the parties is the other's next most commonly chosen alternative;
or
 - (b) The share of referrals reallocated to the other party is 30% or greater.
59. 43 of the 48 specialties in which the Parties overlap failed the ASP/RSC filter in one or more treatment settings.
60. The CMA believes that referral analysis is a useful starting point, and that there are a number of potential factors which could affect the interpretation of the results of referral analysis, such as possible coding differences between trusts.²⁶ However, for the purposes of its assessment at Phase 1, and in light

²⁵ See [ASP/RSC](#), Annex A, and [Bournemouth/Pool](#), paragraph 6.195 ff.

²⁶ The CMA is aware of possible refinements to its referral analysis. In the referral analysis undertaken in previous cases, the CMA made an assumption that each patient's registered GP practice was also the referring organisation. The Parties submitted that the analysis should not include referrals from sources in which patients have little or no ability to exercise choice. Not all first outpatient appointments result from a referral by a GP, as

of the Parties' request for use of the fast-track procedure, the CMA did not complete its investigation of the potential factors which could affect the interpretation of the referral analysis for every specialty. For the following 16 specialties in which the CMA believes that such factors could be relevant, the CMA left open the question of whether there is a realistic prospect of an SLC as a result of the Merger: Audiology; Cardiac Surgery; Dietetics; Cardiothoracic Surgery; Endocrinology; Infectious Diseases; Neonatology; Nephrology; Oral Surgery; Orthodontics; Paediatric Cardiology; Paediatric Neurology; Paediatric Plastic Surgery; Physiotherapy; Transplantation Surgery; and Trauma and Orthopaedics.

61. For the following five specialties, the CMA believes that there is no realistic prospect of an SLC as a result of the Merger: Anticoagulant Service; Clinical Oncology; Interventional Radiology; Medical Oncology; and Palliative Medicine. In these specialties, the referral analysis suggested that the Parties were not close alternatives for patients and referrers, or that third-party competitors provided a strong competitive constraint on the Parties, and these five specialties did not fail the ASP/RSC filter.
62. For the following two specialties, although they failed the ASP/RSC filter, the CMA does not believe that the Merger gives rise to a realistic prospect of an SLC:
 - (a) **Gynaecological oncology:** in 2014 NHS England made CMFT and Christie the only providers of these services in Greater Manchester. Therefore, UHSM no longer provides these services.
 - (b) **Anaesthetics:** in ASP/RSC, the CMA excluded anaesthetics because while this is recorded as a 'first consultant-led outpatient appointment' in the HES data, patients are directed towards an anaesthetist according to a well-defined clinical pathway and it is also clear that the choice of anaesthetist plays little or no role in their choice of provider for their initial outpatient appointment for the speciality concerned.²⁷
63. However, the CMA believes that that there is a realistic prospect of an SLC as a result of the Merger in one or more treatment settings in the following 25 specialties: Cardiology; Chemical Pathology; Clinical Haematology;

they can also be made by other community-based clinicians (eg dentists) and by consultants within the acute provider (eg 'tertiary' referrals). The Parties submitted that, in particular, referrals after the first outpatient consultation (ie where the patient is already in the care of an acute provider), either to admit for inpatient care or for another outpatient appointment in a different specialty which is part of their treatment, do not involve any further patient choice of provider. For the purposes of its assessment at Phase 1, and in light of the Parties' request for use of the fast-track procedure, the CMA has not explored further the extent to which a departure from its approach in past cases is appropriate. However, the CMA may investigate this further at phase 2.

²⁷ ASP/RSC paragraph 6.144, footnote 180.

Dermatology; Diabetic Medicine; ENT; Gastroenterology; General Medicine; General Surgery; Geriatric Medicine; Gynaecology; Occupational Therapy; Obstetrics and Midwifery Services; Pain Management; Paediatric Diabetic Medicine; Paediatrics; Paediatric Surgery; Paediatric Urology; Plastic Surgery; Podiatry; Respiratory Medicine; Rheumatology; Speech and Language Therapy; Urology and Vascular Surgery. For these specialties, the referral analysis suggested that the Parties were close alternatives for patients and referrers and that third-party competitors may not provide a sufficient competitive constraint on the Parties.

Conclusion on horizontal unilateral effects in the provision of acute elective services (and maternity services)

64. As set out above, the CMA believes that there is a realistic prospect of an SLC as a result of the Merger in one or more treatment settings in 25 specialties.
65. In relation to 16 further specialties, the CMA has not concluded on whether the Merger raises competition concerns.
66. In relation to 7 further acute elective specialties, the CMA does not believe that there is a realistic prospect of an SLC in relation to outpatient, day-case or inpatient services.

Horizontal unilateral effects in the provision of non-elective acute services

67. Non-elective care involves the admission of a patient through the Accident and Emergency (A&E) department. CMFT has a full A&E department at the Royal Manchester Infirmary, at its Oxford Road site, and also an Urgent Care Centre (for non-elective but non-life threatening conditions) at Trafford General Hospital. UHSM has an A&E department at Wythenshawe Hospital.
68. In all previous cases, the CMA (and its predecessors) have not found competition concerns in relation to the provision of non-elective acute services, due to the urgent and unplanned nature of the care, and the relative unprofitability of treating non-elective patients under the payment structures at the time.
69. In this case, the Parties submitted that non-elective care does not involve patient choice, given the urgent and unplanned nature of the care. They further submitted that acute trusts do not compete for contracts to supply A&E services.

70. The CMA has examined the provision of non-elective services in terms of competition for non-elective patient and competition for contracts to provide non-elective services. Given the fast track reference, the CMA has not been able to review this area in detail and reach a conclusion that there is no realistic prospect of a substantial lessening of competition in non-elective care. In particular, the CMA notes the following facts which support, on a cautious basis, to a more detailed assessment being necessary in this case.

Closeness of competition

71. The CMA accepts that patients are unlikely to exercise choice over which A&E department to attend when they are taken by ambulance.²⁸ However, in 2015/16, only around 15% of A&E patients at CMFT and around 26% of A&E patients at UHSM arrived by ambulance.²⁹ The CMA could not, at this stage, rule out the possibility that there may be incentives for providers to compete for such referrals and by implication, mergers between closely competing providers may reduce their incentives to maintain the quality of services and other aspects of their offer to patients in non-elective services.
72. In relation to the Parties' submission that acute trusts do not compete for contracts to supply A&E services, whilst the CMA agrees that competitive tenders for such contracts are not typical, the CMA believes that there is a possibility for a process of rivalry between trusts seeking to win or retain A&E services to lead trusts to maintain or improve quality.³⁰
- *Lack of spare capacity*
73. The CMA notes that both CMFT and UHSM failed in 2015/16 to meet the NHS operational target for 95% of A&E patients to be treated within 4 hours. In Q1 of 2016/17 (1 April to 30 June 2016), CMFT treated 93.61% and UHSM

²⁸ [ASP/RSC](#), paragraph 7.12.

²⁹ This proportion is higher for those patients that were admitted to hospital after attending A&E. Around 19% of A&E patients at CMFT had their destination recorded as a non-elective inpatient admission at the Trust. The equivalent figure for UHSM was 31%. Of those A&E patients that were admitted at CMFT in 2015-16, around 35% arrived by ambulance. At UHSM, this figure was around 44%. For other patients (e.g. self-referrals), actual and perceived quality differentials may play a role in the choice of provider.

³⁰ For instance, UHSM's 2014-19 Strategic Plan placed great reliance on achieving designation as a Specialist Major Emergency Centre (SMEC), with Major Trauma services. UHSM planned to secure this designation by delivering the highest quality services locally and demonstrating to commissioners that it can comply with all the standards expected of a SMEC, and also by investing in new facilities and other improvements to key specialties (heart, lung, and vascular services). In the event, CMFT was awarded SMEC status and UHSM was not. This is consistent with the CMA's view that, at least for specialised non-elective services, there may be competition for the market. Parties Submission..

treated 76.89% of A&E patients within 4 hours.³¹ UHSM also submitted an internal document outlining a business case for expanding its A&E facilities.³²

74. The CMA accepts that the Parties' A&E services are under pressure. However, in the context of a fast-track phase 1 investigation, the CMA was not able to conclude that the Parties' A&E services are operating close to the point at which they could no longer accept additional patients, in particular outside of peak demand periods.

- *Lack of marginal profitability*

75. The marginal rate emergency rule, in the 2016/17 National Tariff Payment System, requires commissioners and providers to set a baseline monetary value for emergency admissions at every provider,³³ and for providers to only receive 70% of the national price for any increases in the value of emergency admissions above this baseline.³⁴

76. The CMA accepts that the marginal rate emergency rule makes it likely that certain non-elective specialties are unprofitable at the margin, eliminating incentives to treat additional patients in these specialties. However, in the context of the Parties' fast-track request, the CMA did not confirm the profitability (or otherwise) of the Parties' non-elective services.

Competitive constraints

77. The Parties submitted that most other acute trusts in Greater Manchester will have an A&E department.

78. However, in the context of a fast-track phase 1 investigation, the CMA could not rule out the possibility that the parties' A&E departments are important alternatives for patients in the City of Manchester and the south of the Trafford CCG area, and that alternative A&E departments located further away may not provide a sufficient competitive constraint on the Parties.

³¹ NHS Improvement, [Quarterly performance of the provider sector as at 30 June 2016, Further underlying data](#).

³² Merger Notice, Submission to the Competition & Markets Authority, Appendix 5.5b, document 40a.

³³ Monitor and NHS England, 2016/17 National Tariff Payment System, p.39. By default, the baseline is assessed as the value of all emergency admissions at the provider in 2008/09 according to current 2016/17 national tariff prices. Local adjustments can be made where there has been significant changes to the pattern of emergency care in a local health economy.

³⁴ Monitor and NHS England, 2016/17 guidance for commissioners on the marginal rate emergency rule and 30-day readmission rule.

Conclusion on horizontal unilateral effects in the provision of non-elective acute services

79. For the purposes of its assessment at Phase 1, and in light of the Parties' request for use of the fast-track procedure, given a number of unresolved questions about closeness of competition between the Parties and the relevance of alternatives, the CMA did not reach a conclusion on whether the Merger gives rise to a realistic prospect of an SLC as a result of horizontal unilateral effects in the provision of specialised services.

Horizontal unilateral effects in the provision of specialised services

80. Specialised services are services for rare conditions, and/or services which are scarce or very costly to provide.³⁵ These services are commissioned directly by NHS England on a regional or national basis. These services are often competitively tendered (i.e. competition for the market), and competition could also take the form of rival trusts developing the expertise of their staff and investing in equipment in anticipation of a possible reconfiguration.
81. In 2015/16, CMFT received £339 million from NHS England to provide specialised services. CMFT provides 74 separate specialised services, including twelve Paediatric-related specialised services, several heart-related services (e.g. Cardiac Surgery, Cardiac Electrophysiology, PPCI and Structural Heart Disease), and various other services.
82. In 2015/16, UHSM received £140 million from NHS England to provide specialised services. UHSM provides 36 separate specialised services, including several heart-related services (e.g. Cardiology), Maxillo-Facial Surgery and Plastic Surgery.

Closeness of competition

83. The Parties submitted that NHS England's commissioning intentions for 2017/18 and 2018/19 cover 13 services, only one of which (Respiratory – Severe Asthma and Interstitial Lung Disease) will be via competitive tender which is expected to commence in July 2017.
84. In its review of internal documents provided by the Parties, the CMA found that competition for specialised services appeared to be particularly important to both Parties' strategy. In particular:

³⁵ Specialised services are specified in NHSCB and CCGs (Responsibilities and Standing Rules) Regulations 2012, Schedule 4.

- (a) CMFT's 2014-19 Strategic Plan noted that the presence of three teaching hospitals in Greater Manchester (two of which, CMFT and UHSM, are in the City of Manchester) was a weakness of its position, and that it was threatened by competition for specialised cancer services and specialised children's services;³⁶ and
- (b) UHSM's 2014-19 Strategic Plan states that UHSM's clinical strategy 'relied entirely' on achieving designation as a Specialist Major Emergency Centre (SMEC), with Major Trauma services, and identified Stockport NHS FT as the main alternative SMEC in its local health economy. It planned to do this by delivering the highest quality services locally and demonstrating to commissioners that it can comply with all the standards expected of a Specialist Major Emergency Centre, but also investing in new facilities and other improvements to key specialties (heart, lung, vascular).³⁷ UHSM wanted to develop a single heart, lung and vascular centre, to defend its market share in its existing specialised services (breast surgery, burns and plastics), and to expand its market share in maternity. Similar to CMFT, UHSM was aware that clinical dependencies among specialised services meant that a strong position as the Specialist Major Emergency Centre would 'secure the Trust with a local monopoly over specialist services'.³⁸

85. These internal documents are consistent with intense 'competition for the market', leading the Parties to maintain or improve the quality of its existing services across a range of specialties, in order to be awarded contracts for specialised services.
86. In the CMA's view, even where formal competitive tenders are not used, the CMA believes that rivalry between providers may play a role. The evidence from the Parties' internal documents is consistent with the Parties seeking to maintain and improve quality in specialised services and also other services with clinical dependencies, in order to defend or win tenders for specialised services.

Competitive constraints

87. The Parties argued that, even if both Parties were to be competitors for this contract, there would be enough other acute trusts capable of providing specialised services such that the Merger would not give rise to an SLC.

³⁶ Merger Notice, Submission to the Competition & Markets Authority, Annex 5.3a.

³⁷ Merger Notice, Submission to the Competition & Markets Authority, Annex 5.3c.

³⁸ Merger Notice, Submission to the Competition & Markets Authority, Annex 5.3c.

88. For the purposes of its assessment at Phase 1, and in light of the Parties' request for use of the fast-track procedure, the CMA was unable to identify sufficiently strong competitive constraints on the Parties across all relevant specialised services.

Conclusion on horizontal unilateral effects in the provision of specialised services

89. For the above reasons, the CMA did not reach a conclusion on whether the Merger gives rise to a realistic prospect of an SLC as a result of horizontal unilateral effects in the provision of specialised services.

Horizontal unilateral effects in the provision of community services

90. Community health services are provided to patients in residential and community settings.
91. The distinction between elective acute services and community services is not always clear-cut. Whilst some services, particularly surgical services, have to be performed in a hospital setting, there are other services which could be provided either in hospital or in a community setting. Commissioners look at ways to redesign services to provide more care in a community setting (e.g. in patients' homes, health centres, schools, community buildings, or in small local hospitals). For some services, non-acute providers may represent an alternative to acute providers and barriers to entry may be lower for these services.
92. The CMA assessed the impact of the Merger with regard to these services both in relation to competition in the market and competition for the market.

Assessment of 'competition in the market'

93. The CMA assessed whether the Merger could remove an important current or potential competitor and so reduce incentives for the merged trust to maintain and provide better quality services to patients.
94. Based on the CMA's experience in previous NHS merger cases, the CMA believes that patients may have a choice of provider for community services in some cases, but this may be limited as most community services are tendered to a single provider over a large area.
95. The Parties submitted that:
- (a) None of the community services that UHSM provides for the South Manchester CCG area are subject to patient choice.

- (b) The vast majority of the community services that CMFT provides are not subject to patient choice, as they are either provided by CMFT on a city-wide or even region-wide basis with no alternative provider, or only to patients registered with a GP practice within a specific CCG area.
96. However, the Parties also note that, for some community services that CMFT provides, there could be some possibility for patient choice and competition in the market, particularly for services which are commissioned on an 'Any Qualified Provider' basis.
97. For the purposes of its assessment at Phase 1, and in light of the Parties' request for use of the fast-track procedure, the CMA has not found sufficient evidence to support the Parties' submission that none of UHSM's community services are subject to patient choice, and that there is no overlap between the Parties in the provision of any community services. Furthermore, the CMA was unable to confirm that the remaining competitive constraints in any overlap would be sufficiently strong to replace any constraints from each Party on the other which would be removed by the Merger.

Assessment of 'competition for the market'

98. The CMA considered whether, in the event of a competitive tender, the Merger would be expected to lead to worse outcomes because there would be fewer bidders (which might 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).
99. The CMA also considered whether providers under existing contracts might provide lower quality services, knowing that commissioners have fewer alternative possible providers of those services, and that therefore commissioners would be less likely to switch away from the existing provider.

- *Closeness of competition*

100. The Parties submitted some information on 14 previous tenders since 2010 that they were aware of. Of these, 11 were tenders in which only one of the Parties bid, and in the remaining three the Parties submitted joint bids.
101. The CMA asked commissioners to submit a list of past tenders since 1 April 2013, including information on bidders and their evaluation of bids in each tender. Commissioners' responses confirmed that the Parties have not submitted competing bids in any tender for community services in recent years.

- *Competitive constraints*

102. CMFT's 2014-19 Strategic Plan stated that CMFT's community services are more vulnerable to competition than its acute and specialised services, especially from Pennine Care NHS FT.³⁹
103. CCGs told the CMA that while the Parties could compete for community services, recent tenders have demonstrated that there is sufficient interest from other providers to maintain competition following the Merger.
104. For the purposes of its assessment at Phase 1, and in light of the Parties' request for use of the fast-track procedure, the CMA was unable to confirm that the competitive constraints in every overlap would be sufficiently strong to replace any constraints from each Party on the other which would be removed by the Merger.

Conclusion on horizontal unilateral effects in the provision of community services

105. For the above reasons, the CMA did not reach a conclusion on whether the Merger gives rise to a realistic prospect of an SLC as a result of horizontal unilateral effects in the provision of community services.

Horizontal unilateral effects in the provision of private patient services

106. The CMA assessed competition in the market for the provision of services paid for by patients or insurers (private patient services), as opposed to services funded by the NHS. Private healthcare providers, including NHS providers of private patient services, have flexibility in choosing the services and specialties which they offer and in setting tariffs for these services.
107. CMFT and UHSM both supply private patient services.⁴⁰ However, at UHSM, the volume of these services is negligible. CMFT had revenue from private patient services of £2.6m in 2015/16, primarily in ophthalmology (£1.2m) and paediatrics (£0.8m). UHSM earned £134,000 from private patient services in 2015/16. The CMA found that there is no material overlap in the specialties of the private patient services that the Parties provided in 2015/16.⁴¹

³⁹ Merger Notice, Submission to the Competition & Markets Authority, Annex 5.3c.

⁴⁰ Referral analysis is not possible for private patient services, as private healthcare providers are not required to record data on patient episodes with NHS Digital.

⁴¹ The CMA noted that, prior to the Merger, UHSM was planning a new private patient unit (PPU), which would be operated on its behalf by HCA. Similarly, CMFT's Strategic Plan 2014-19 noted, in passing, an opportunity to increase its profile with international patients by developing its private hospital. The CMA reviewed UHSM and HCA's proposed PPU arrangement in June 2015, under the Private Healthcare Market Investigation Order 2014, and concluded that there were no grounds for considering that HCA faced weak competitive constraints in the

108. Furthermore, the CMA notes that, within the Parties' immediate local area, there are a number of private providers that offer private patient services across a range of specialties, and these specialties overlap with the vast majority of the private patient services that the Parties provided in 2015/16. For example, Spire Manchester Hospital and BMI The Alexandra Hospital are both approximately 20 minutes' drive-time from CMFT's main site and UHSM's Wythenshawe Hospital.⁴² [X]. Therefore, the CMA considers that, if the Parties did start competing more strongly to provide private patient services, other providers, including Spire and BMI, would also compete closely with the Parties.

Conclusion on horizontal unilateral effects in the provision of private patient services

109. The CMA believes that, due to the absence of any material overlap, the limited amount of private patient services provided by the Parties, and the presence of several larger alternative providers, 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 provision of private patient services.

Hospital-wide unilateral effects

110. The CMA considered whether the Merger might reduce incentives to maintain and improve the quality of services more widely than the individual specialties where the parties appear particularly close alternatives. This is because patient choice may be based on aspects of quality which are broader than individual specialties, either because aspects of quality are set at hospital level (for example the availability of facilities) or are reported at hospital level (for example infection control, re-admission and mortality rates). The greater the extent of overlap between providers at specialty level, the greater is the extent to which providers have incentives to improve hospital wide quality, since the potential for gaining additional revenues is greater as a result of the overlap.
111. The Parties' activity in overlap specialties account for a large proportion of their total activity by volume, in the period 2012/13 to 2015/16. In addition, the

provision of privately-funded general hospital services in UHSM's catchment area. See [Private patient unit arrangements between HCA International Limited and University Hospital of South Manchester NHS Foundation Trust](#).

⁴² There are also PUs at Christie NHS FT, Salford Royal NHS FT, Wrightington, Wigan and Leigh NHS FT, and PAHT. However, like the Parties and unlike PUs in London, these PUs in Manchester do not generate significant revenues.

results of the referral analysis, aggregated across all overlap specialties, show that:

- (a) For CMFT, UHSM is the closest alternative for day-case ([40-50]% of reallocated referrals) and outpatient ([30-40]%) specialties. However, Salford Royal is the closest alternative for CMFT's inpatient specialties ([20-30]%), and UHSM is the second closest ([10-20]%).
- (b) For UHSM, CMFT is the closest alternative for inpatient ([40-50]%), day-case ([50-60]%) and outpatient ([40-50]%) specialties.

112. Several of the Parties' internal documents suggest that UHSM, in particular, regarded CMFT as a competitive constraint, which led to a response by UHSM to improve or maintain the quality of its services, across a wide range of specialties and at a hospital-level, in order to attract more referrals. For instance:

- (a) UHSM's 2014-19 Strategic Plan stated, in its competitor analysis, that it faced intense competition and that its main competitor is CMFT.⁴³ This analysis, which included a breakdown of each competitors' activity by strategic service lines and associated strategies, made extensive references to competition with CMFT in multiple service lines.
- (b) In addition, some of UHSM's monthly performance reports includes 'market share' analysis of South Manchester CCG's referrals for certain elective inpatient and outpatient specialties, and these focus on UHSM's performance against CMFT.⁴⁴
- (c) Similarly, UHSM's Withington Community Hospital Strategy Report details its plan to win back South Manchester CCG outpatient referrals from neighbouring trusts (including CMFT), particularly from GP practices around Withington where less than 50% of referrals are going to UHSM, and to increase its capacity utilisation.⁴⁵ In addition, it stated UHSM's belief that strong quality indicators appeal to patients and referring GPs, and that it planned to attract referrals to Withington by effectively promoting its quality indicators. It also detailed plans to develop and improve the services and facilities at Withington, and to market and communicate these to GPs to encourage change in referral behaviour.

113. The Parties submitted that there are a number of alternative providers of acute NHS services in the area immediately surrounding their sites. They note

⁴³ Merger Notice, Submission to the Competition & Markets Authority, Annex 5.3c

⁴⁴ Merger Notice, Submission to the Competition & Markets Authority, Annexes 5.3(e)-(k).

⁴⁵ Merger Notice, Submission to the Competition & Markets Authority, Annex 5.3d.

that the catchment areas for these sites overlap with those of other providers. Therefore, the Parties submitted that the merged entity could not reduce service quality, as patients would be able to readily access other providers of NHS acute services.

114. Most CCGs were not concerned about the effects of the Merger on quality and value for money. Several CCGs submitted that if quality or waiting times were to worsen at either CMFT or UHSM, they would inform GPs and patients, and redirect patients to other providers such as Salford Royal FT, Stockport FT, PAHT, and also independent sector providers. One CCG stated that the Merger may have an impact on specialties in which the Parties are in competition with each other, and that there may be concerns about maintaining an adequate level of quality and costs in those specialties.

Conclusion on hospital-wide unilateral effects

115. In light of the above, given the impact of the Merger at specialty level, the Merger may also reduce the parties' incentives to maintain and improve their offer to patients at the hospital level. The CMA therefore believes that there is a realistic prospect of an SLC as a result of the hospital-wide effects of the Merger.

Barriers to entry and expansion

116. Entry, or expansion of existing firms, can mitigate the initial effect of a merger on competition, and in some cases may mean that there is no substantial lessening of competition. In assessing whether entry or expansion might prevent a substantial lessening of competition, the CMA considers whether such entry or expansion would be timely, likely and sufficient.⁴⁶
117. The Parties have not submitted that there is easy entry or expansion in general, and no other evidence has been provided to the CMA to indicate that entry or expansion is likely on a significant scale in the near future.
118. Based on the CMA's experience in previous NHS merger cases and in the absence of evidence indicating entry or expansion in this case, the CMA believes that entry or expansion would not be sufficiently timely or likely to prevent a realistic prospect of an SLC as a result of the Merger.

⁴⁶ [Merger Assessment Guidelines](#), from paragraph 5.8.1.

Exceptions to the duty to refer

Relevant customer benefits

119. Section 33(2)(c) of the Act allows the CMA to exercise its discretion not to make a reference under section 33 if it believes that RCBs in relation to the creation of the relevant merger situation outweigh the SLC concerned and any adverse effects resulting from it.

Parties' submissions

120. In the context of their request for a fast-track reference, the Parties have not asked the CMA to consider efficiencies or relevant customer benefits at phase 1. However, the CMA expects to receive an extensive formal submission on relevant customer benefits from the Parties at phase 2.

NHS Improvement

121. In the context of NHS mergers, NHS Improvement has a specific role in advising the CMA on whether there are RCBs arising from the merger. Section 79(5) of the HSCA requires Monitor to provide advice to the CMA as soon as reasonably practicable after receiving notification that the CMA is investigating a merger involving an NHS FT.⁴⁷
122. NHS Improvement informed the CMA that it has been working with the Parties to prepare for the Merger since before August 2016. NHS Improvement has supported the Trusts throughout the pre-notification process and has visited the Trusts on numerous occasions. NHS Improvement has told the CMA that it is encouraged by the work which the Parties have been undertaking to demonstrate relevant customer benefits, that it believes the proposed merger could generate significant benefits to the local health economy and that it believes the Parties are very committed to achieving this.
123. Given that the Parties have not made a formal submission on relevant patient benefits, and that they have made a request for a fast-track reference, NHS improvement has not submitted any advice on any relevant patient benefits for the purposes of the CMA's phase 1 decision.

⁴⁷ Since 1 April 2016, NHS Improvement has been the operational name for an organisation which includes Monitor and other several other NHS regulatory bodies. See also [NHS Mergers Guidance](#) (CMA29), paragraph 7.5.

Third party views

124. The CMA contacted commissioners and competitors of the Parties. A few commissioners and competitors raised concerns regarding the reduction of patient choice, a potential loss of quality and higher costs in specialties in which the Parties are in competition, a potential loss in total capacity as a result of consolidating specialties on to a single site leading to higher waiting times for treatment and the significant influence that the merged trust would have over health decisions locally and nationally. There was a concern that this could allow it to attract scarce funding and staff, focussing on the needs and priorities of the merged trust itself, at the expense of the wider system and population as a whole. Third party comments have been taken into account where appropriate in the competitive assessment above.
125. No third party objected to the CMA making a fast-track reference of the Merger to phase 2, although some third parties were supportive of the merger, [✂].

Decision

126. Consequently, the CMA believes 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. The CMA therefore considers that it is under a duty to refer under section 33(1) of the Act.
127. The Parties requested and consented to the use of the fast track process and waived their right to offer UILs. The CMA has therefore referred the Merger pursuant to sections 33(1) and 34ZA(2) of the Act.

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27 February 2017