ANTICIPATED MERGER BETWEEN CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST AND UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST

Issues statement

9 March 2017

The reference

1. On 27 February 2017, the Competition and Markets Authority (CMA), in exercise of its duty under section 33(1) of the Enterprise Act 2002 (the Act), referred the anticipated merger between Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) ('the merger') for further investigation and report by a group of CMA panel members (the inquiry group).

2. The inquiry group must decide:

   (a) whether arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation; and

   (b) if so, whether the creation of that situation may be expected to result in a substantial lessening of competition (SLC) within any market or markets in the UK for goods or services.

3. If any relevant merger situation may be expected to result in an SLC, then the inquiry group must also decide:

   (a) whether action should be taken by the CMA for the purpose of remedying, mitigating or preventing the SLC concerned or any adverse effect which has resulted from, or may be expected to result from, the SLC;

   (b) whether to recommend the taking of action by others for such purposes; and

   (c) in either case, what action should be taken and what is to be remedied.

4. In deciding what actions should be taken, the inquiry group shall, in particular, have regard to the:

   (a) need to achieve as comprehensive a solution as is reasonable and practicable to the SLC and any adverse effects resulting from it; and

   (b) effect of any action on any relevant customer benefits (RCBs) in relation to the creation of the relevant merger situation concerned.

5. In this issues statement, we set out the main issues we are likely to consider in reaching our decisions, having had regard to the merger parties' submissions and the evidence gathered to date including evidence set out in the phase 1 decision to refer the merger for further investigation (the reference decision).[1] This does not preclude the consideration of any other issues which may be identified during the course of our investigation.

6. We are publishing this issues statement in order to assist parties submitting evidence to focus on the issues we currently envisage being relevant to our inquiry and to invite interested parties to notify us if there are any additional relevant issues which they believe we should consider.

7. Throughout this document we refer to CMFT and UHSM collectively as 'the parties'.

Background

The parties

8. CMFT's constituent hospitals comprise:

   (a) Manchester Royal Infirmary, a large teaching hospital, which provides a range of emergency care, elective care and tertiary care services;

   (b) Royal Manchester Children's Hospital, which provides specialist paediatric and other services for children and young people;

   (c) Saint Mary's Hospital, a teaching hospital, which provides specialist services for women and babies and a genomic clinic;

   (d) Manchester Royal Eye Hospital, which provides specialist ophthalmology services;

[1] Reference decision.

(e) University Dental Hospital of Manchester, which provides specialist dental services;

(f) Trafford General Hospital, which provides elective care services on an inpatient and outpatient basis; and

(g) Altrincham Hospital, which provides outpatient and diagnostic services.

9. CMFT also provides a range of community services, teaching services and undertakes medical research. CMFT is the largest acute NHS trust by revenue, and the largest provider of specialised services, in Greater Manchester. CMFT overall was rated as 'good' by the Care Quality Commission (CQC) in 2016.

10. UHSM provides services at Wythenshawe Hospital and Withington Community Hospital. Wythenshawe Hospital provides district general hospital services including a wide range of elective and non-elective services including specialised services. Withington Community Hospital provides general outpatient surgery and other outpatient-based services as well as diagnostic imaging services.

11. UHSM also provides a range of community services, teaching services and undertakes medical research. It is the fourth largest acute trust by revenue in Greater Manchester. The CQC rated UHSM overall as 'requires improvement' in 2016.

12. In addition, both CMFT and UHSM provide some elective services to private, fee-paying patients.

13. The proposed transaction is a statutory merger between the parties which will be effected under sections 56 and 57 of the National Health Service Act 2006. The statutory merger process will result in the dissolution of both CMFT and UHSM and the incorporation of a new NHS foundation trust authorised by the relevant regulator, NHS Improvement.[2] The property and liabilities of CMFT and UHSM will transfer to the new NHS foundation trust. As with other NHS mergers, there is no consideration associated with this transaction.

[2] In doing so, NHS Improvement will be acting in its capacity as Monitor. NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams. It is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

The services that the parties provide

14. CMFT and UHSM both offer the following services:

    (a) NHS elective acute services: services that are planned and typically require a referral from a GP or an allied healthcare professional.

    (b) NHS non-elective acute services: services that are unplanned or provided in urgent circumstances, such as emergency care as well as emergency surgery, maternity and critical care services.

    (c) NHS specialised services: services which are typically low-volume and have few, if any, other providers in a region. They are commissioned separately from other services by NHS England and might be either elective or non-elective.

    (d) Community services: services which can cover a wide range of care and preventative measures typically provided in a residential or community setting.

    (e) Services to private patients: elective services to private, fee-paying patients.

15. In addition, both provide teaching services and medical research activities.

Competition in the NHS

16. As providers of publicly funded NHS services for patients, foundation trusts seek to deliver high-quality care for their patients. 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, foundation trusts may have an incentive to compete on quality (clinical and non-clinical) to attract patients to their hospitals and to attract contracts from commissioners.

17. The arrangements supporting patient choice, including the National Tariff payment system, were designed to 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.[3] Thus a merger may harm competition if it removes an important current or potential provider, resulting in a reduced incentive for the merged

[3] *CMA guidance on the review of NHS Mergers (CMA29),* July 2014, paragraph 1.5.

provider to maintain and provide better quality services to patients and value for money for commissioners.[4] This effect is sometimes known as a 'horizontal unilateral effect' and we use that terminology in this issues statement.

18. Factors other than competition, notably regulation and commissioners' requirements, will also influence providers' behaviour. We will consider such factors in our assessment in this inquiry.

Market definition

19. The purpose of market definition is to provide a framework for the CMA's analysis of the competitive effects of a proposed merger.

20. Market definition is a useful analytical tool, but not an end in itself, and identifying the relevant market involves an element of judgement. The boundaries of the market do not determine the outcome of the CMA's analysis of the competitive effects of a merger in any mechanistic way. In assessing whether a merger may give rise to an SLC, the CMA may take into account constraints outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others.[5]

Product scope

21. The CMA has previously adopted the following segmentations for defining the relevant product market:

    (a) Each specialty was generally considered a separate product market.

    (b) Within each specialty, the following were considered separately:

        (i) elective and non-elective care;

        (ii) outpatient, day-case, and inpatient care; and

        (iii) community and hospital-based care.[6]

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[4] *CMA29*, paragraph 6.46.
[5] *Merger assessment guidelines* (CC2/OFT1254), September 2010, paragraph 5.2.2.
[6] *A report on the anticipated merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey Country Hospital NHS Foundation Trust (Final report on Ashford and St Peter's and Royal Surrey County)*, 16 September 2015.

(c) Private and NHS-funded services were also considered separately from each other, with the delineations at *(a)* and *(b)* being applicable to both private and NHS-funded services.[7]

22. As regards specialty level distinctions, the CMA's view in previous cases was that demand- and supply-side considerations in the provision of healthcare generally indicate consideration of markets which are no wider than specialties. On the demand side, the CMA's view has been that patients and the referring GPs are restricted in their choice of procedures to those that are appropriate to the specific healthcare issue with which the patient has been diagnosed. On the supply side, the CMA's view was that supply-side substitution is possible across a core set of procedures, suggesting that considering the competitive effects of the merger at the specialty level is likely to capture the effects on most sets of procedures within specialties.[8]

23. We consider that the product market analysis set out above provides a useful framework for assessing the competitive effects of the proposed merger. During our investigation we will assess the scope of the product markets on the basis of the evidence we receive during the course of the inquiry. We will consider aggregating some product markets where the conditions of competition are the same across these markets.[9] Similarly, we will consider examining some product markets at the sub-specialty level where the conditions of competition are significantly different across sub-specialties.

24. We will also consider the parties' submission that we should assess the overall treatment of patients (the 'patient pathway') in our product market analysis rather than treating the initial outpatient consultation and any follow-up day-case and inpatient treatments as separate markets. It may be that an analysis of the patterns of first outpatient referrals would already take into account some patients' preferences across both outpatient and inpatient services in that specialty. However, such an approach may give too high a weight to the choices of outpatient-only patients and the conditions of competition may differ across outpatient, day-case, and inpatient services, even within a particular clinical specialty.

Geographic scope

25. In relation to the geographic market, the CMA in phase 1 did not conclude on the exact boundaries of the geographic market as it considered closeness of

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[7] *CMA29*, paragraphs 6.37–6.39.
[8] *Final report on Ashford and St Peter's and Royal Surrey County*, 16 September 2015.
[9] *CC2/OFT1254*, paragraph 5.2.17.

competition between the parties, using data on referral patterns to provide an insight into patient/GP preferences.

26. The parties compete locally in the City of Manchester, Trafford, and parts of the surrounding area. We will consider the geographic scope for our analysis with reference to the geographic area over which a proportion of the parties' patients travel in order to receive treatments.

Assessment of the competitive effects of the merger

Counterfactual

27. We will assess the possible effects of the merger on competition compared with the competitive conditions in the counterfactual situation (ie the competitive situation absent the merger). We will therefore consider what would be likely to happen if the merger does not take place.

28. In making our assessment we will consider possible alternative scenarios and decide upon the appropriate counterfactual situation based on the facts available to us and the extent of foreseeable future developments. Further information on the counterfactual is given in the guidance on NHS mergers.[10]

29. Factors that we will consider include, but are not limited to:

    (a) The extent to which there has historically been cooperation, including partnerships and clinical networks, between the parties and between each of the parties and other NHS service providers which has affected the level of competition between them.

    (b) The basis on which services have been organised in the past and the ability, incentives and intentions of commissioning entities to reconfigure provision of services and therefore change the scope for competition between the parties in the future.

    (c) Financial, operational and clinical challenges faced by the parties in their provision of services.

30. We will also investigate whether the current level of competition between the parties would change absent the merger due to financial and regulatory changes in the landscape in which they operate.

31. Of interest in this case is the devolution of health and social care to Greater Manchester. In 2015 Greater Manchester's local authorities, Clinical

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[10] *CMA29*, paragraphs 6.10–6.32.

Commissioning Groups (CCGs), NHS England together with HM Treasury agreed to the full devolution of funding and decision making for public health and social care in Greater Manchester.[11] As a result, the health and social care budget of around £6 billion has been devolved to Greater Manchester.

32. Moreover, in November 2015 the Manchester Health and Wellbeing Board adopted the City of Manchester Locality Plan, in the context of the Greater Manchester devolution process[12] and the Healthier Together programme.[13] This plan included a proposal for a single Manchester hospital service to deliver acute services. To support this ambition, the Manchester Single Hospital Service Review was commissioned to assess how this should be implemented.[14]

33. We will investigate what effect the devolution of health and social care to Greater Manchester and the proposed single provider model will have on competition between the parties and, if need be, the quality of service to patients. We invite comments on any consequences of devolution or the proposed single provider model which may be relevant to our assessment of the merger.

Theories of harm

34. Theories of harm describe the possible ways in which an SLC could arise as a result of a merger and provide the framework for our analysis of the competitive effects of a merger. They are the hypotheses which we shall test. We have set out below the theories of harm that we intend to investigate. However, we may revise our theories of harm as our inquiry progresses and new evidence emerges. Also, the identification of a theory of harm does not preclude an SLC being identified on another basis following further work by us, or the receipt of additional evidence. We welcome views on the theories of harm set out below.

35. The merger may give rise to the following four theories of harm:

    (a) Theory of harm 1: unilateral effects in the provision of NHS elective acute and maternity services to inpatients, day-cases or outpatients.

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[11] Memorandum of Understanding, Greater Manchester Health and Social Care Devolution, February 2015.
[12] 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.
[13] Healthier Together is a transformation programme of Greater Manchester CCGs.
[14] *The report of CMFT, UHSM and PAHT on arrangements to implement the recommendations of the Single Hospital Service Review*, 22 July 2016.

(b) Theory of harm 2: unilateral effects in the provision of NHS non-elective emergency acute services to patients.

(c) Theory of harm 3: unilateral effects in the provision of specialised NHS services to inpatients and/or outpatients.

(d) Theory of harm 4: unilateral effects in the provision of community services.

36. We will also consider whether any of these theories of harm lead to hospital-wide effects. These might arise because the effects of the merger on the parties' incentives to compete across individual specialties, or in other respects, mean that their incentives to maintain their overall quality, service and reputational offer is dampened as a result of the merger. In considering whether this is likely to arise, and to the extent it is relevant, we will take into account that the parties in this case are major teaching and research hospitals (and whether the merger could lead to changes in quality which may be felt across a number of specialties and services offered by the parties).

37. The CMA's phase 1 decision found no realistic prospect of an SLC in the provision of services to private patients as a result of the merger. We are not minded to investigate this in our inquiry.

Theory of harm 1: unilateral effects in the provision of NHS elective acute and maternity services to patients

38. In our assessment of this theory of harm, we will assess the extent and nature of competition between the parties relative to the counterfactual, and the extent of competition that would remain post-merger from other providers.

39. Maternity services are non-elective services, but we will consider these together with elective acute services as patients are often able to exercise choice of providers thereby possibly imparting the same sort of competitive dynamic between providers that elective services do.[15]

40. In assessing this theory of harm, we will make use of Hospital Episodes Statistics (HES) data covering the period 2012/13 to 2015/16. HES contains details of all admissions (day-case and inpatient), outpatient appointments and A&E attendances for NHS treatments in England.

41. We expect to consider the following:

[15] Maternity services may include obstetrics and midwifery services.

(a) The overlaps between the parties' services:

(i) Identification of the overlapping specialties. How treatments are recorded may differ at different hospitals. Where needed and practicable we will check for issues of inconsistency which are highlighted to us.

(ii) Sub-specialty level analysis. Generally within a specialty, providers offer the majority of the most common procedures and may be able to easily and quickly offer procedures they do not currently provide within the specialty. However, providers may not be able to provide all complex procedures. Conditions of competition would, therefore, differ in these complex procedures compared with the specialty as a whole. If we have reason to believe that this is the case we will examine constraints at a sub-specialty level.

(iii) Assessment of existing or expected reconfiguration of service provision. We will examine evidence on commissioner-led service reconfiguration which may remove or enhance competition between the parties for certain specialties or procedures. Depending on the level of certainty of any future changes we may do this as a part of our counterfactual assessment or as a part of our competitive assessment.[16]

(iv) Specialties where patient choice does not drive competition between providers. We may seek to differentiate between specialties which drive choice and services which support or are ancillary to services that drive patient choice.[17]

(b) Closeness of competition analysis:

(i) Referral analysis. Historical referral patterns offer an insight into GP/patient preferences and by implication the relative importance of the alternative providers for each referrer. This gives one indication of the closeness of competition between the parties. We will use the HES data to undertake this analysis. We may also be able to consider whether referrals have changed over time, or in response to the closure/opening of facilities where relevant. We will also consider what weight should be attached to these data, both generally and in relation to individual specialties, given they do not measure how many

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[16] *CC2/OFT1254*, paragraph 4.3.2.
[17] By way of example, the CMA has previously found that for the anaesthetics specialty, the anaesthetist plays little or no role in the choice of provider for the patient's first outpatient appointment. *Final report on Ashford and St Peter's and Royal Surrey County*, 16 September 2015, paragraph 6.144.

patients would go to other providers after the merger or patients' strength of preferences between providers.

(ii) Linkages between specialties. We will consider whether there are linkages between certain specialties, for example whether there are aspects of quality or the delivery of care which are common across specialties. Such linkages may be relevant to how we conduct the referral analysis and how we interpret the results in determining where harm may arise.

(iii) In considering hospital-wide effects, relevant factors are likely to include both the extent of the overlap between the parties' elective services, and the closeness of competition at hospital or trust level (as reflected, for example in HES data aggregated across overlap specialties).

(c) Incentives analysis:

(i) Networks or partnership arrangements. We will take account of any existing arrangements whereby the parties (and/or other providers) collaborate rather than compete in the provision of particular services.

(ii) Service reconfiguration plans. There are a number of commissioner led programmes designed to reconfigure service provision in Greater Manchester (for example the 'Healthier Together' programme to consolidate provision of emergency and high risk General Surgery). We will consider the status of these plans and the impact, if any, on competitive incentives in the counterfactual for particular (sub-) specialties or more generally.

(iv) Payments. We will consider whether the level of applicable tariffs may reduce or remove incentives to increase the number of patients treated (if, for example, payments at the margin are no larger than the marginal cost of treatment).

(v) Capacity constraints. The incentives of a provider to compete can be diminished where the provider does not have capacity for additional patients and cannot readily expand capacity in the short term. There are various potential measures of capacity, including the number and utilisation of theatres and beds, and staff numbers, although we note that capacity can be difficult to measure. We will consider the extent of any capacity constraints of the parties and other providers in the local area, where relevant, taking into account both the current circumstances and the extent to which they may change over a longer period.

(d) Competitive responses:

(i) The parties' internal documents. We will consider the internal documents of the parties, particularly those pertinent to how competition works in the supply of the relevant services and the aspects of quality that may be affected by a reduction in competition.

(ii) Evidence from published literature. We will refer to the CMA's previous review of evidence from the literature on choice and competition, and update it if appropriate.[18]

(iii) The parties' and third party submissions, including, for example, CCGs, patients, GPs and other providers (for example, whether they would enter or expand provision of services raising competition concerns).

42. The CMA's phase 1 investigation found no realistic prospect of an SLC as a result of the merger in relation to seven overlapping elective specialties.[19] We are not minded to investigate these specialties further.

Theory of harm 2: unilateral effects in the provision of NHS non-elective (emergency) acute services to patients

43. In assessing this theory of harm, we would expect to consider:

(b) The extent of patient choice for non-elective acute services. In many cases, patients are not able to exercise choice over non-elective services (for example, when they are taken to hospital by ambulance), and patients may have less access to information on quality considerations compared with elective services. We will, therefore, consider the volume of non-elective activity where patients may have exercised choice and how this affects the Parties' incentives.

(c) The profitability of increasing activity given the tariff and cost structures and the incentives these give to the parties.

(d) Capacity constraints. We will consider the extent of any capacity constraints of the parties and other providers in the local area which may limit the providers' incentives to compete, taking into account both the

[18] See the final report on Ashford and St Peter's and Royal Surrey County, Appendix H.
[19] These are anaesthetics, palliative medicine, anticoagulant services, medical oncology, clinical oncology, gynaecological oncology and interventional radiology.

current circumstances and the extent to which they may change over a longer period.

(e) Future plans of commissioners. We will consider whether there are any plans to reconfigure A&E or other non-elective services which may affect the parties' incentives.

Theory of harm 3: unilateral effects in the provision of specialised NHS services

44. In assessing this theory of harm, we expect to consider the following:

(a) The extent of competition between the parties to win contracts. We will consider the extent to which the parties have competed to win contracts for the same specialised services, or could be expected to compete in the future. We will analyse tender data in respect of services for which the parties have bid.

(b) The extent of competition between the parties through developing the expertise of their staff and investing in equipment and research.

(c) Future reconfiguration of services. We will consider if commissioners have any plans to reconfigure services, such that there may be tenders for these services in the future. We will consider the extent to which the parties are both capable of offering the services that might be reconfigured, whether the parties would be likely to bid to provide these services, and which other providers would be likely to bid.

45. We will analyse both elective and non-elective specialised services.

Theory of harm 4: unilateral effects in the provision of community services

46. In assessing this theory of harm we expect to consider the following:

(a) The extent of competition between the parties to win contracts. We will consider the extent to which the parties have competed to win contracts for community services or could be expected to compete in the future. We note that the providers against whom the parties may have bid in the past may not be the same providers that we shall identify in theories of harm one to three above.

(b) Future reconfiguration of services. We will consider if commissioners have any plans to reconfigure community services contracts, and any implications for the nature of competition between potential providers.

(c) Competition in the market. We will also assess whether there is direct competition for patients for certain community services (that is, whether patients can exercise direct choice of provider), and whether the parties are current or potential competitors.

Countervailing factors

47. Where necessary we will investigate whether there are countervailing factors which are likely to prevent or mitigate any SLC that we may find in any of the above theories of harm. In particular, we intend to consider the following:

(a) Entry and expansion. We will consider whether entry and/or expansion could occur to constrain any market power of the merged entity.

(b) Buyer power. We will assess the extent to which commissioners would be likely to have the ability to prevent the merged provider from reducing quality or increasing price in respect of those specialties where it was less constrained by a competitor.

(c) Efficiencies. We will examine any arguments made in relation to efficiencies arising from the merger and the evidence put forward. In particular, we will examine whether any potential efficiencies are rivalry-enhancing and could be expected to offset any loss of competition.

48. We are not currently aware of any other countervailing factors but will consider any other that are suggested to us.

Possible remedies and relevant customer benefits

49. Without prejudice to our decision on SLC in this case, should we conclude that the merger may be expected to result in an SLC in any market(s), we will consider whether, and if so what, remedies might be appropriate and will issue a further statement.

50. In any consideration of possible remedies, we may have regard to their effect on any RCBs in relation to the merger and, if so, what these RCBs are likely to be and which customers would benefit.

51. To be considered, RCBs should be in the form of:

(a) lower prices, higher quality or greater choice of services or goods in any market in the UK, or

(b) greater innovation in relation to such services or goods.

52. In addition, the RCBs should be expected to accrue within a reasonable period of time and would be unlikely to accrue without the merger or a similar lessening of competition.

53. The parties have indicated to us that the merger will deliver RCBs in the form of reduced mortality rates, shorter waits for treatment, reduced lengths of hospital stays, fewer complications after surgery, fewer patients being readmitted following discharge and more convenient access to certain services. The parties have told us that the merger will realise RCBs in various specialties.

54. The parties have indicated that the RCBs will arise as a direct result of the merger through the new foundation trust having the ability and incentive to:

(a) introduce more efficient (sometimes seven day) rotas;

(b) introduce better out-of-hours cover;

(c) arrange dedicated surgical lists and sites for particular specialties which would lead to reduced cancellations resulting from competing priorities from other specialties; and

(d) treat higher volumes of patients within specialties leading to higher quality care.

55. We welcome views and evidence on these or other RCBs and note that the existence or otherwise of RCBs will not prejudice our decision as to whether the merger may be expected to result in an SLC. A non-confidential version of the parties' submission on RCBs will be published once it has been submitted.

Responses to the issues statement

56. Any party wishing to respond to this issues statement should do so in writing, by no later than 5pm on Thursday, 30 March 2017. Please email cmft.uhsm.nhs@cma.gsi.gov.uk or write to:

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