Submission to the Competition & Markets Authority

Phase 2 merger review

Anticipated merger

Central Manchester University Hospitals NHS Foundation Trust, and

University Hospital of South Manchester NHS Foundation Trust

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1. INTRODUCTION

1. This submission to the CMA by Central Manchester University Hospitals Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) follows the fast-track referral of their planned merger to a Phase 2 review (consistent with the Trusts' request). The Trusts believe that a Phase 2 review provides the best opportunity to assess the merger's benefits as well as its effect on competition.

2. This submission supplements the evidence and arguments provided by the Trusts to the CMA for its Phase 1 review (as set out in the submission of 9 December 2016 and in response to subsequent requests for information by the CMA). It responds to various points in the Phase 1 decision and the Statement of Issues for the Phase 2 review, published on 9 March 2017. It should be read alongside the Trusts' Phase 1 submission on competition issues as it supplements, rather than replaces, this earlier submission. A detailed submission on the patient benefits (i.e. relevant customer benefits) arising from the merger will also be provided to the CMA.

3. The Trusts' believe that their planned merger may reduce competition, such as it exists, in certain acute services in Greater Manchester and the surrounding region. However, the scale and scope of this reduction in competition, and the size of any adverse effects arising from its loss, is considerably smaller than might be implied by the Phase 1 reference decision. The benefits to patients that can be expected from the merger more than offset any adverse effects that could possibly arise from the merger.

4. The remainder of this submission discusses:

   - the *counterfactual* to the merger (Section 2);
   - *product and geographic market definition* (Section 3);
   - *routine elective care* services, and why any loss in competition affects a relatively small number of specialties with adverse effects that are both small and insufficient to create hospital-wide effects (Section 4);
   - *specialised services*, and why the limited nature of market-based mechanisms in the NHS generally, and in relation to specialised services in particular, limits any adverse effects that could reasonably be expected from the merger (Section 5);
   - *non-elective care*, and why the flow of patients through a hospital means that the scope for competition identified by in the Phase 1 decision is not possible (Section 6); and
   - *community services*, and why the upcoming establishment of the Local Care Organisation for the City of Manchester means that the scope for competition between CMFT and UHSM in relation to these services will no longer exist (Section 7).

2. COUNTERFACTUAL TO THE MERGER

5. The CMA's Phase 1 reference decision states that:

> "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 … 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 … Therefore, for the purposes of its phase 1 assessment, the CMA has adopted the prevailing conditions as the counterfactual."

6. CMFT and UHSM appreciate the constraints on the CMA's ability to consider any counterfactual that differs from the prevailing conditions in Phase 1, particularly in the context of a request for a fast-track referral to Phase 2. However, the Trusts' expectation is that the CMA will be able to give appropriate consideration to the full range of issues concerning the counterfactual that are set out in the Phase 1 submission.

7. In summary, the key points related to the counterfactual that the Trusts expect the CMA to consider in its Phase 2 review of their planned merger are the following:

   - commissioners' stated plans, in the lead up to the Trusts' merger decision, for a single contract for acute services in the City of Manchester (see Section 4.1 of the Trusts' Phase 1 submission);

   - UHSM's future ability to compete with CMFT given the financial pressures on the Trust and the impact on its ability to maintain its existing portfolio of specialised services in the light of planned service reconfigurations (see Section 4.2 of the Trusts' Phase 1 submission);

   - the impact on competition between CMFT and UHSM in certain routine elective care specialties and specialised services of planned service reconfigurations, which would result in either CMFT or UHSM ceasing to supply certain services (see Section 4.3 of the Trusts' Phase 1 submission); and

   - the impact on competition between CMFT and UHSM in community services of the Manchester CCG's intention to establish a Local Care Organisation responsible for out of hospital care services in the City (see Section 10.2 of the Trusts' Phase 1 submission.

8. CMFT and UHSM note the references to the matters set out above in the Phase 2 Issues Statement, and look forward to engaging further with the CMA on these points. The Trusts will provide further information to the CMA in relation to the counterfactual in responding to the Financial and Counterfactual Questionnaire.

3. PRODUCT AND GEOGRAPHIC MARKET DEFINITION

9. CMFT and UHSM, in their Phase 1 submission, made several points about product and geographic market definition. The CMA, in responding to the points made by the Trusts in its Phase 1 decision, discusses: (i) separate analysis of day-case and inpatient services; (ii) specialties as separate product markets; and (iii) the scope of the geographic market.

10. This section makes several further points regarding these issues. These are additional to those in the Trusts' submission to the Phase 1 review, and should be read alongside the earlier submission.

3.1 Separate analysis of day-case and inpatient services

11. CMFT and UHSM are pleased that the CMA in its Phase 1 decision and the Phase 2 Issues Statement appears to have recognised that patients do not know which treatment services they will access at hospital, and therefore take into account information regarding both outpatient and inpatient services when choosing their provider for their first outpatient appointment. As a result, an analysis of referral patterns for first outpatient appointments will take into account patients' preferences across both outpatient and inpatient services.

12. The Issues Statement, however, qualifies the apparent acceptance of this point by stating that this approach "may give too high a weight to the choices of outpatient-only patients". This qualification, however, only makes sense if the CMA believes that outpatient-only patients systematically make different choices to patients that receive day-case or elective inpatient services because they know – at the time of referral – which treatment services they will access. As the Trusts have set out, this is not the case.

13. It is not possible for the CMA to accept the logic of the Trusts' submissions about all patients taking the quality of both outpatient and inpatient services into account when choosing their provider, and simultaneously have concerns about the possibility of giving too great a weight to the choices of outpatient-only patients.

14. The CMA's Phase 1 decision and the Issues Statement also point to potential differences in competitive conditions in outpatient, day-case and inpatient services from a supply-side perspective as a reason for separately analysing the competitive effects of the merger with respect to these different services.

15. CMFT and UHSM believe that the CMA should review provider activity levels in day case and elective inpatient services in each specialty to determine whether there is, in reality, any difference in competitive conditions in these services compared with outpatient services that it needs to take account of in its analysis. A difference in competitive conditions could be expected to take the form of fewer providers being present in day-case or elective inpatient services compared with outpatient services. Based on a review of provider activity across Greater Manchester, the Trusts do not believe this to be a common occurrence.[1]

16. Where the CMA believes there is a material difference in competitive conditions, it can then decide on the most appropriate way of taking this into account in its competitive assessment. The CMA may wish to review the results of the patient referral analysis in relation to day-case and elective inpatient services in those specialties where there is a potential difference in competitive conditions. However, the Trusts would note that the results of the patient referral analysis in these segments have the potential to be skewed by additional extraneous factors, such as differences between acute trusts in clinical practice (e.g. the extent to which patients are admitted for treatment at one trust compared with another).

[1] See Appendix 3.1.

17. The Trusts believe that assessing specialties according to the choices made by all patients at the point of referral, and separately assessing the competitive effects of the merger on day-case and elective inpatient services in a specialty only where a review of provider activity indicates a difference in competitive conditions, is an approach that better takes into account how patient choice operates, while still being responsive to potential differences in competitive conditions in outpatient, day-case and elective inpatient services where these are present. Such an approach would be an improvement on the simple application of the patient referral analysis to all first outpatient appointments, day-case and elective inpatient activity in each specialty as the starting point for the CMA's analysis.

3.2 Specialties as separate product markets

18. The CMA's Phase 1 decision acknowledges the point made by the Trusts 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)".

19. The Phase 1 decision goes on to state that "the CMA accepts that where the conditions of competition are the same, it may be appropriate to group certain specialties together".

20. CMFT and UHSM would note that there are two separate, albeit related, issues concerning whether individual specialties form separate product markets.

21. First, it may be appropriate to group certain specialties together where patients with similar conditions are being recorded by Trusts as being referred to different specialties than similar patients that have been referred to another Trust. One example of this is Oral Surgery and Maxillo-Facial Surgery. Grouping Obstetrics and Midwife Episodes, as the CMA did in Phase 1, also often appears to be the right approach. In these instances, patients are being recorded as having been directly referred to one of these specialties, but grouping the specialty makes sense from an analytical perspective.

22. Second, there are other specialties where a patient is never, or only very rarely, referred directly to that specialty by their GP. These specialties should not be assessed as separate product markets because patients are not separately accessing services in these specialties.

23. The Phase 1 decision states that the "CMA has taken these factors into account in its competitive assessment". However, the Trusts are concerned to ensure that this is the case, and believe that it is important that in Phase 2 the CMA reviews the data that has been drawn to its attention regarding the source of referral for patients (as noted in the Phase 1 decision) to ensure that it does not erroneously assume that patients are being referred directly into specialties where this is not the case. CMFT and UHSM are encouraged by the Issues Statement making note of the CMA taking into account "specialties where patient choice does not drive competition between providers".

3.3 Geographic market

24. The CMA's Phase 1 decision states that "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". The Trusts note the CMA's view that the extent to which catchment areas overlap is an indicator of the closeness of competition between providers.

4. ROUTINE ELECTIVE CARE

25. This section sets out the views of CMFT and UHSM on issues that go to: (a) whether a substantial lessening of competition (SLC) can be expected in elective care specialties as a result of the merger; and (b) how serious the adverse effects might be in any specialty where an SLC is present.[2]

26. The Trusts note that points made in this section that concern the size of any adverse effects arising from an SLC should not be confused with those that go to whether an SLC is present at all. The Trusts believe that there was some conflation of these two issues in the CMA's Phase 1 decision.[3] The scale of any adverse effect arising from an SLC is important in the context of any choice of remedy, and whether a remedy would be proportionate given its impact on relevant customer benefits (i.e. patient benefits).

4.1 Profit measurement and elective care profitability

27. The CMA, in its Phase 1 decision, notes that "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". It is implicit that if acute trusts compete at the specialty level (as per the CMA's approach to market definition), then the they will have a greater incentive to attract patients to those services that are most profitable, and less incentive to attract patients to those services that are less profitable.

28. In practice, however, neither Trust monitors their financial performance at the specialty level. At CMFT, financial reporting is against divisional income and expenditure budgets for the Trust's nine clinical divisions ((Royal Manchester Children's Hospital, University Dental Hospital of Manchester, Medicine and Community Services, Specialist Medical Services, Saint Mary's Hospital, Surgery, Trafford Hospitals, Manchester Royal Eye Hospital and Clinical and Scientific Support). Similarly, at UHSM, financial reporting is against the income and expenditure budgets that have been set for the Trust's three clinical divisions (scheduled care, unscheduled care and clinical support).

29. CMFT has service line reporting but it is not widely used as the allocation methodologies are not considered to be robust. For example, prior to 2016/17 the Trust did not have electronic consultant job plans, and therefore the allocation of this significant cost was not an accurate reflection of how consultants spent their time. In addition, the service line

[2] As with other parts of this submission, the points made here supplement those in the Trusts' submission to the Phase 1 review, and should be read alongside that submission.

[3] For example, the Phase 1 decision acknowledges points made by the Trusts regarding regulatory constraints, factors other than financial incentives that influence Trust decision-making, and recent developments in health sector policy that have reduced Foundation Trust autonomy (and the distinction between Foundation Trusts and non-Foundation Trusts). The discussion of these factors concludes that "the CMA has not accepted that these arguments in themselves negate a finding of a realistic prospect of an SLC in the relevant markets". This implies that the CMA thought that this was the argument being advanced by the Trusts. However, this was not the case given that the Trusts had asked for a fast-track referral, and as a result, accepted that there was a realistic prospect of an SLC. Rather, the Trusts' view of these factors is that they are important for the CMA to consider in deciding on the scale and scope of any SLC that may be present.

reporting system is not user friendly and requires interpretation by the finance team. The Board does not routinely receive service line reporting information.

30. UHSM has been developing service line reporting and patient-level costing. However, this information is not used for decision making as the allocation methodologies are not robust. Work has been ongoing to address this, but – assuming the merger proceeds – will be overtaken by whatever new arrangements for financial reporting that the merged Trust puts in place.

31. This lack of profit measurement is indicative that competitive pressures are not having a major effect on the way in which either Trust operates. If competitive pressures were strong, then both Trusts could be expected to be closely monitoring financial performance at the specialty level and adjusting their behaviour in line with this. If competitive pressures were to weaken as a result of the merger, it is difficult to see this translating into a much stronger incentive to monitor specialty-level financial performance such that the merged Trust can adjust the quality of services at the specialty level accordingly.

32. In summary, the lack of systematic specialty-level financial reporting that would allow CMFT and UHSM to monitor and respond to quality-based competition at the specialty level points to the limited effect of competition on their behaviour, and as a consequence, any adverse effects arising from an SLC as likely to be very small.

4.2 Capacity constraints

33. The ability of CMFT and UHSM to compete with one another to attract additional patient referrals is dependent on each Trust having spare capacity to treat extra patients.

34. There is no single measure of capacity at an acute trust that can be used to assess the extent to which it is able to treat additional patients either in an individual specialty or for routine elective care patients more generally. This is because patients that are treated at the Trust receive a package of services (with the precise package depending on the needs of the patient), and each of these services may have its own capacity limitations.

35. Examples of factors that may limit treatment capacity at an acute trust include: the physical premises in which services are delivered; theatre availability; bed availability, including both intensive care and high dependency beds as well as more general beds on wards; diagnostics capacity; and workforce size. A trust that has spare capacity in one area may not be able to apply that spare capacity to treating additional patients because it is capacity constrained in another area.

36. The total capacity available to treat routine elective care patients is also be affected by demand for non-elective services given that acute trusts, for the most part, use the same assets and resources for both patient categories.[4]

37. This means that any one of a number of factors may, at any particular point in time, be the binding constraint on a Trust's ability to treat more patients. Given this, the Trusts' view is that the best way to assess their ability to treat more patients (and thus their incentive to compete for additional referrals) is to look at outcome measures, rather than seeking to

[4] There are some exceptions to this sharing of resources across elective and non-elective patients, such as orthopaedic services at CMFT, where beds for elective orthopaedic patients are ring-fenced by virtue of being located on separate sites.

monitor individual measures of capacity and capacity utilisation that may, or may not, represent a binding constraint at any particular moment.

38. The main outcome measure relevant to whether CMFT or UHSM have additional capacity to treat routine elective care patients is Referral to Treatment (RTT) waiting times. Routine elective care providers in England work to a regulatory standard of commencing the treatment of 92% of routine elective care patients within 18 weeks. Against this standard, CMFT is currently treating 91.6% of patients, while UHSM is currently treating 83.3% of patients. RTT performance varies at each Trust according to specialty. CMFT's performance ranges from 86.3% in Urology to 99.1% in Dermatology, while UHSM's performance ranges from 75.9% in Gastroenterology to 98.1% in General Medicine (see Table 4.1).

Table 4.1: Proportion of patients being treated within 18 weeks, CMFT and UHSM

Specialty	UHSM	CMFT
General Surgery	82.6%	92.2%
Urology	96.0%	86.3%
Trauma & Orthopaedics	78.0%	89.1%
ENT	78.8%	91.8%
General Medicine	98.1%	98.6%
Gastroenterology	75.9%	91.4%
Cardiology	79.6%	93.7%
Dermatology	89.8%	99.1%
Rheumatology	94.4%	98.1%
Geriatric Medicine	85.7%	94.4%
Gynaecology	90.0%	93.0%
All	83.3%	91.6%

Source: National RTT statistics – see Appendix 4.1.

39. These figures indicate that UHSM has limited ability to compete for additional routine elective care referrals in most specialties due to its inability to commence treatment for any additional patients within the 18 week RTT requirement. This is particularly the case for surgical specialties, whereas it may have some scope for treating additional patients in some medical specialties, such as General Medicine, Rheumatology and Dermatology.

4.3 Scope for post-merger quality reductions

40. The CMA's Phase 1 decision notes that a merger may harm competition if it results "in a reduced incentive for the merged provider to maintain and provide better quality services to patients". To assess the significance of any adverse effect, it is important to think further about how this reduced incentive might manifest itself in the actual behaviour of the merged Trust.

41. CMFT and UHSM believe that there is no prospect of the merged Trust consciously, or explicitly, adopting a strategy that involves reducing the relative quality of services at the Trust in return for improved financial performance. The environment in which NHS

providers operate is very different to a commercial private sector organisation, which – following a merger – could easily contemplate and implement, for example, an increase in prices so as to improve its profitability as a result of acquiring a stronger market position. This comparison is important for the CMA to bear in mind when thinking about the scale of any adverse effect that might arise from a merger, and the speed with which it might occur.

42. The Trusts, in their Phase 1 submission, pointed to the external constraints that constrain any reduction in service quality. These include not only regulation and commissioners' requirements, as acknowledged in the Issues Statement, but also the intrinsic behavioural motivations for public service organisations charged with providing the best possible care for their patients.

43. Internal and professional governance arrangements also play an important role in preventing an NHS acute trust from deliberately deciding to diminish the quality of the services that it offers. For example, the Board of Directors for an NHS acute trust is required to have a Medical Director and a Nursing Director. Both have professional duties / standards that require them, as clinical professionals, to be focused on quality, and to consciously decide to implement a quality reduction would be inconsistent with these codes of behaviour.[5]

44. Both Trusts have Board sub-committees involving Non-Executive Directors (Quality and Performance Committee at CMFT, and Quality Improvement Committee at UHSM) as well as operational management committees looking at quality (Quality Committee at CMFT, and Clinical Standards Sub-Committee at UHSM). Further, Governors hold Foundation Trusts to account for delivery of strategy, including in relation to quality. Both Trusts have patient experience committees as sub-committees to their Board of Governors. There is no reason to believe that the merged Trust would be able to adopt less comprehensive arrangements.

45. Further, CMFT and UHSM have a robust process for Quality Impact Assessments.[6] At both Trusts, Quality Impact Assessments are completed for every Cost Improvement Project. At CMFT, the Chief Nurse signs off every Quality Impact Assessment, while at UHSM, the Nursing Director and Medical Director review and approve every Quality Impact Assessment.

46. The totality of the internal and external constraints on a deliberate deterioration in service quality following a merger means that it would not be reasonable for the CMA to conclude that such a strategy is something that the merged Trust could explicitly pursue. Moreover, the practical difficulties of such a policy cannot be underestimated. It may be possible to reduce quality, but to do so in a way that improves the financial performance of the Trust and does not have damaging and unintended effects for the Trust (e.g. on its ability to recruit staff to a poor quality organisation) is incredibly complex. This is particularly the case for an organisation that does not have the sophisticated financial monitoring tools (see Section 4.1) that would allow it to assess and adjust the impact of its strategy.

[5] This includes the Nursing and Midwifery Council Code (Professional standards of practice and behaviour for nurses and midwives) available at https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf and the General Medical Council Good Medical Practice (advice to doctors on the standards expected of them) – "Make the care of your patient your first concern" available at http://www.gmc-uk.org/guidance/good_medical_practice.asp.
[6] NHS Improvement's Well Led Framework refers to the need for this – see p28 at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/422057/Well-led_framework_April_2015.pdf

47. The alternative to a deliberate policy of quality deterioration for financial gain could be an implicit or unconscious realisation of reduced quality arising from a loss of competitive pressure (although it is difficult to see this readily translating into improved financial performance). The main way this could potentially manifest itself would be investment decisions, and actively choosing to reduce investment, as a way of improving financial performance, and thus allowing relative quality to deteriorate over time. However, the review of business cases submitted at Phase 1 showed that competition is rarely a significant factor in the Trusts' investment decisions. As a result, any reduction in competition could not be expected to have a significant impact on the future investment behaviour of the merged Trust.

48. In summary, the merged Trust could not be expected to have an explicit policy of quality reduction for the purposes of improved financial performance. Internal governance, external organisational regulation, professional regulation and commissioner requirements would all prevent such a policy from being adopted. The complexity of implementing such a policy – in any event – would be very high. The Trusts lack the financial control systems that would let a policy of quality deterioration, with quality differentiated by specialty, be executed. To the extent that a quality deterioration might come about, in a way that is unconsciously realised by the merged Trust as a result of a loss of competitive pressure, would most likely appear to be through reduced investment. However, the business case review shows that competition already only plays a very small role in investment decisions, and as a result, the effects of a loss of competition will be minor.

4.4 Future competitive constraints from other providers

49. The CMA's Phase 1 decision states that "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".

50. An increase in the relative quality of services at a competing provider of routine elective care services, however, can be seen as analogous to expansion. This is because the competitive strength of that provider, and its attractiveness as a referral destination, has increased relative to other providers.

51. The CMA in clearing the planned merger between Ashford & St Peter's Hospitals NHS Foundation Trust (ASP) and Royal Surrey County Hospital NHS Foundation Trust (RSC) placed significant weight on the increased competitive constraint that would be offered by Heatherwood and Wexham Park Hospitals following their acquisition by Frimley Park Hospital NHS Foundation Trust as well as by West Middlesex Hospital following its acquisition by Chelsea & Westminster Hospital NHS Foundation Trust.[7] Prior to its acquisition, Heatherwood and Wexham Park Hospitals NHS Foundation Trust was a particularly weak competitor with an 'Inadequate' rating by the Care Quality Commission, while its acquirer, Frimley Park, was rated 'Outstanding'.

52. A similar increase in the competitive constraint offered by two neighbouring acute trusts is also relevant in the context of the planned CMFT/UHSM merger.

[7] The CMA's Final Report stated that one of the factors it took into account was "The strength of the reputation and market position, and investment plans, of certain alternative providers [i.e. Frimley and West Middlesex] who we considered were likely to become increasingly strong alternatives in the near term" (para 6.148).

53. Pennine Acute Hospitals NHS Trust, which is ranked Inadequate by the CQC, has come under the management of Salford Royal NHS Foundation Trust, which is ranked Outstanding. Services at Pennine Acute can be expected to improve (in the same way as services improved at Heatherwood and Wexham Park Hospitals following their acquisition by Frimley Park Hospital NHS Foundation Trust). This can be expected to increase the competitive constraint offered by Pennine Acute Hospitals in the future.

54. Tameside and Glossop Integrated Care NHS Foundation Trust (formerly Tameside Hospital NHS Foundation Trust), a neighbouring Trust for CMFT and UHSM, was identified nationally in 2013 as having high mortality rates and was one of 14 hospital trusts to be investigated as part of the Keogh Mortality Review. It subsequently entered special measures because of concerns about the care of emergency patients, staffing levels, patients' experiences of care, and was rated Inadequate by the CQC.

55. Since then, the quality of services at Tameside have improved significantly. The Trust was rated 'Good' by the CQC in its most recent inspection report, published in February 2017. This improvement in the quality of services at Tameside will strengthen the competitive constraint that Tameside places on its neighbouring acute trusts, and can be expected to impact on referral patterns as its reputation catches up with its performance.

4.5 Internal documents

56. Two sets of internal documents at CMFT and UHSM are relevant to the CMA's consideration of the merger's effect on competition. These are, first, the business cases reviewed by the Trusts for the purposes of their submission, and second, the strategic plans and other internal documents referenced by the CMA in its Phase 1 decision.

57. The CMA's Phase 1 decision refers to the systematic review of 82 business cases submitted by CMFT and UHSM in which only 7 business cases were motivated by competition-related considerations. This is compared with 44 business cases motivated by regulatory requirements and 15 business cases that responded to increased demand. Elsewhere in the Phase 1 decision, the CMA refers to other internal documents at CMFT and UHSM, including in relation to specialised services and community services, that discuss competition between providers.

58. The Trusts believe significantly greater weight, in any assessment of the internal documents at CMFT and UHSM, should be placed on the review of business cases than on other documents. This is because these business cases are a comprehensive record of the rationale for every significant business-related decision at either Trust (i.e. those decisions involving significant monetary expenditure). This is a much more reliable source of evidence, given that it is a record of actual decisions made by each Trust, than periodic strategy documents that are intended to inform future decision-making, but where the link between the strategy and any subsequent implementation is not clear.

59. The business case review presented by CMFT and UHSM is a source of evidence that is not available to the CMA in its review of private sector mergers. This is because public sector organisations, like CMFT and UHSM, are under an obligation to produce business cases that is not mirrored in the private sector. This has consequences for how the CMA goes about assessing the parties' internal documents in this merger, and the weight that it accords to different types of internal documents, that are not present in a usual merger review. The Trusts look forward to seeing the CMA's assessment of this issue.

60. There are also a number of points to note regarding the inferences and conclusions drawn by the CMA in its review of strategic plans and other documents at the two Trusts in the Phase 1 decision. The CMA's decision states: "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:

- UHSM's 2014-19 Strategic Plan stated, in its competitor analysis, that it faced intense competition and that its main competitor is CMFT.[8] 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.
- 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.[9]
- 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.[10] 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."

61. It is important that the CMA's references to these documents be placed in their proper context. Taking each in turn:

62. ***UHSM's 2014-19 Strategic Plan***: The plan says "Our main competitor for most key specialties is CMFT" (p.28). This is the only such reference, however, in the whole of the 78 page document. The detail of the document shows a more complex picture, including many references to competitive pressures from other sources, including other Trusts and hospitals and CCGs. The document recognises a range of other competitors e.g. p29 and Table 11 on p30. Page 62, for example, says:

> "Analysis provided by PWC in 2012 highlighted that Greater Manchester is a competitive health economy, with a wide range of DGH and acute providers and an expanding private and third sector provision. It further identified that UHSM predominantly competes with providers from Greater Manchester for local services, and for specialist services with hospitals in Cheshire and Derbyshire. Our most important local competitors are CMFT and Stockport, with some services competing with Pennine Acute Trust. We compete with Liverpool Chest and Heart for specialist cardiac, cardiology, cardiothoracic and respiratory work. New providers are considering entering the market (e.g. Circle Healthcare). They are likely to focus on either specific specialties, or on the provision of high-quality services in modern, flexible facilities. Competition from smaller providers,

[8] Merger Notice, Submission to the Competition & Markets Authority, Annex 5.3c
[9] Merger Notice, Submission to the Competition & Markets Authority, Annexes 5.3(e)-(k).
[10] Merger Notice, Submission to the Competition & Markets Authority, Annex 5.3d.

including the third sector, may be a future feature and the Trust must adapt its offer to successfully bid for and deliver such services in this setting."

63. Other examples in the Strategic Plan include the following:
    - p29, Table 10 - which shows significant 'market share' gains by other Trusts, at the expense of UHSM and CMFT;
    - p42 - Regarding breast surgery: "We will use access to our state of the art facilities and our radiology service to attract patients from Tameside, Stockport and Salford ..."; and
    - p56. - Whole table on attracting growing catchment area to Cheshire.

64. At page 31 the document refers to benchmarking performance against other (unspecified) peers:

> "To respond to the changes in the market we have assessed our capacity, efficiency and productivity by assessing ourselves against peers to identify where further improvements can be made within the organisation, either creating additional capacity for utilisation or if more appropriate, removal of cost. We will continue to benchmark on day case rates and elective inpatient activity, aiming to perform amongst the best in class."

65. There are also many references within the document that support contentions that the parties have made but that the CMA have not quoted in its assessment to date. For example:
    - p.8: "What we envisaged as our future five years ago may no longer be viable today";
    - p.8: sets out potential funding gap if nothing is done;
    - p.8: "The Trust and the LHE have been capacity constrained for a number of years. This is adversely impacting the Trust's ability to be compliant with core targets";
    - p.9: "Commissioners are struggling to commission sufficient capacity"; and
    - p.12: Importance of recruitment (which would be undermined by actions to reduce the Trust's performance as alleged in the theories of harm).

66. ***Performance monitoring: Annexes 5.3(e to k)***: The description in the Phase 1 decision appears to overstate the significance of the source references, for the following reasons:

    - There is no reference to CMFT in Annex 5.3(e, f, g and k).

    - There is one table in Annex 5.3(h) that mentions CCG shares. However, this is very narrowly focused on geriatric medicine. While it is true that CMFT is the only other Trust specifically mentioned, the table shows that the scale of activity by 'others' (besides UHSM and CMFT) is, in many months, of the same (very low) order of magnitude to CMFT's.

    - In Annexes 5.3(i and j), the picture is very mixed. There are many instances where the CMFT activity is very small compared to that for UHSM and many where the activity in the 'others' category is of a similar order to that of CMFT or sometimes much greater.

67. ***Withington Strategy Report - Annex 5.3(d)***: the CMA's conclusions omit any mention of the following:

- Page 74, in a slide entitled "Competitors - Provider Landscape" states that: "UHSM is one of a number of trusts that provide services for (sic) in the southern part of Greater Manchester". The map goes on to identify six other Trusts besides UHSM.

- The benchmarking slides that follow consider four or more other Trusts and do not conclude that CMFT is the strongest or closest competitor.

- The analysis slide on p.78 contains over 20 factors that it says are driving the need to change. Only one (briefly) mentions competition or competitors. The slide notes three main drivers of change, not including competition: "The key points to note are: Financial pressures within the system; drive towards more integrated services and a focus on care closer to home; technology will be a key driver in achieving integrated working".

- 'Competition' is mentioned only three times in a document that runs to 115 pages. Other than as section headings, the word 'competitor' appears only three times.

5. SPECIALISED SERVICES

68. The CMA, in its Phase 1 decision, stated that "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".

69. CMFT supplies 89 specialised services and UHSM supplies 31 specialised services. The two Trusts overlap in the provision of 18 specialised services across six treatment areas, namely: Cardiology; Cancer; Colorectal Surgery; Endocrinology; Gynaecology; Major Trauma; and Vascular Surgery (see Table 5.1).[11]

Table 5.1: Specialised services supplied by both CMFT and UHSM

Treatment Area	Service	Geographic Scope of commissioning	No. of other contracted providers in region
Cardiology	Implantable Cardioverter Defibrillator and Cardiac Resynchronisation Therapy (Adult)	Greater Manchester	2
	Electrophysiology and Ablation Service	Greater Manchester	0
	Primary Percutaneous Coronary Intervention (Adult)	Greater Manchester	0
	Magnetic Resonance Imaging	Greater Manchester	0
	Cardiac Surgery	Greater Manchester	0
Cancer	Oesophagael and Gastric (Adult)	Greater Manchester	1
	Specialised Kidney, Bladder and Prostate	Greater Manchester	3
	Chemotherapy (Adult)	Greater Manchester	9

[11] The number of specialised services supplied by CMFT and UHSM that is set out in this paragraph differs from that quoted by the CMA in the Phase 1 decision (which reflected information supplied by the Trusts in its initial submission), but is consistent with revised information on specialised services supplied to the CMA during Phase 1.

	Chemotherapy (Children, Teenagers and Young Adults)	Greater Manchester	3
	Head and Neck (Adult)	Greater Manchester	2
Colorectal Surgery	Faecal Incontinence (Adult)	Greater Manchester	0
	Transanal Endoscopic Microsurgery	Greater Manchester	0
Endocrinology	Specialised Endocrinology Services (Adult)	North West	7
Gynaecology	Complex Gynaecology: Urogenital and Anorectal Conditions	Greater Manchester	1
	Complex Gynaecology: Recurrent Prolapse and Urinary Incontinence	Greater Manchester	1
	Complex Gynaecology: Urinary Fistulae	North West	3
Major Trauma	Major Trauma (All Ages)	Greater Manchester	1
Vascular Surgery	Specialised Vascular Services (Adult)	Greater Manchester	2

Note: CMFT and UHSM are both commissioned to supply specialised burns care services. However, the UHSM burns care service is for adults, while the CMFT service is for children.

70. The Trusts do not believe that their merger gives rise to an SLC in relation to any of the specialised services in which they overlap. The remainder of this section discusses the six overlapping specialised services treatment areas in more detail.

5.1 Cardiology

71. CMFT and UHSM overlap in five cardiology services. In four of these services, CMFT and UHSM are the only providers in Greater Manchester, while in the fifth service there are two other providers.

72. Specialised cardiac services are discussed at length in the Trusts' patient benefits submission to the CMA. In that submission, the Trusts explain how the merger will allow significant service improvements to be achieved by concentrating the resources of both Trusts at a single site.

73. Rather than facilitating a decline in the quality of specialised cardiology services, the merger will actually enable an improvement in these services. As a result, the Trusts do not believe that their planned merger gives rise to an SLC in specialised cardiology services.

5.2 Cancer services

74. CMFT and UHSM overlap in five cancer-related specialised services, two of which encompass chemotherapy, two of which are currently subject to reconfiguration exercises, and one that is the subject of a patient benefits case that the Trusts are submitting to the CMA.

75. In the two chemotherapy services (Chemotherapy (Adult) and Chemotherapy (Children, Teenagers and Young Adults)), there are a significant number of other providers in Greater Manchester. If there were any deterioration in the quality of services at the merged Trust, the commissioner would be readily able to shift patient treatment volumes and services to

other providers. As a result, the Trusts do not believe their planned merger gives rise to an SLC in relation to these services.

76. Two of the cancer services (Specialised Kidney, Bladder and Prostate, and Oesophageal and Gastric (Adult)) are currently the subject of reconfiguration exercises. Under these new arrangements, Urology cancer services (i.e. kidney, bladder and prostate) [✂], while Oesophageal and Gastric cancer services will be provided at Salford Royal. That is, if the merger were not to proceed, the overlap between CMFT and UHSM in the provision of these services would no longer exist. As a result, the merger does not give rise to an SLC in these services.

77. The final cancer-related specialised service, Head and Neck (Adult), has two other providers in the Greater Manchester region, namely Pennine Acute Hospitals NHS Trust and The Christie NHS Foundation Trust. CMFT and UHSM believe that this provides NHS England with sufficient choice of other providers, in the event that service quality was to decline at the merged Trust, to shift either patient volumes or contracts.

78. Moreover, as set out in the patient benefits submission, the Trusts believe that their merger will allow significant improvements in head and neck cancer services to be delivered. That is, far from facilitating a decline in the quality of head and neck cancer services, the merger will actually enable an improvement in these services. As a result, the Trusts do not believe that their planned merger gives rise to an SLC in head and neck cancer services.

5.3 Colorectal Surgery

79. CMFT and UHSM are the only two providers in Greater Manchester of two specialised colorectal surgery services, namely Faecal Incontinence (Adults) and Transanal Endoscopic Microsurgery.

80. Salford Royal NHS Foundation Trust also provides two specialised services in colorectal surgery. These are a Distal Sacrectomy (Adult) and a Complex Inflammatory Bowel Disease service. CMFT and UHSM consider that Salford Royal’s expertise in specialised colorectal surgery services, as well as other specialised intestinal services, means that it would be a ready alternative for commissioners in the event that they were dissatisfied with services at the merged Trust. For this reason, the Trusts do not believe that their merger gives rise to an SLC in relation to specialised colorectal surgery services.

5.4 Endocrinology

81. Specialised endocrinology services are commissioned across the North West region. There are seven further providers of these services in the North West, other than CMFT and UHSM. This includes, in Greater Manchester, Salford Royal NHS Foundation Trust and The Christie NHS Foundation Trust. As a result of the large number of other providers, CMFT and UHSM do not believe that their merger gives rise to an SLC in relation to specialised endocrinology services.

5.5 Gynaecology

82. CMFT and UHSM both provide three specialised complex gynaecology services: Urogenital and Anorectal Conditions; Recurrent Prolapse and Urinary Incontinence; and

Urinary Fistulae. Each of these services is also provided at Salford Royal NHS Foundation Trust as well as by other providers across the North West region. As a result, CMFT and UHSM consider that it would be a ready alternative for commissioners in the event that they were dissatisfied with services at the merged Trust. For this reason, the Trusts do not believe that their merger gives rise to an SLC in relation to specialised gynaecology services.

5.6 Major Trauma

83. Following a recent reconfiguration exercise, Salford Royal has been designated as the primary major trauma centre for Greater Manchester, with CMFT providing major trauma services for penetrating chest trauma, and UHSM continuing to receive burns patients and major isolated orthoplastic trauma (complex, mainly lower limb, fractures). At the moment, UHSM continues to receive major trauma patients during the day (consistent with historic arrangements), but is awaiting confirmation from Salford Royal to stop this service (as part of the transition to the new arrangements).

84. Given this reconfiguration of major trauma services, CMFT and UHSM can no longer be regarded as providers of overlapping major trauma services. As a result, the merger does not give rise to an SLC in relation to major trauma services.

5.7 Vascular Surgery

85. Vascular Surgery services, as part of the merger, will be concentrated on a single site. Details of these plans are set out in the Trusts' submission on patient benefits. This is consistent with longstanding efforts by commissioners to improve the quality of these services, and this change is now enabled by the merger between CMFT and UHSM.

86. The merger, rather than facilitating a decline in the quality of vascular surgery services, will enable an improvement in these services. As a result, the Trusts do not believe that their planned merger gives rise to an SLC in vascular surgery services.

6. NON-ELECTIVE CARE

87. In its Phase 1 decision, the CMA considered competition for non-elective patients and competition for contracts to provide services to non-elective patients. 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 non-elective care services.

88. This section considers the potential for competition between Trusts for non-elective patients. As the CMA notes in its Phase 1 review, competition for A&E contracts are very rare (if not non-existent) and there are no such plans for a tender on the horizon in Manchester. Competition for contracts for non-elective services (as opposed to A&E services) is discussed in Section 5 in the context of specialised services.

89. The CMA, in its Phase 1 decision, raised the possibility that acute trusts could compete for those non-elective patients that self-present at A&E. The CMA agrees with the Trusts that patients who are transported to A&E by ambulance are unable to exercise choice of hospital.

90. The Trusts' view is that those patients that self-present at A&E with a major illness or injury are unlikely to be exercising choice. These patients require care urgently and are likely to be in pain. Their priority will be to attend their nearest A&E. On the other hand, those patients that are presenting at A&E with a minor injury or illness are more likely to exercise choice. However, for these patients, choice extends beyond A&E departments and may include walk-in centres, urgent care centres, GP services, out of hours GP services, pharmacies, and NHS 111 services.

91. CMFT and UHSM have drawn the CMA's attention to the pressure under which their A&E services are operating.[12] The CMA has also said that it "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".

92. The CMA has raised the possibility that the Trusts could, however, accept additional non-elective patients outside peak demand periods. The Trusts do not believe that, even if there was a financial incentive to attract additional A&E patients (which the Trusts do not believe is the case), it would be possible to implement an acceptable strategy that aimed to attract additional A&E patients outside peak demand periods and not during peak periods.

93. Moreover, a significant proportion of A&E attendances result in a non-elective admission at both CMFT and UHSM (19% and 31%, respectively). This means that the Trusts' capacity to treat additional non-elective patients is not only a function of the capacity of their A&E departments, but also the availability of beds within their hospitals to admit these patients. This beds issue is a constraint regardless of whether the patient arrives at A&E inside or outside peak demand periods in the A&E department.

94. Bed occupancy levels are high at both Trusts. In Quarter 3 of 2016/17, bed occupancy at UHSM was 84.1% and at CMFT it was 93.1%.[13] The National Audit Office suggests hospitals with average occupancy levels in excess of 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections,[14] while the Department of Health also says that occupancy of greater than 85% is a cause for concern.[15] These high levels of bed occupancy mean that there is a further disincentive to attract additional non-elective care patients.

95. A further consideration relates to financial incentives. As noted above, the CMA has acknowledged 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 addition, those non-elective patients that are admitted will be taking a bed that could otherwise be used for an elective care patient where there is no marginal rate rule. All else being equal, the elective care patient is likely to be more financially attractive than the non-elective patient.

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[12] In addition to the information supplied to the CMA in Phase 1, it is worth noting that UHSM has not met the A&E target for over 18 months and on 16 occasions during the period December 2016 to February 2017 has had to divert patients to other A&E departments to provide temporary respite compared to two diverts in the corresponding period in 2015/16. See national SITREP data at https://www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps/).

[13] See https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/

[14] See https://www.nao.org.uk/wp-content/uploads/2000/02/9900254.pdf

[15] See http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/Browsable/DH_4989760.

96. For these reasons, the Trusts do not believe that they have any ability or incentive to compete for additional A&E patients. As a consequence, the Trusts do not believe that their merger gives rise to an SLC in competition for non-elective care.

7. COMMUNITY SERVICES

97. The CMA, in its Phase 1 decision, concluded that in the context of the Trusts' request for a fast-track referral, it could not rule out the possibility of there being a realistic prospect that the merger could give rise to an SLC in community services by virtue of either: (a) a reduction of choice for patients in relation to those community services where CMFT and UHSM both offer services to the same patients; and (b) a reduction in competition for community services contracts.

98. The Trusts believe that, if the current model of community services was to continue in the future, a detailed review of the evidence would support the conclusion that their merger does not give rise to an SLC in community services as a result of a reduction in either patient choice or competition for community services contracts.

99. However, as set out in Section 10.2 of their Phase 1 submission (and consistent with the discussion of the counterfactual in Section 4), the establishment of a Local Care Organisation (LCO) by Manchester CCG, which will be responsible for all out of hospital services in Manchester, will remove any potential for competition between CMFT and UHSM in the provision of these services. Even if the CMFT/UHSM merger did not proceed, the LCO would still be established, removing the potential for competition between the two Trusts in relation to community services.