Submission to the Competition & Markets Authority

Anticipated merger

Central Manchester University Hospitals NHS Foundation Trust, and

University Hospital of South Manchester NHS Foundation Trust

Contents

1. EXECUTIVE SUMMARY

1. Following the devolution of health and social care services to Greater Manchester in February 2015, an independent review of hospital services in the City of Manchester was commissioned. The Manchester Health and Wellbeing Board, which includes elected representatives from the Manchester City Council, subsequently concluded in June 2016 that the best way to improve hospital services for the City of Manchester's residents would be to establish a single NHS acute trust for the City.

2. A merger between Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester (UHSM) is the first step in establishing this new acute trust for Manchester. It is anticipated that the new, merged Trust will acquire North Manchester General Hospital (NMGH) around 12-18 months following its own merger, and thus complete the establishment of a single NHS acute trust for Manchester.

3. This new trust is regarded by Manchester City Council's leaders and elected councillors, as well as by Manchester's CCGs, as an essential part of their plans to address unacceptable levels of variation in clinical outcomes, patient experience and access to hospital services in the City.

4. It is also part of a broader strategy to address population health outcomes in Manchester that lag significantly behind those elsewhere in England. This broader strategy includes establishing a new Local Care Organisation to deliver improved community-based health services that prevent illness and care for people closer to their homes, a pooling of health and social care commissioning budgets across the City, and a merger of the City's three CCGs.

5. The decision to establish a single acute trust for Manchester follows longstanding efforts to improve acute services, under the current configuration of providers, which have delivered disappointing results.

6. This submission to the CMA sets out CMFT's and UHSM's assessment of the effect of their planned merger on competition in acute services in Greater Manchester and the surrounding region.

7. CMFT and UHSM are two of nine NHS acute trusts located in Greater Manchester. CMFT is the largest acute trust in Greater Manchester, by revenue. It operates from four hospital sites in the Manchester and Trafford local authority areas, and had revenue of £967 million in 2015-16. UHSM is the fourth largest acute trust in Greater Manchester, by revenue. It operates from two hospitals in the Manchester local authority area, and had revenue of £437 million in 2015-16.

8. The Trusts request that the CMA make a fast-track reference to Phase 2 given the likelihood that the CMA's Phase 1 review will conclude that their planned merger gives rise to a realistic prospect of a substantial lessening of competition (SLC) in several routine elective care specialties. CMFT and UHSM are, however, confident that their merger will be cleared by the CMA at Phase 2.

9. Without the merger, the Manchester CCGs have signalled their intention to implement a single contract for acute services in Manchester. This will inevitably reduce competition given the lead- and sub-contractor arrangements between CMFT and UHSM that are implied by this arrangement. In addition, UHSM's ability to compete with CMFT can be

expected to progressively decline if it remains an independent entity. The loss of further specialist services on top of the financial challenges presented by UHSM's PFI commitments could be expected to lead to a financial and operational performance deterioration that would make the Trust a significantly less attractive alternative to CMFT.

10. Further, in several specialties such as specialised cancer surgery and vascular surgery, competition between CMFT and UHSM will be removed, even if the merger does not proceed, due to decisions by commissioners to consolidate these services at individual providers.

11. Collectively, these factors mean that competition between CMFT and UHSM, to the extent that it currently exists, will be reduced even if the merger does not proceed. As a result, the merger's effect on competition in acute services in Greater Manchester is minimal.

12. The role of competition in influencing the provision of acute services by CMFT and UHSM, in any case, is limited. CMFT and UHSM acknowledge that the CMA has considered the role of competition in previous reviews of acute trust mergers, and concluded that competition in the NHS is associated with improved service quality. While having reservations on this point, CMFT and UHSM are not seeking to question the CMA's opinion. The Trusts, however, believe that it is important that the role of competition in influencing the provision of NHS acute services be placed in its proper context so that any assessment of the effect of its loss can be properly evaluated.

13. Markets and competition may have a role in NHS acute services, but they are not the basic organising principle for these services. This is quite different to other industries reviewed by the CMA in exercising its merger control responsibilities, and where the constraint of market mechanisms, which unchecked would harm consumers, is the goal of the CMA. By contrast, the NHS is a publicly funded and operated service (with some small exceptions) that exists within a public sector administrative and accountability framework combined with extensive regulatory mechanisms. These arrangements fundamentally constrain the ability of acute trusts to 'flex' their offer in response to 'market' conditions.

14. CMFT and UHSM do not wish to reprise debates that have been had in previous CMA reviews of NHS mergers. The Trusts are not seeking to argue that competition between provides of NHS acute services does not exist. Rather, the Trusts wish the CMA to consider, and set out its views on, the importance of competition relative to other factors influencing acute trust behaviour, and how this influences the CMA's approach to deciding on the threshold for reaching an SLC decision, and the size of the adverse impact on patients when an SLC arises. The Trusts note that the CMA has recently done so in reviewing a pharmacy merger where it applied a higher threshold for identifying competition problems given the regulatory framework under which that sector operates.

15. The Trusts believe that changes to the administrative and regulatory framework for the NHS in the past 12 months (i.e. since the last NHS merger review by the CMA in 2015), largely in response to the financial constraints that have been placed on the NHS, have had an important impact on how NHS mergers should be viewed.

16. Specifically, the deterioration in the financial performance of NHS acute trusts (which has been a consequence of the NHS budget not increasing in line with demand or cost pressures) has led to an increased emphasis on centralised management, and a reduced emphasis on NHS acute trust autonomy, as a means of bringing the financial performance of individual NHS acute trusts into line with the overall budget that is available for the NHS.

17. Three recent initiatives underline the reduction in Foundation Trust autonomy that has taken place over the past 12 months in response to financial pressures on the NHS as a whole. These are: (i) the introduction of financial control totals for NHS acute trusts; (ii) the establishment of regional Sustainability and Transformation Plans; and (iii) the introduction of an integrated oversight framework for all NHS acute trusts, including both Foundation Trusts and NHS Trusts. Collectively, these measures (alongside very limited capital expenditure budgets) have further limited the freedom individual Trusts have to pursue independent strategies aimed at improving service quality and attracting patient referrals (i.e. their ability to compete with other Trusts).

18. Putting these sector-wide considerations to one side, CMFT and UHSM believe that their merger's effect on competition would also be limited as a result of patients' ability to readily access services at other acute trusts in Greater Manchester or the surrounding region. This ability to access services at other Trusts can be seen in the drive-time distances between CMFT, UHSM and other acute trusts in Greater Manchester.

19. There are five acute trusts, other than UHSM, with one or more hospitals offering a broad range of clinical services within 30 minutes' drive-time of CMFT's main site on Oxford Road. This includes Pennine Acute Hospitals NHS Trust, Salford Royal NHS Foundation Trust, Stockport NHS Foundation Trust, Bolton NHS Foundation Trust, and Tameside & Glossop Integrated Care NHS Foundation Trust.

20. Similarly, there are also five acute trusts, other than CMFT, with one or more hospitals offering a broad range of clinical services within 30 minutes' drive-time of UHSM's main site, Wythenshawe Hospital. This includes Pennine Acute Hospitals NHS Trust, Salford Royal NHS Foundation Trust, Stockport NHS Foundation Trust, Tameside & Glossop Integrated Care NHS Foundation Trust, and Warrington & Halton Hospitals NHS Foundation Trust.

21. Notwithstanding the close location of other acute trusts, and patients' ability to access services at other hospitals, the GP referral analysis shows that CMFT and UHSM would gain the largest share of referrals from the other Trust, if these were to switch to another provider, in 29 specialties across one or more CMFT and UHSM hospital sites. These results, however, need to be interpreted in the light of several factors that affect the analysis of individual specialties.

22. These include:
    - planned service reconfigurations, which would remove competition between the two Trusts in any event,
    - service differentiation between CMFT and UHSM, which would prevent referrals from switching between the two Trusts;
    - coding issues, which result in some Trusts inaccurately not showing up in the analysis as providers of certain services; and
    - analytical results based on small numbers of referrals, which bring into question the robustness and/or materiality of the results.

23. Each of these factors will result in the GP referral analysing overstating the closeness of competition between CMFT and UHSM, and the impact on competition of their planned merger. Together, these issues affect, to some degree, 26 out of the 29 specialties in which the GP referral analysis suggests that CMFT and UHSM are each other's closest competitor in relation to services at one or more of their hospitals.

24. To the extent that the CMA ultimately concludes, in its Phase 2 review of the CMFT/UHSM merger, that it can be expected to result in an SLC in one or more markets, the Trusts are confident that any adverse effects for patients will be more than offset by the benefits that will arise from the merger for both patients and commissioners. A full patient benefits submission will be provided to the CMA at the commencement of its Phase 2 review.

2. INTRODUCTION

25. Following the devolution of health and social care services to Greater Manchester,[1] and an independent review of hospital services in the City of Manchester,[2] the Manchester Health and Wellbeing Board[3] concluded in June 2016 that the best way to improve hospital services for the City of Manchester's residents would be to establish a single NHS acute trust to serve the City.[4]

26. The first step in establishing a single NHS acute trust for the City of Manchester is a merger between CMFT and UHSM.[5] The merged Trust will then acquire North Manchester General Hospital (NMGH), which is currently operated by Pennine Acute Hospitals NHS Trust (PAHT). It is anticipated that the acquisition of NMGH will take place approximately 12-18 months following the completion of the CMFT/UHSM merger.[6]

27. A single acute provider for the City, including NMGH, is regarded by Manchester City Council's leaders and elected councillors, as well as by Manchester's CCGs, as an essential part of their plans to address unacceptable levels of variation in clinical outcomes, patient experience and access to hospital services in the City. It is also part of a broader strategy to address population health outcomes in Manchester that lag significantly behind those elsewhere in England.

28. The decision to establish a single acute provider for the City of Manchester follows longstanding efforts, with disappointing outcomes, to improve acute services under the current configuration of providers.

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[1] In this submission references to Greater Manchester will use the full term, while references to the City of Manchester will use the full term or may be shortened to Manchester.
[2] The *City of Manchester Single Hospital Service Review* was led by Sir Jonathan Michael, former Chief Executive of Oxford University Hospitals NHS Foundation Trust. Reports from the review's two stages are at Appendices 2.1 and 2.2. The review is discussed in further detail in Section 3.3.
[3] The Manchester Health and Wellbeing Board is a statutory organisation established under the Health & Social Care Act 2012. It is chaired by the leader of Manchester City Council, and includes elected representatives from Manchester City Council as well as representatives from Manchester's three Clinical Commissioning Groups (CCGs), CMFT, UHSM and PAHT, and other commissioners and providers of health and social care services in the City. Further information on the role of Health and Wellbeing Boards generally is available at http://webarchive.nationalarchives.gov.uk/20130805112926/http://healthandcare.dh.gov.uk/hwb-guide/ and http://www.local.gov.uk/health/-/journal_content/56/10180/3510973/ARTICLE. Details of the membership of the Manchester Health and Wellbeing Board are available at http://www.manchester.gov.uk/info/997/committee_membership/6024/the_health_and_wellbeing_board.
[4] The merged Trust will also be a major provider of acute services to the residents of Trafford, which neighbours the City of Manchester local authority area. Trafford CCG and Trafford Council are both fully supportive of the planned merger (see letter at Appendix 2.3).
[5] Copies of documents relevant to bringing about the merger situation are at Appendix 2.4.
[6] This two stage process reflects the complexities of transferring NMGH to the new Trust given the need to separate NMGH from the rest of PAHT and the need to ensure that services at both NMGH and the remainder of PAHT continue to be viable and sustainable following their separation (see City of Manchester Single Hospital Service Six Week Scoping Report at Appendix 2.5, and media briefing note at Appendix 2.6). A copy of a media report relating to the planned merger is at Appendix 2.7.

29. This submission to the CMA sets out the Trusts' assessment of the effect on competition in acute services of the planned merger between CMFT and UHSM.[7] The Trusts request that the CMA make a fast-track reference to Phase 2 given the likelihood that its Phase 1 review will conclude that their planned merger gives rise to a realistic prospect of a substantial lessening of competition (SLC) in several routine elective care specialties.[8]

30. CMFT and UHSM are confident that their merger will be cleared by the CMA at Phase 2. This is due to the significant number of providers of routine elective care services in Greater Manchester and Cheshire, Manchester's CCGs' plans to commission acute services in the City by way of a single acute care contract regardless of the merger, UHSM's weakening position as a competitor to CMFT, and the significant benefits for patients and commissioners arising from the merger. A full submission on relevant customer benefits will be made to the CMA for its Phase 2 review.

31. The submission is set out as follows:
    - Section 3 sets out the background to, and rationale for, the transaction and provides an overview of the merging Trusts;
    - Section 4 considers the counterfactual to this merger;
    - Section 5 discusses the role of competition in NHS acute care services;
    - Section 6 considers the appropriate approach to defining the markets affected by this merger;
    - Section 7 discusses the effect of the merger on competition in routine elective care and maternity services;
    - Section 8 discusses the effect of the merger on competition in private patient services;
    - Section 9 discusses the effect of the merger on competition in non-elective and specialised acute services; and
    - Section 10 discusses the effect of the merger on competition in community-based health services.

32. Accompanying this submission is a completed merger notification form that contains additional details required by the CMA (e.g. in relation to CMA jurisdiction). Supporting documentation for the CMA's assessment is contained in the appendices to this submission.

3. BACKGROUND AND RATIONALE FOR THE PLANNED MERGER

33. This section provides an overview of healthcare services in Greater Manchester, and the rationale for establishing a single acute trust for the City of Manchester that encompasses CMFT, UHSM and NMGH.

34. The transaction rationale set out in this submission is for the wider merger between CMFT, UHSM and NMGH. The CMFT/UHSM merger is only the first step in the broader project to create a single acute trust for the City of Manchester. As set out in Section 2, this two stage process reflects the complexities of transferring NMGH to the new Trust. The

[7] Consistent with the CMA's advice, a separate merger notification will be made to the CMA in due course by the merged CMFT/UHSM concerning the acquisition of NMGH.
[8] CMFT and UHSM do not believe that their planned merger gives rise to a realistic prospect of an SLC in relation to any other services (i.e. community-based health services, non-elective services, specialised acute services and private patient services).

CMFT/UHSM merger does not have a separate, substantive rationale that is independent of the rationale for the broader transaction.

35. The establishment of a single acute trust for Manchester (comprising CMFT, UHSM and NMGH) is itself part of a broader strategy for health and care services in Manchester that aims to secure improved health and care services and outcomes for Manchester's residents, while also responding to the financial pressures on the health and care sector.

36. This broader strategy will also see the establishment of a new Local Care Organisation to deliver improved community-based health services aimed at preventing illness and caring for people closer to their homes. It will also pool commissioning budgets for health and social care, and as part of this, Manchester's three CCGs are planning to merge into a single CCG by April 2017.

37. The remainder of this section is set out as follows:
    - Section 3.1 provides an overview of healthcare services in Greater Manchester and key facts about CMFT, UHSM and PAHT;
    - Section 3.2 discusses the devolution of health and care to Greater Manchester and the new health and care strategies that have subsequently been adopted; and
    - Section 3.3 sets out the findings of the City of Manchester Single Hospital Service review, which recommended the merger between CMFT, UHSM and NMGH so as to establish a single acute trust for the City.

3.1 Healthcare services in Greater Manchester

38. CMFT and UHSM are two of nine NHS acute trusts located within Greater Manchester that serve the residents of Greater Manchester and its surrounds. Eight of these acute trusts provide district general hospital services to their local population (e.g. A&E, maternity and routine elective care services) as well as, to varying degrees, specialised hospital services that serve a regional, and in some cases national, population.[9]

39. CMFT is the largest acute trust, by revenue, and the largest provider of specialised services, in Greater Manchester. UHSM is the fourth largest acute trust, by revenue, and the fourth largest provider of specialised services. Table 3.1 provides details of other acute trusts in Greater Manchester. Both Trusts (as well as other acute trusts in Greater Manchester, such as Salford Royal and The Christie) carry out significant amounts of medical research, and work together through the Manchester Academic Health Science Network.

40. The distribution of acute trusts across Greater Manchester is shown in Figure 3.1. CMFT and UHSM are both located in the south of the region geographically (albeit in the centre demographically), with their main sites in the City of Manchester local authority area. CMFT also has a presence in the Trafford local authority area through its Trafford and Altrincham Hospitals. To the south of Greater Manchester, NHS acute services are provided by East Cheshire NHS Trust, primarily at Macclesfield District General Hospital.

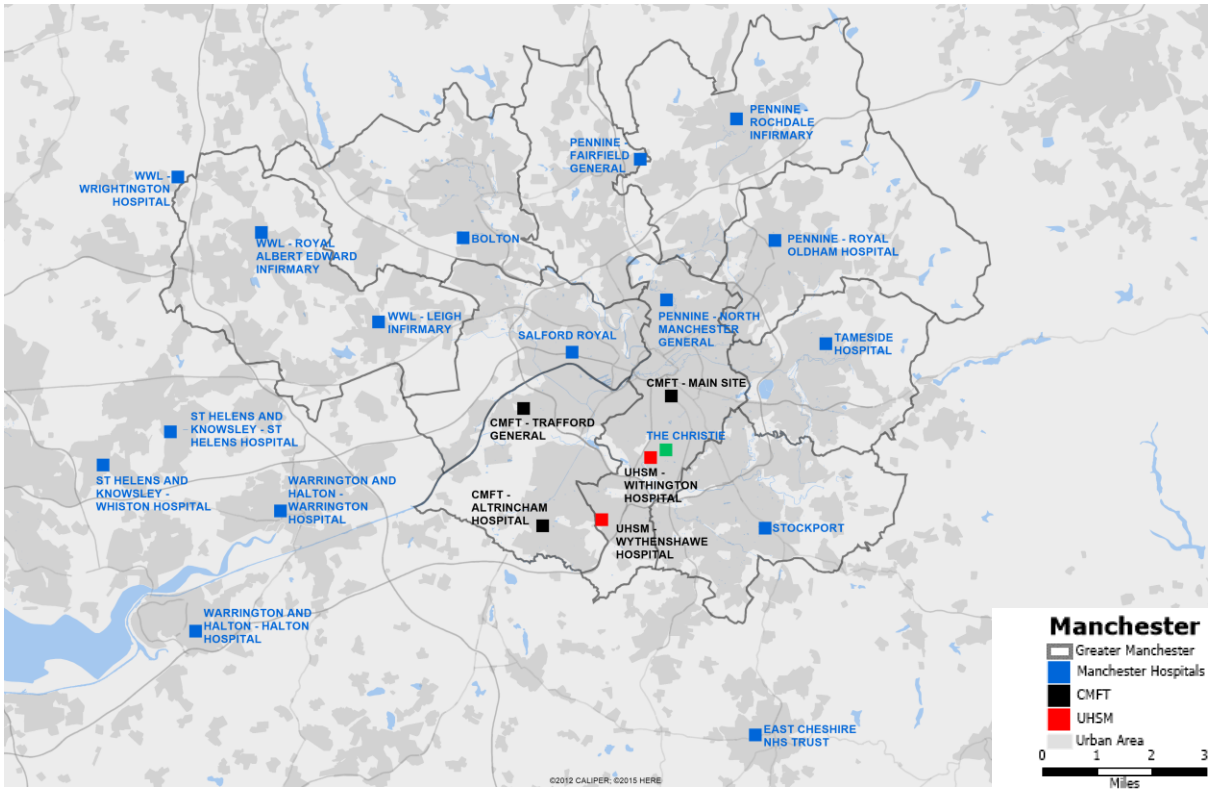
[9] The remaining acute trust (The Christie NHS Foundation Trust) concentrates on providing specialised cancer-related services to Greater Manchester and beyond.

Table 3.1: NHS acute trusts in Greater Manchester

	Total revenue (2015-16)	Specialised services revenue* (2015-16)
CMFT	£972 million	£339 million
Pennine Acute Hospitals NHS Trust	£592 million	£94 million
Salford Royal NHS Foundation Trust	£518 million	£176 million
UHSM	£437 million	£140 million
Bolton NHS Foundation Trust**	£292 million	£30 million
Stockport NHS Foundation Trust	£310 million	less than £4.6 million***
Wrightington, Wigan & Leigh NHS Foundation Trust	£247 million	£15 million
The Christie NHS Foundation Trust	£191 million	£187 million
Tameside & Glossop Integrated Care NHS Foundation Trust	£159 million	£7 million

* Assumes all revenue from NHS England is for specialised services.
** Most recent published revenue figure is for 2014-15.
*** Inferred from published accounts.
Source: Annual reports of NHS acute trusts in Greater Manchester.

Figure 3.1: CMFT, UHSM and neighbouring NHS acute trusts



Source: Aldwych Partners

41. The main private sector providers of NHS acute services in Greater Manchester are Care UK, which treats NHS patients in seven specialities through its North West mobile Clinical Assessment and Treatment Service, and BMI, which provides services in around 15

specialties from hospitals in Cheadle (Stockport), Bolton and Rochdale.[10] There are several other private providers in the region that carry out both NHS and private services. (Further details on these providers, where relevant to our analysis of the effects of the merger, are set out in Sections 7 and 8 of this submission.)

42. Community-based healthcare in Greater Manchester is provided by NHS, private and third sector providers. In common with elsewhere in England, there are high value contracts for the supply of a broad range of community health services in each CCG, and a large number of smaller contracts to provide individual community health services. CMFT and UHSM hold contracts to provide a broad range of community-based health services in the Central Manchester and South Manchester CCG areas respectively, while PAHT holds a similar contract for the North Manchester CCG area.

43. The arrangements for providing community healthcare services in Greater Manchester are currently undergoing significant change. Local Care Organisations that bring together community-based healthcare, social care, primary care and some acute services are in the process of being established. Further details of these changes are set out in Section 3.2, which discusses Greater Manchester devolution, and Section 10, which discusses the effect of the merger on community services.

44. Commissioning of health and care services in Greater Manchester is carried out by twelve NHS Clinical Commissioning Groups (for NHS services),[11] NHS England (for specialised services), and ten local authorities (for public health services and social care). Greater Manchester devolution is resulting in the pooling of health and care budgets across commissioners, and the joint development of health and care strategies for each locality and the region as a whole. Further details are set out in Section 3.2.

3.1.1 Central Manchester University Hospitals NHS Foundation Trust

45. CMFT was established as a Foundation Trust on 1 January 2009. Previously known as Central Manchester and Manchester Children's University Hospitals NHS Trust, it was formed as an NHS Trust in 2001 through the merger of Central Manchester Healthcare NHS Trust and Manchester Children's Hospitals NHS Trust.[12] CMFT acquired Trafford Healthcare NHS Trust in April 2012.

46. CMFT's constituent hospitals include:
    - Manchester Royal Infirmary: which provides emergency care, secondary and tertiary services;
    - Royal Manchester Children's Hospital: a specialist children's hospital;
    - Saint Mary's Hospital: a specialist hospital for women, babies and genetics;
    - Manchester Royal Eye Hospital: a specialist eye hospital;
    - University Dental Hospital of Manchester: a specialist dental hospital;
    - Trafford General Hospital: which provides secondary care services; and
    - Altrincham Hospital: which provides outpatient and diagnostic services.

[10] Care UK's service in Greater Manchester is described at http://www.greater-manchester-cats.nhs.uk/. BMI Healthcare's service at The Alexandra Hospital, which offers treatment to NHS and private patients, is described at https://www.bmihealthcare.co.uk/hospitals/bmi-the-alexandra-hospital.
[11] As set out in the introduction to Section 3.1, the three City of Manchester CCGs plan to merge by April 2017 to form a single City-wide CCG. This will reduce the total number of CCGs in Greater Manchester from twelve to ten.
[12] CMFT can trace its history back to the establishment of the Manchester Royal Infirmary in 1752.

Table 3.2: CMFT revenue, 2015-16

	Acute	Specialist	Total
	£'000	£'000	£'000
Income from Activities			
Elective Income (incl maternity services)	92,936	40,997	133,934
Non-Elective Income (incl A&E)	110,942	28,410	139,352
Community Services	64,473	0	64,473
Private Patient Income	2,596	0	2,596
Sub Total	270,947	69,408	340,355
Outpatient Income	80,998	26,286	107,284
Other NHS Clinical Income	126,434	243,127	369,561
Other Clinical Income	2,849	0	2,849
Total Income from Activities	481,228	338,821	820,048
Other Operating Income			
Research and Development	32,326	0	32,326
Education and Training (HEE £47.7m)	49,659	0	49,659
Charitable and Other Contributions to Expenditure	877	0	877
Non-Patient Care Services to Other Bodies	28,253	0	28,253
Other Income	32,533	0	32,533
Reversal of Impairment	3,698	0	3,698
Total Other Operating Income	147,346	0	147,346
Total Operating Income	628,574	338,821	967,394

Source: CMFT

47. CMFT's constituent hospitals, other than Trafford General and Altrincham, are located on a single site approximately 1.5 miles south of Manchester city centre.[13] Trafford General Hospital is located in the Trafford local authority area to the west of CMFT's main site on Oxford Road, while Altrincham Hospital is also in the Trafford local authority area (see Figure 3.1). The Trust has around 1,600 beds and approximately 12,300 whole-time equivalent employees.[14]

48. Specialised services offered by CMFT include those for women, babies and families, children and young people, ophthalmology services, kidney and pancreas transplants, haematology and sickle cell disease. CMFT also runs adult community health services in Central Manchester CCG area, children's community health services across North, Central and South Manchester CCG areas and a small amount of private patient services. The Trust carries out a significant amount of medical research and is a member of the Manchester Academic Health Science Centre. Further details of CMFT's specialised services are set out in Section 9.

[13] University Dental Hospital of Manchester is situated a short distance from the main site as part of the University of Manchester campus.
[14] Figures taken from CQC, Central Manchester University Hospitals NHS Foundation Trust, Quality Report, June 2016 at Appendix 3.1.

49. CMFT's main commissioners are NHS England, through its North West Commissioning Hub (£339 million in 2015-16), Central Manchester CCG (£123 million) and Trafford CCG (£79 million). The three Manchester City CCGs (Central Manchester CCG, North Manchester CCG and South Manchester CCG) plan to merge by 1 April 2017. In 2015-16, these three CCGs collectively commissioned services to the value of £201 million at CMFT.[15]

50. CMFT is rated Good by the Care Quality Commission, and NHS Improvement places it in segment 2 out of 4 of its segmentation process to determine support needed under its Single Oversight Framework (where a segment of 1 is strongest and 4 is weakest).

51. In common with most other NHS acute trusts in England, CMFT is experiencing significant financial pressures as a result of a tight overall financial settlement for the NHS. In 2015-16, CMFT recorded a deficit of £29.2 million after impairments of £10.7 million. The trading deficit of £18.5 million was slightly better than the planned £19 million deficit but represented a deterioration compared to the £4.1 million surplus reported in 2014/15. This largely reflects the national picture: significant pressures on urgent care services and a corresponding reduction in planned activity combined with overspends on medical and nursing staffing due to higher cost agency staff.

52. CMFT's 2016/17 operational plan forecasts a surplus of £4.9 million (excluding non-operating income), which is consistent with the control total agreed with NHS Improvement.[16] This includes receipt of £20.2 million from the Sustainability and Transformation Fund.[17]

53. Given the scale of the financial challenge faced by CMFT, the Trust has entered an internal turnaround process to support a return to financial sustainability through reducing costs and increasing efficiency. At month 7, CMFT reported a cumulative operating surplus of £0.3 million (excluding non-operating income) and continues to forecast the delivery of a year-end surplus of £4.9 million (excluding non-operating costs).[18] This forecast surplus assumes receipt of £20.2m Sustainability and Transformation Funding, the underlying deficit is therefore £15.3m (excluding non-operating costs).

3.1.2 University Hospital of South Manchester NHS Foundation Trust

54. UHSM was established as a Foundation Trust on 1 November 2006, having been an NHS Trust since 1994.[19] It provides services at Wythenshawe Hospital and Withington Community Hospital as well as community-based health services in the South Manchester CCG area. Wythenshawe Hospital and Withington Community Hospital are located approximately 8 miles and 5 miles, respectively, south of Manchester city centre. In 2015-16, UHSM had approximately 915 beds and around 5,500 employees.

55. UHSM offers both district general hospital services for local patients and specialised services that are regional and national in scope. UHSM's specialised services include cardiology and cardiothoracic surgery, heart and lung transplantation, respiratory

[15] Contact details for CMFT's main commissioners, and customers, are provided at Appendix 3.2.
[16] CMFT's most recent operational plan and monthly management accounts are at Appendices 3.3 and 3.4.
[17] Further details on control totals and the Sustainability and Transformation Fund are set out in Section 5.1.3.
[18] Further details on CMFT are available in its Annual Report for 2015-16, which is at Appendix 3.5.
[19] UHSM Wythenshawe Hospital can trace its beginnings to 1902 with the building of the Baguley Sanatorium.

conditions, burns and plastics, cancer and breast care services. UHSM, like CMFT, is a member of the Manchester Academic Health Science Centre.

Table 3.3: UHSM revenue, 2015-16

	Acute	Specialist	Total
	£'000	£'000	£'000
Income from Activities			
Elective Income (incl maternity services)	68,406	19,052	87,458
Non-Elective Income (incl A&E)	72,880	16,267	89,147
Community Services	16,169		16,169
Private Patient Income	134		134
Sub Total	157,589	35,319	192,908
Outpatient Income	48,180	5,370	53,550
Other NHS Clinical Income	32,005	98,006	130,011
Other Clinical Income	1,352		1,352
Total Income from Activities	239,126	138,695	377,821
Other Operating Income			
Research and Development	5,443	0	5,443
Education and Training	27,649	0	27,649
Non-Patient Care Services to Other Bodies	7,267	0	7,267
Other Income	10,699	1,533	12,232
Rental revenue from operating leases - minimum lease receipts	1,752	0	1,752
Income in respect of staff costs where accounted on gross basis	3,835	0	3,835
NHS charitable funds: Incoming resources excluding investment income	935	0	935
Total Other Operating Income	57,580	1,533	59,113
Total Operating Income	296,706	140,228	436,934

Source: UHSM

56. The main commissioners of NHS services at UHSM are NHS England, through its North West Commissioning Hub (£140 million in 2015-16), South Manchester CCG (£83 million) and Trafford CCG (£64 million). The three Manchester City CCGs have announced plans to merge by 1 April 2017. In 2015-16, these three CCGs collectively commissioned services to the value of £99 million at UHSM.[20]

57. UHSM has experienced challenges in both its financial and operational performance in recent years. It has been in breach of its Monitor (now NHS Improvement) licence conditions for around 2.5 years (since May 2014), and NHS Improvement places it in

[20] Contact details for UHSM's main commissioners, and customers, are provided at Appendix 3.6.

segment three out of four in its segmentation process to determine support needed under its Single Oversight Framework (where one is the strongest and four is the weakest). The CQC, which carried out a planned inspection on 26-29 January 2016 (i.e. prior to the merger decision), rates UHSM as Requires Improvement.[21]

58. UHSM posted a deficit of £5.8 million[22] and a Financial Sustainability Risk Rating (FSRR) of 1 in 2015/16 (under previous regulatory oversight arrangements) against a planned surplus of £0.2m.[23] Part of the financial challenge faced by UHSM has been due to its PFI commitments. These have had an ongoing impact on the Trust's liquidity, and payments associated with the PFI will increase to a maximum of £42 million per year in 2022/23.[24] [25]

59. UHSM has also faced challenges in recent years to its ability to continue offering specialised services. This has been reflected in decisions to concentrate major trauma services at Salford Royal, and the Healthier Together service reconfiguration, under which UHSM will no longer provide urgent and high risk general surgery. There have also been threats to UHSM's provision of specialised services in other areas, such as complex cancer surgery.

60. UHSM's ability to respond to its financial and operational challenges, as well as the strategic challenge in relation to specialised services, has been constrained by ongoing turnover in its leadership. Between 2009 and the decision to merge with CMFT, the Trust had five different CEOs, and many senior executives have also been lost to the Trust over this time.[26] The CQC in its recent Quality Report for UHSM (at Appendix 3.5) noted that "there had been a number of significant senior executive changes which had limited the long term stability of the Board and had negatively affected the general morale" (p.3), and "the unsettled culture within the executive team was evident at the inspection" (p.4).

61. [✂].[27] Poor stakeholder management, prior to the decision to merge with CMFT, affected UHSM's reputation and relationships with other providers and commissioners across Greater Manchester. These relationships were affected by the judicial review of the Healthier Together decision in early 2016 that was sponsored by clinicians at UHSM. UHSM clinicians pursued the judicial review due to concerns about the effect that the Healthier Together decision would have on UHSM's ability to retain specialised and other services.

[21] This was based on ratings in the five constituent domains of Safe Services (Requires Improvement), Effective Services (Requires Improvement), Caring Services (Good), Responsive Services (Requires Improvement) and Well-led Services (Requires Improvement). See CQC, University Hospital of South Manchester NHS Foundation Trust, Quality Report, 30 June 2016, p.4 at Appendix 3.7.
[22] After adjusting for exceptional items relating to restructuring costs of £1.5m and impairments on revaluation of £1.4 million.
[23] Underperformance was driven by a shortfall on the delivery of Cost Improvement Programmes (CIPs) and a lower than planned elective programme. The Trust's low is driven by relatively high level of debt servicing as a result of the Trust's PFI scheme, historically low levels of liquidity and the in-year deficit. The Trust has a 35 year PFI scheme for two buildings at Wythenshawe Hospital which expires in 2033. The net liability of the scheme was £46.7 million at 31 March 2016. The PFI payment profile increases to a maximum of £42 million in 2022/23 (total payment was £38.5 million in 2015/16).
[24] Further details on control totals and the Sustainability and Transformation Fund are set out in Section 5.1.3.
[25] UHSM's most recent operational plan and its most recent monthly management accounts are at Appendices 3.8 and 3.9.
[26] For example, a number of senior managers left UHSM for Tameside & Glossop Integrated Care NHS Foundation Trust in 2013/14. For this and other reasons several Director and Senior Manager posts have, at one time or another, recently been held by interims. This has included: Chief Operating Officer in 2013-14; Strategy Director in 2014; HR Director in 2014; Finance Director in late 2015; and all three Divisional Directors of Operations in 2014, with the last of these interims departing the Trust in mid-2015.
[27] [✂] at Appendix 3.11.

62. The CQC in its recent Quality Report (based on its inspection which pre-dated the merger decision) noted that "the trust must address the lack of strategic direction for the organisation in line with the changing landscape of health care within the Greater Manchester area" (p.4).

63. UHSM believes that its decision to pursue a merger with CMFT has helped repair its relationships with stakeholders across Greater Manchester. [✂].[28]

64. UHSM is concerned, however, that these rebuilt relationships are still fragile, and that if the merger with CMFT does not proceed, then recent support for UHSM from NHS commissioners, including both CCGs and NHS England, would diminish.

65. By way of example, the recent agreement of a financial control total for 2016/17 between UHSM and NHS Improvement was achieved with support from local CCGs and NHS England, and resulted in UHSM receiving £8.3 million of Sustainability and Transformation Funding. This has significantly improved the Trust's cash position. Without strong local support for UHSM this agreement is unlikely to have been achieved, and would have resulted in increased financial pressure on the Trust.

66. This support for UHSM does not mean that the Trust does not still face significant financial challenges. At month 7, UHSM reported a cumulative deficit of £4.5 million, in line with plan.[29] The Trust is forecasting achievement of its year end surplus of £0.4 million. However, this forecast surplus assumes receipt of £8.3 million Sustainability and Transformation Funding, the deficit without this funding being £7.9 million.[30]

67. Given this background, UHSM's future as an independent acute trust (i.e. without the merger) could be expected to be one of increasing financial and operational challenge as well as ongoing challenges to the retention of its specialised services. The implications of this for UHSM's ability to compete with CMFT and other providers of acute services is considered as part of the counterfactual to the merger (see Section 4).[31]

3.1.3 Pennine Acute Hospitals NHS Trust

68. PAHT provides services at NMGH, The Royal Oldham Hospital, Fairfield General Hospital and Rochdale Infirmary. In 2015-16, PAHT had approximately 1,300 beds, around 9,000 employees, and revenues of £592 million.

69. NMGH is located in the Manchester City local authority area, and its transfer to a merged CMFT/UHSM will complete the vision of a single acute trust for the city (as set out in Section 2). The remaining three hospitals that form part of PAHT are located to the north of the City of Manchester in Bury, Rochdale and Oldham (see Figure 3.1).

[28] [✂] at Appendix 3.12.
[29] The Trust is one of sixteen trusts nationally who are participating in the Financial Improvement Programme launched by NHS Improvement and supported by KPMG. Phase 2 is now complete with a handover plan in place to ensure identification of additional CIP schemes and continued delivery of existing schemes. Given the Trust is forecasting a year end cash balance of around £10 million, it is focusing on cash specific mitigation strategies such as restructuring of existing loans (including agreeing a £25m working capital loan with DH to smooth the profile of PFI payments), and increased use of leases and commercial borrowing to support the Trust's capital programme.
[30] The Trust's underlying forecast deficit is £17.9 million as the forecast includes a number of other non-recurrent items.
[31] Further details on UHSM are available in its Annual Report for 2015-16, which is at Appendix 3.13.

70. PAHT was rated Inadequate by the CQC in August 2016 (the lowest of the CQC's four quality ratings).[32] PAHT is currently collaborating with Salford Royal NHS Foundation Trust to address its immediate patient safety and service quality challenges.

71. Improving services for patients at NMGH, is a key part of the rationale for establishing a single acute trust for Manchester given their contribution to the unacceptable variation in clinical outcomes, patient experience and access to hospital services across the City (see Section 3.2.2).[33]

3.2 Devolution of health and social care to Greater Manchester

72. The devolution of health and social care responsibilities to Greater Manchester forms an important backdrop to the planned establishment of a single acute trust for the City of Manchester. The development of new regional health and social care strategies, as a consequence of devolution, led to the decision by the Manchester Health and Wellbeing Board to recommend the establishment of a single acute trust for Manchester.

73. This section provides further detail on the Greater Manchester devolution arrangements in relation to health and social care, and the new health and care strategies that have been adopted as a result.

3.2.1 Background

74. The Greater Manchester devolution programme aims to improve public services' responsiveness to local priorities by increasing local control over these services and the accountability of local decision-makers to Greater Manchester's residents.[34] The devolution agreement signed on 3 November 2014 by the UK Government and the Greater Manchester Combined Authority (which brings together the ten local authorities in Greater Manchester) devolves powers to the Authority in local transport, policing, housing and planning.[35]

75. A further agreement, signed on 25 February 2015, devolves control over health and social care expenditure in Greater Manchester. Parties to this agreement include NHS England, the 12 NHS CCGs in Greater Manchester and the 10 Greater Manchester local authorities. The agreement covers acute care, primary care, community services, mental health services, social care and public health, and accounts for around £6 billion in annual expenditure.[36]

76. Devolution in health and care is intended to allow the region to pursue changes needed to improve the region's population health outcomes, which in many cases lag behind those

[32] As part of the CQC's review of PAHT, each of its constituent hospitals also received a rating, and consistent with PAHT's overall rating, NMGH was also rated Inadequate. Fairfield General Hospital was rated Requires Improvement, Rochdale Infirmary was rated Good, and The Royal Oldham Hospital was rated Inadequate. (CQC, The Pennine Acute Hospitals NHS Trust, Quality Report, August 2016 at Appendix 3.14.)
[33] In the short-term, however, services at NMGH are being stabilised as part of PAHT through a collaborative arrangement with Salford Royal NHS Foundation Trust, while longer term improvements will be realised through its transfer to the merged CMFT/UHSM.
[34] Local accountability is being increased with the adoption of a directly elected mayor. The first mayoral elections for Greater Manchester will take place on 4 May 2017.
[35] Further information on the Greater Manchester Combined Authority and the overall devolution programme can be found at https://www.greatermanchester-ca.gov.uk/site/index.php.
[36] Additional information on the health and social care devolution agreement, beyond the summary set out in this submission, can be found at http://www.gmhsc.org.uk/.

achieved elsewhere in England, while also addressing the financial challenges faced by health and care services in the region.

77. The agreement on health and social care devolution has three related aims:

- first, to improve (and manage demand for) health and social care services in the region, which have been characterised by variable service quality and population health outcomes that are behind those in the rest of England;
- second, to draw together health and care services with other devolved services and policy areas, like housing, employment, early years' support, education and skills, that contribute to the health and wellbeing of Greater Manchester's residents; and
- finally, to improve Greater Manchester's productivity by helping more people to become fit for work, get jobs, get better jobs and stay in work longer.[37]

78. A Strategic Partnership Board, co-chaired by the Greater Manchester Combined Authority and NHS England, brings together the parties to the health and care devolution agreement, and sets the vision, direction and strategy for Greater Manchester health and social care. The Board is supported by an executive team, and a Joint Commissioning Board has been established to commission services at the Greater Manchester level.

3.2.2 Health and care strategy for Greater Manchester

79. A five-year strategy for health and care in Greater Manchester developed following the devolution agreement was adopted in December 2015. *Taking Charge of our Health and Social Care in Greater Manchester* (at Appendix 3.12) identifies four major challenges for health and social care that it seeks to address, namely:
    i. poor population health outcomes;
    ii. high demands on acute services that could be better met in the community;
    iii. inconsistent quality of acute services; and
    iv. major financial constraints.

80. The strategy that has been adopted to address these challenges includes:
- improving health outcomes, and reducing demand for acute services, by upgrading the region's approach to prevention, early intervention and self-care;
- improving community-based care, through establishing Local Care Organisations, so that people who require care can access it in a community-setting wherever possible, which will both improve the patient experience and reduce demand for more expensive acute services;
- standardising acute care pathways and reorganising service provision so that high quality hospital care is accessible to all residents;

[37] "Greater Manchester has the fastest growing economy in the country and yet people here die younger than people in other parts of England. Cardiovascular and respiratory illnesses mean people become ill at a younger age, and live with their illness longer, than in other parts of the country. Our growing number of older people often have many long term health issues to manage. Thousands of people are treated in hospital when their needs could be better met elsewhere, care is not joined up between teams and is not always of a consistent quality. We also spend millions of pounds dealing with illnesses caused by poverty, loneliness, stress, debt, smoking, drinking, air quality, unhealthy eating and physical inactivity. The £6 billion we currently spend on health and social care – and the way we spend it - has not improved this picture across Greater Manchester" (GMCA and NHS in Greater Manchester, *Taking Charge of our Health and Social Care in Greater Manchester: The Plan*, December 2015, p.2 at Appendix 3.15).

- increasing the efficiency of acute services through streamlining back-office support; and
- pooling commissioning budgets for health, care and support services in each locality to ensure a joined up approach to buying services.

81. The five-year strategy for Greater Manchester sits alongside locality plans for each of the ten local authorities in Greater Manchester.[38] To create a clear line of accountability to local populations through their elected representatives, the locality plans are approved, and delivery is overseen, by each local authority's Health and Wellbeing Board.[39] The locality plan most relevant to this submission is the City of Manchester Locality Plan, *A Healthier Manchester*,[40] given its role in initiating the planned CMFT, UHSM and NMGH merger.

82. The Manchester Locality Plan is consistent with the overall strategy for Greater Manchester in terms of seeking to upgrade prevention, improve community-base care, standardise acute care pathways, and pool commissioning budgets. It describes the Manchester strategy as having three 'pillars':
    - first, a single commissioning system that combines the health and care commissioning responsibilities held by the three Manchester CCGs and Manchester City Council;[41]
    - second, establishing a Local Care Organisation to deliver community-based health and care services; and
    - finally, a 'Single Manchester Hospital Service' that delivers acute services to consistent standards and quality across the City.[42]

83. In relation to acute services, the Manchester Locality Plan notes at p.55 that:

> "Hospital services in Manchester include some of the best and highly regarded teams in the UK, with real areas of excellence in clinical care. However, there are also significant inconsistencies and variations in the way that acute hospital services are provided at present.
>
> "Standards of care can be variable, best practice is not consistently adopted or adhered to, and there are important gaps in services alongside areas of service duplication. The existing arrangements also fail to provide a clear Manchester focus for acute hospital care, or for the relationship between providers and commissioners."

84. The Locality Plan sets out commissioners' intention to commission an independent review of the potential benefits and mechanisms for improved cooperation between hospital services that delivers high quality hospital care to all Manchester residents. This

[38] These ten local authority areas are: Bolton, Bury, Rochdale (including Heywood and Middleton), Manchester, Oldham, Salford, Stockport, Tameside (including Glossop), Trafford and Wigan.
[39] Health and Wellbeing Boards were established under the Health and Social Care Act 2012. Each top tier and unitary authority has its own Health and Wellbeing Board. The Boards are intended to have strategic influence over commissioning decisions across health, public health and social care. Membership of each board includes one local elected representative, a representative of local Healthwatch organisation, a representative of each local clinical commissioning group, the local authority director for adult social services, the local authority director for children's services, and the director of public health for the local authority.
[40] A copy of the Manchester Locality Plan is at Appendix 3.16.
[41] As set out above, a merger of the three Manchester CCGs is scheduled for 1 April 2017.
[42] The Locality Plan also sets out nine transformation programmes that cover: public health; cancer care; primary care; integrated community-based care; mental health services; learning disability services; the organisation and delivery of acute hospital services in Manchester; children and young people's services; and housing and assistive living technology.

independent review (the City of Manchester Single Hospital Service review) commenced in January 2016, and its findings of are set out in Section 3.3.

85. In November 2015, at the time of adopting the Locality Plan and announcing the Single Hospital Service review, the Manchester CCGs informed CMFT, UHSM and PAHT of their plan to commission acute services for the City by way of a single acute services contract, which would encompass services at CMFT, UHSM and NMGH.[43] The way in which a single contract for acute services would be implemented, in the absence of a merger, was not set out by the CCGs. The Trusts believe that such an arrangement would take the form of either CMFT or UHSM taking the role of lead provider with the other Trust acting as a sub-contractor.

86. The Trusts understand that the CCGs' decision to implement a single acute services contract stemmed from the difficulties experienced by commissioners in pursuing service improvement initiatives with CMFT and UHSM as separate entities. This had caused increasing levels of frustration and a loss of patience on the part of commissioners with the existing configuration of providers in Manchester.[44]

87. The Trusts understand that the CCGs in setting out this intention were not seeking to pre-judge the outcome of the SHS review, although their actions were to have an important influence on the reviews findings (see Section 3.3). It was, however, seen by the CCGs as a means of driving the Trusts towards closer collaboration, whether by way of a merger or some other form of collaborative arrangement.

88. It is the Trusts' understanding that if their merger is prohibited by the CMA, the CCGs intend to proceed with implementing a single acute services contract for the City of Manchester. The implications of this are considered further in Section 4, which discusses the counterfactual to the merger.

3.3 City of Manchester Single Hospital Service review

89. Sir Jonathan Michael was appointed in January 2016 to lead the SHS review, which had been foreshadowed in the Manchester Locality Plan, and report to the Manchester Health and Wellbeing Board. The review recommended the merger of CMFT, UHSM and NMGH as the best way of delivering the benefits that it identified as arising from adopting single service models across a variety of specialties.

90. The review took place in two stages. The first stage assessed the potential benefits of adopting single hospital service models in a range of specialties. The second stage provided an appraisal of the most appropriate organisational / governance arrangements for CMFT, UHSM and NMGH to deliver these benefits.

91. The approach adopted by the Single Hospital Service (SHS) review was a clinician-led assessment in eight exemplar services considered in the review were:
    - Cardiac services (including Cardiac Surgery and Cardiology);

[43] See UHSM Board Paper, Single Manchester Hospital Service, 26 November 2015 at Appendix 3.17.
[44] There have been at least 17 separate initiatives to improve services involving CMFT and UHSM over the past 10-15 years. These include both commissioner-led service reconfigurations, and efforts to establish collaborative arrangements for the provision of services between acute trusts. These efforts have frequently been delayed, compromised or even abandoned. Out of 17 initiatives identified by the Trusts, eight came to an end without achieving any significant change in service provision, seven delivered service improvements but with significant delays in implementation, and two delivered new models of service provision but with significant compromises that resulted in lost opportunities to improve patient outcomes. Further details will be supplied as part of the submission on patient benefits for the CMA's Phase 2 review of this merger.

- Respiratory services;
- Maternity services (excluding Gynaecology);
- Secondary care paediatrics;
- Radiology, including interventional radiology;
- Infectious Diseases;
- Rheumatology; and
- Critical Care.

Table 3.4: Spectrum of Single Service Models considered in the SHS review

Shared pathways / standards across a specialty	Shared staff and assets across a specialty	Differentiated sites / hub and spoke for a specialty	Single site for a specialty
• Standardised care pathways and protocols across all teams who provide the service • Each team must adhere to minimum staffing requirements • Shared clinical data • Shared audit processes	• One clinical team shared between sites (joint rota) • Shared assets (e.g. theatres, cath labs, outpatient suites)	• Coordinated services across multiple sites with some sites providing care for high complexity/risk cases and other sites providing care for lower risk patients, with common protocols and rapid transfer arrangements between sites	• All resources for a single specialty pooled on a single site

Source: Manchester SHS Review, Stage One Report, April 2016 at Appendix 2.1.

92. The term 'single service' was used to refer to a spectrum of service delivery models, ranging from separate clinical teams at each Trust working to agreed and standardised clinical policies/procedures, to the delivery of a service to patients from across the City from a single site (see Table 3.4).

93. The way in which these single service models would ideally apply to the eight exemplar services is summarised below. In many cases, more than one model was recommended for a service, with different models preferred for different aspects of that service.

- *Shared clinical protocols*: Respiratory Services (acute and chronic services), Rheumatology, Maternity Services, Critical Care, Secondary Paediatrics, Cardiac Services

- *Shared staff and assets*: Radiology (for on call rotas and routine scanning), Rheumatology (shared staff, assets and patients. single virtual coordination centre), Maternity Services (shared staff and patients), Critical Care (shared staff), Secondary Paediatrics (shared staff and patients), Cardiac Services (shared clinical staff and shared patients)

- *Differentiated sites / Hub and spoke model*: Infectious Diseases, Radiology (Vascular Interventional Radiology, Complex Reporting) Respiratory Services (complex services), Maternity Services (transfer of patients across sites according to complexity and capacity), Critical Care (differentiation of case mix across sites, development of sub-specialisation), Secondary Paediatrics (potential to differentiate with fewer low complexity patients at CMFT), Cardiac Services (or single site model)

- *Single site*: Cardiac Services (or differentiated site model)

94. These different single service models could, in some cases, be taken as implying a service-level merger, while in others implementation could potentially be achieved by way of an agreement between the Trusts with the services at each Trust remaining independent.

95. The review found that adopting one or more of the four single service models set out above would deliver benefits in each of the eight exemplar services. These benefits encompassed quality of care, patient experience, workforce, finance and operational efficiency, research and innovation, and education and training. The benefits that were identified in each of these areas are summarised below.

- *Quality of Care*: reduce variations in the effectiveness of care; reduce variation in the safety of care; develop appropriately specialised clinicians and reduce variation in access to specialist care, equipment and technologies;
- *Patient experience*: patients have equal access to the same high quality care and their journey through the system will be coordinated rather than fragmented;
- *Workforce*: improved recruitment and retention of a high quality and appropriately skilled workforce; reduced reliance on bank and locum/agency staff; improved education, training and research opportunities which attract the best individuals to work in the City;
- *Finance and operational efficiency*: total gross savings in the region of 8-10% of costs in the eight specialties, and potential back office savings;
- *Research and innovation*: creation of a single research hub would allow a single point of entry to all clinical trials, combine research governance, strategy, finance and communications to enable common pathways, protocols and sponsorship, ensure research is linked across specialties, ensure new research and best practice guidelines are implemented consistently across the city;
- *Education and training*: optimised curriculum delivery, clinical exposure and reduced variability in student experience; widen student exposure to different clinical environments.

96. The second stage of the SHS review provided an appraisal of the most appropriate organisational / governance arrangements at the Trust level to deliver the benefits that had been identified from adopting single service models in the eight specialties. The review recommended the merger of CMFT, UHSM and NMGH as the best way of delivering these benefits.

97. More specifically, the review stated that “a range of enablers would be required in order to successfully implement a Single Hospital Service. These include clarity of leadership, accountability for care, joint IT systems and common HR processes … the organisational form most likely to support the enablers and to deliver the benefits of a Single Hospital Service would be the creation of a new NHS organisation that would take responsibility for the full range of services currently provided by CMFT, UHSM and by PAHT on the NMGH site”.[45]

[45] Sir Jonathan Michael, *Manchester Single Hospital Service Review, Stage Two Report*, May 2016, p.30 at Appendix 2.2.

98. Key issues highlighted by the SHS review as contributing to its recommendation of a merger include commissioner requirements and the scale and complexity of the change that is required. The report states that "Manchester commissioners have made it clear that the existing structure and arrangements for providing hospital services are no longer acceptable. Their minimum requirement is a single system with unified focus for authority and accountability and a single contract for hospital services in the City".[46] As set out above, the requirements of Manchester's CCGs are discussed further in Section 4, which considers the counterfactual to the merger.

99. It also says that "many of the organisational forms reviewed might be suitable for managing a small and limited number of single service models within the City. However, the Single Hospital Service model applies to all clinical service areas, back office functions, estates, education, research and innovation. The interdependency between clinical and non-clinical services has to be managed as part of a whole system approach. It is therefore important that the organisational form is able to manage both the interdependency issues and also the scale of change required. In addition, there is also a degree of urgency with which change is required. Any organisational form must support the benefits of a Single Hospital Service to be delivered at pace and should not add unnecessary layers of complexity, bureaucracy or cost into the system".[47]

100. In other words, Sir Jonathan Michael concluded that while some benefits were potentially achievable through collaborative arrangements short of a merger, the breadth of the change that it is necessary to pursue over a large number of service areas means that this is only feasible through a merger.

4. COUNTERFACTUAL

101. CMFT and UHSM understand that the merger's effect on competition needs to be assessed against the level of competition that would be observed if the merger did not take place. If the merger does not proceed, neither CMFT nor UHSM have any plans to enter into a transaction with any other acute trust.

102. There are three key factors that CMFT and UHSM believe should be taken into account in the CMA's consideration of the counterfactual to the planned merger. First, Manchester CCGs' intention to let a single contract for acute services in Manchester if the CMA does not clear the CMFT/UHSM merger. Second, the reduction in UHSM's ability to act as competitive constraint on CMFT if the merger does not proceed. Finally, the plans of NHS commissioners in Greater Manchester to reconfigure several clinical services.

103. CMFT and UHSM, having requested that their planned merger be fast-tracked to a Phase 2 review, are not expecting these issues to be explored by the CMA during Phase 1. The Trusts accept that it may be more appropriate for the CMA, in its Phase 1 review, to use the existing level of competition as the benchmark against which to assess whether the realistic prospect of an SLC test has been met in one or more routine elective care specialties.

[46] ibid.
[47] ibid.

104. The remainder of this section discusses in further detail the three issues set out above in readiness for the Phase 2 review of the CMFT/UHSM merger.

4.1 Single contract for acute services in Manchester

105. As set out in Section 3.2, how the CCGs would implement a single contract for acute services in Manchester, in the absence of a CMFT/UHSM/NMGH merger, has not been set out. The CMA will no doubt, in due course, wish to explore this issue with the CCGs.

106. The Trusts believe, however, that such an arrangement would involve either CMFT or UHSM taking the role of lead provider, and the other Trust acting as a sub-contractor (with services at NMGH being subcontracted as well). Both Trusts would retain their independent identities, and their ability to separately contract with other commissioners for other services (e.g. with NHS England for specialised services).

107. Under these circumstances, patients would (presumably) continue to be able to choose between the two Trusts for routine elective care services. However, the ability of the sub-contracting Trust to pursue strategic initiatives to attract additional patients, independently of the lead contractor and with a view to attracting patients from the lead contractor, would be constrained. This is because of the sub-contractor's contractual accountability to the lead contractor, and the potential for such an initiative to result in adverse commercial consequences for the sub-contractor.

108. In these circumstances, the extent of any competition between CMFT and UHSM (and NMGH) can be expected to decline without the merger, and as a result, any judgement about the merger's effect on competition needs to be assessed against this benchmark.

4.2 UHSM's ability to compete with CMFT

109. UHSM's ability to provide a strong competitive constraint on CMFT, and other providers of NHS acute services, can be expected to decline if the merger does not proceed. As set out in Section 3.1, UHSM has been in breach of its NHS Improvement licence conditions since May 2014, and is rated Requires Improvement by the CQC.

110. Prior to the decision to merge with CMFT, UHSM's relationships with other organisations in Greater Manchester and national NHS bodies were poor. This is reflected in the reviews of board governance at UHSM dating from 2014 and 2015 that are discussed in Section 3.1.2. Since the decision to merge with CMFT, UHSM has been able to repair these relationships, and secure the support needed to improve its position.[48]

111. However, UHSM anticipates that if the merger does not proceed, then recent support for it from NHS commissioners, including both CCGs and NHS England, would reduce. This would adversely impact on UHSM's financial position, requiring the Trust to make greater cost savings, reduce its ability to maintain facilities and equipment, and maintain clinical and support staffing levels. This would impact on the quality of services that an independent UHSM could offer, and its attractiveness for patients as an alternative to CMFT and other providers of NHS acute services.

[48] As set out in Section 3.1.2, an example of this is the recent agreement of a financial control total for 2016/17 between UHSM and NHS Improvement. This was achieved with support from local CCGs and NHS England, and resulted in UHSM being offered £8.3 million of Sustainability and Transformation Funding, which will, if received, significantly improve the Trust's cash position.

112. UHSM's position, in the absence of the merger, would be further weakened in the event that it was to lose more of its specialised services. For example, UHSM's ability to maintain its specialised services in burns and vascular surgery may come into question given the interdependency of these services general surgery,[49] and the transfer to CMFT of high risk general surgery as a result of Healthier Together.[50] UHSM, if it remained independent, would also be likely to be adversely affected by service reconfigurations that are currently planned for Greater Manchester (see Section 4.3) in the event that these were implemented. A loss of specialised services would impact on UHSM financially, and also affect its attractiveness as an employer for clinicians and as a destination for patients.

113. CMFT, while facing its own financial challenges (see Section 3.1), will be in a relatively better position if the merger does not proceed, and thus be a more attractive provider of acute services for patients and their referring GPs. Without the merger, CMFT would have greater financial scale allowing it to better manage the financial challenges it faces, and has a stable leadership team with longstanding relationships across Greater Manchester. It is also likely that it would be significant beneficiary of planned service reconfiguration decisions in Greater Manchester (to the extent that these could be implemented without the CMFT/UHSM merger).

114. In summary, the weakening of UHSM's financial position, that could be expected in the absence of the merger, would impact on the Trust's operational performance and its ability to act as an attractive alternative for patients. Further, UHSM's ability to maintain its existing portfolio of specialised services could be expected to weaken (subject to the constraints set out in Section 4.3), reducing the Trust's attractiveness as an employer for clinicians (which would ultimately impact on patient care), and as a destination for patients given the range of services that it could offer. This, in total, means that UHSM could be expected to offer a weaker competitive constraint on CMFT in the absence of the merger than has been the case prior to the merger.

4.3 Service reconfiguration plans for Greater Manchester

115. There are a number of commissioner-led change programmes in train to address the shape of service provision across Greater Manchester. These programmes will influence the range and location of services that will be provided across the merged Trust's sites in the future.

116. These programmes include the following:

- *Oesophageal and Gastric (OG) Cancer Services*: following a commissioner-led review, which started in January 2016, CMFT and UHSM were informed in October 2016 that Salford Royal NHS Foundation Trust had been appointed lead provider for the OG cancer single service for Greater Manchester, and all OG cancer surgery will be carried out at Salford Royal in line with the new service specification. Under the

[49] The co-dependency of an Adult Burn Centre with General Surgery is set out in NHS London, *Co-dependencies framework for Specialised Burns Services: A report from the Burns Clinical Expert Panel*, October 2011, p.17 (at Appendix 4.1) and the co-dependency of Vascular Surgery with General Surgery is set out in NHS South East Coast Clinical Senate, *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review*, December 2014, pp.29-32 (at Appendix 4.2). While a General Surgery service would remain at an independent UHSM following implementation of Healthier Together, the downgrading of this service relative to CMFT would affect the ongoing attractiveness to commissioners of UHSM as a provider of these specialised services.

[50] That said, the Trusts do not believe that it would be possible to implement Healthier Together, in the form agreed with Greater Manchester's CCGs, without the merger. Further detail on this is set out in the Trusts' submission on patient benefits.

previous arrangements, CMFT, UHSM and Salford Royal each provided OG cancer services.[51]

- *Urology Cancer Services*: consolidation on two sites: one site for Kidney and Bladder Cancer Surgery and one for Prostate Cancer Surgery. Currently, there are five Trusts providing urology cancer services: CMFT, UHSM, Salford Royal, The Christie and Stockport.

- *Benign Urology services*: NHS Greater Manchester and the GCMA have signalled their intention to establish a new model of care for benign urology in Greater Manchester that is aligned with the new model for urology cancer services. This includes potential consolidation of acute inpatient urology and specialist complex procedures.[52] The Trusts do not know precisely how the results of this review will impact on their provision of urology services, and would suggest that the CMA explores this issue further with the Greater Manchester Health & Social Care Partnership (which acts on behalf of NHS Greater Manchester and the GCMA).

- *MSK and Orthopaedic Services*: NHS Greater Manchester and the GCMA have signalled their intention to consolidate surgery onto fewer sites as well as a range of other measures to improve outcomes and productivity in these services (e.g. agreeing a ring-fencing policy for orthopaedic beds, separating orthopaedic work from other surgical work, improving access to conservative management and implementation of seven day rehabilitation services).[53] The Trusts do not know precisely how the results of this review will impact on them, but to the extent that it would results in either Trust losing some, or all, of these services if it remains independent, then this would have a significant effect on the assessment of how the merger would affect competition in these services. The Trusts suggest that the CMA explores this issue further with the Greater Manchester Health & Social Care Partnership (which acts on behalf of NHS Greater Manchester and the GCMA).

- *Paediatrics*: NHS Greater Manchester and the GCMA have signalled their intention to improve services for children through several related initiatives. This includes reducing the number of paediatric inpatient units from the current eight units that provide Paediatric General Surgery (including emergency and elective surgery) following on from the changes to adult general surgery under Healthier Together, and reflecting the fact that only four out of the eight current providers of paediatric surgery meet Royal College of Surgeons standards for non-specialist emergency surgical care for children.[54] The Trusts believe that, consistent with the outcome of Healthier Together, an independent UHSM would be likely to lose its Paediatric Surgery service, and other related paediatric services, including Paediatric Cardiology and Paediatric Urology.

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[51] See (i) NHS Greater Manchester and GMCA, *Overview of the Transformation Process for the Commissioning of Specialised OG and Urology Cancer in Greater Manchester*, 8 July 2016; (ii) Letter from Jon Rouse, Chief Officer, Greater Manchester Health & Social Care Partnership to Diane Whittingham, Chief Executive, UHSM, *Re: The transformation of Oesophageal and Gastric Cancer Services in Greater Manchester,* 18 October 2016; and (iii) NHS Greater Manchester and GCMA, *Oesophageal and Gastric Cancer Service Specification*, 2 June 2016 at Appendix 4.3.
[52] See NHS Greater Manchester and GCMA, *Theme 3: Benign Urology Project Initiation Document*, 24 October 2016 at Appendix 4.4.
[53] See NHS Greater Manchester and GCMA, *Theme 3: Musculoskeletal (MSK) and Trauma and Orthopaedics Project Initiation Document*, 24 October 2016 at Appendix 4.5.
[54] See NHS Greater Manchester and GCMA, *Theme 3: Paediatric Services Project Initiation Document*, 24 October 2016 at Appendix 4.6.

- *Vascular Services*: NHS Greater Manchester and the GCMA have signalled their intention to establish a single vascular service for Greater Manchester through the consolidation of the existing separate services at CMFT, UHSM and PAHT. The intention is to bring vascular services in Greater Manchester into line with the national service specification issued by NHS England. The Project Initiation Document issued by NHS Greater Manchester and the GCMA indicates that it is likely that the planned CMFT/UHSM merger (and the subsequent acquisition of NMGH) will largely achieve commissioner's intentions in terms of service consolidation.[55] However, the Trusts believe that, given the ongoing compliance issues with the NHS England service specification, such a consolidation would be likely to be attempted in the absence of the merger in any event.[56]

- *Gynaecological Cancer Services*: following a decision by NHS England in 2014, CMFT, in partnership with The Christie NHS Foundation Trust, is the sole provider of gynaecological cancer services. Salford Royal and UHSM no longer provide these services.[57]

- *Healthier Together*: under this programme, emergency and high risk General Surgery will be consolidated at four sites in Greater Manchester. One of these sites will be at CMFT, while UHSM will no longer deliver these services.[58]

117. There are several other services where NHS Greater Manchester plans reconfigurations, but which are not relevant to considering the planned merger's effect on competition because these services are only provided by one of the two Trusts, or because it seems likely that the planned services changes will not impact on the location of services at CMFT and UHSM. These include Respiratory Medicine, Cardiology, Neuro-rehabilitation and Breast Services.[59] In addition, under a previous reconfiguration decision, CMFT will be the major trauma centre for children and provide major trauma care for adults in partnership with Salford Royal NHS Foundation Trust, while in future UHSM will no longer provide major trauma services. The Trusts, however, do not believe that this affects the analysis of the merger's competitive effect on individual specialties given that trauma services are non-elective.

118. Where these reconfiguration plans consolidate existing services at CMFT and UHSM onto a single site (or at a single Trust), the merger will not reduce competition, as patients' ability to choose between separate providers will be removed even if the merger does not

[55] See NHS Greater Manchester and GCMA, *Theme 3: Vascular Project Initiation Document*, 24 October 2016 at Appendix 4.7.
[56] Notwithstanding this, the Trusts also believe that consolidation in vascular services would be unlikely to be achieved in the absence of the merger given the history of previous service reconfiguration efforts being delayed, compromised or abandoned due to objections by providers. As a result, the Trusts believe that the ability to achieve this consolidation of services, and the benefits that this will deliver to patients, is attributable to the merger. Consistent with this, the patient benefits submission that will be made to the CMA for its Phase 2 merger review sets out the basis for the CMA taking this benefit into account in its review of the merger. This is also a relevant consideration for other service reconfigurations, and these are also addressed in the patient benefits submission.
[57] This reconfiguration decision, having already been implemented is not relevant to the counterfactual in that it does not affect a future change in service provision. However, it has been included on this list for completeness. See Letter from NHS England (Cheshire, Warrington & Wirral Area Team) to Roger Spencer A/g Chief Executive, The Christie and Mike Deegan, Chief Executive, CMFT, *Specialised Gynaecology Cancer Service*, (undated, but understood to have been sent in April 2014) for confirmation of this decision at Appendix 4.8.
[58] Various reports relevant to the Healthier Together reconfiguration are included at Appendix 4.9.
[59] See NHS Greater Manchester and GCMA, *Theme 3: Respiratory and Cardiology Project Initiation Document*, 24 October 2016 at Appendix 4.10; NHS Greater Manchester and GCMA, *Theme 3: Neuro-Rehab Project Initiation Document*, 24 October 2016 at Appendix 4.11; NHS Greater Manchester and GCMA, *Theme 3: Breast Services Project Initiation Document*, 24 October 2016 at Appendix 4.12.

proceed. That is, competition in these specialties is removed in the counterfactual, and thus the merger has no effect on competition.

119. The Trusts believe that competition between CMFT and UHSM is removed in the counterfactual in relation to OG Cancer, Urology Cancer, Paediatric Surgery (and related specialties) and Vascular Surgery. The Trusts note that recent reconfiguration decisions have also had this effect in relation to Gynaecological Cancer, and high risk General Surgery. The direction of travel set out by NHS Greater Manchester and the GCMA means that this is also likely in relation to Urology more generally (i.e. not just Urology Cancer) as well as Orthopaedics.

120. That said, as set out in Section 3.2, there has been a long history of attempted service reconfiguration in Greater Manchester where implementation has been delayed, compromised or abandoned as a result of resistance from those providers that would be adversely affected by such changes. This means that it cannot be readily assumed, in the counterfactual, that the service reconfigurations set out above would necessarily take place in the counterfactual.

121. CMFT and UHSM believe that the service reconfigurations set out above, where they affect services at both CMFT and UHSM, are far more likely to be implemented if their merger proceeds. This is because their merger will remove the barriers, such as separate financial and organisational incentives, that have previously prevented the successful implementation of these types of initiatives.

122. An example of how the CMFT/UHSM merger will facilitate planned service reconfigurations is the implementation of Healthier Together, under which CMFT will be the hub site for General Surgery providing emergency and high risk elective surgery for the Manchester and Trafford Sector in Greater Manchester. Since the announcement of their planned merger, CMFT and UHSM have been working together very effectively to implement the Healthier Together decision.[60] This contrasts with the resistance to Healthier Together that has been observed prior to the merger decision (e.g. the UHSM clinician-led judicial review of the commissioners' decision).

123. A further example is in relation to Breast services, where the merged CMFT/UHSM is significantly more likely to cooperate with efforts to reconfigure these services than UHSM would if were to remain an independent Trust (and thus have a higher degree of dependence on Breast services revenues).[61]

124. As a result, CMFT and UHSM believe that the more likely scenario is that their merger enables benefits to patients from planned service reconfigurations to be realised, rather than that these service reconfigurations will be implemented in the counterfactual and thus remove competition between CMFT and UHSM in these specialties. This will be reflected

[60] See, for example, the Greater Manchester Transformation Unit report dated 7 October 2016 at Appendix 4.13, which states: "The panel acknowledged the huge amount of work that the [Manchester and Trafford] sector had undertaken so far. There was a real sense that the two sites [CMFT and UHSM] were working together to develop the models with great levels of engagement and communication with all colleagues. Significant progress has been made on the workforce, activity and estates modelling which is highly commendable … The plan is now in place to deliver the commissioning intentions for April 1st which is welcomed … It seems highly possible MATS [Manchester and Trafford Sector] could be the first sector to fully implement Healthier Together" (p.2).

[61] "A case for change was developed in 2014 and a set of GM clinical standards has recently been developed. However, provider support has been mixed (particularly following discussion of a reduced number of sites) and the project has stalled. Now nominated … as the Transformation Lead, UHSM have a new opportunity to work in a collaborative way with the system to deliver this transformational project" in NHS Greater Manchester and GCMA, *Theme 3: Breast Services Project Initiation Document*, 24 October 2016, p.4 at Appendix 4.12.

in the patient benefits submission that the Trusts will provide to the CMA as part of its Phase 2 review of this transaction.

125. Notwithstanding this, reference is made, where relevant, to these planned service reconfigurations in Section 7, which considers the merger's effect on competition in routine elective services.

5. ROLE OF COMPETITION IN INFLUENCING THE PROVISION OF NHS ACUTE SERVICES

126. Understanding the competitive effects of the planned merger between CMFT and UHSM, requires an understanding of the role that competition plays in influencing the delivery of NHS acute services. CMFT and UHSM acknowledge that the CMA has considered the role of competition in previous reviews of acute trust mergers, including reviewing the relevant economic literature, and concluded that competition in the NHS is associated with improved service quality.

127. While having reservations on this point, CMFT and UHSM are not seeking to question the CMA's opinion. The Trusts, however, believe that it is important that the role of competition in influencing the provision of NHS acute services be placed in its proper context. Markets and competition may have a role in NHS acute services, but they are not the basic organising principle for these services. This is quite different to other industries reviewed by the CMA in exercising its merger control responsibilities, and where the constraint of market mechanisms, which unchecked would harm consumers, is the goal of the CMA. The limited role for competition in the NHS is complemented by extensive administrative regulatory mechanisms that constrain the ability of providers to 'flex' their offer in response to 'market' conditions.

128. In other recent merger reviews, the CMA has recognised the important role that regulation plays in constraining competition, and the ability of suppliers to adjust their offering to consumers. It has explicitly taken this into account in how it has analysed the competitive effects of the merger. In particular, in the CMA's recent review of the Celesio's acquisition of Sainsbury's pharmacy business, the CMA applied a higher threshold for identifying those local markets that it would review (a diversion ratio of 30% as opposed to the 15% usually applied in supermarket mergers). The CMA's report states that: "We recognised that the Parties had less ability to compete … by using substantially higher intervention thresholds".[62]

129. This section provides an overview of the *administrative and regulatory framework* within which NHS providers operate. This submission uses the term 'administrative and regulatory framework' so as to avoid misleading comparisons with the less severe regulatory requirements under which private sector businesses operate. The NHS, as a publicly-owned (for the vast majority of providers), publicly-financed healthcare system, operates within a public-sector administrative framework that reflects the accountability requirements for public sector institutions (e.g. requirements regarding decision-making processes, consultation, transparency, expenditure of public money, purchasing, planning and coordination). This administrative framework is applied in addition to a regulatory

[62] See CMA, *A report on the anticipated acquisition by Celesio AG of Sainsbury's Pharmacy Business*, 29 July 2016 at paragraph 7.227 and 8.3.

framework that applies to prices, quality, production inputs and processes for NHS acute trusts, and which goes well beyond any comparable regulatory framework that is applied to market-based sectors of the economy.

130. The purpose of this section is to set out the constraints on providers' ability to 'flex' their offering. As set out above, the Trusts are not seeking to argue that competition between provides of NHS acute services does not exist, but do wish to demonstrate that any competition that does exist is heavily constrained (and, most likely, more heavily constrained than in any other sector reviewed by the CMA). The Trusts believe that this should be explicitly allowed for in the CMA's decision-making in the same way that it allows for this in merger reviews in other sectors.

131. A further point made in this section is that the administrative and regulatory framework for the NHS has changed significantly, and in ways that are important for the CMA's analysis of the effects of this merger, since the last NHS merger reviewed by the CMA in 2015. The financial situation in which NHS providers are operating has deteriorated substantially over the past 12 months, and in response new coordination and control mechanisms have been introduced, such as control totals for Trust surpluses/deficits, the development of regional Sustainability and Transformation Plans, and the move towards new models of care that deliver greater coordination between providers along the patient care pathway.

132. The Trusts are not raising these issues to suggest that the threshold for a Phase 2 reference may not be met. Rather, the Trusts are setting the issues out now, as part of this submission, in readiness for a full assessment of their impact and importance as part of the Phase 2 review. The Trusts believe that these issues go to the scale of any adverse impact that could be expected for patients in the event of an SLC finding in one or more markets, and to the threshold that the CMA should apply in deciding whether an SLC can be expected in each market that it reviews.

133. The remainder of this section:
    - first, discusses the range of factors that influence acute trust decision-making and performance (Section 5.1);
    - second, sets out the results of a review of CMFT and UHSM business cases, which seeks to assess the extent to which competition influences key strategic decisions at the two Trusts (Section 5.2); and
    - finally, sets out the Trusts' conclusions on the importance of competition in influencing NHS acute services (Section 5.3).

5.1 Regulatory and financial factors influencing Acute Trust decision-making and performance

134. CMFT and UHSM consider that competition plays a limited role in influencing their decision-making and performance. As set out above, the Trusts acknowledge the CMA's opinion that competition in the provision of NHS acute services is associated with improved service quality.

135. However, NHS acute services are publicly funded services, subject to an annual expenditure limit (for the NHS as a whole), that are provided (in the vast majority) by public sector organisations, and staffed by clinicians, whose primary goal is to treat patients rather than maximise profits, and other professionals with a strong public service ethos. Markets and competition are not the basic organising principle for these services, and have

much less influence on organisational decisions over how these services should be provided compared with other industries. (The Trusts are not saying that competition has no influence, just that it is very limited, and particularly so, when compared with other sectors reviewed by the CMA.)[63]

136. The Trusts believe that factors such as regulation, commissioning, public service (or public interest) objectives, government policy objectives, and the constraints imposed by annual budget limits for the NHS as a whole all play a more important role than competition in influencing acute trust decision-making and performance. The following describes these influences in further detail.

5.1.1 Public service objectives of NHS acute trusts

137. The primary strategic objective for an Acute Trust is to provide the best possible patient care in each of the services it offers to their local population. Clinicians working at Acute Trusts also have strong professional obligations to provide the best possible care. While Acute Trusts work under financial objectives and constraints, these are not the same as requirement to maximise profits that holds in private sector dominated, market-based services.

138. Acute Trusts will, for example, continue to operate loss-making services that are essential to providing a high quality health service for their local population. This public service objective (i.e. providing a high quality health service) plays perhaps the most important role in motivating the decisions made by each Acute Trust in managing each of their services. It will be far more important for a Trust in deciding on any course of action than interactions with neighbouring Acute Trusts and responding to the actions of these Acute Trusts (which broadly describes how competition in other sectors works).

139. Acute Trusts' willingness to operate loss-making services has been underlined by the fact that is requiring centrally-driven initiatives by NHS England to rationalise the provision of financially unsustainable services.[64] By contrast, in a market-based sector, suppliers could be expected to quickly exit the provision of these services.

5.1.2 Administrative and regulatory framework for the NHS

140. Regulation of Acute Trusts (and other providers in the NHS) is probably more extensive than the regulation of suppliers in any other UK industry. Regulation of Acute Trusts (as set out in Table 5.1) encompasses:
    - who can provide services (through provider licensing by both NHS Improvement and the CQC);
    - the services that these providers can supply, the price at which these services are sold, the volume of services that are supplied, and the quality of these services;
    - permission to cease supplying certain services (i.e. commissioner requested services); and

[63] CMFT and UHSM do not wish to reprise debates that have been had in previous CMA reviews of NHS mergers. Rather, the Trusts wish the CMA to consider, and set out its views on, the importance of competition relative to other factors influencing acute trust behaviour, and how this influences the CMA's approach to deciding on the threshold for reaching an SLC decision, and the size of the adverse impact for patients when an SLC arises.
[64] See, for example, Simon Stevens' speech to NHS Providers Conference on 30 November 2016 as reported in HSJ, *Cut medical locum rates or close services, Stevens tells trusts*, 30 November 2016 at Appendix 5.1.

- the type, quality and price of the inputs that providers must use in supplying these services (as well as the way in which these inputs are combined together).

Table 5.1: Regulatory framework for NHS Acute Trusts

Area	Regulator	Form of regulation
Provider licensing	NHS Improvement CQC	NHS Improvement licenses Foundation Trust providers of NHS services so as to ensure sound governance and finances. The CQC licenses providers of NHS services so as to ensure that all providers meet certain quality standards.
Output/outcomes regulation		
Services (Entry and Exit)	NHS Improvement CCGs / NHS England	Licensing regime specifies certain services to be provided by a Foundation Trust. Not possible for a Foundation Trust to decide to cease providing these specified services. CCGs and NHS England limit entry into the provision of each clinical service by requiring providers to have a contract for the provision of the service.
Prices	NHS Improvement / NHS England CCGs	NHS Improvement sets the national tariff for acute services, while NHS England decides the tariff structure (eg threshold for marginal rates) CCGs set local prices for acute services where there is no national tariff
Quantity	CCGs	CCGs oversee the level of activity carried out by each acute provider through activity planning mechanisms in provider contracts. Providers that exceed planned activity levels can expect to be challenged by CCGs before this additional activity is paid for.
Quality	CQC CCGs Department of Health Monitor Royal Colleges Coroners Local Safeguarding Boards Health & Safety Executive Parliamentary and Health Service Ombudsman	Oversight of service quality as per licensing regime set out above Incentivisation of quality improvement through CQUIN payments National target setting re waiting times (eg A&E, Referral to Treatment, 2 week cancer pathway) Certain quality indicators treated as a governance issue (eg MRSA infection rates) Review quality in context of approving an Acute Trust as a provider of training to junior doctors (see below) Responsible for investigating deaths Oversight of arrangements for ensuring the safeguarding of children and vulnerable adults Oversight of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, under which Acute Trusts must file reports concerning qualifying clinical incidents Investigates and reports on complaints of poor service
Input regulation		
Workforce	General Medical Council, Nursing & Midwifery Council, & around 10 other regulators Department of Health Royal Colleges	Licensing and revalidation of clinicians Remuneration of NHS employees under national wage setting arrangements. Entry into clinical specialisms, approval of new consultant positions at Acute Trusts, oversight of junior doctor training (NB. withdrawal of approval to carry out junior doctor training in a specialty will mean that an Acute Trust no longer has access to the workforce necessary to deliver services in that specialty)
Medical devices	Medicines & Healthcare Products Regulatory Agency (MHRA)	Approval of medical devices for use in the UK
Drugs	MHRA NICE Cancer Drug Fund Department of Health	Approval of drugs for use in the UK Approval of drugs for use in the NHS in England Approval of cancer drugs for use in the NHS outside of NICE arrangements Drug pricing
Clinical processes	NICE Royal Colleges	Best practice guidance on clinical processes Best practice guidance on clinical processes

141. This regulatory framework exists on top of a set of administrative requirements for NHS acute trusts that reflect their position as public sector organisations. These administrative requirements affect Trust decision-making processes in terms of how money is spent (e.g.

requirements for business cases, transparency of expenditure, procurement obligations), the need to consult with people affected by Trust decisions (and the potential for Trust decisions to be judicially reviewed), and the need to plan and coordinate with other public sector bodies.

142. The extensiveness of the administrative and regulatory framework within which Acute Trusts operate means that their ability to determine their own strategy, or respond to the actions of competitors, is far more limited than in other industries. Even in the utilities sector, where suppliers face a comprehensive regulatory regime, there is not the same extensive regulation of their labour force and the way in which they provide services.

143. The CMA in considering mergers in regulated industries will consider variation in, say, service quality between providers, and whether this is evidence of regulation setting a minimum standard, and competition being used to drive a service quality offering that is above this minimum.[65] This may be appropriate in other sectors where competition and regulation are the two main influences on business decision-making and performance. However, it is too simplistic, in the case of the services supplied by NHS acute trusts, to conclude that competition can explain differences in the quality of services offered by these providers. As set out in this section, there are many other influences, beyond competition and regulation, that influence acute trust decision-making and performance.

5.1.3 Financial constraints on the NHS and recent changes to provider autonomy

144. The NHS in England, as a publicly-funded health system, is subject to an annual expenditure limit (i.e. a requirement to deliver services within the budget the Government has made available for the NHS). The amount of money made available to the NHS in recent years has not increased in line with demand or cost pressures.

145. The resulting deterioration in the financial performance of NHS acute trusts (and other NHS providers) has led to an increased emphasis on centralised management, and a reduced emphasis on provider autonomy (which is at the heart of any competitive market), as a means of bringing the financial performance of individual NHS acute trusts into line with the overall budget that is available for the NHS.

146. Three recent initiatives underline the reduction in Foundation Trust autonomy that has taken place over the past 12 months in response to financial pressures on the NHS as a whole. These are: (i) the introduction of financial control totals for NHS acute trusts; (ii) the establishment of regional Sustainability and Transformation Plans; and (iii) the introduction of an integrated oversight framework for all NHS acute trusts, including both Foundation Trusts and NHS Trusts.

147. *Financial control totals for NHS providers*: Financial control totals are the minimum level of financial performance against which Trust boards must deliver, and for which they will be held directly accountable. The introduction of financial control totals has been accompanied by a new intervention regime of special measures that is applied to NHS acute trusts (and other NHS providers) that do not meet various financial conditions. Trusts

[65] See, for example, the Competition Commission's decision on the Bournemouth / Poole merger (paragraph 2.22).

that meet their financial control totals, however, are able to access additional central funding (£1.8 billion nationally in 2016/17).[66]

148. The effect of control totals is to constrain the autonomy of NHS providers, and their independent ability to decide on, and adopt, the most appropriate strategy to attract patient referrals. Strategies that are inconsistent with delivering the financial control total that has been set centrally cannot be adopted. The reduced autonomy that control total entail in relation to overall decision-making are also accompanied by specific initiatives that constrain acute trust autonomy in areas like caps on agency pay, controls on other areas of expenditure (e.g. interim management, consultancy), and delivering cost savings in procurement. The strategic autonomy of NHS providers is further constrained by the extreme difficulties faced by NHS acute trusts in accessing capital to implement any new strategies.[67]

149. *Sustainability and Transformation Plans (STPs)*: STPs for health and social care are being developed in 44 regions across England. In Greater Manchester, the plans produced as part of the devolution programme (discussed in Section 3.2), are the STP for this region. STPs are placing an increased emphasis on collaboration between commissioners, local authorities and NHS providers to plan the delivery of services, including through new care models (such as those that bring together primary, community, acute and social care under single contractual and/or organisational frameworks). There is correspondingly less emphasis on competition between autonomous providers as a driver for improved services.[68]

150. *Regulatory oversight for NHS acute trusts and other NHS providers*: The distinction between more autonomous Foundation Trusts and less autonomous NHS Trusts has been eroded by the introduction of a single oversight framework for all NHS acute trusts, regardless of their legal status as Foundation Trusts or NHS Trusts. Autonomy is granted to Trusts based on their performance.[69] This erosion of the distinction between Foundation Trusts and NHS Trusts follows the merging of the previously separate regulators for Foundation Trusts and NHS Trusts (Monitor and the NHS Trust Development Authority) into a new entity, NHS Improvement.[70]

151. It follows that Foundation Trusts with more limited autonomy have less scope to compete through taking independent strategic initiatives that make themselves a more attractive destination for patient referrals. Neither CMFT nor UHSM have the maximum degree of autonomy that is allowed under the new single oversight framework.

152. In summary, the degree of autonomy that was previously enjoyed by FTs, including CMFT and UHSM, has been constrained by Government through a series of initiatives over the past 12 months as a result of measures to ensure that the NHS can meet the budget that has been set for it. This, in turn, means that the freedom that CMFT, UHSM and other

[66] See NHS England, *NHS action to strengthen trusts' and CCGs' financial and operational performance for 2016/17*, 21 July 2016 at https://www.england.nhs.uk/2016/07/operational-performance/

[67] See, for example, HSJ, *Exclusive: Treasury could tighten grip on NHS capital spending*, 29 September 2016; HSJ, *Exclusive: Officials warn over 'extremely constrained' capital for STPs*, 25 August 2016; HSJ, *Trusts urged to defer capital spending in exchange for revenue cash*, 11 November 2015; and HSJ, *Exclusive: DH agrees £1.2bn raid on its 2016-17 capital budget*, 27 November 2015 at Appendix 5.2.

[68] Further details on NHS England's Sustainability and Transformation Plans are available at https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/

[69] Details of the new Single Oversight Framework for NHS trusts are at https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework_published_30_September_2016.pdf

[70] Indeed, it is not clear that the distinction that the CMA has previously made between Foundation Trusts and NHS Trusts as the basis for its approach to merger control in the sector (and by which it chooses to review mergers between Foundation Trusts and NHS Trusts, but not between two NHS Trusts) remains valid.

Trusts have previously had to pursue independently strategic initiatives that would make them a more attractive destination for patient referrals is no longer present to the same degree. That is, the role, and influence, of competition in delivering higher quality acute services has been reduced from an already limited role to something that is limited even further.

153. This further reduction in the role of competition in the NHS in driving improved service quality logically means that a higher threshold should be applied before concluding that a reduction in competition arising from an acute trust merger warrants an SLC finding, and that the adverse effects for patients (and commissioners) arising from a loss of competition have been reduced further.

5.1.4 Financial constraints on the NHS and payment arrangements for routine elective care

154. The incentives for providers of NHS acute care services to compete for patient referrals will be affected by the way in which they are paid for these services by commissioners. Providers operating under standard Payment by Results arrangements, where an activity-based tariff is applied, will have a greater incentive to attract patient referrals than those providers operating under, for example, a block contract where the amount paid to the provider is fixed regardless of patient volumes.

155. At CMFT, over the past three years several different payment arrangements have been used for acute services. These are summarised in Table 5.2. In most cases, CMFT has been on full Payment by Results (i.e. tariff) for all services with the exception of 2015/16 when it was on a block contract with Central Manchester CCG. UHSM has consistently been on full Payment by Results arrangements over this period.[71]

Table 5.2: Payment arrangements for CMFT, 2014/15 to 2016/17

	2014/15	2015/16	2016/17
Central Manchester CCG	Full PbR other than Urgent Care	Block contract	Full PbR
Trafford CCG	Full PbR	Full PbR	Near full but excluding Macular, Drugs (at cost) and Trauma & Orthopaedics (marginal rate)
NHS England Specialised Commissioning	Full PbR but excluding Drugs and Devices (at cost)	Full PbR but excluding Drugs and Devices (at cost)	Full PbR except for critical care outliers
Other	Full PbR other than North Manchester CCG – Urgent Care	Full PbR other than North Manchester CCG – Urgent Care	Full PbR

Source: CMFT

[71] Neither CMFT nor UHSM has service line reporting or patient-level costing that allow the management of either Trust to make decisions based on the profitability of individual specialties.

5.2 Analysis of the role of competition CMFT and UHSM decision-making

156. Competition in NHS acute services is aimed at using the incentive to attract patient referrals (and earn revenue) to drive providers towards offering higher quality services. As set out above, the CMA has previously concluded that competition in the NHS is associated with improved service quality.

157. To assist in understanding the importance of competition as a driver for improved service quality relative to other factors, CMFT's and UHSM's past business cases have been reviewed to identify the driver(s) for the service quality improvement decision being taken in each business case.[72]

158. This review of business cases allows the systematic identification of the drivers for service quality initiatives at each Trust. This is because most service quality initiatives require at least some expenditure and, as public sector organisations, NHS trusts must under HM Treasury rules prepare business cases to authorise this expenditure.[73] This means that each Trust will have a documentary record of their most important decisions on initiatives to improve quality.[74]

159. Business cases are a robust way of identifying the factors motivating service quality improvement 'actions' because the standard business case methodology specified by HM Treasury includes setting out the strategic case (i.e. the motivation) for each expenditure proposal.[75] From this, it is possible to see whether a service quality improvement initiative is being motivated by the actions of other providers (i.e. competition) or by other drivers, such as regulation or commissioner requirements (or some combination thereof).

160. The systematic nature of this review contrasts with more general reviews of internal documents from merging parties, where the status and influence of each document that is being reviewed can be open to question.

161. We reviewed 82 business cases at CMFT and UHSM that were presented to either Trust's Board or management board. Of these, only 7 business cases (around 9%) were motivated by competition-related considerations, such as a desire to invest in new facilities or personnel to retain a service that might otherwise switch to another Trust. The remainder were motivated by a range of concerns including:
    - a need to respond to regulatory requirements (44 business cases);
    - a need to invest in additional capacity to meet demand (15 business cases);
    - to fund replacement equipment (1 business case); and
    - other motivations (15 business cases).[76]

162. The small proportion of business cases that are attributable to competition-related matters is indicative of its limited overall influence on decision making at CMFT and UHSM (and other acute trusts).

[72] Additional internal documents from both CMFT and UHSM that address the market conditions faced by each Trust are contained in Appendix 5.3. This includes the most recent five year strategic plan for each Trust as well as other documents.
[73] See HM Treasury, *Public Sector Business Cases Using the Five Case Model*, Green Book Supplementary Guidance on Delivering Public Value from Spending Proposals, 2013 at Appendix 5.4.
[74] Not all actions taken by a Trust that are aimed at improving quality will have been supported by a business case, and not all business cases will be aimed at improving service quality. Nevertheless, this material provides a strong evidence base for analysis.
[75] ibid. p.5.
[76] Copies of the CMFT and UHSM business cases that were reviewed, and our assessment of these business cases is available at Appendix 5.5.

5.3 Conclusion on the role of competition in NHS acute services

163. In summary, the link between competition and service quality is weaker for Acute Trusts than in other sectors. This is because NHS acute services are not provided in the usual market-based environment that the CMA usually encounters when reviewing mergers. Other factors are much more important in motivating Acute Trust decision making and performance, including at CMFT and UHSM.

164. The role of competition in motivating improvements in the quality of acute services has declined over the past 12 months as a result of a series of central Government initiatives that have reduced Foundation Trust autonomy, and their ability to pursue independently strategic initiatives to improve patient care and attract referrals. Further, the limited role played by competition is demonstrated in a review of recent business cases at CMFT and UHSM, which shows that less than ten per cent of business cases are motivated by competition-related considerations. In contrast, more than half were motivated by regulatory considerations.

165. The implications of this for the CMA's review of the CMFT/UHSM merger is that because competition only plays a limited role in influencing Acute Trust decision making, a much greater than usual reduction in competition would be needed (compared with other sectors) before it could be expected to have adverse consequences for patients.

6. MARKET DEFINITION

166. The parties note that the CMA in its most recent review of an acute trust merger concluded that:

- Each specialty is a separate product market. Where not all providers have the ability or incentive to offer all treatments within a specialty, the extent to which providers compete with each other in respect of these treatments differs, and this should be taken into account in the competitive assessment.
- Within each specialty, the following are considered as separate markets: (i) outpatient, day-case and inpatient activity; (ii) community and hospital-based care; and (iii) elective and non-elective care.
- Private and NHS-funded services are also considered to be separate markets, with the delineations above being applicable to both private and NHS-funded services.

167. CMFT and UHSM have doubts about separately defining markets for outpatient, day-case and inpatient activity given the way in which patients access these services. The Trusts believe 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. The effectiveness of different providers in that specialty may then be assessed with reference to their ability to offer different types of treatment. This is discussed further in Section 7.2.

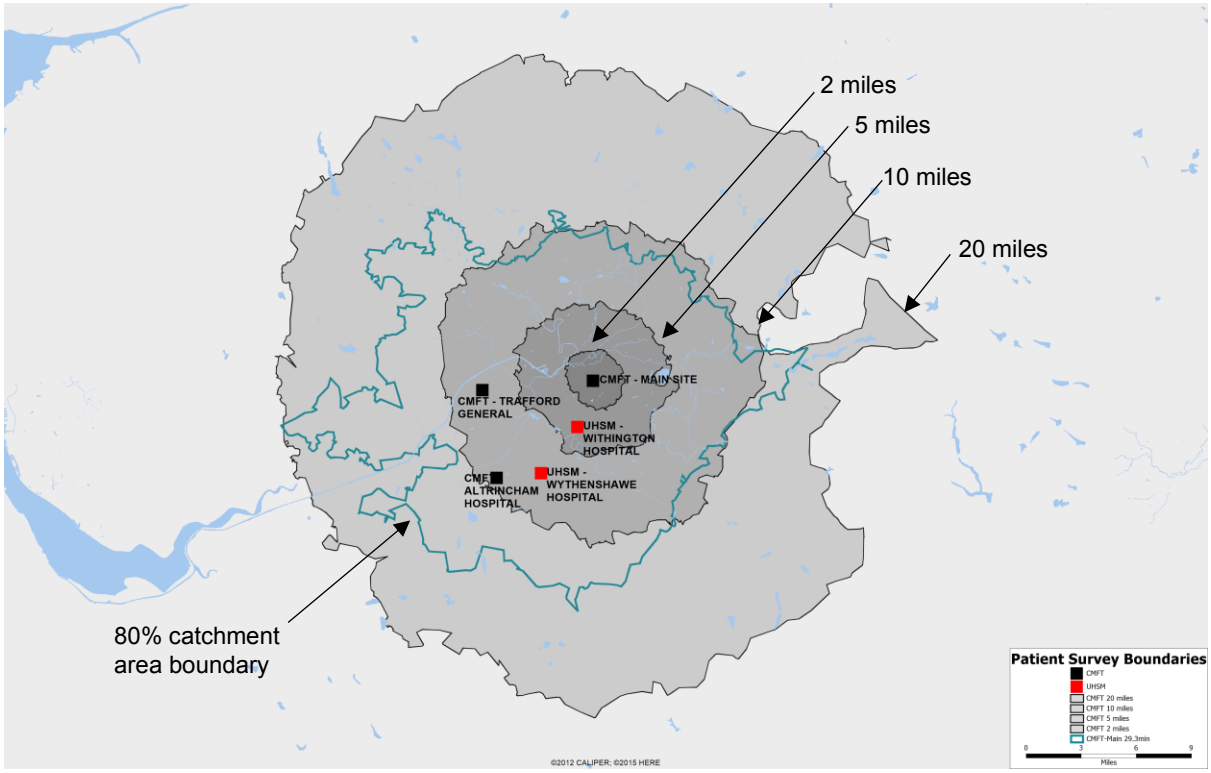
168. CMFT and UHSM also have doubts about the CMA's conclusion that each specialty is a separate product market. There are several specialties where services will be supplied to patients only as part of their treatment in another specialty. For example, in *Anaesthetics* patients will only receive services if they are undergoing surgery as part of their treatment in another specialty.

169. There are several other specialties, that are identified in the analysis set out in Section 7, where patients receive services as part of a broader treatment programme, or only having first received treatment in another specialty. These include, for example, Speech & Language Therapy, Cardiac Surgery and Transplantation Surgery. These examples imply that the CMA's approach to market definition requires some qualification.

170. Notwithstanding the CMA's formal statement of its approach to defining healthcare markets, CMFT and UHSM understand that the CMA has taken the issues identified above into account in its previous assessment of NHS acute trust mergers, and anticipates that the CMA will similarly do so again in its review of the CMFT/UHSM merger.

171. Regarding the geographic market, the Trusts submit that they compete in Greater Manchester and Cheshire. Evidence from catchment area analysis indicates that CMFT attracts 80% of its patients at each of its hospitals from within 29 minutes' drive-time of its Oxford Road site, 14 minutes' drive-time of Trafford Hospital and14 minutes' drive-time miles of Altrincham Hospital. UHSM attracts 80% of its patients at each of its hospitals from within 22 minutes' drive-time of Wythenshawe Hospital and 17 minutes' drive-time of Withington Hospital.

Figure 6.1: CMFT catchment area based on 80% catchment and travel survey responses



Source: Aldwych Partners

172. CMFT's most recent patient and visitor travel survey, carried out in 2016, provides further information on its catchment area. According to the survey results (and excluding don't knows), 74% of patients and visitors attending CMFT's hospitals lived within 10 miles of the hospital. In terms of journey times, two thirds of respondents travelled up to 30 minutes to attend CMFT, while a further 27% travelled 31-60 minutes. The remaining 8% travelled

for longer than 60 minutes. Most of these journey times related to car travel, with 69% of respondents travelling by car to CMFT, and a further 10% travelling by taxi.[77]

173. Figure 6.1 provides a comparison of CMFT's 80% catchment area (calculated using HES data), and the distance that patients and visitors live from CMFT's hospitals according to its patent and visitor travel survey (based on CMFT's Oxford Road site). Survey responses indicate that 16% live within 2 miles of CMFT, 49% within 5 miles, 74% within 10 miles and 93% within 20 miles. It can be seen that there is a relatively close match between the 10 mile limit (applying to 74% of patients and visitors) and the 80% catchment area calculated using HES data.

Table 6.1: Acute Trust catchment areas

Acute Trust	Hospital	Catchment Area (minutes)
CMFT	Oxford Road site	29 mins
CMFT	Trafford Hospital	14 mins
CMFT	Altrincham Hospital	14 mins
UHSM	Wythenshawe Hospital	22 mins
UHSM	Withington Hospital	17 mins
St Helen's & Knowsley Hospital Services NHS Trust	St Helen's Hospital	16 mins
St Helen's & Knowsley Hospital Services NHS Trust	Whiston Hospital	16 mins
Mid Cheshire Hospitals NHS Foundation Trust		23 mins
The Christie NHS Foundation Trust		42 mins
East Cheshire NHS Trust		24 mins
Countess of Chester Hospitals NHS Foundation Trust	Countess of Chester Hospital	21 mins
Salford Royal NHS Foundation Trust		26 mins
Bolton NHS Foundation Trust		18 mins
Tameside & Glossop Integrated Care NHS Foundation Trust		14 mins
Wrightington, Wigan & Leigh NHS Foundation Trust	Wrightington Hospital	41 mins
Wrightington, Wigan & Leigh NHS Foundation Trust	Leigh Infirmary	23 mins
Wrightington, Wigan & Leigh NHS Foundation Trust	Royal Albert Infirmary	19 mins
Pennine Acute Hospitals NHS Trust	Rochdale Infirmary	20 mins
Pennine Acute Hospitals NHS Trust	Fairfield General Hospital	17 mins
Pennine Acute Hospitals NHS Trust	North Manchester General Hospital	17 mins
Pennine Acute Hospitals NHS Trust	Royal Oldham Hospital	16 mins
Stockport NHS Foundation Trust		18 mins
Warrington & Halton Hospitals NHS Foundation Trust	Warrington Hospital	19 mins
Warrington & Halton Hospitals NHS Foundation Trust	Halton Hospital	15 mins

Source: Aldwych Partners analysis of HES data.

[77] See AECOM, *Patient and Visitors Travel Survey 2016 – Technical Note*, August 2016 at Appendix 6.1.

174. Catchment areas for other NHS acute trusts in Greater Manchester and the surrounding area (as well as CMFT and UHSM) are set out in Table 6.1.

175. The CMA, in its decision on the Ashford & St Peter's / Royal Surrey merger, noted that the catchment area is typically narrower than the geographic market identified using the hypothetical monopolist test, and that it took this into account in its competitive assessment. We have similarly taken this into account in the competitive assessment, particularly in Section 7, which considers competition in routine elective care and maternity services.

7. ROUTINE ELECTIVE CARE AND MATERNITY SERVICES

176. In 2015-16, CMFT provided services in 81 specialties, while UHSM provided services in 55 specialties.[78] Both Trusts provided services in the same 41 specialties at the outpatient level, 18 specialties at the day-case level, and 16 specialties at the elective inpatient level. Full details of these overlap specialties are at Appendix 7.1.

177. As set out in Section 2, CMFT and UHSM request that the CMA make a fast-track reference to Phase 2 given the likelihood that the CMA's Phase 1 review will conclude that their planned merger gives rise to a realistic prospect of an SLC in routine elective care in one or more specialties.

178. This section sets out the Trusts' analysis of the planned merger's effect on competition in these services. In particular:
    - patients' ability to access services at other acute trusts in the vicinity of CMFT and UHSM (as measured by the proximity of other providers to the merging trusts) is reviewed in Section 7.1;
    - GP referrals for routine elective care to CMFT, UHSM and other providers are assessed in Section 7.2;
    - speciality-specific factors impacting on competition between CMFT and UHSM in routine elective care are identified in Section 7.3; and
    - a conclusion is set out in Section 7.4.

7.1 Patients' ability to access services at different Trusts: proximity of other providers

179. The extent to which competition in routine elective care and maternity services will be adversely affected by the CMFT/UHSM merger depends, in large part, on the ability and willingness of enough patients to attend other acute trusts (or for GPs to refer patients to other acute trusts) in the event that patients (or their referring GPs) are dissatisfied with the quality of services at the merged Trust.

180. Patients' ability and willingness to access services at other Trusts will be strongly influenced by the distance that they will need to travel to access services at other providers. As set out in Section 6, CMFT's 2016 patient and visitor travel survey found that

[78] These specialties are defined as Treatment Function Codes in the HES dataset, and for the Trust to be providing a service in that specialty a minimum of ten first outpatient, day-case and/or elective inpatient events must have been carried out.

one third of patients and visitors who responded to the survey travelled more than 30 minutes to attend CMFT, and 69% of respondents used a car to travel to the site.[79]

Table 7.1: CMFT hospitals' proximity to other NHS acute trusts (minutes' drive-time)

	Oxford Road	Trafford Hospital	Altrincham Hospital
UHSM Wythenshawe Hospital	21.8 mins	19.1 mins	10.5 mins
UHSM Withington Hospital	12.6 mins	16.4 mins	17.6 mins
The Christie NHS Foundation Trust*	11.8 mins	20.1 mins	21.4 mins
Salford Royal NHS Foundation Trust	15.9 mins	13.0 mins	25.3 mins
Stockport NHS Foundation Trust	25.3 mins	26.0 mins	28.7 mins
Bolton NHS Foundation Trust	28.9 mins	21.4 mins	33.9 mins
Tameside & Glossop Integrated Care NHS Foundation Trust	23.7 mins	30.2 mins	32.9 mins
Pennine Acute Hospitals NHS Trust (Royal Oldham Hospital)	27.6 mins	29.9 mins	36.8 mins
Pennine Acute Hospitals NHS Trust (North Manchester General Hospital)	19.5 mins	25.6 mins	38.1 mins
Wrightington, Wigan & Leigh NHS Foundation Trust (Leigh Infirmary)	33.9 mins	26.4 mins	34.8 mins
Pennine Acute Hospitals NHS Trust (Fairfield General Hospital)	34.5 mins	28.9 mins	41.4 mins
Warrington & Halton Hospitals NHS Foundation Trust (Warrington Hospital)	34.8 mins	27.8 mins	29.6 mins
Warrington & Halton Hospitals NHS Foundation Trust (Halton Hospital)	39.9 mins	37.2 mins	25.3 mins
East Cheshire NHS Trust	38.6 mins	38.1 mins	33.6 mins
Pennine Acute Hospitals NHS Trust (Rochdale Infirmary)	38.5 mins	33.2 mins	45.7 mins
St Helen's and Knowsley Hospital Services NHS Trust (Whiston Hospital)	38.9 mins	31.8 mins	33.6 mins
St Helen's and Knowsley Hospital Services NHS Trust (St Helen's Hospital)	39.1 mins	32.0 mins	33.8 mins
Wrightington, Wigan & Leigh NHS Foundation Trust (Wrightington Hospital)	40.3 mins	33.2 mins	34.5 mins
Wrightington, Wigan & Leigh NHS Foundation Trust (Royal Albert Infirmary)	41.8 mins	34.4 mins	37.3 mins

* The Christie NHS Foundation Trust is a specialist cancer services hospital and does not provide the same range of routine elective care services as other NHS acute trusts in this table.

181. As might be expected in a large urban area like Greater Manchester, there is a significant number of hospitals operated by other acute trusts within a relatively short journey of CMFT's three hospital sites and UHSM's two hospital sites.

[79] See AECOM, *Patient and Visitors Travel Survey 2016 – Technical Note*, August 2016 at Appendix 6.1. UHSM has not carried out a patient transport survey, but a copy of its travel plan for Wythenshawe Hospital, which includes the results of a staff travel survey is included at Appendix 7.1 (AECOM, *Wythenshawe Hospital Travel Plan*, August 2015.)

- There are five acute trusts, other than UHSM, with one or more hospitals offering a broad range of clinical services within 30 minutes' drive-time of CMFT's main site on Oxford Road.[80] These are PAHT, Salford Royal NHS FT, Stockport NHS FT, Bolton NHS FT and Tameside Hospital NHS FT.

Table 7.2: UHSM hospitals' proximity to other NHS acute trusts (minutes' drive-time)

	Wythenshawe Hospital	Withington Hospital
CMFT Oxford Road	21.8 mins	13.0 mins
CMFT Trafford Hospital	18.9 mins	17.4 mins
CMFT Altrincham Hospital	9.2 mins	17.2 mins
The Christie NHS Foundation Trust*	15.0 mins	4.2 mins
Salford Royal NHS Foundation Trust	22.2 mins	19.3 mins
Bolton NHS Foundation Trust	30.8 mins	29.3 mins
Tameside & Glossop Integrated Care NHS Foundation Trust	25.8 mins	24.0 mins
Pennine Acute Hospitals NHS Trust (Royal Oldham Hospital)	29.7 mins	28.0 mins
Stockport NHS Foundation Trust	21.6 mins	19.8 mins
Warrington & Halton Hospitals NHS Foundation Trust (Halton Hospital)	29.0 mins	30.6 mins
East Cheshire NHS Trust	30.1 mins	32.0 mins
Pennine Acute Hospitals NHS Trust (North Manchester General Hospital)	33.2 mins	24.6 mins
Wrightington, Wigan & Leigh NHS Foundation Trust (Leigh Infirmary)	35.8 mins	34.3 mins
Pennine Acute Hospitals NHS Trust (Fairfield General Hospital)	37.6 mins	35.8 mins
Warrington & Halton Hospitals NHS Foundation Trust (Warrington Hospital)	33.3 mins	34.9 mins
Pennine Acute Hospitals NHS Trust (Rochdale Infirmary)	40.6 mins	38.8 mins
St Helen's and Knowsley Hospital Services NHS Trust (Whiston Hospital)	37.4 mins	38.9 mins
St Helen's and Knowsley Hospital Services NHS Trust (St Helen's Hospital)	37.5 mins	39.1 mins
Wrightington, Wigan & Leigh NHS Foundation Trust (Wrightington Hospital)	38.2 mins	39.8 mins
Wrightington, Wigan & Leigh NHS Foundation Trust (Royal Albert Infirmary)	41.1 mins	42.2 mins

* The Christie NHS Foundation Trust is a specialist cancer services hospital and does not provide the same range of routine elective care services as other NHS acute trusts.

- There are also five acute trusts, other than CMFT, with one or more hospitals offering a broad range of clinical services within 30 minutes' drive-time of UHSM's main site,

[80] We consider that a 30 minute drive-time is a reasonable benchmark to assess the accessibility of other hospitals given that CMFT's patient and visitor travel survey indicates that one third of its patients and visitors are travelling more than 30 minutes to attend CMFT.

Wythenshawe Hospital. These are PAHT, Salford Royal NHS FT, Tameside & Glossop Integrated Care NHS FT, Stockport NHS FT, and Warrington & Halton Hospitals NHS FT. In addition, two further Trusts have hospitals only just beyond 30 minutes' drive-time of Wythenshawe Hospital, namely East Cheshire NHS Trust and Bolton NHS FT.[81]

182. CMFT also provides services at Trafford Hospital and Altrincham Hospital. There are six acute trusts, other than UHSM, with hospitals within 30 minutes' drive-time of Trafford Hospital, and four acute trusts, other than UHSM, with hospitals within 30 minutes' drive-time of Altrincham Hospital. UHSM also provides services at Withington Hospital. There are six acute trusts, other than CMFT, with hospitals within 30 minutes' drive-time of Withington Hospital.

183. In addition to other NHS acute trusts, there are also various private providers of NHS acute services in the vicinity of CMFT and UHSM. This includes Care UK[82] and BMI Healthcare,[83] and other private providers of NHS acute services (such as Spire and Ramsay Healthcare). As set out in Section 7.3, Care UK and BMI Healthcare are important providers of services in several specialties (e.g. *General Surgery* and *Trauma & Orthopaedics*), while Specsavers is an important provider of services in *Audiology*. Further details on these providers, where relevant, are set out in the GP referral analysis in Section 7.3.

184. Patients' ability to readily access other providers of NHS acute services needs to be taken into account when considering whether the CMFT/UHSM merger gives rise to an SLC. In particular, while the CMA may believe that the GP referral analysis (in Section 7.3) allows inferences to be drawn about patients' preferences for different acute trusts, these preferences would be likely to change in the event that the merged Trust sought to exercise market power. In these circumstances, patients' ability to access services at other acute trusts is a fundamental constraint on the merged CMFT/UHSM.

7.2 Analysis of GP referrals for routine elective care

185. The GP referral analysis, as the CMA knows, seeks to measure the 'closeness' of competition between acute trusts. The share of referrals each acute trust gains at each GP practice (in each specialty) is used as a proxy for the strength of patients' (and/or referring GPs') preferences for different providers of acute services (at the specialty level).

186. This share of referrals data is used by the CMA to draw conclusions about GPs' and/or patients' willingness to use other acute trusts if the merged trust seeks to exercise market power, and thus the merged trust's ability to exercise market power profitably.[84]

[81] In addition, The Christie NHS Foundation Trust, a specialist cancer services provider, is closely located to both CMFT and UHSM. Of the acute trusts identified in this paragraph, Salford Royal NHS Foundation Trust does not offer maternity services.
[82] Care UK provides a mobile clinic service that rotates between sites in Greater Manchester. The Care UK North West CATS service frequents 11 locations across Manchester (see http://www.greater-manchester-cats.nhs.uk/locations).
[83] BMI Healthcare provides a range of NHS acute services from its hospital in Cheadle.
[84] In the context of a merger between NHS acute trusts, the concept of exercising market power is problematic given acute trusts' inability to influence prices for most services they offer, and the highly regulated nature of service quality regulation in the NHS. Further, the Trusts would find it, as a practical matter, very difficult to lower service quality as a means of improving their financial performance given that service quality deterioration is often associated with an increase in costs (e.g. reducing ward staffing may increase patient readmissions, which carry a financial penalty). However, the Trusts understand, without necessarily fully accepting, the approach adopted by the CMA to this issue in previous assessments of acute trust mergers.

187. This section sets out our analysis of GP referrals for routine elective care.[85] The results of this analysis are presented separately for:
    - GP referrals for first outpatient appointments (Section 7.2.4);
    - day-case admissions (Section 7.2.5); and
    - elective inpatient admissions (Section 7.2.6).

188. Prior to this, the patient pathway for routine elective care is described and the implications for carrying out, and interpreting the results of, the GP referral analysis is set out in Section 7.2.1. One of the key conclusions in this section is that the GP referral analysis cannot be meaningfully or robustly applied to the analysis of day-case or elective inpatient admission data. The Trusts consider that any robust analysis of competition in the provision of these services must rely on other sources of evidence. The approach proposed by the Trusts is set out in Section 7.2.5 and Section 7.2.6. We also set out our reservations about its application to analysing competition between Trusts in relation to first outpatient appointments.

189. Other assumptions underlying the GP referral analysis are discussed in Section 7.2.2. In Section 7.2.3 overlaps between CMFT and UHSM in routine elective care specialties are identified and discussed.

190. Sections 7.2.1 and 7.2.2 are particularly important for understanding the weight that should be accorded to the GP referral analysis in considering the effect of the merger on competition in routine elective care services. As the CMA has acknowledged in previous acute trust merger reviews, the GP referral analysis is based on a range of assumptions about patient, GP and acute trust preferences and behaviour, which means that this analysis cannot be the only source of evidence relied upon by the CMA in reaching a decision about the competitive effects of a merger on routine elective care and maternity services.

7.2.1 Patient pathways for routine elective care

191. All patients receiving routine elective care at a provider of NHS acute services start with a first outpatient appointment with a consultant in the specialty to which they have been referred. (Details of these first outpatient appointments, as recorded in HES, form the dataset used for the GP referral analysis in relation to outpatient services.)

192. Two key points about first outpatient appointments that are particularly relevant to the GP referral analysis are as follows.

    - First, not all first outpatient appointments result from a referral by GP (or another clinician where choice of provider, either by the clinician or the patient, could be expected). First outpatient appointments can be made by other clinicians in primary or community-based settings (e.g. dentists, optometrists), and by consultants within the acute provider (e.g. from a consultant at the Trust as part of an A&E attendance or to access additional services from other specialties at the Trust as part of the patient's treatment programme). Some of these referrals will encompass choice of provider (most likely those that arise in a primary or community-base setting), while others will not (e.g. where the patient is already in the care of an acute care provider).

[85] The results set out and discussed in this section are for a site-level analysis. The results of a Trust-level analysis are provided in Appendix 7.2.

- Second, a patient may have multiple first outpatient appointments with consultants in different specialties as part of their treatment. For example, a patient may be referred for a first outpatient appointment with a cardiologist, and it transpires that the patient needs to be admitted for a procedure. If the patient has a certain risk profile, then prior to their admission the patient may need to see an anaesthetist for an assessment. This appointment with the anaesthetist will be recorded in HES as a first outpatient appointment, but it does not reflect a process where a patient has made a choice of provider in relation to the services being received in that specialty.

193. For the GP referral analysis to reflect patients' (or referring GPs') preferences regarding different providers (as measured by the share of referrals that providers gain at each GP practice), it follows that the analysis should only be based on referrals that actually originate from a GP practice.

- Referrals for a first outpatient appointment that are made by consultants (or other clinicians) within a routine elective care provider, where choice of provider cannot be exercised, must be excluded from the analysis.

- Further, referrals for first outpatient appointment that are made by clinicians in primary care or community-based settings, where choice of provider might be expected, must also be excluded from the analysis. This is because assigning these referrals to the patients' registered GP practice will result in the dataset for that GP practice including referrals that were not made by GPs at that practice (but were made by other clinicians when the patient was accessing care in some other setting e.g. dentists at a separate dental practice). Including these choice-based referrals that were made in other clinical settings would distort the analysis of referrals from GP practices, and the conclusions that can be drawn about the preferences of GPs/patients at these practices.[86]

194. Referral source data in HES allows those referrals from GP practices to be isolated from other sources of referrals for first outpatient appointments.[87] Table 7.3 shows that, in 2015-16, [20-30]% of referrals for first outpatient appointments at CMFT, and [60-70]% of referrals for first outpatient appointments at UHSM, were from GPs. It is these referrals on which the GP referral analysis should be based.

195. Approximately [40-50]% of referrals for first outpatient appointments at CMFT, and [20-30]% of referrals for first outpatient appointments at UHSM, were from consultants within the Trust, including those from the A&E department. The remaining referrals for first outpatient appointments ([20-30]% at CMFT, and [10-20]% at UHSM) were from other sources.[88]

[86] The appropriate way to deal with these referrals, if they were to be included in the analysis, would be to separately analyse these referrals according to their individual source. For example, all referrals from General Dental Practitioners could be analysed according to each dental practice that makes a referral in the same way as referrals from GP practices are analysed. There is, however, no basis for assigning referrals from dentists to the patient's registered GP practice.
[87] The HES dataset identifies 19 sources of first outpatient appointments. We have classified these 19 referral routes according to whether the patient, or their referring clinician, can or cannot be expected to be able to exercise choice of provider. In general, choice can generally be expected when a referral is made from a primary care or community setting, but cannot be expected when the patient is being referred from a secondary care setting.
[88] Source of referral data at the specialty level for each of CMFT and UHSM is at Appendix 7.3.

Table 7.3: Patient pathways – referral routes for first outpatient appointments

Referral route	Choice of provider for referring clinician or patient?	Proportion of first outpatient appointment referrals (2015-16)		Comments
		CMFT	UHSM	
Referrals not initiated by the Consultant responsible for the first outpatient appointment				
Referral from a General Medical Practitioner	Yes	[20-30]%	[60-70]%	Primary care setting where choice by patient or referring clinician is likely to have been exercised under NHS rules on patient choice.
Referral from a Consultant, other than in an A&E Department	No	[30-40]%	[20-30]%	A consultant in an acute trust can only be expected to offer patients appointments at their own Trust. Patients wishing to be treated at another Trust will be referred back to their GP.
Referral from an A&E Department (including Minor Injuries Units and Walk In Centres)	No	[5-10]%	[0-5]%	A&E clinicians can only be expected to have access to systems that will enable first outpatient appointments to be booked at their own Trust.
Referral from a General Dental Practitioner	Yes	[5-10]%	[0-5]%	Primary care setting where choice by patient or referring clinician is likely to have been exercised under NHS rules on patient choice.
Self-referral	Yes	[0-5]%	[0-5]%	Where patients have the ability to self refer to a routine elective care service, then they are clearly exercising a choice between different providers.
Referral from a Specialist Nurse (Secondary Care)	No	[0-5]%	[0-5]%	This is a secondary care setting where the referring nurse can only be expected to make referrals within their own Trust.
Other not initiated by the consultant responsible for the first outpatient appointment	Yes	[0-5]%	[0-5]%	It is not clear whether or not these patients, or the referring clinicians, will have exercised choice of provider. We have adopted a conservative approach and assumed that choice has been offered.
Referral from a Community Dental Service	Yes	[0-5]%	[0-5]%	This is a community-based care setting where choice by patient or referring clinician is likely to have been exercised under NHS rules on patient choice.
Referral from an Optometrist	Yes	[0-5]%	[0-5]%	Primary care setting where choice by patient or referring clinician likely to have been exercised under NHS rules on patient choice.
Referral from a General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)	Yes	[0-5]%	[0-5]%	Primary care setting where choice by patient or referring clinician is likely to have been exercised under NHS rules on patient choice.
Referral from an Allied Health Professional (AHP)	Yes	[0-5]%	[0-5]%	AHPs making a referral are likely to be working in a community-based care setting where choice by patient or referring clinician is likely to have been exercised under NHS rules on patient choice.

Referral from a National Screening Programme	No	[0-5]%	[0-5]%	National screening programmes are generally operated by acute trusts, and as a result, referring clinicians within these Programmes can be expected to only make referrals to their own Trust.
Referral from an Orthoptist	..	[0-5]%	[0-5]%	Neither Trust recorded any referrals from this source in 2015-16
Referral from a Prosthetist	..	[0-5]%	[0-5]%	Neither Trust recorded any referrals from this source in 2015-16
A&E Source other	..	[0-5]%	[0-5]%	Neither Trust recorded any referrals from this source in 2015-16
Referrals initiated by the Consultant responsible for the first outpatient appointment				
Following an emergency admission	No	[0-5]%	[0-5]%	Consultants that make a referral to themselves (as a result of seeing a patient in another care setting) cannot be expected to have offered the patient a choice of provider.
Other – initiated by the consultant responsible for the first outpatient appointment	No	[5-10]%	[0-5]%	
Following a domiciliary consultation	No	[0-5]%	[0-5]%	
Following an A&E attendance (including Minor Injuries Units and Walk In Centres)	No	[0-5]%	[0-5]%	

Source: Aldwych Partners analysis of HES data

Patient pathways following a referral for routine elective care

196. All patients receiving routine elective care at a provider of NHS acute services, as set out above, start with a first outpatient appointment with a consultant in the specialty to which they have been referred.

197. At this first appointment, tests may be ordered, and either at this appointment or a follow up outpatient appointment, a decision will be made regarding whether the patient can be discharged, treated as an outpatient or requires an admission for treatment (either as a day-case patient or for an overnight stay). Following an initial round of treatment (e.g. an admission for surgery, or medication, or some form of therapy), the patient may be discharged or may be undergo further treatment, depending on their condition.

198. Each patient that is referred for routine elective can be thought of as consuming a package of treatment services that might include, for example, consultant reviews, diagnostic testing, surgery (including by way of a day-case or elective inpatient admission), medication and therapy. Some patients may consume all of these services, while others may only consume only a few services, while some may be discharged after their first outpatient appointment having only needed an initial consultant review.

199. The proportion of patients admitted for treatment is much smaller than those that have a first outpatient appointment. For example, in 2015-16, there were [21,000-22,000] first outpatient appointments in Cardiology across the three CMFT sites, while there were [1,000-2,000] day-case admissions and [900-1,000] elective inpatient admissions. (The equivalent figures at UHSM were [19,000-20,000] first outpatient appointments, [2,000-3,000] day-case admissions, and [1,000-2,000] elective inpatient admissions.) That is,

around 10-20% of first outpatient appointments resulted in a day-case or elective inpatient admission in Cardiology.

200. A critical point of importance for the GP referral analysis is that neither the patient nor their referring GP knows, at the time at which the patient is being referred, what package of services will be consumed by the patient (including whether the patient will be admitted for day case or elective inpatient services).

201. The Cardiology example set out above shows the small proportion of patients that are referred to hospital for treatment compared with those that are admitted. The Trusts will submit further information on the ratio of patients admitted to those that are referred. These low ratios, however, are indicative of patients, and their referring GPs, not knowing whether a patient is likely to be admitted for treatment at the time of referral.

202. There are several examples of how this works in practice in different specialties.

- In orthopaedics, a patient that is complaining of hip or knee pain may be referred to hospital. Following a review by a consultant the patient may be admitted to hospital for an operation, or alternatively, the condition may be treated through a joint injection and/or physiotherapy. Neither the GP nor the patient will know at the time of admission whether they will be admitted. It follows that all patients in this position will take into account the possibility that they will be admitted, including those patients that do not end up having an operation.

- In gynaecology, continence problems may be treated through physiotherapy or by way of an operation. The referring GP (and the patient) will not know when referring the patient which course of action will be decided upon by the consultant at the time of making the referral. Therefore the choice of provider for all patients will reflect the possibility of an admission. It will not differ between those patients that are admitted and those that are not admitted.

- In cancer, NICE guidance sets out the threshold for 'high risk' cancer referrals, which qualify for the two week waiting time target, at a 3-5% chance of having any cancer.[89] This means that large numbers of patients are referred to hospital with suspected cancer who are subsequently cleared and discharged. However, at the time of referral, each of these patients would know that there is some possibility of requiring an admission for treatment, and all of these patients could be expected to take this into account in choosing a hospital, not just those that are subsequently admitted.

203. The Trusts plan to provide further evidence to the CMA on this point by way of an internal clinical review of common causes of GP referral in the largest specialties at each Trust. The Trusts anticipate providing this review for the CMA's Phase 2 review of the planned merger. An analysis of admissions to referral ratios will also be provided to the CMA.

204. In summary, the Trusts agree with the CMA that, to the extent that they compete, they will compete on the quality of their inpatient, as well as their outpatient, services. All patients that are referred for treatment face the possibility of being admitted for treatment (putting to one side those specialties where admission never takes place) at the time the patient,

[89] See Pulse, *GPs to refer more patients with low-risk cancer symptoms under new NICE Guidance*, 23 June 2015 at Appendix 7.4, and NICE, *Suspected cancer: recognition and referral*, NICE guideline, 23 June 2015 at Appendix 7.5.

together with their GP, is choosing their provider. This means all patients take into account the quality of outpatient and inpatient services offered by each provider.

205. The GP referral analysis, however, when applied to day-case and elective inpatients separately reviews the choices made by those patients that actually end up being admitted. It applies the *ex-post* information about which patients have been admitted to analysing the *ex-ante* choices made by those patients who have been admitted. The GP referral analysis when applied to referrals first outpatient appointments, on the other hand, includes those patients that will subsequently be admitted as well as those that are discharged without an admission (i.e. all patients who are referred, all of whom will face the possibility of being admitted at the time of their choice of provider).

206. Given these issues, there is no conceptual basis for analysing the choices made by admitted patients separately from the broader cohort of all patients that have been referred for treatment.

207. An analogy can be drawn with insurance services. Analysing the choice of insurer by those customers that subsequently go on to make a claim versus those customers who do not make a claim is not meaningful. Both groups of customers had the same set of information at the time of choosing their insurer. In the same way, all GPs and patients will have the same information about providers of routine elective care at the time their referral is made.

208. The conceptual issues set out above clearly invalidate any GP referral analysis that applies to day case and elective inpatient services. Further, it is not possible to identify in the HES data those patients who have been admitted for day-case and elective inpatient treatment on the basis of a GP referral compared with those patients who have been referred from some other source.[90]

209. Further, as set out above, referrals from non-GP sources account for 72% and 40% of referrals for first outpatient appointments at CMFT and UHSM, respectively. Even if the conceptual issues set out above were not present, the day-case and elective inpatient data includes so many referrals from non-GP sources it makes it impossible to meaningfully analyse GP referral patterns when the data is dominated by referrals from other sources.

210. In Sections 7.2.4 and 7.2.5 we supply the results of the GP referral analysis as applied to day-case and elective inpatient services, despite our view that these figures are meaningless in terms of their ability to provide insight into competition conditions in the provision of these services. However, we also set out in these sections what we believe to be an appropriate alternative methodology for assessing the effect of the merger in relation to these services.

7.2.2 Other underlying assumptions for the GP referral analysis

211. This section discusses several important assumptions on which the GP referral analysis is based as well as other limitations to its ability provide insight into patients'/GP's preferences regarding different providers.

212. Doubts about the validity of these assumptions, as well as the inherent limitations of the analysis, mean that the weight given to the results of the GP referral analysis in drawing

[90] Day-case and elective inpatient activity for each provider is recorded in a separate HES dataset from outpatient activity. Source of referral information is only available in the outpatient dataset.

conclusions about the competitive effects of the CMFT/UHSM merger needs to be discounted accordingly. We set out in the conclusion to Section 7 our views on how the different sources of evidence should be weighed up by the CMA. The remainder of this section discusses six issues in relation to the GP referral analysis.

213. *GP referral analysis does not allow an assessment of how close a competitor there is to the merged Trust*: the GP referral analysis uses referral share data to assess closeness of competition between the merging Trusts. However, this does not tell us about patients'/GP's willingness to select other Trusts following the merger. Patients/GPs may have a relatively weak preference for a Trust. This preference could be driving large referral volumes, but if the preference is weak, it would not take a significant deterioration in quality at the merged Trust to result in significant referral volumes switching elsewhere. The strength of preferences cannot be measured using the GP referral analysis.

214. *GP referral analysis is based on referral shares at GP practices*: the analysis does not reflect the behaviour of individual GPs. As a result, GPs with quite different preferences could be located within a single GP practice, and the referral shares that are observed are an average that may, or may not, provide an accurate indicator of the behaviour/preferences of individual GPs. To draw an analogy, one GP at a surgery may shop at Tesco, one at Coop and one at their local convenience store, but this does not make these grocery stores substitutes at the practice level. The relevant substitutes will depend on the preferences of the individual GPs.

215. *Coding differences between Trusts*: these can have major effects on the accuracy and reliability of the GP referral analysis (as was demonstrated in the Ashford & St Peter's / Royal Surrey merger review). To the extent that the Trusts become aware of any significant coding issues that appear to impact on the GP referral analysis, they will bring these to the CMA's attention. However, the Trusts are concerned that there may be inaccuracies or inconsistencies of which they are not aware.

216. *Referral analysis based on historic data*: the GP referral analysis reflects historic referral patterns. It does not reflect changes in the relative competitive strength of providers that might be expected in the future. The results of the GP referral analysis need to be weighed against any changes that can be expected (including at the merging Trusts under the counterfactual).

217. *Clinical networks and collaborative arrangements*: to the extent that clinical networks or other collaborative arrangements are in place at the merging Trusts or other acute trusts in their vicinity, then this will affect the accuracy of the GP referral analysis.

218. *Referral analysis assumes that all diversion remains in the existing market*: the analysis assumes that if referrals switch from one provider, then these will shift in their totality to other providers. However, this may not be the case. It seems possible that some GPs could take other actions, such as prescribing different/additional medicines, adopting a 'wait and see' approach before making a referral to another provider, or accessing services from an out of hospital provider. By assuming that all referrals divert to other providers, the strength of the competitive constraint offered by these providers will be overstated.

7.2.3 Overlaps in routine elective care services

219. This section identifies overlaps between CMFT and UHSM in the provision of routine elective care services. It also applies source of referral data to identify those specialties where: (i) there is a sufficient number of GP referrals such that the GP referral analysis methodology can be meaningfully applied; and (ii) the number of choice-based referrals is sufficient to create a meaningful incentive for CMFT and UHSM to compete for referrals in that specialty.

220. Table 7.4 shows the 47 specialties where both Trusts recorded first outpatient appointments in 2015-16.[91] (In total, CMFT recorded first outpatient appointments in 80 specialties, while UHSM recorded first outpatient appointments in 53 specialties.) The total number of first outpatient appointments in the 47 overlap specialties accounted for 65% of all first outpatient appointments at CMFT and 89% of all first outpatient appointments at UHSM.

221. Of these 47 specialties, there were three specialties (*Clinical Oncology*, *Midwife Episodes* and *Neonatology*) where one of the two Trusts recorded less than 10 first outpatient appointments. Consistent with previous CMA decisions, *Clinical Oncology* and *Neonatology* should not considered to be overlap specialties on the basis of these small volumes of activity.[92] These two specialties are coloured grey in Table 7.4. *Midwife Episodes* is retained in our analysis as both CMFT and UHSM are providers of maternity services, and as discussed further below, *Midwife Episodes* and *Obstetrics* data has been grouped for analytical purposes.

222. For each of the 47 specialties where CMFT and UHSM both recorded first outpatient appointments, referrals from GP practices have been identified. As set out in Section 7.3.1, a substantial proportion of referrals for first outpatient referrals come from other sources, and should not be attributed to GP practices. Further, some GP practices, in some specialties, only refer patients to one provider. For these GP practices it is not possible to assess where their referrals would be directed if they could no longer refer patients to their existing provider.

223. As a result, from the total number of first outpatient appointments in each specialty at CMFT and UHSM, there is only a subset of appointments to which the GP referral analysis can be applied. This is referrals from GP practices which refer patients to more than one provider. The number of these referrals at each CMFT and UHSM site, in each specialty, is set out in Table 7.4.

224. There are eleven specialties where each CMFT and UHSM site has less than 10 GP referrals. These specialties, coloured amber in Table 7.4, are: *Cardiac Surgery*, *Dietetics*, *Interventional Radiology*, *Nephrology*, *Occupational Therapy*, *Orthodontics*, *Paediatric Diabetic Medicine*, *Paediatric Neurology*, *Palliative Medicine, Podiatry* and *Transplantation Surgery*.

225. In each of these specialties, other than *Orthodontics*, CMFT and UHSM consider that patients access these services as part of their broader treatment programme, which is why

[91] Day case and elective inpatient activity for CMFT and UHSM, by specialty, for 2015-16 is set out in Appendix 7.6.
[92] Ten first outpatient appointments per year is the equivalent of around one outpatient clinic per year in that specialty. The Trusts believe that a more realistic threshold for deciding whether they deliver services in a specialty would be the equivalent of one outpatient clinic per fortnight. This would equate to around 150-200 first outpatient appointments per year given the need to accommodate both first and follow up appointments.

they are not referred directly to these services by their GPs. That is, the Trusts do not compete for referrals in these specialties. In *Orthodontics*, patient referrals would be made by dentists rather than GP practices. As a result, the Trusts may compete for referrals from dentists, but it is not possible to analyse the extent to which patients are choosing between CMFT and UHSM using the GP referral analysis. For these reasons, these eleven specialties are excluded from the GP referral analysis.

226. There are seven further specialties where one of the two Trusts has less than 100 GP referrals at each of its site, and as a result, the GP referral analysis is likely to have issues of statistical robustness. These are Anaesthetics, Chemical Pathology, Gynaecological Oncology, Infectious Diseases, Paediatric Plastic Surgery, Physiotherapy, and Speech & Language Therapy. These specialties have been included in our GP referral analysis, but with this qualification noted.

227. In four of these seven specialties, while CMFT or UHSM may have recorded more than 10 first outpatient appointments in 2015-16 at one of its sites, it is not clear that there is meaningful competition for GP referrals. These specialties include:

- *Anaesthetics*: where patients can only be expected to be referred for a first outpatient appointment as part of a surgical pathway, and the [0-100] GP referrals for first outpatient appointments at Wythenshawe Hospital are likely to be coding errors.
- *Gynaecological Oncology*: where UHSM recorded only [0-100] first outpatient appointments resulting from GP referrals in 2015-16. These are highly likely to be coding errors given that patients could be expected to have a first outpatient appointment in Gynaecology before being referred by their consultant for a first outpatient appointment in Gynaecological Oncology.
- *Paediatric Plastic Surgery*: where UHSM recorded only [0-100] first outpatient appointments from GP referrals and CMFT recorded only [0-100] first outpatient appointments from GP referrals in 2015-16.
- *Speech & Language Therapy*: where CMFT only recorded [0-100] GP referrals for first outpatient appointments, and UHSM only recorded [0-100] GP referrals for first outpatient appointments.

228. In summary, this means that there are 27 specialties where it is possible to apply the GP referral analysis with a degree of confidence regarding the underlying number of GP referrals for first outpatient appointments. In the remaining 20 specialties, there will be either insufficient observations to allow the GP referral analysis to be carried out, or questions about the robustness of the results to which the analysis has been applied.

229. The approach set out in this section is to apply the GP referral analysis wherever there are more than 10 observations, but to note where there are small numbers that may affect the robustness of the analysis.

Table 7.4: Specialties where CMFT and UHSM both record first outpatient appointments, 2015-16

	Specialty	CMFT				UHSM		
		All first outpatient appoint-ments	Referrals from GPs that can be analysed			All first outpatient appoint-ments	Referrals from GPs that can be analysed	
			Oxford Rd	Traff-ord	Altrin-cham		Wythen-shawe	With-ington
1.	Anaesthetics	[1,000-2,000]	[0-100]	[0-100]	[0-100]	[1,000-2,000]	[0-100]	[0-100]
2.	Anticoagulant Service	[500-600]	[100-200]	[0-100]	[0-100]	[1,000-2,000]	[300-400]	[0-100]
3.	Audiology	[3000-4000]	[0-100]	[700-800]	[700-800]	[3000-4000]	[200-300]	[3,000-4,000]
4	Cardiac Surgery	[1,000-2,000]	[0-100]	[0-100]	[0-100]	[500-600]	[0-100]	[0-100]
5	Cardiology	[20,000-30,000]	[2,000-3,000]	[800-900]	[100-200]	[19,000-20,000]	[7,000-8,000]	[0-100]
6	Chemical Pathology	[200-300]	[0-100]	[0-100]	[0-100]	[100-200]	[0-100]	[0-100]
7	Clinical Haematology	[4,000-5,000]	[800-900]	[400-500]	[100-200]	[1,000-2,000]	[400-500]	[200-300]
8	Clinical Oncology	[100-200]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
9	Dermatology	[4,000-5,000]	[1,000-2,000]	[1,000-2,000]	[800-900]	[4,000-5,000]	[500-600]	[3,000-4,000]
10	Diabetic Medicine	[2,000-3,000]	[300-400]	[200-300]	[40-50]	[900-1,000]	[300-400]	[100-200]
11	Dietetics	[3,000-4,000]	[0-100]	[0-100]	[0-100]	[500-600]	[0-100]	[0-100]
12	Endocrinology	[1,000-2,000]	[600-700]	[100-200]	[20-30]	[1,000-2,000]	[800-900]	[0-100]
13	ENT	[16,000-17,000]	[4,000-5,000]	[2,000-3,000]	[1,000-2,000]	[10,000-20,000]	[4,000-5,000]	[5,000-6,000]
14	Gastroenterology	[6,000-7,000]	[1,000-2,000]	[1,000-2,000]	[0-100]	[6,000-7,000]	[2,000-3,000]	[2,000-3,000]
15	General Medicine	[3,000-4,000]	[700-800]	[300-400]	[0-100]	[2,000-3,000]	[1,000-2,000]	[0-100]
16	General Surgery	[9,000-10,000]	[2,000-3,000]	[600,700]	[200-300]	[6,000-7,000]	[3,000-4,000]	[1,000-2,000]
17	Geriatric Medicine	[800-900]	[100-200]	[200-300]	[0-100]	[1,000-2,000]	[600-700]	[0-100]
18	Gynaecological Oncology	[2000-3000]	[200-300]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
19	Gynaecology	[20,000-30,000]	[4,000-5,000]	[1,000-2,000]	[100-200]	[5,000-6,000]	[4,000-5,000]	[600-700]
20	Infectious Diseases	[2,000-3,000]	[100-200]	[0-100]	[0-100]	[900-1000]	[0-100]	[0-100]
21	Interventional Radiology	[100-200]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
22	Midwife Episode	[0-100]	[0-100]	[0-100]	[0-100]	[6,000-7,000]	[500-600]	[200-300]
23	Neonatology	[900-1,000]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
24	Nephrology	[4,000-5,000]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
25	Obstetrics	[10,000-20,000]	[2,000-3,000]	[0-100]	[0-100]	[5,000-6,000]	[1,000-2,000]	[0-100]

26	Occupational Therapy	[1,000-2,000]	[0-100]	[0-100]	[0-100]	[500-600]	[0-100]	[0-100]
27	Oral Surgery	[9,000-10,000]	[600-700]	[100-200]	[0-100]	[1,000-2,000]	[100-200]	[0-100]
28	Orthodontics	[1,000-2,000]	[0-100]	[0-100]	[0-100]	[700-800]	[0-100]	[0-100]
29	Paediatric Cardiology	[2,000-3,000]	[100-200]	[0-100]	[0-100]	[200-300]	[100-200]	[0-100]
30	Paediatric Diabetic Medicine	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
31	Paediatric Neurology	[800-900]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
32	Paediatric Plastic Surgery	[1,000-2,000]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
33	Paediatric Surgery	[3,000-4,000]	[800-900]	[0-100]	[0-100]	[700-800]	[400-500]	[0-100]
34	Paediatric Urology	[2,000-3,000]	[200-300]	[0-100]	[0-100]	[400-500]	[200-300]	[0-100]
35	Paediatrics	[7,000-8,000]	[2,000-3,000]	[2,000-3,000]	[0-100]	[3,000-4,000]	[3,000-4,000]	[0-100]
36	Pain Management	[700-800]	[0-100]	[500-600]	[100-200]	[1,000-2,000]	[1,000-2,000]	[0-100]
37	Palliative Medicine	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
38	Physiotherapy	[9,000-10,000]	[0-100]	[0-100]	[0-100]	[20,000-30,000]	[3,000-4,000]	[9,000-10,000]
39	Plastic Surgery	[200-300]	[100-200]	[0-100]	[0-100]	[8,000-9,000]	[1,000-2,000]	[0-100]
40	Podiatry	[200-300]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
41	Respiratory Medicine	[3,000]	[1,000]	[400-500]	[100-200]	[9,000-10,000]	[3,000-4,000]	[200-300]
42	Rheumatology	[2,000-3,000]	[900-1,000]	[400-500]	[300-400]	[3,000-4,000]	[700-800]	[2,000-3,000]
43	Speech & Language Therapy	[600-700]	[0-100]	[0-100]	[0-100]	[400-500]	[0-100]	[0-100]
44	Transplantation Surgery	[1,000-2,000]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]	[0-100]
45	Trauma & Orthopaedics	[20,000-30,000]	[4,000-5,000]	[2,000-3,000]	[900-1,000]	[10,000-20,000]	[6,000-7,000]	[100-200]
46	Urology	[5,000-6,000]	[2,000-3,000]	[800-900]	[100-200]	[6,000-7,000]	[2,000-3,000]	[2,000-3,000]
47	Vascular Surgery	[6,000-7,000]	[1,000-2,000]	[0-100]	[0-100]	[3,000-4,000]	[2,000-3,000]	[0-100]

Source: Aldwych Partners analysis of HES data

230. A further way of looking at the 47 specialties where both CMFT and UHSM both carried out first outpatient appointments in 2015-16 is to assess the proportion of referrals in each specialty came from a source where the patient or referring clinician could be expected to be able to exercise choice of provider.

231. The Trusts will only have limited incentives to improve quality as a means of attracting additional referrals where the proportion of their total activity in that specialty come from choice-based sources. This is because it would not be worthwhile incurring the costs of improving quality where it would affect the behaviour of only a small proportion of patients, but would have to be delivered to all patients in that specialty (given the inability to ringfence quality improvements to those patients).

Table 7.5: Specialties where choice-based referrals to CMFT and UHSM is 10% or less of total referrals, 2015-16

Specialty	Proportion of referrals from choice based sources
Cardiac Surgery	[5-10]%
Clinical Oncology	[0-5]%
Dietetics	[0-5]%
Interventional Radiology	[0-5]%
Neonatology	[0-5]%
Occupational Therapy	[0-5]%
Palliative Medicine	[5-10]%
Podiatry	[0-5]%

Source: Aldwych Partners analysis of HES data

232. Building on the CMA's approach in other sectors, CMFT and UHSM consider that those specialties where 10% or less of total referrals to the two Trusts are from choice-based sources, the threat of competition should be regarded as providing an immaterial incentive for quality improvement.[93] Eight specialties fulfil this criteria (see Table 7.5). These eight specialties also overlap with the 20 specialties excluded from the GP referral analysis for other reasons set out above.

7.2.4 First outpatient appointments

233. This section sets out the GP referral analysis for each of CMFT's and UHSM's hospital sites in relation to first outpatient appointments.[94] For each site, the accompanying table sets out both the proportion of referrals that would switch to from the relevant CMFT hospital site to UHSM (or vice versa) as well as setting out the proportion of referrals that would divert internally to other CMFT (or UHSM) hospital sites.

234. The additional information on internal diversions is included so that the CMA is able to identify where a low switching proportion may be explained by switching to other third party providers or by internal diversion.

CMFT's Oxford Road site

235. At CMFT's Oxford Road site, there are 29 overlap specialties where it is possible to carry out the GP referral analysis.

- In 17 specialties, UHSM would receive [30-40]% or more of the referrals that switched from CMFT's Oxford Road site, and would also receive more referrals switching from any other provider. These specialties are coloured red in Table 7.6. In two of these specialties, this analysis was based on less than 100 GP referrals (*Physiotherapy* and *Paediatric Plastic Surgery*).

- In four specialties, UHSM would either receive [30-40]% or more of the referrals that switched from CMFT's Oxford Road site, but there would be another provider that would receive more referrals than UHSM, or UHSM would receive less than [30-40]%

[93] This approach is applied by the CMA to merger reviews in the transport sector where bus-on rail overlapping routes are excluded from further analysis those where the parties' combined revenue derived from the bus service on those flows (or number of passengers) accounts for less than 10% of the overall bus route revenue (or passengers).
[94] Supporting data for the analysis of GP referrals for first outpatient appointments is set out in Appendix 7.7.

of referrals switching from CMFT's Oxford Road site, but would still receive more referrals than any other provider. These specialties are coloured amber in Table 7.6.

i. In *Anticoagulant Services*, PAHT would receive [60-70]% of referrals switching from CMFT's Oxford Road site compared with [25-35]% switching to UHSM, while in *Endocrinology*, Salford Royal would receive [25-35]% of referrals switching from CMFT's Oxford Road site compared with [25-35]% switching to UHSM.

ii. In *Diabetic Medicine*, UHSM would receive [20-30]% and PAHT would receive [10-20]% of referrals switching from CMFT's Oxford Road site. Around [10-20]% of referrals would have switched to CMFT's Stretford Hospital, but this hospital is now closed. In *Gynaecology*, UHSM would receive [20-30]%, Care UK would receive [20-30]% and PAHT would receive [10-20]% of referrals switching from CMFT's Oxford Road site.

- In seven specialties, UHSM would receive neither more than [30-40]% of referrals switching from CMFT's Oxford Road site nor would it be the provider receiving the largest proportion of referrals switching from UHSM. These specialties are coloured green in Table 7.6.

i. In *ENT*, UHSM was the provider that would receive the second largest proportion of referrals switching from CMFT's Oxford Road site at [20-30]% behind Care UK on [40-50]%.

ii. In *General Medicine*, UHSM would receive [10-20]% compared with Stockport at [20-30]%.

iii. In *General Surgery*, UHSM would receive [10-20]% behind Care UK at [30-40]%.

iv. In *Infectious Diseases*, UHSM would receive [0-5]% behind PAHT at [90-100]%.

v. In *Trauma & Orthopaedics*, UHSM would receive [10-20]% behind Care UK at [40-50]%.

236. A 30% threshold has been used to identify those specialties that may be of most interest to the CMA in terms of the results of the GP referral analysis. However, consistent with the points made in Section 5 regarding the role of competition in influencing the provision of routine elective care services by NHS acute trusts, CMFT and UHSM believe that there are grounds for this screening threshold to be considerably higher.

Table 7.6: GP referral analysis for first outpatient appointments in overlap specialties at CMFT's Oxford Road site

		Proportion of referrals that would switch to:		
Overlap specialty	**Referrals from GPs that can be analysed**	**UHSM (and UHSM's ranking as alternative provider)**	**Trafford General**	**Altrincham**
Anticoagulant Service	[100-200]	[30-40]% (2nd)	[0-5]%	[0-5]%
Cardiology	[2,000-3,000]	[40-50]% (1st)	[5-10]%	[0-5]%
Clinical Haematology	[800-900]	[40-50]% (1st)	[0-5]%	[0-5]%
Dermatology	[1,000-2,000]	[40-50]% (1st)	[0-5]%	[0-5]%
Diabetic Medicine*	[300-400]	[20-30]% (1st)	[0-5]%	[0-5]%
Endocrinology	[600-700]	[30-40]% (2nd)	[0-5]%	[0-5]%
ENT	[4,000-5,000]	[20-30]% (2nd)	[0-5]%	[0-5]%
Gastroenterology	[1,000-2,000]	[50-60]% (1st)	[0-5]%	[0-5]%
General Medicine	[2,000-3,000]	[10-20]% (2nd)	[5-10]%	[0-5]%
General Surgery	[2,000-3,000]	[10-20]% (2nd)	[0-5]%	[0-5]%
Geriatric Medicine	[100-200]	[50-60]% (1st)	[5-10]%	[0-5]%
Gynaecology	[4,000-5,000]	[20-30]% (1st)	[5-10]%	[0-5]%
Gynaecological Oncology	[200-300]	[1-5]% (>3rd)	[0-5]%	[0-5]%
Infectious Diseases	[100-200]	[1-5]% (2nd)	[0-5]%	[0-5]%
Nephrology	[600-700]	[1-5]% (>3rd)	[0-5]%	[0-5]%
Obstetrics	[2,000-3,000]	[40-50]% (1st)	[0-5]%	[0-5]%
Oral Surgery	[600-700]	[5-10]% (>3rd)	[5-10]%	[0-5]%
Paediatric Cardiology	[100-200]	[70-80]% (1st)	[0-5]%	[0-5]%
Paediatric Plastic Surgery	[0-100]	[40-50]% (1st)	[0-5]%	[0-5]%
Paediatric Surgery	[800-900]	[40-50]% (1st)	[0-5]%	[0-5]%
Paediatric Urology	[200-300]	[80-90]% (1st)	[0-5]%	[0-5]%
Paediatrics	[2,000-3,000]	[40-50]% (1st)	[5-10]%	[0-5]%
Physiotherapy	[0-100]	[40-50]% (1st)	[0-5]%	[0-5]%
Plastic Surgery	[100-200]	[70-80]% (1st)	[0-5]%	[0-5]%
Respiratory Medicine*	[1,000-2,000]	[50-60]% (1st)	[0-5]%	[0-5]%
Rheumatology	[900-1,000]	[50-60]% (1st)	[0-5]%	[0-5]%
Trauma & Orthopaedics	[4,000-5,000]	[10-20]% (2nd)	[0-5]%	[0-5]%
Urology	[2,000-3,000]	[30-40]% (1st)	[0-15%	[0-5]%
Vascular Surgery	[1,000-2,000]	[30-40]% (1st)	[5-10]%	[0-5]%

* For Diabetic Medicine and Respiratory Medicine analysis of 2015-16 GP referrals shows that a material number of referrals at Oxford Road would switch to CMFT's Stretford Hospital, which is now closed. This figure is [10-20]% for Diabetic Medicine and [10-20]% for Respiratory Medicine.
Source: Aldwych Partners analysis of HES data

237. Currently, it appears that applying a 30% threshold to the screening of specialties in NHS acute trust mergers places this sector on an equivalent status to pharmacies in terms of the ability of providers to 'flex' their offer in response to changing market conditions. However, as set out in Section 5, the administrative and regulatory framework in which NHS acute trusts operate, and the changes to this framework in the past 12 months in response to tighter NHS finances, mean that NHS acute trusts have considerably less freedom and autonomy to compete with each other than private sector owners of retail pharmacy businesses.

CMFT's Trafford General Hospital

238. At CMFT's Trafford General Hospital, there are 21 overlap specialties where it is possible to carry out the GP referral analysis.

- In ten specialties, UHSM would receive [30-40]% or more of the referrals that switched from CMFT's Trafford General Hospital, and would also receive more referrals switching than any other provider. These specialties are coloured red in Table 7.7. In one of these specialties, this analysis was based on less than 100 GP referrals (*Vascular Surgery*).

- In five specialties, UHSM would either receive [30-40]% or more of the referrals that switched from CMFT's Trafford General Hospital, but there would be another provider that would receive more referrals than UHSM, or UHSM would receive less than [25-35]% of referrals switching from CMFT's Trafford General Hospital, but would still receive more referrals than any other provider. These specialties are coloured amber in Table 7.7.
    i. In *Endocrinology*, Salford Royal would receive [40-50]% of referrals switching from CMFT's Trafford General Hospital compared with [30-40]% switching to UHSM.
    ii. In *Chemical Pathology*, UHSM would receive [10-20]% of referrals switching from CMFT's Trafford General Hospital, while Altrincham Hospital would receive [70-80]%. This analysis, however, is based on less than 100 GP referrals.
    iii. In *Clinical Haematology*, UHSM would receive [20-30]% of referrals switching from CMFT's Trafford General Hospital, while Altrincham Hospital would receive [30-40]%. Salford Royal would receive [20-30]% of referrals switching from CMFT's Trafford General Hospital. This implies that Salford Royal and UHSM are both close competitors for GP referrals to Trafford General Hospital in Clinical Haematology.
    iv. In *General Medicine*, UHSM would receive [20-30]% of referrals switching from CMFT's Trafford General Hospital, while its Oxford Road site would receive [30-40]% and Altrincham Hospital would receive [10-20]%. The provider that would receive the second largest share of referrals after UHSM was Care UK at [0-10]%.
    v. In Gynaecology, UHSM would receive [20-30]% of referrals switching from CMFT's Trafford General Hospital, while its Oxford Road site would receive [20-30]%. The provider that would receive the second largest share of referrals after Salford Royal at [10-20]%.

- In six specialties, UHSM would receive neither more than [30-40]% of referrals switching from CMFT's Trafford General Hospital nor would it be the provider

receiving the largest proportion of referrals switching from UHSM. These specialties are coloured green in Table 7.7.

i. In *Audiology*, UHSM was the provider that would receive the second largest proportion of referrals switching from CMFT's Trafford General Hospital at [20-30]% behind Specsavers on [50-60]%.
ii. In *ENT*, UHSM would receive [20-30]% behind Care UK at [20-30]%.
iii. In *General Surgery*, UHSM would receive [20-30]% behind Care UK at [30-40]%.
iv. In *Oral Surgery*, UHSM would receive 10% behind Salford Royal at [40-50]%.
v. In Pain Management, UHSM would receive [20-30]% behind Salford Royal at [40-50]%.
vi. In *Trauma & Orthopaedics*, UHSM would receive [10-20]% behind Care UK at [40-50]%.

Table 7.7: GP referral analysis for first outpatient appointments in overlap specialties at CMFT's Trafford General Hospital

		Proportion of referrals that would switch to:		
Overlap specialty	**Referrals from GPs that can be analysed**	**UHSM (and UHSM's ranking as alternative provider)**	**CMFT Oxford Road**	**Altrincham Hospital**
Audiology	[700-800]	[20-30]% (2nd)	[0-5]%	[10-20]%
Cardiology	[1,000-2,000]	[50-60]% (1st)	[10-20]%	[10-20]%
Chemical Pathology	[0-100]	[10-20]% (=1st)	[0-5]%	[70-80]%
Clinical Haematology	[400-500]	[20-30]% (1st)	[10-20]%	[30-40]%
Dermatology	[1,000-2,000]	[40-50]% (1st)	[0-5]%	[20-30]%
Diabetic Medicine	[200-300]	[30-40]% (1st)	[10-20]%	[10-20]%
Endocrinology	[100-200]	[30-40]% (2nd)	[10-20]%	[0-5]%
ENT	[2,000-3,000]	[20-30]% (2nd)	[5-10]%	[10-20]%
Gastroenterology	[1,000-2,000]	[40-50]% (1st)	[10-20]%	[0-5]%
General Medicine	[300-400]	[20-30]% (1st)	[30-40]%	[10-20]%
General Surgery	[600-700]	[20-30]% (2nd)	[10-20]%	[5-10]%
Geriatric Medicine	[200-300]	[40-50]% (1st)	[0-5]%	[30-40]%
Gynaecology	[1,000-2,000]	[20-30]% (1st)	[20-30]%	[5-10]%
Oral Surgery	[100-200]	[10-20]% (2nd)	[30-40]%	[0-5]%
Pain Management	[500-600]	[20-30]% (2nd)	[0-5]%	[10-20]%
Paediatrics	[2,000-3,000]	[60-70]% (1st)	[20-30]%	[0-5]%
Respiratory Medicine*	[400-500]	[40-50]% (1st)	[5-10]%	[10-20]%
Rheumatology	[400-500]	[30-40]% (1st)	[10-20]%	[20-30]%
Trauma & Orthopaedics	[2,000-3,000]	[10-20]% (2nd)	[5-10]%	[10-20]%
Urology	[800-900]	[40-50]% (1st)	[0-10]%	[5-10]%
Vascular Surgery	[0-100]	[30-40]% (1st)	[50-60]%	[5-10]%

* For Diabetic Medicine and Respiratory Medicine analysis of 2015-16 GP referrals shows that a material number of referrals at Trafford General would switch to CMFT's Stretford Hospital, which is now closed. This figure is 12% for Diabetic Medicine and 15% for Respiratory Medicine.
Source: Aldwych Partners analysis of HES data

CMFT's Altrincham Hospital

239. At CMFT's Altrincham Hospital, there are 19 overlap specialties where it is possible to carry out the GP referral analysis.

- In 18 specialties, UHSM would receive [30-40]% or more of the referrals that switched from CMFT's Altrincham Hospital, and would also receive more referrals switching than any other provider. These specialties are coloured red in Table 7.8. In six of these specialties, this analysis was based on less than 100 GP referrals (*Diabetic Medicine*, *Endocrinology*, *Gastroenterology*, *General Medicine*, *Geriatric Medicine*, and *Vascular Surgery*).

- In one specialty (*Chemical Pathology*), UHSM would receive less than [30-40]% of referrals switching from CMFT's Altrincham Hospital, but would still receive more referrals than any other provider. In this case, [50-60]% of referrals to Altrincham Hospital would switch to Trafford Hospital. However, this analysis is based on less than 100 GP referrals.

Table 7.8: GP referral analysis for first outpatient appointments in overlap specialties at CMFT's Altrincham Hospital

		Proportion of referrals that would switch to:		
Overlap specialty	**Referrals from GPs that can be analysed**	**UHSM (and UHSM's ranking as alternative provider)**	**CMFT Oxford Road**	**Trafford Hospital**
Audiology	[700-800]	[40-50]% (1st)	[0-5]%	[20-30]%
Cardiology	[100-200]	[60-70]% (1st)	[5-10]%	[20-30]%
Chemical Pathology	[0-100]	[20-30]% (1st)	[0-5]%	[50-60]%
Clinical Haematology	[100-200]	[30-40]% (1st)	[0-5]%	[50-60]%
Dermatology	[800-900]	[40-50]% (1st)	[0-5]%	[30-40]%
Diabetic Medicine	[0-100]	[50-60]% (1st)	[0-5]%	[40-50]%
Endocrinology	[0-100]	[50-60]% (1st)	[5-10]%	[10-20]%
ENT	[1,000-2,000]	[50-60]% (1st)	[0-5]%	[20-30]%
Gastroenterology	[0-100]	[60-70]% (1st)	[0-5]%	[20-30]%
General Medicine	[0-100]	[40-50]% (1st)	[5-10]%	[30-40]%
General Surgery	[200-300]	[40-50]% (1st)	[5-10]%	[10-20]%
Geriatric Medicine	[0-100]	[40-50]% (1st)	[0-5]%	[50-60]%
Gynaecology	[100-200]	[40-50]% (1st)	[5-10]%	[20-30]%
Pain Management	[100-200]	[40-50]% (1st)	[0-5]%	[20-30]%
Respiratory Medicine	[100-200]	[60-70]% (1st)	[0-5]%	[20-30]%
Rheumatology	[300-400]	[50-60]% (1st)	[5-10]%	[20-30]%
Trauma & Orthopaedics	[900-1,000]	[40-50]% (1st)	[0-5]%	[10-20]%
Urology	[100-200]	[60-70]% (1st)	[0-5]%	[10-20]%
Vascular Surgery	[0-100]	[60-70]% (1st)	[20-30]%	[5-10]%

Source: Aldwych Partners analysis of HES data

UHSM's Wythenshawe Hospital

240. Of the 22 specialties there is a sufficient number of referrals from GP practices that allow the GP referral analysis to be carried out, 22 specialties are offered at UHSM's Wythenshawe Hospital. In 18 of these 22 specialties, CMFT would receive either more than 30% of referrals for first outpatient appointments that switched from Wythenshawe Hospital, or would receive more of these referrals than any other provider.

    - In 11 specialties, CMFT would receive [20-40]% or more of the referrals that switched from Wythenshawe Hospital, and is also the provider that would receive the most referrals.

    - In two specialties (Endocrinology and Pain Management), CMFT would receive more than [30-40]% of referrals switching from Wythenshawe Hospital, but would not receive the largest quantity of referrals. Salford Royal would receive [40-50]% of Endocrinology referrals, and [30-40]% of Pain Management referrals, switching from Wythenshawe Hospital.

    - In five specialties (Dermatology, ENT, Gastroenterology, Rheumatology and Urology), CMFT would receive less than [30-40]% of the referrals that switched from Wythenshawe Hospital, but would be the provider that would receive the most referrals. Most of these referrals would switch to Withington Hospital in the first instance.

Table 7.9: GP referral analysis for first outpatient appointments in overlap specialties at UHSM's Wythenshawe Hospital

		Proportion of referrals that would switch to:	
Overlap specialty	**Referrals from GPs that can be analysed**	**CMFT (and CMFT's ranking as alternative provider)**	**Withington**
Anaesthetics	[0-100]	[5-10]% (>3rd)	[0-5]%
Anticoagulant Service	[300-400]	[20-30]% (2nd)	[0-5]%
Audiology	[200-300]	[10-20]% (2nd)	[50-60]%
Cardiology	[7,000-8,000]	[50-60]% (1st)	[5-10]%
Chemical Pathology	[0-100]	[90-100]% (1st)	[0-5]%
Clinical Haematology	[400-500]	[40-50]% (1st)	[30-40]%
Dermatology	[500-600]	[20-30]% (1st)	[50-60]%
Diabetic Medicine	[300-400]	[40-50]% (1st)	[30-40]%
Endocrinology	[900-1,000]	[40-50]% (2nd)	[0-5]%
ENT	[4,000-5,000]	[20-30]% (1st)	[40-50]%
Gastroenterology	[2,000-3,000]	[10-20]% (1st)	[60-70]%
General Medicine	[2,000-3,000]	[60-70]% (1st)	[0-5]%
General Surgery	[3,000-4,000]	[10-20]% (2nd)	[20-30]%
Geriatric Medicine	[600-700]	[50-60]% (1st)	[0-5]%
Gynaecology	[4,000-5,000]	[30-40]% (1st)	[10-20]%
Infectious Diseases	[0-100]	[0-5]% (3rd)	[0-5]%
Midwife Episodes	[500-600]	[0-5]%	[60-70]%
Obstetrics	[1,000-2,000]	[70-80]% (1st)	[0-10]%
Oral Surgery	[100-200]	[40-50]% (1st)	[0-5]%
Paediatric Cardiology	[100-200]	90-100% (1st)	[0-5]%
Paediatric Surgery	[400-500]	[30-40]% (1st)	[0-5]%
Paediatric Urology	[200-3000]	[80-90]% (1st)	[0-5]%
Paediatrics	[3,000-4,000]	[60-70]% (1st)	[0-5]%
Pain Management	[1,000-2,000]	[30-40]% (2nd)	[0-5]%
Physiotherapy	[3,000-4,000]	[0-5]% (>3rd)	[80-90]%
Plastic Surgery	[1,000-2,000]	[30-40]% (1st)	[0-5]%
Respiratory Medicine	[3,000-4,000]	[40-50]% (1st)	[20-30]%
Rheumatology	[800-900]	[10-20]% (1st)	[50-60]%
Speech & Language Therapy	[0-100]	[0-5]%	[0-5]%
Trauma & Orthopaedics	[6,000-7,000]	[20-30]% (3rd)	[0-5]%
Urology	[2,000-3,000]	[10-20]% (1st)	[40-50]%
Vascular Surgery	[2,000-3,000]	[70-80]% (1st)	[0-5]%

Source: Aldwych Partners analysis of HES data

UHSM's Withington Hospital

241. At UHSM's Withington Hospital, there are 16 overlap specialties where it is possible to carry out the GP referral analysis.

- In six specialties, CMFT would receive [30-405]% or more of the referrals that switched from Withington Hospital, and would also receive more referrals switching than any other provider. These specialties are coloured red in Table 7.10. In one of these specialties, this analysis was based on less than 100 GP referrals (*Obstetrics*).

- In six specialties, CMFT would either receive [30-40]% or more of the referrals that switched from Withington Hospital, but there would be another provider that would receive more referrals than CMFT, or CMFT would receive less than [30-40]% of referrals switching from Withington Hospital, but would still receive more referrals than any other provider. These specialties are coloured amber in Table 7.10.

    i. In *Cardiology*, CMFT would receive [10-20]% of referrals switching from Withington Hospital, while UHSM's Wythenshawe Hospital would receive [70-80]%. The next largest provider would be Tameside with [5-10]%.

    ii. In *ENT*, CMFT would receive [20-30]% of referrals switching from Withington Hospital, while UHSM's Wythenshawe Hospital would receive [40-50]%. The next largest provider would be Care UK with [10-20]%.

    iii. In *Gastroenterology*, CMFT would receive [20-30]% of referrals switching from Withington Hospital, while UHSM's Wythenshawe Hospital would receive [50-60]%. The next largest provider would be BMI Healthcare with [5-10]%.

    iv. In *Respiratory Medicine*, CMFT would receive [10-20]% of referrals switching from Withington Hospital, while UHSM's Wythenshawe Hospital would receive [70-80]%. The next largest provider would be East Cheshire NHS Trust with [5-10]%.

    v. In *Trauma & Orthopaedics*, CMFT would receive [10-20]% of referrals switching from Withington Hospital, while UHSM's Wythenshawe Hospital would receive [35-45]%. Care UK would also receive [10-20]% of referrals while BMI Healthcare would receive [10-20]%.

    vi. In *Urology*, CMFT would receive [20-30]% of referrals switching from Withington Hospital, while UHSM's Wythenshawe Hospital would receive [40-50]%. The next largest provider would be Care UK with [10-20]%.

- In four specialties, CMFT would receive neither more than [30-40]% of referrals switching from Withington Hospital nor would it be the provider receiving the largest proportion of referrals switching from that site. These specialties are coloured green in Table 7.10.

    i. In Audiology, the provider with the largest share of referrals switching from Withington Hospital would be Specsavers with [70-80]%.

    ii. In General Surgery, the provider with the largest share of referrals switching from Withington Hospital would be Care UK with [10-20]%.

Table 7.10: GP referral analysis for first outpatient appointments in overlap specialties at UHSM's Withington Hospital

		Proportion of referrals that would switch to:	
Overlap specialty	**Referrals from GPs that can be analysed**	**CMFT (and CMFT's ranking as alternative provider)**	**Wythenshawe**
Audiology	[3,000-4,000]	[5-10]% (2nd)	[10-20]%
Cardiology	[0-100]	[10-20]% (1st)	[70-80]%
Clinical Haematology	[200-300]	[40-50]% (1st)	[30-40]%
Dermatology	[3,000-4,000]	[40-50]% (1st)	[20-30]%
Diabetic Medicine	[100-200]	[30-40]% (1st)	[50-60]%
ENT	[5,000-6,000]	[20-30]% (1st)	[40-50]%
Gastroenterology	[2,000-3,000]	[20-30]% (1st)	[50-60]%
General Surgery	[1,000-2,000]	[10-20]% (=2nd)	[30-40]%
Gynaecology	[600-700]	[30-40]% (1st)	[30-40]%
Midwife Episode	[200-300]	[0-5]%	[90-100]%
Obstetrics	[0-100]	[40-50]% (1st)	[40-50]%
Physiotherapy	[9,000-10,000]	[0-5]% (3rd)	[80-90]%
Respiratory Medicine	[200-300]	[10-20]% (1st)	[70-80]%
Rheumatology	[2,000-3,000]	[30-40]% (1st)	[30-40]%
Trauma & Orthopaedics	[100-200]	[10-20]% (=1st)	[30-40]%
Urology	[2,000-3,000]	[20-30]% (1st)	[40-50]%

Source: Aldwych Partners analysis of HES data

Summary of first outpatient appointment results

242. Table 7.11 summarises the results of the analysis of GP referrals for first outpatient appointments by specialty according to the Red, Amber, Green categorisation used above. That is:

- *Red*: the other merging Trust would receive more than 30% of referrals switching from the hospital that is being analysed, and would also receive the largest proportion of referrals switching to other Trusts.
- *Amber*: either (i) the other merging Trust would receive more than 30% of referrals switching from the hospital that is being analysed, but not the largest proportion of referrals switching to other Trusts; or (ii) the other merging Trust would receive less than 30% of referrals switching from the hospital that is being analysed, but would still receive the largest proportion of referrals switching to other Trusts.
- *Green*: the other merging Trust would receive less than 30% of the referrals switching from the hospital that is being analysed, and also not the largest proportion of referrals switching to other Trusts.

Table 7.11: Summary of GP referral analysis for first outpatient appointments

	Number of CMFT and UHSM hospitals in each category		
	Red	**Amber**	**Green**
Vascular Surgery	4 (Ox, T, A, Wy)		
Geriatric Medicine	4 (Ox, T, A, Wy)		
Clinical Haematology	4 (Ox, A, Wy, Wi)	1 (T)	
Cardiology	4 (Ox, T, A, Wy)	1 (Wi)	
Dermatology	4 (Ox, T, A, Wi)	1 (Wy)	
Respiratory Medicine	4 (Ox, T, A, Wy)	1 (Wi)	
Diabetic Medicine	4 (T, A, Wy, Wi)	1 (Ox)	
Rheumatology	4 (Ox, T, A, Wi)	1 (Wy)	
Obstetrics	3 (Ox, Wy, Wi)		
Paediatrics	3 (Ox, T, Wy)		
Gastroenterology	3 (Ox, T, A)	2 (Wy, Wi)	
Urology	3 (Ox, T, A)	2 (Wy, Wi)	
Gynaecology	3 (A, Wy, Wi)	2 (Ox, T)	
General Medicine	2 (A, Wy)	1 (T)	1 (Ox)
Paediatric Cardiology	2 (Ox, Wy)		
Paediatric Surgery	2 (Ox, Wy)		
Paediatric Urology	2 (Ox, Wy)		
Plastic Surgery	2 (Ox, Wy)		
Chemical Pathology	1 (Wy)	2 (T, A)	
Endocrinology	1 (A)	3 (Ox, T, Wy)	
ENT	1 (A)	2 (Wy, Wi)	2 (Ox, T)
Trauma & Orthopaedics	1 (A)	1 (Wi)	3 (Ox, T, Wy)
Pain Management	1 (A)	1 (Wy)	1 (T)
General Surgery	1 (A)		4 (Ox, T, Wy, Wi)
Audiology	1 (A)		3 (T, Wy, Wi)
Oral Surgery	1 (Wy)		2 (Ox, T)
Physiotherapy	1 (Ox)		2 (Wy, Wi)
Paediatric Plastic Surgery	1 (Ox)		
Anticoagulant service		1 (Ox)	1 (Wy)
Infectious Diseases			2 (Ox, Wy)
Midwife Episode			2 (Wy, Wi)
Speech & Language Therapy			1 (Wy)
Anaesthetics			1 (Wy)
Nephrology			1 (Ox)
Gynaecological Oncology			1 (Ox)

Note: Ox – CMFT's Oxford Road site; T – Trafford General Hospital; A – Altrincham Hospital; Wy – Wythenshawe Hospital; Wi – Withington Hospital
Source: Aldwych Partners

243. There are eight specialties where four of the five CMFT and UHSM hospitals are in the red category, and a further five specialties where three of the five CDFT and UHSM hospitals are in the red category. At the other end of the spectrum, there are seven specialties

where all CMFT and UHSM hospitals providing services in these specialties are in the green category.

244. Section 7.4 sets out various specialty-specific factors that are relevant to assessing whether the merger gives rise to an SLC in each of these routine elective care specialties. We expect that the CMA will be better able to fully take these factors into account in its Phase 2 review of the planned merger.

7.2.5 Day-case services

245. In 2015-16, CMFT reported carrying out ten or more day-cases in 43 specialties, while UHSM reported carrying out ten or more day-cases in 24 specialties. Both Trusts provided day-case services in 18 of the same specialties. This accounted for around 40% of the total number of specialties at CMFT where it provided day-case services (and 51% of all day-case admissions in 2015-16), and 75% of the total number of specialties at UHSM where it provided day-case services (and 75% of all day-case admissions in 2015-16).[95]

246. As set out in Section 7.3.1, neither the patient nor their referring GP knows with certainty, when the GP refers the patient for a first outpatient appointment, what package of treatment services will be supplied to the patient. This includes whether or not the patient will require day-case surgery.

247. It follows that there is no coherent conceptual basis for analysing the choice of provider made by those patients that end up receiving day case surgery separately from those patients that do not receive day case surgery. Neither group of patients (or referring GPs) knows, with certainty, when choosing a provider whether they will have day case surgery.

248. As a result, all patients (and their referring GPs), regardless of whether they end up having day case surgery, can be expected to take into account in selecting a provider the possibility that they will have day case surgery. That is, there is no basis for differentiating between those patients that do, and do not, ultimately undergo day case surgery.

249. In addition to the conceptual problem associated with seeking to analyse the choices of patients that have had day case surgery separately from those that have not had this surgery, there are practical difficulties with seeking to apply the GP referral analysis to HES data in relation to patients that have had day case surgery. This is because it is not possible to identify those patients who have been admitted for day-case surgery (or elective inpatient treatment) on the basis of a GP referral separately from those patients who have been referred from another source.

250. As referrals from clinicians other than GPs account for 72% and 40% of first outpatient appointments at CMFT and UHSM, then it can be expected that many patients having day-case surgery will have been initially referred to their provider by someone other than their registered GP. For the GP referral analysis to be accurate, however, it should only be based on patients that have actually been referred for treatment by their GP. Carrying out such an analysis, based only on those patients referred by their GP, for day case surgery (or elective inpatient surgery) is not possible given the data issue outlined above.

[95] See Appendix 7.6 for further details on specialty-level overlaps between CMFT and UHSM.

251. The Trusts understand that, notwithstanding these issues, the CMA will wish to see the results of the GP referral analysis, as applied to day case services, in any event. The results of this analysis are set out in Tables 7.12 to 7.15.[96] These are colour coded consistent with the methodology set out above for first outpatient appointments. No commentary is offered on the results given that the Trusts believe that the results of the analysis are meaningless.

Table 7.12: CMFT Oxford Road - GP referral analysis for day-case admissions

Specialty	No. day case admissions	Proportion of referrals switching to UHSM (and ranking of UHSM as alternative)	Proportion of referrals that would switch to Trafford General
Cardiology	[1,000-2,000]	[30-40]% (1st)	[5-10]%
Endocrinology	[200-300]	[0-5]% (>3rd)	[0-5]%
ENT	[700-800]	[10-20]% (1st)	[10-20]%
Gastroenterology	[13,000-14,000]	[30-40]% (1st)	[5-10]%
General Medicine	[100-200]	[0-5]% (>3rd)	[10-20]%
General Surgery	[700-800]	[10-20]% (>3rd)	[20-30]%
Gynaecology	[4,000-5,000]	[10-20]% (1st)	[5-10]%
Gynaecological Oncology	[100-200]	[70-80]% (1st)	[0-5]%
Nephrology	[1,000-2,000]	[0-5]% (>3rd)	[0-5]%
Oral Surgery	[1,000-2,000]	[10-20]% (2nd)	[5-10]%
Paediatric Surgery	[1,000-2,000]	[10-20]% (3rd)	[10-20]%
Paediatric Urology	[1,000-2,000]	[50-60]% (1st)	[0-5]%
Paediatrics	[600-700]	[20-30]% (1st)	[0-5]%
Respiratory Medicine	[400-500]	[30-40]% (1st)	[0-5]%
Rheumatology	[800-900]	[30-40]% (1st)	[0-5]%
Trauma & Orthopaedics	[0-100]	[5-10]% (>3rd)	[20-30]%
Urology	[2,000-3,000]	[30-40]% (1st)	[10-20]%
Vascular Surgery	[800-900]	[40-50]% (1st)	[0-5]%

Note: No day case admissions are made at Altrincham Hospital so there is no internal diversion to this site.
Source: Aldwych Partners analysis of HES data

[96] Supporting data for the analysis of day case admissions is set out in Appendix 7.7.

Table 7.13: Trafford General Hospital - GP referral analysis for day-case admissions

Specialty	No. day case admissions	Proportion of referrals that would switch to UHSM (and ranking of UHSM as alternative)	Proportion of referrals that would switch to CMFT Oxford Road site
Cardiology	[0-100]	[30-40]% (1st)	[50-60]%
ENT	[600-700]	[40-50]% (1st)	[20-30]%
Gastroenterology	[2,000-3,000]	[20-30]% (1st)	[40-50]%
General Medicine	[700-800]	[10-20]% (2nd)	[30-40]%
General Surgery	[2,000-3,000]	[50-60]% (1st)	[10-20]%
Gynaecology	[600-700]	[30-40]% (1st)	[50-60]%
Oral Surgery	[300-400]	[40-50]% (1st)	[40-50]%
Paediatric Surgery	[0-100]	[0-5]% (2nd)	[80-90]%
Pain Management	[800-900]	[40-50]% (1st)	[0-5]%
Respiratory Medicine	[0-100]	[40-50]% (1st)	[20-30]%
Trauma & Orthopaedics	[2,000-3,000]	[20-30]% (1st)	[0-5]%
Urology	[1,000-2,000]	[50-60]% (1st)	[20-30]%

Note: No day case admissions are made at Altrincham Hospital so there is no internal diversion to this site.
Source: Aldwych Partners analysis of HES data

Table 7.14: Wythenshawe Hospital - GP referral analysis for day-case admissions

Specialty	No. day case admissions	Proportion of referrals that would switch to CMFT (and ranking of CMFT as alternative)	Proportion of referrals that would switch to Withington Hospital
Cardiology	[2,000-3,000]	[30-40]% (1st)	[0-5]%
Endocrinology	[0-100]	[5-10]% (3rd)	[0-5]%
ENT	[800-900]	[40-50]% (1st)	[5-10]%
Gastroenterology	[5,000-6,000]	[70-80]% (1st)	[0-5]%
General Medicine	[0-100]	[40-50]% (1st)	[0-5]%
General Surgery	[4,000-5,000]	[40-50]% (1st)	[0-5]%
Gynaecology	[2,000-3,000]	[70-80]% (1st)	[0-5]%
Gynaecological Oncology	[100-200]	[90-100]% (1st)	[0-5]%
Interventional Radiology	[100-200]	[0-5]% (>3rd)	[0-5]%
Oral Surgery	[1,000-2,000]	[50-60]% (1st)	[0-5]%
Paediatric Surgery	[0-100]	[70-80]% (1st)	[0-5]%
Paediatric Urology	[100-200]	[90-100]% (1st)	[0-5]%
Paediatrics	[100-200]	[70-80]% (1st)	[0-5]%
Pain Management	[2,000-3,000]	[20-30]% (2nd)	[0-5]%
Respiratory Medicine	[1,000-2,000]	[10-20]% (2nd)	[0-5]%
Rheumatology	[700-800]	[30-40]% (2nd)	[0-5]%
Trauma & Orthopaedics	[1,000-2,000]	[20-30]% (2nd)	[0-5]%
Urology	[2,000-3,000]	[30-40]% (1st)	[30-40]%

Vascular Surgery	[400-500]	[70-80]% (1st)	[0-5]%

Source: Aldwych Partners analysis of HES data

Table 7.15: Withington Hospital - GP referral analysis for day-case admissions

Specialty	No. day case admissions	Proportion of referrals that would switch to CMFT (and ranking of CMFT as alternative)	Proportion of referrals that would switch to Wythenshawe Hospital
ENT	[0-100]	[20-30]% (1st)	[40-50]%
Trauma & Orthopaedics	[0-100]	[10-20]% (=1st)	[30-40]%
Urology	[600-700]	[20-30]% (1st)	[50-60]%

Source: Aldwych Partners analysis of HES data

252. Given the conceptual and practical issues outlined above, and the consequent lack of robustness that can be expected of any GP referral analysis that is applied to day-case or elective inpatient services, there is a question of the appropriate evidence base for assessing the merger' effect on day case (and elective inpatient) services.

253. The Trusts believe that the GP referral analysis, as applied to first outpatient appointments, is to some degree informative (putting to one side the Trusts overall concerns about the robustness of this methodology). This is because it reflects the preferences of patients/GPs when making a referral that could lead to a day-case admission (even if this only eventuates in a minority of cases).

254. The Trusts acknowledge that there can be shortcomings in applying the GP referral analysis in this way when not all providers offer day case (or elective inpatient) services in a specialty. In these circumstances, a provider could capture a significant share of first outpatient appointments, and then have to refer these patients on to other providers for day-case (or elective inpatient) services. However, CMFT and UHSM are not aware of any providers in the Greater Manchester or surrounding region that are offering this type of service.

255. The Trusts also believe that the evidence on proximity of other providers (Section 7.1) and catchment area overlaps (Section 7.2) is also relevant to any assessment of the effect on competition in day case and elective inpatient services of the CMFT/UHSM merger.

256. An alternative approach, as foreshadowed in Section 6, would be for the CMA to treat each specialty (where a direct referral by GP is possible) as a single product market (or frame of reference), and assess the competitive strength of different providers in this market (or frame of reference) according to whether they offer day-case and elective inpatient services. This would recognise that patients referred for treatment in a specialty will each consume a package of services that is suitable for their condition, and this may (or may not) include an admission for surgery as well as treatment by clinicians from other specialties (e.g. anaesthetics, occupational therapy, dietetics and so on).

7.2.6 Elective inpatient services

257. In 2015-16, CMFT reported carrying out more than 10 elective inpatient admissions in 46 specialties, while UHSM reported carrying out more than 10 elective inpatient admissions in 26 specialties. The two Trusts both provided services in 18 elective inpatient specialties.

258. These overlap specialties accounted for around 33% of the total number of specialties at CMFT where elective inpatient activity was recorded (and 47% of all elective inpatient admissions in 2015-16), and 60% of the total number of specialties at UHSM where elective inpatient activity was recorded (and 75% of all elective inpatient admissions in 2015-16).[97]

259. The results of applying the GP referral analysis to elective inpatient admissions at CMFT and UHSM are set out in Tables 7.16 to 7.18.[98] These are colour coded consistent with the methodology set out above for first outpatient appointments. No commentary is offered on these results given that the Trusts believe that the application of this analysis to elective inpatient admissions data is meaningless.

260. These tables also include the results of analysing maternity admissions. For the purposes of this analysis, midwife episodes and obstetrics have been combined together with all day case, elective inpatient and non-elective admissions. Child birth is classified as a non-elective event, and consistent with the CMA's approach in past acute trust merger reviews, the GP referral analysis has included this activity.

Table 7.16: CMFT's Oxford Road site - GP referral analysis for elective inpatient admissions

Specialty	No. elective inpatient admissions	Proportion of referrals that would switch to UHSM (and ranking of UHSM as alternative)	Proportion of referrals that would switch to Trafford General
Cardiac Surgery	[400-500]	[70-80]% (1st)	[0-5]%
Cardiology	[900-1,000]	[40-50]% (1st)	[0-5]%
ENT	[400-500]	[20-30]% (1st)	[0-5]%
Gastroenterology	[900-1,000]	[30-40]% (1st)	[5-10]%
General Medicine	[0-100]	[0-5]%	[20-30]%
General Surgery	[1,000-2,000]	[20-30]% (1st)	[0-5]%
Gynaecology	[1,000-2,000]	[20-30]% (1st)	[0-5]%
Gynaecological Oncology	[300-400]	[10-20]% (>3rd)	[0-5]%
Midwife Episodes & Obstetrics	[19,000-20,000]	[30-40]% (1st)	[0-5]%
Oral Surgery	[400-500]	[20-30]% (2nd)	[0-5]%
Paediatrics	[0-100]	[20-30]% (1st)	[0-5]%
Respiratory Medicine	[0-100]	[80-90]% (1st)	[0-5]%
Transplantation Surgery	[700-800]	[10-20]% (>3rd)	[0-5]%
Trauma & Orthopaedics	[200-300]	[10-20]% (=1st)	[20-30]%
Urology	[1,000-2,000]	[30-40]% (1st)	[0-5]%
Vascular Surgery	[400-500]	[50-60]% (1st)	[0-5]%

Note: There was no internal diversion to Altrincham Hospital in any specialty (as no elective inpatient admissions are carried out at Altrincham Hospital).
Source: Aldwych Partners analysis of HES data

[97] See Appendix 7.6 for further details on specialty-level overlaps between CMFT and UHSM.
[98] Supporting data for the analysis of elective inpatient admissions is set out in Appendix 7.7.

Table 7.17: Trafford General Hospital - GP referral analysis for elective inpatient admissions

Specialty	No. elective inpatient admissions	Proportion of referrals that would switch to UHSM (and ranking of UHSM as alternative)	Proportion of referrals that would switch to CMFT main site
Cardiology	[0-100]	[50-60]% (1st)	[40-50]%
Gastroenterology	[0-100]	[30-40]% (1st)	[50-60]%
General Medicine	[0-100]	[10-20]% (2nd)	[40-50]%
General Surgery	[0-100]	[20-30]% (1st)	[50-60]%
Trauma & Orthopaedics	[1,000-2,000]	[20-30]% (1st)	[10-20]%

Note: There was no internal diversion to Altrincham Hospital in any specialty (as no elective inpatient admissions are carried out at Altrincham Hospital).
Source: Aldwych Partners analysis of HES data

Table 7.18: UHSM's Wythenshawe Hospital - GP referral analysis for elective inpatient admissions

Specialty	Total no. elective inpatient events at Wythenshawe Hospital	Proportion of referrals that would switch to CMFT (and ranking of CMFT as alternative)
Cardiac Surgery	[700-800]	[80-90]% (1st)
Cardiology	[1,000-2,000]	[40-50]% (1st)
ENT	[600-700]	[30-40]% (1st)
Gastroenterology	[400-500]	[60-70]% (1st)
General Surgery	[1,000-2,000]	[40-50]% (1st)
Gynaecology	[600-700]	[50-60]% (1st)
Gynaecological Oncology	[0-100]	-
Midwife Episodes & Obstetrics	[5,000-6,000]	[60-70]% (1st)
Oral Surgery	[200-300]	[40-50]% (1st)
Paediatrics	[100-200]	[50-60]% (1st)
Respiratory Medicine	[1,000-2,000]	[0-10]% (>3rd)
Rheumatology	[0-100]	[0-5]%
Trauma & Orthopaedics	[1,000-2,000]	[20-30]% (2nd)
Urology	[1,000-2,000]	[40-50]% (1st)
Vascular Surgery	[500-600]	[60-70]% (1st)

Note: There was no internal diversion to Withington Hospital in any specialty (as no elective inpatient admissions are carried out at Withington Hospital).
Source: Aldwych Partners analysis of HES data

7.3 Specialty-specific factors relevant to merger assessment

261. This section discusses several factors that need to be taken into account when interpreting the results of the GP referral analysis and understanding the implications for the merger's effect on competition in various specialties. These include:
    - service reconfigurations in various specialties (Section 7.4.1);
    - differences in the types of services that are provided by CMFT and UHSM within individual specialties (Section 7.4.2)

- differences in coding between CMFT, UHSM and other acute trusts in Greater Manchester and the surrounding area (Section 7.4.3); and
- the importance of choice-based referrals and the impact this has on incentives to improve quality as a means of attracting referrals (Section 7.4.4).[99]

7.3.1 Service reconfigurations

262. Plans for the reconfiguration of several services are set out in Section 4.3. This sets out the Trusts' conclusion, that without the merger, competition between CMFT and UHSM would be removed in the following specialties (or sub-specialties) as a result of commissioners' reconfiguration plans:
    - OG Cancer;
    - Urology Cancer;
    - Gynaecological Cancer;
    - Paediatric Surgery (and related specialties);
    - Vascular Surgery; and
    - high risk General Surgery.[100]

263. This means that the results of the GP referral analysis in relation to Paediatric Surgery, Paediatric Cardiology, Paediatric Urology and Vascular Surgery can be disregarded. The GP referral analysis reflects a configuration of service provision that will not continue in the future, and patients can be expected to no longer be able to choose between CMFT and UHSM.

264. Gynaecological Oncology is similarly affected as a result of UHSM no longer providing this service. Further, as a cancer-related service, patient choice does not apply in any event.

265. OG Cancer, Urology Cancer and high risk General Surgery do not map completely on to a single TFC-based specialty (which is the basis for the GP referral analysis).

    - OG Cancer is part of a broader set of services that are coded to General Surgery. the GP referral analysis shows that CMFT and UHSM are not particularly close competitors in General Surgery (see Table 7.11). The planned reconfiguration of OG Cancer services will only further reduce the degree of competition between the two Trusts in this specialty.

    - Urology Cancer is a subset of services that are provided in the Urology specialty. The reconfiguration plans for Urology Cancer will remove competition between CMFT and UHSM in relation to these services, but not in relation to non-cancer urology services. Commissioners, however, are planning further service changes in relation to benign Urology (see Section 4.3), and the Trusts believe that in the absence of the merger this would, if implemented, be likely to limit competition between the two Trusts in this specialty. The GP referral analysis infers that UHSM is a strong competitor for CMFT

[99] Clinical networks in a specialty, where outpatient activity may be provided by several Trusts but inpatient activity is only provided one Trust, can also affect how the results of the GP referral analysis should be interpreted. In this regard, UHSM has service level agreements (SLAs) with East Cheshire, Stockport and Tameside acute trusts in relation to Plastic Surgery, ENT and Vascular Surgery, and with The Christie in relation to Urology. Under these agreements, UHSM is providing consultants to carry out outpatient clinics at these Trusts. Copies of these SLAs are at Appendix 7.8. The way in which the Trusts are reporting resulting activity, in terms of attributing it to either UHSM or the host acute trust, appears to be variable across the Trusts.

[100] Section 4.3 also sets out the Trusts' view that implementation of these reconfiguration plans are likely to dependent on the CMFT/UHSM merger. As a result, the benefits from these reconfigurations are attributable to the merger, and are claimed as such by the Trusts in their submission on patient benefits.

patient referrals in this specialty, but not quite so strong in the other direction. However, as a result of the planned service reconfigurations, the number of referrals over which CMFT and UHSM compete will reduce, and this could be a large proportion of the total once reconfigurations in relation to both Urology Cancer and Benign Urology are in place.

- High risk General Surgery is part of the wider General Surgery specialty. The planned reconfiguration of high risk General Surgery means that CMFT and UHSM will no longer compete in this service, and competition will only remain in low risk General Surgery. UHSM, if it remained independent, would provide a weaker constraint on CMFT given that it could no longer offer the same breadth of service in General Surgery as CMFT. Further the volume of patients that UHSM would treat in General Surgery would reduce. In any event, the GP referral analysis shows that CMFT and UHSM are not particularly close competitors in General Surgery (see Table 7.11). The planned reconfiguration of services in this specialty will only further reduce the degree of competition between the two Trusts.

266. The Trusts also set out in Section 4.3 the likely impact of service reconfiguration plans in Orthopaedics on competition between CMFT and UHSM. The Trusts note, however, that the GP referral analysis does not indicate that competition between the two Trusts in relation to this specialty will be adversely affected by their proposed merger. As a result, the implications of planned service reconfiguration plans for orthopaedics on competition between CMFT and UHSM and the results of the GP referral analysis are not considered further.

7.3.2 Differences between CMFT and UHSM services and patient cohorts

267. The results of the GP referral analysis may infer closeness of competition between CMFT and UHSM in a specialty, but this may be misleading where the two Trusts are providing significantly different services and/or treating significantly different patient cohorts within that specialty. Where this is the case, it means that, in practice, some of the referrals that are made to CMFT, or UHSM, in a particular specialty could not switch to the other Trust as the other Trust would not have the ability to treat those patients.

268. Where CMFT or UHSM provides a specialised service in a specialty, which is not provided by the other Trust, then it can be expected that those patients receiving the specialised service at CMFT, or UHSM, could not be treated at the other Trust.

- To the extent that specialised services at CMFT or UHSM are accessed by way of a consultant to consultant referral, then the effects of these specialised services on the results of the GP referral analysis for first outpatient appointments, as set out in this section, will have been screened out. This is because our GP referral analysis for first outpatient appointments is based only on GP referrals, and excludes consultant to consultant referrals.

- CMFT and UHSM, however, submit that several of their specialised services are accessed through direct referrals by GPs into those services, and not just from consultant to consultant referrals. This means that the interpretation of the results of the GP referral analysis needs to take into account the fact that referrals in some specialties could not switch between CMFT and UHSM.

269. The main specialties where CMFT and UHSM believe that GPs are making referrals directly to specialised services at CMFT or UHSM that could not switch to the other Trust are the following:
    - Obstetrics (and maternity services generally) and Gynaecology;
    - Paediatric specialties, including Paediatrics, Paediatric Cardiology, Paediatric Urology, Paediatric Surgery;
    - Oral Surgery
    - Respiratory Medicine; and
    - Plastic Surgery.

270. In Obstetrics and Gynaecology, the GP referral analysis implies that CMFT and UHSM are each other's closest competitor. However, St Mary's Hospital at CMFT is a specialist hospital for maternity and gynaecological services. GPs and local patients are aware of St Mary's status, and as a result, where an issue arises that they consider warrants more specialist services, patients will be referred directly to this hospital at CMFT.

271. An example of this is women who have had complications during a previous pregnancy. These women may have been referred to St Mary's during the course of their previous pregnancy to access its specialised services. In a subsequent pregnancy, these women will be referred directly to St Mary's Hospital at CMFT rather than their local hospital (e.g. UHSM or another acute trust in Greater Manchester). These referrals could not switch back to their local hospital, which the GP referral analysis implies, because their local hospital could not provide the appropriate treatment.

272. This means that the GP referral analysis will overstate the closeness of competition between CMFT and UHSM in both Obstetrics and Gynaecology.

273. A similar issue arises in relation to the various Paediatric specialties, including Paediatrics, Paediatric Cardiology, Paediatric Urology and Paediatric Surgery. The GP referral analysis implies that UHSM is CMFT's closest competitor in each of these specialties. However, the Royal Manchester Children's Hospital at CMFT is a regional specialist hospital for children. The vast majority of services that are provided at RMCH are specialised services that cannot be provided in District General Hospital paediatrics department. This is reflected in the commissioning arrangements for RMCH, which receives more than three quarters of its funding (77%) from NHS England through specialised services commissioning.

274. In Oral Surgery, where CMFT's University Dental Hospital is a specialist hospital it is also unlikely that many of the referrals that are made to CMFT could switch to UHSM due to the specialist nature of the service that is being provided at CMFT. The implications of this for interpreting the results of the GP referral analysis, however, do not be considered further given that UHSM is not inferred to be a close competitor to CMFT for referrals in this specialty.

275. In Respiratory Medicine and Plastic Surgery, UHSM is a regional provider of specialised services. The GP referral analysis implies that CMFT is UHSM's closest competitor for patient referrals in Respiratory Medicine and Plastic Surgery. However, in Plastic Surgery, UHSM had [8,000-9,000] first outpatient appointments in 2015-16 compared with [200-300] at CMFT (i.e. UHSM had 30 times more referrals than CMFT), while in Respiratory Medicine, UHSM had 2.5 times more referrals than CMFT. Considering referrals into these specialties that were made directly by GPs, UHSM still received ten times as many

referrals to its Plastic Surgery service than CMFT, and 3.5 times more referrals to its Respiratory Medicine than UHSM.

276. These figures are indicative that GPs are making direct referrals into the specialised services at UHSM in both of these specialties that could not switch to CMFT. This means that the results of the GP referral analysis, which is based only on referrals from GPs, in relation to both Respiratory Medicine and Plastic Surgery is overstating CMFT's closeness as a competitor to UHSM in these two specialties.

7.3.3 Coding differences between Trusts

277. Differences between how Trusts code activity can have a significant impact on the GP referral analysis. This was recognised in the CMA's review of the planned merger between Ashford & St Peter's NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust when, as a result of inconsistent coding patterns, a major local acute trust (Frimley Park Hospital NHS Foundation Trust) did not show up in the GP referral analysis as a competitor in several specialties.

278. Activity at Trusts in Greater Manchester has been reviewed to see whether inconsistent coding patterns can be identified. Table 7.19 shows the number of first outpatient appointments and inpatient admissions (grouping together day-case and elective inpatient admissions) at CMFT, UHSM and other acute trusts in Greater Manchester and the surrounding area.

279. Several observations can be made from this data, combined with other evidence that is indicative of coding differences between Trusts, which is impacting on the results of the GP referral analysis.

280. First, in Audiology, the only Trusts that are recording any activity are CMFT, UHSM, and St Helen's and Knowsley Hospital Services NHS Trust. However, most other acute trusts in Greater Manchester provide audiology services. This is likely to be impacting on the results of the GP referral analysis. However, given that the GP referral analysis does not show CMFT and UHSM as close competitors, other than in relation to the relatively small number of referrals that are made to CMFT's Altrincham Hospital, then this coding issue is unlikely to be material to the CMA's assessment of the effect of the merger. (This is because an adverse finding in relation to Audiology is unlikely in any event.)

281. Second, in Cardiology, Stockport NHS Foundation Trust did not record any first outpatient appointments during 2015-16 despite recording [1000,-2,000] patient admissions in this specialty. Given that Stockport would have had to have had first outpatient appointments in this specialty in order to be admitting patients, there appears to have been some kind of coding error. The implications for the GP referral analysis in relation to first outpatient appointments for Cardiology is that CMFT's and UHSM's closeness as competitors will have been overstated as the analysis will not have taken into account Stockport's presence as an alternative for patients in this specialty.

Table 7.19: Outpatient and inpatient activity, by NHS acute trust, Greater Manchester and vicinity, 2015-16

Treatment function	CMFT		UHSM		Bolton Foundation Trust		Countess of Chester Hospital NHS Foundation Trust		East Cheshire NHS Trust		Mid Cheshire Hospital NHS Foundation Trust		Pennine Acute Hospitals NHS Trust	
	OPFA	IP	OPFA	IP	OPFA	IP	OPFA	IP	OPFA	IP	OPFA	IP	OPFA	IP
Audiology	[3,000-4,000]	-	[3,000-4,000]	-	-	-	-	-	-	-	-	-	-	-
Cardiology	[21,000-22,000]	[2,000-3,000]	[19,000-20,000]	[3,000-4,000]	[20,000-21,000]	[400-500]	[6,000-7,000]	[700-800]	[1,000-2,000]	[100-200]	[3,000-4,000]	[0-100]	[13,000-14,000]	[3,000-4,000]
Chemical pathology	[200-300]	[0-100]	[100-200]	-	-	-	[200-300]	-	[0-100]	-	[0-100]	-	-	-
Clinical haematology	[4,000-5,000]	[10,000-11,000]	[1,000-2,000]	[0-100]	[900-1,000]	[1,000-2,000]	[1,000-2,000]	[3,000-4,000]	[400-500]	[1,000-2,000]	[1,000-2,000]	[1,000-2,000]	[3,000-4,000]	[11,000-12,000]
Dermatology	[4,000-5,000]	-	[4,000-5,000]	-	[6,000-7,000]	-	[5,000-6,000]	[0-100]	[3,000-4,000]	-	[6,000-7,000]	-	-	-
Diabetic medicine	[2,000-3,000]	-	[900-1,000]	[0-100]	-	-	[1,000-2,000]	[0-100]	[0-100]	-	[1,000-2,000]	[0-100]	[5,000-6,000]	[0-100]
Endocrinology	[1,000-2,000]	[200-300]	[1,000-2,000]	[0-100]	[1,000-2,000]	[0-100]	[1,000-2,000]	[100-200]	[0-100]	-	-	-	[1,00-2,000]	[0-100]
ENT	[16,000-17,000]	[1,000-2,000]	[11,000-12,000]	[1,000-2,000]	[7,000-8,000]	[1,000-2,000]	[15,000-16,000]	[1,000-2,000]	[2,000-3,000]	[300-400]	[7,000-8,000]	[1,000-2,000]	[15,000-16,000]	[2,000-3,000]
Gastroenterology	[6,000-7,000]	[16,000-17,000]	[6,000-7,000]	[6,000-7,000]	[6,000-7,000]	5,000-6,000]	[3,000-4,000]	[5,000-6,000]	[1,000-2,000]	[3,000-4,000]	[2,000-3,000]	[200-300]	[8,000-9,000]	[12,000-13,000]
General medicine	[3,000-4,000]	[900-1,000]	[2,000-3,000]	[0-100]	[2,000-3,000]	[400-500]	[3,000-4,000]	[0-100]	[4,000-5,000]	[0-100]	[300-400]	[6,000-7,000]	[6,000-7,.000]	[4,000-5,000]
General surgery	[9,000-10,000]	[5,000-6,000]	[6,000-7,000]	[4,000-5,000]	[3,000-4,000]	[6,000-7,000]	[5,000-6,000]	[3,000-4,000]	[4,000-5,000]	[4,000-5,000]	[14,000-15,000]	[6,000-7,000]	[4,000-5,000]	[3,000-4,000]
Geriatric medicine	[800-900]	[0-100]	[1,000-2,000]	[0-100]	[700-800]	[0-100]	[3,000-4,000]	[200-300]	[300-400]	-	[800-900]	[0-100]	[1,000-2,000]	[0-100]
Gynaecology	[22,000-23,000]	[6,000-7,000]	[5,000-6,000]	[3,000-4,000]	[7,000-8,000]	[1,000-2,000]	[10,000-11,000]	[2,000-3,000]	[5,000-6,000]	[800-900]	[7,000-8,000]	[1,000-2,000]	[19,000-20,000]	[3,000-4,000]
Obstetrics	[14,000-15,000]	[0-100]	[5,000-6,000]	[0-100]	[14,000-15,000]	[100-200]	[4,000-5,000]	[0-100]	[3,000-4,000]	[0-100]	[100-200]	[0-100]	[24,000-25,000]	[0-100]
Oral surgery	[9,000-10,000]	[2,000-3,000]	[1,000-2,000]	[1,000-2,000]	[2,000-3,000]	[1,000-2,000]	[0-100]	[1,000-2,000]	[2,000-3,000]	[500-600]	-	-	[9,000-10,000]	[5,000-6,000]
Paediatric Cardiology	[2,000-3,000]	[100-200]	[200-300]	[0-100]	[0-100]	-	-	-	[0-100]	-	-	-	-	-
Paediatric plastic surgery	[1,000-2,000]	[400-500]	[0-100]	-	-	-	-	-	-	-	-	-	-	-
Paediatric surgery	[3,000-4,000]	[1,000-2,000]	[700-800]	[0-100]	[800-900]	[100-200]	[100-200]	-	-	-	-	-	[0-100]	-
Paediatric urology	[2,000-3,000]	[1.00-2,00]	[400-500]	[100-200]	-	-	-	-	[0-100]	-	-	-	-	-

Paediatrics	[7,000-8,000]	[700-800]	[3,000-4,000]	[200-300]	[6,000-7,000]	[200-300]	[10,000-11,000]	[200-300]	[2,000-3,000]	[100-200]	[4,000-5,000]	[100-200]	[12,000-13,000]	[300-400]
Pain management	[700-800]	[800-900]	[1,000-2,000]	[2,000-3,000]	[1,000-2,000]	[400-500]	[1,000-2,000]	[1,000-2,000]	-	-	[700-800]	[400-500]	[3,000-4,000]	[6,000-7,000]
Physiotherapy	[9,000-10,000]	-	[21,000-22,000]	-	[11,000-12,000]	-	[9,000-10,000]	-	[4,000-5,000]	-	-	-	[2,000-3,000]	-
Plastic surgery	[200-300]	-	[8,000-9,000]	[5,000-6,000]	[1,000-2,000]	[700-800]	[3,000-4,000]	[2,000-3,000]	[0-100]	[0-100]	-	-	[500-600]	[300-400]
Respiratory medicine	[3,000-4,000]	[500-600]	[9,000-10,000]	[2,000-3,000]	[4,000-5,000]	[200-300]	[5,000-6,000]	[400-500]	[1,000-2,000]	[200-300]	[2,000-3,000]	[0-100]	[8,000-9,000]	[900-1,000]
Rheumatology	[2,000-3,000]	[800-900]	[3,000-4,000]	[700-800]	[3,000-4,000]	-	[2,000-3,000]	[600-700]	[700-800]	[0-100]	[1,000-2,000]	[100-200]	[4,000-5,000]	[1,000-2,000]
Trauma & orthopaedics	[23,000-24,000]	[3,000-4,000]	[11,000-12,000]	[3,000-4,000]	[22,000-23,000]	[2,000-3,000]	[13,000-14,000]	[2,000-3,000]	[10,000-11,000]	[2,000-3,000]	[12,000-13,000]	[3,000-4,000]	[30,000-31,000]	[7,000-8,000]
Urology	[5,000-6,000]	[4,000-5,000]	[6,000-7,000]	[4,000-5,000]	[4,000-5,000]	[1,000-2,000]	[4,000-5,000]	[5,000-6,000]	[2,000-3,000]	[200-300]	[4,000-5,000]	[1,000-2,000]	[15,000-16,000]	[5,000-6,000]
Vascular surgery	[6,000-7,000]	[1,000-2,000]	[3,000-4,000]	[1,000-2,000]	[1,000-2,000]	-	[3,000-4,000]	[800-900]	[600-700]	-	-	-	[4,000-5,000]	1,000-2,000]

Treatment function	**Salford Royal NHS Foundation Trust**		**St Helens and Knowsley Hospital Services NHS Trust**		**Stockport NHS Foundation Trust**		**Tameside Hospital NHS Foundation Trust**		**Warrington and Halton Hospitals NHS Foundation Trust**		**Wrightington, Wigan and Leigh NHS Foundation Trust**		**The Christie NHS Foundation Trust**	
	OPFA	IP	OPFA	IP	OPFA	IP	OPFA	IP	OPFA	IP	OPFA	IP	OPFA	IP
Audiology	-	-	[7,000-8,000]	-	-	-	-	-	-	-	-	-	-	-
Cardiology	[6,000-7,000]	[200-300]	[7,000-8,000]	[1,000-2,000]	-	[1,000-2,000]	[5,000-6,000]	[200-300]	[6,000-7,000]	[700-800]	[10,000-11,000]	[2,000-3,000]	-	-
Chemical pathology	[100-200]	[0-100]	-	-	[100-200]	-	-	-	[300-400]	[800-900]	[200-300]	-	-	-
Clinical haematology	[800-900]	[4,000-5,000]	[2,000-3,000]	[200-300]	[800-900]	[2,000-3,000]	[700-800]	[900-1,000]	[700-800]	[2,000-3,000]	[1,000-2,000]	[3,000-4,000]	[900-1,000]	[0-100]
Dermatology	[24,000-25,000]	[600-700]	[16,000-17,000]	-	-	-	[9,000-10,000]	[0-100]	-	-	[9,000-10,000]	-	-	-
Diabetic medicine	[500-600]	[0-100]	[2,000-3,000]	[0-100]	-	-	[0-100]	[0-100]	[1,000-2,000]	-	[1,000-2,000]	[0-100]	-	-
Endocrinology	[3,000-4,000]	[500-600]	[1,000-2,000]	[0-100]	-	-	-	[0-100]	[700-800]	[0-100]	[1,000-2,000]	[0-100]	[1,000-2,000	-
ENT	[6,000-7,000]	[1,000-2,000]	[11,000-12,000]	[900-1,000]	[8,000-9,000]	[1,000-2,000]	[6,000-7,000]	[1,000-2,000]	[8,000-9,000]	[1,000-2,000]	[10,000-11,000]	[1,000-2,000]	[400500]	[100-200]
Gastroenterology	[6,000-7,000]	[10,000-11,000]	[8,000-9,000]	[14,000-15,000]	-	-	[3,000-4,000]	[4,000-5,000]	[4,000-5,000]	[4,000-5,000]	[6,000-7,000]	[9,000-10,000]	-	-
General medicine	[700-800]	[100-200]	[2,000-3,000]	[0-100]	[12,000-14,000]	[3,000-4,000]	[1,000-2,000]	[900-1,000]	[1,000-2,000]	[800-900]	[6,000-7,000]	[300-400]	-	-

General surgery	[4,000-5,000]	[1,000-2,000]	[7,000-8,000]	[3,000-4,000]	[8,000-9,000]	[8,000-9,000]	[2,000-3,000]	[5,000-6,000]	[700-800]	[5,000-6,000]	[6,000-7,000]	[1,000-2,000]	[100-200]	-
Geriatric medicine	[600-700]	[0-100]	[800-900]	-	[2,000-3,000]	[500-600]	[600-700]	[0-100]	[300-400]	[0-100]	[1,000-2,000]	[100-200]	-	-
Gynaecology	[5,000-6,000]	[1,000-2,000]	[13,000-14,000]	[1,000-2,000]	[6,000-7,000]	[1,000-2,000]	[8,000-9,000]	[1,000-2,000]	[8,000-9,000]	[1,000-2,000]	[11,000-12,000]	[1,000-2,000]	[700-800]	-
Obstetrics	-	-	[4,000-5,000]	[0-100]	[3,000-4,000]	-	[5,000-6,000]	[0-100]	[2,000-3,000]	[200-300]	[2,000-3,000]	[0-100]	-	-
Oral surgery	[2,000-3,000]	[200-300]	[5,000-6,000]	[100-200]	[3,000-4,000]	[1,000-2,000]	[3,000-4,000]	[600-700]	[0-100]	-	[3,000-4,000]	[2,000-3,000]	[200-300]	-
Paediatric cardiology	-	-	[300-400]	-	-	-	[0-100]	-	-	-	[100-200]	-	-	-
Paediatric plastic surgery	-	-	[0-100]	[0-100]	-	-	-	-	-	-	-	-	-	-
Paediatric surgery	-	-	-	-	[200-300]	[0-100]	-	-	[200-300]	[0-100]	-	-	-	-
Paediatric urology	-	-	-	-	-	-	-	-	[0-100]	-	[100-200]	-	-	[2,000-3,000]
Paediatrics	-	-	[2,000-3,000]	-	[7,000-8,000]	[400-500]	[8,000-9,000]	[0-100]	[4,000-5,000]	[300-400]	[5,000-6,000]	[100-200]	-	-
Pain management	[2,000-3,000]	[3,000-4,000]	[2,000-3,000]	[700-800]	[2,000-3,000]	[1,000-2,000]	[3,000-4,000]	[1,000-2,000]	[1,000-2,000]	[1,000-2,000]	[2,000-3,000]	[1,000-2,000]	[100-200]	-
Physiotherapy	[0-100]	-	[5,000-6,000]	-	[7,000-8,000]	-	[10,000-11,000]	-	[16,000-17,000]	-	[12,000-13,000]	-	[800-900]	-
Plastic surgery	-	-	[10,000-11,000]	[11,000-12,000]	-	-	[900-1,000]	[400-500]	[0-100]	-	[1,000-2,000]	[700-800]	[1,000-2,000]	-
Respiratory medicine	[2,000-3,000]	[300-400]	[5,000-6,000]	[400-500]	-	-	[3,000-4,000]	[200-300]	[3,000-4,000]	[200-300]	[5,000-6,000]	[700-800]	-	[3,000-4,000]
Rheumatology	[3,000-4,000]	[700-800]	[3,000-4,000]	-	[1,000-2,000]	[1,000-2,000]	[1,000-2,000]	[0-100]	[1,000-2,000]	[200-300]	[2,000-3,000]	[1,000-2,000]	-	-
Trauma & orthopaedics	[13,000-14,000]	[3,000-4,000]	[16,000-17,000]	[3,000-4,000]	[14,000-15,000]	[4,000-5,000]	[13,000-14,000]	[3,000-4,000]	[16,000-17,000]	[5,000-6,000]	[27,000-28,000]	[12,000-13,000]	-	-
Urology	[4,000-5,000]	[1,000-2,000]	[13,000-14,000]	[3,000-4,000]	[6,000-7,000]	[4,000] 5,000]	[4,000-5,000]	-	[3,000-4,000]	[2,000-3,000]	[6,000-7,000]	[1,000-2,000]	[800-900]	[900-1,000]
Vascular surgery	-	-	[1,000-2,000]	[100-200]	-	-	[5,000-6,000]	[200-300]	[1,000-2,000]	[400-500]	[1,000-2,000]	[400-500]	-	-

282. Finally, in Respiratory Medicine, the HES data does not record any activity at Stockport in this specialty. However, this reflects a coding issue rather than a lack of service provision by Stockport in this specialty. This coding issue is identified in a recent document issued by NHS Greater Manchester and GCMA in relation to Respiratory Medicine services.[101] The implications for the GP referral analysis in relation to first outpatient appointments for Respiratory Medicine is that CMFT's and UHSM's closeness as competitors will have been overstated as the analysis will not have taken into account Stockport's presence as an alternative for patients in this specialty.

7.3.4 Small numbers of GP referrals for first outpatient appointments

283. The closeness of competition between CMFT and UHSM in several further specialties, as inferred by the GP referral analysis, is based on a very small number of first outpatient appointments that have resulted from a GP referral.

284. This raises questions about both the robustness of the results based on such a small number of referrals, and the materiality of the competition between the Trusts for referrals to a particular specialty at a particular site. Specialties where close competition between CMFT and UHSM is inferred based on a small number of GP referrals (i.e. less than 200 GP referrals for first outpatient appointments) includes the following:

- *CMFT's Oxford Road site*: Anticoagulant Service ([100-200] referrals), Geriatric Medicine ([100-200] referrals), Infectious Diseases ([100-200] referrals), Paediatric Cardiology ([100-200] referrals), Paediatric Plastic Surgery ([0-100] referrals), Physiotherapy ([0-100] referrals), and Plastic Surgery ([100-200] referrals).

- *CMFT's Trafford General Hospital*: Chemical Pathology ([0-100] referrals), Endocrinology ([100-200] referrals), Oral Surgery ([100-200] referrals), Vascular Surgery ([0-100] referrals).

- *CMFT's Altrincham Hospital*: Cardiology ([100-200] referrals), Chemical Pathology ([20-30] referrals), Clinical Haematology ([100-200] referrals), Diabetic Medicine ([0-100] referrals), Endocrinology ([0-100] referrals), Gastroenterology ([0-100] referrals), General Medicine ([0-100] referrals), Geriatric Medicine ([0-100] referrals), Gynaecology ([100-200] referrals), Pain Management ([100-200] referrals), Respiratory Medicine ([100-200] referrals), Urology ([100-200] referrals), Vascular Surgery ([0-100] referrals).

- *UHSM's Wythenshawe Hospital*: Chemical Pathology ([0-100] referrals), Infectious Diseases ([0-100] referrals), Oral Surgery ([100-200] referrals), Paediatric Cardiology ([100-200] referrals), Speech & Language Therapy ([0-100] referrals).

- *UHSM's Withington Hospital*: Cardiology ([40-50] referrals), Diabetic Medicine ([100-200] referrals), Obstetrics ([0-100] referrals), and Trauma & Orthopaedics ([100-200] referrals).

[101] See NHS Greater Manchester and GMCA, *Theme 3: Respiratory and Cardiology Project Initiation Document*, 24 October 2016, footnote 4, p.4 at Appendix 4.10, which notes the lack of activity recording for Respiratory Medicine at Stockport NHS Foundation Trust.

285. In a significant number of cases, the GP referral analysis that is based on this small number of referrals for first outpatient appointments at these sites is indicating that CMFT and UHSM are in close competition. These specialties are underlined in the list above.

286. The CMA's concerns about the merger's effect on competition in individual specialties should be based on those specialties where there is: (a) a significant amount of activity being carried out; (b) a significant number of referrals for which the Trusts can potentially compete; and (c) enough referrals to ensure that are any conclusions are based on a sufficient number of observations. CMFT and UHSM would submit that these conditions are not met in relation to the specialties at each site that are underlined above.

7.3.5 Conclusion on specialty-specific factors

287. In summary, there are at least four specialty-specific factors that are affecting the conclusions that can be drawn from the GP referral analysis, namely:
    i. service reconfigurations, which mean that competition between CMFT and UHSM in certain specialties will not happen in the future or will be significantly more constrained than is currently the case;
    ii. service and patient cohort differences between CMFT and UHSM, which mean that certain referrals in individual specialties cannot switch between the two Trusts;
    iii. coding differences between Trusts that give a misleading impression of the number and strength of providers in various specialties; and
    iv. small numbers of GP referrals in certain specialties that mean that the materiality of any competition for referrals in those specialties is questionable as is the robustness of the analysis on which any conclusions are based.

288. These specialty-specific factors are affecting the results of the GP referral analysis in 26 out of the 29 specialties where the site based analysis indicates that CMFT or UHSM would gain more than 30% of the referrals switching from one of the other Trust's sites, or where CMFT or UHSM would be the provider that would gain the largest share of referrals switching from one of the other Trust's sites. (That is, in those specialties where one of the CMFT or UHSM sites is rated red or amber according the system set out above for classifying the results of the GP referral analysis.) Given this, the extent to which the results of the GP referral analysis translates into the finding of a realistic prospect of an SLC requires careful consideration.

Table 7.20: Summary of specialty-specific factors impacting on different specialties

	Number of CMFT and UHSM hospitals in each category			Specialty specific factors
	Red	Amber	Green	
Vascular Surgery	4 (Ox, T, A, Wy)			Reconfiguration; Small numbers of GP referrals at one or more sites
Geriatric Medicine	4 (Ox, T, A, Wy)			Small numbers of GP referrals at one or more sites
Clinical Haematology	4 (Ox, A, Wy, Wi)	1 (T)		Small numbers of GP referrals at one or more sites
Cardiology	4 (Ox, T, A, Wy)	1 (Wi)		Coding issues; Small numbers of GP referrals at one or more sites
Dermatology	4 (Ox, T, A, Wi)	1 (Wy)		

Respiratory Medicine	4 (Ox, T, A, Wy)	1 (Wi)		Service differentiation between CMFT and UHSM; Coding issues; Small numbers of GP referrals at one or more sites
Diabetic Medicine	4 (T, A, Wy, Wi)	1 (Ox)		Small numbers of GP referrals at one or more sites
Rheumatology	4 (Ox, T, A, Wi)	1 (Wy)		
Obstetrics	3 (Ox, Wy, Wi)			Service differentiation between CMFT and UHSM; Small numbers of GP referrals at one or more sites
Paediatrics	3 (Ox, T, Wy)			Service differentiation between CMFT and UHSM;
Gastroenterology	3 (Ox, T, A)	2 (Wy, Wi)		Small numbers of GP referrals at one or more sites
Urology	3 (Ox, T, A)	2 (Wy, Wi)		Reconfiguration; Small numbers of GP referrals at one or more sites
Gynaecology	3 (A, Wy, Wi)	2 (Ox, T)		Service differentiation between CMFT and UHSM; Small numbers of GP referrals at one or more sites
General Medicine	2 (A, Wy)	1 (T)	1 (Ox)	Small numbers of GP referrals at one or more sites
Paediatric Cardiology	2 (Ox, Wy)			Service differentiation between CMFT and UHSM; Small numbers of GP referrals at one or more sites
Paediatric Surgery	2 (Ox, Wy)			Service differentiation between CMFT and UHSM;
Paediatric Urology	2 (Ox, Wy)			Service differentiation between CMFT and UHSM;
Plastic Surgery	2 (Ox, Wy)			Service differentiation between CMFT and UHSM; Small numbers of GP referrals at one or more sites
Chemical Pathology	1 (Wy)	2 (T, A)		Small numbers of GP referrals at one or more sites
Endocrinology	1 (A)	3 (Ox, T, Wy)		Small numbers of GP referrals at one or more sites
ENT	1 (A)	2 (Wy, Wi)	2 (Ox, T)	
Trauma & Orthopaedics	1 (A)	1 (Wi)	3 (Ox, T, Wy)	Small numbers of GP referrals at one or more sites
Pain Management	1 (A)	1 (Wy)	1 (T)	Small numbers of GP referrals at one or more sites
General Surgery	1 (A)		4 (Ox, T, Wy, Wi)	Small numbers of GP referrals at one or more sites
Audiology	1 (A)		3 (T, Wy, Wi)	Coding issues
Oral Surgery	1 (Wy)		2 (Ox, T)	Small numbers of GP referrals at one or more sites
Physiotherapy	1 (Ox)		2 (Wy, Wi)	Small numbers of GP referrals at one or more sites
Paediatric Plastic Surgery	1 (Ox)			Small numbers of GP referrals at one or more sites
Anticoagulant service		1 (Ox)	1 (Wy)	Small numbers of GP referrals at one or more sites
Infectious Diseases			2 (Ox, Wy)	
Midwife Episode			2 (Wy, Wi)	
Speech & Language Therapy			1 (Wy)	
Anaesthetics			1 (Wy)	

Nephrology			1 (Ox)	
Gynaecological Oncology			1 (Ox)	

Note: Ox – CMFT's Oxford Road site; T – Trafford General Hospital; A – Altrincham Hospital; Wy – Wythenshawe Hospital; Wi – Withington Hospital
Source: Aldwych Partners

7.4 Conclusion on merger's effect on competition in routine elective care services

289. CMFT and UHSM accept that there is sufficient evidence for the CMA to refer their planned merger to a Phase 2 review on the grounds that there is a *realistic prospect* of a significant lessening of competition (SLC) in several of the specialties in which they both provide routine elective care services. It is for this reason that the two Trusts have requested that the CMA make a fast-track reference decision.

290. Whether there is sufficient evidence for the CMA to conclude at Phase 2 that an SLC in various routine elective care specialties can be expected to arise from the merger is much less clear cut. To summarise the relevant issues identified in this submission:

- Without the merger, the Manchester CCGs have signalled their intention to implement a single contract for acute services in Manchester. This will inevitably reduce competition given the lead- and sub-contractor arrangements that this implies. Further UHSM's ability to compete with CMFT can be expected to progressively decline if it remains an independent entity. Competition between CMFT and UHSM in several individual specialties is, in any event, likely to be removed through planned commissioner-led service reconfigurations.

- The extent of any competition between CMFT and UHSM is very limited. CMFT's and UHSM's ability to compete with one another has been further constrained in the past 12 months through changes to the administrative and regulatory framework in which NHS acute trusts operate. Provider autonomy has been curtailed through financial oversight measures, a lack of capital for new initiatives, new regulatory arrangements, and a deliberate move by the NHS to increase collaboration between providers.

- Patients that currently attend CMFT and UHSM would readily be able to access services at many of the other acute trusts in Greater Manchester or the surrounding region. This can be seen through both the drive-time distances between CMFT, UHSM and other acute trusts in Greater Manchester.

- The GP referral analysis, as it applies to first outpatient appointments at a site level, shows that CMFT and UHSM would gain the largest share of referrals that switched from the other Trust from one or more of their sites in 29 specialties. However, these results need to be interpreted in the light of factors, such as planned service reconfigurations, service differentiation between CMFT and UHSM, coding issues, and small numbers of referrals, which indicate that the GP referral analysis overstates the planned merger's effect on competition.

8. PRIVATE PATIENT SERVICES

291. CMFT and UHSM both supply private patient services. At UHSM, however, the volume of these services is negligible, but prior to the decision to merge, it was planning to increase its private patient activities. These plans have now been put on hold pending the merger with CMFT. The Trusts do not believe that their merger gives rise to a realistic prospect of an SLC in relation to private patient services due to the significant number of other providers of private patient services in Greater Manchester.

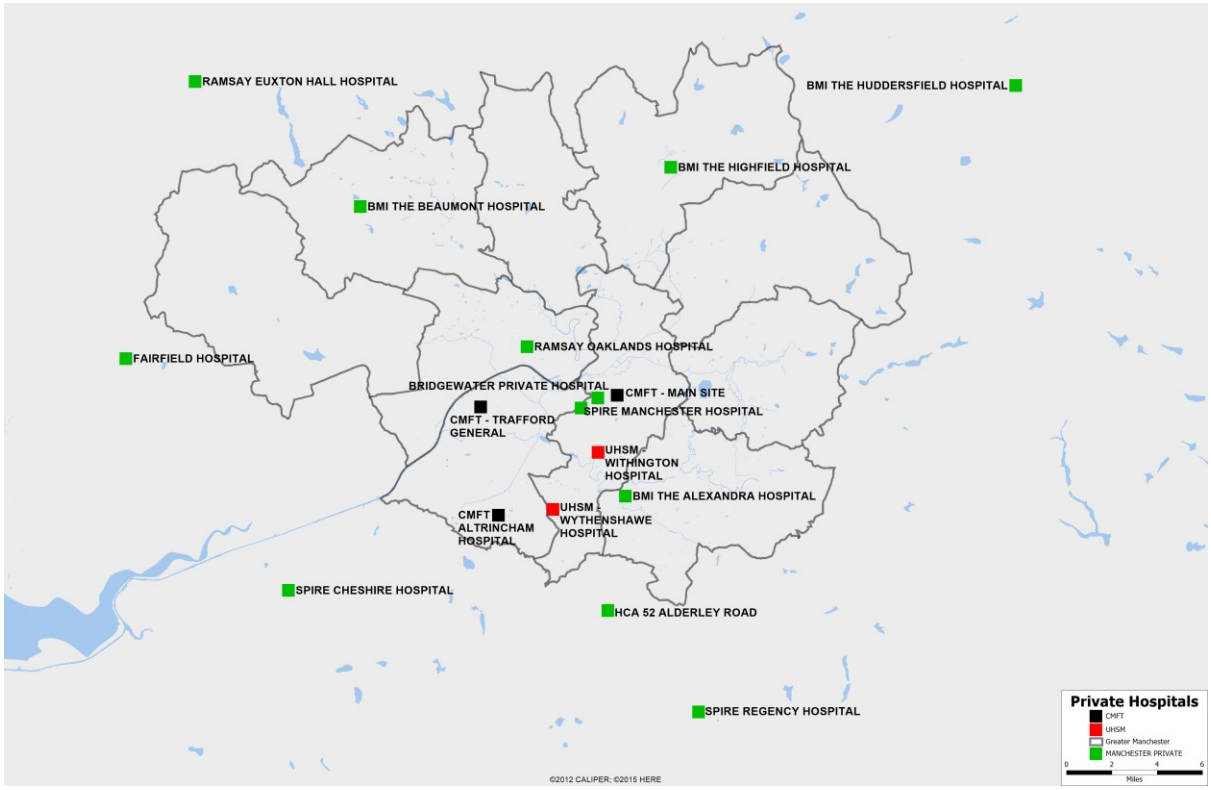
292. The remainder of this section sets out further details of CMFT's and UHSM's private patient services, UHSM's plans (prior to the merger decision) to expand these services, and other providers of private patient services in Greater Manchester.

293. CMFT had revenue from private patient services of £2.6 million in 2015-16 (see Table 3.2). This was primarily in ophthalmology (£1.2 million) and paediatrics (£0.8 million).[102] UHSM's provision of private patient services has been more limited than CMFT. It earned revenue of £134,000 from private patient services in 2015-16 (see Table 3.3). There is no readily available breakdown, by specialty, of this revenue.[103]

294. Prior to the merger, UHSM was planning a new private patient unit, which would be operated on its behalf by HCA. According to analysis reported to UHSM management, Greater Manchester private patient hospital services are worth approximately £140 million per annum, and there are thirteen facilities serving private hospital patients in Greater Manchester and the surrounding region (see Figure 8.1).[104] There are also private patient units at the following NHS acute trusts: The Christie NHS Foundation Trust, Salford Royal NHS Foundation Trust, Wrightington, Wigan & Leigh NHS Foundation Trust, and Pennine Acute Hospitals NHS Trust.

[102] A breakdown of CMFT's private patient revenue by specialty is set out at Appendix 8.1.
[103] UHSM advise that to providing a specialty-level breakdown of its private patient revenue would require a review and classification of each individual invoice. Given the resource implications of such a task, we would wish to confirm with the CMA that it considers this necessary before proceeding.
[104] See Paper for consideration at UHSM Strategic Direction Committee meeting, *The proposed new HCA Hospital at UHSM*, 15 April 2014 at Appendix 8.2.

Figure 8.1: Private hospitals in the vicinity of CMFT and UHSM



Source: Aldwych Partners

295. Given the number of other providers of private patient services in the vicinity of CMFT and UHSM, the Trusts consider that there is no realistic prospect of their merger giving risk to an SLC in private patient services.

9. NON-ELECTIVE CARE AND SPECIALISED SERVICES

296. This section considers the effect of the planned merger between CMFT and UHSM on competition in the provision of non-elective care and specialised services. For the reasons set out in this section, the Trusts believe that there is no realistic prospect of an SLC in relation to these services.

9.1 Non-elective care

297. Non-elective care, involving the admission of a patient through A&E, does not involve patient choice given the urgent and unplanned nature of the care that is being provided. Patients can be expected to attend their nearest A&E department. By way of background, non-elective acute services provided by CMFT and UHSM, and other Acute Trusts in Greater Manchester and its vicinity, are set out in Table 9.1. All Acute Trusts providing DGH style services (ie all NHS Acute Trusts other than certain specialist Trusts) will have an A&E Department.

298. There is no experience in the NHS of Acute Trusts competing for contracts to supply A&E services. The commissioning intentions set out by Manchester CCGs do not set out any

intention to hold a competitive tender process for the provision of A&E or non-elective services.

299. For this reason, and consistent with past CMA reviews of NHS acute trust mergers, there are no grounds for believing that the proposed merger between CMFT and UHSM gives rise to an SLC in relation to A&E services, and the non-elective patient care services that can arise from an A&E attendance.

9.2 Specialised services

300. Specialised services are commissioned by NHS England. These services, by their very nature, are accessed by fewer patients than typical district general hospital services, and as a result, are provided by a smaller number of acute trusts over a wider geographic area. NHS England has stated that catchment populations for specialised services are usually more than one million people.[105] NHS England's budget for specialised services is around £15.5 billion annually.

[105] See https://www.england.nhs.uk/commissioning/spec-services/

Figure 9.1: Non-elective activity, CMFT UHSM and other acute trusts in Greater Manchester, 2015-16

301. In 2015-16, CMFT received £339 million from NHS England to provide specialised services. According to an analysis of 2014-15 specialised services commissioning, CMFT is the sixth largest supplier of specialised services to NHS England.[106] It 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.[107]

302. In 2015-16, UHSM received £140 million from NHS England to provide specialised services. It provides 36 separate specialised services, including several heart-related services (e.g. Cardiology), Maxillo-Facial Surgery and Plastic Surgery.[108]

303. NHS England's intentions for specialised services commissioning in the North of England in 2017/18 and 2018/19 cover 13 services, namely: HIV (adult) services; Respiratory – Severe Asthma and Interstitial Lung Disease (ILD); Renal Dialysis; Dermatology; Spinal Cord Injury; Adult Critical Care; Specialised Orthopaedics; Spinal Surgery; Specialised Neurology; Neuro-rehabilitation; Neonatal Transport; Vascular; and Ophthalmology.[109]

304. The commissioning intentions set out by NHS England in relation to these 13 services identify only one competitive tender. This is in relation Respiratory – Severe Asthma and ILD, where a procurement is expected to commence in July 2017 to select providers for a regional services that is compliant with the National Service Specifications standards.

305. Even if both Trusts were to be competitors for this contract, there would be enough other acute trusts capable of providing specialised services such that the planned merger between CMFT and UHSM would not give rise to an SLC in relation to this particular specialised service, or specialised services more generally.

10. COMMUNITY-BASED HEALTH SERVICES

306. CMFT and UHSM do not believe that their planned merger gives rise to a realistic prospect of an SLC in relation to community-based health services. Under the current arrangements for commissioning community health services, there are no examples of CMFT and UHSM competing for community health contracts. Further, the Manchester Local Care Organisation (MLCO) that Manchester's CCGs plan to establish from April 2017 is likely to preclude the possibility of any future competition between CMFT and UHSM for community services contracts.

307. The remainder of this section sets out further details of current and planned contracting arrangements for community services in Manchester, and the effect of the planned CMFT/UHSM merger on competition to provide these services.

[106] See Health Service Journal, *Analysed: The biggest NHS providers of specialised services*, 16 October 2015 at Appendix 9.1.
[107] A full list of specialised services commissioned from CMFT is available in CMFT's contract with NHS England at Appendix 9.2.
[108] A full list of specialised services commissioned from UHSM is available in UHSM's contract with NHS England at Appendix 9.3.
[109] See letter to UHSM from North Regional Specialised Commissioning Team, NHS England, 30 September 2016 at Appendix 9.4.

10.1 Competition for community services contracts under existing arrangements

308. Community-based NHS healthcare services in Greater Manchester, and the rest of England, are currently provided through a combination of high value contracts for the supply of a broad range of community health services in each CCG that sit alongside a large number of smaller contracts for individual community health services. Providers that hold the large, high value contracts for community services include specialist community health trusts, acute trusts, mental health trusts and private providers.

309. CMFT and UHSM hold community services contracts for the Central Manchester CCG area and South Manchester CCG area respectively, and under these contracts provide a broad range of community services. CMFT earned £64.5 million in revenue from the provision of community services in 2015-16, while UHSM earned £16.2 million from its community services contract for the same period (see Tables 3.2 and 3.3).

310. Elsewhere in Greater Manchester, high value / broad scope community services contracts are held by:
    - Pennine Acute Hospitals NHS Trust for North Manchester CCG area;
    - Pennine Care NHS Foundation Trust for Trafford, Bury, Oldham (adults' services) and Rochdale CCG areas;
    - Bridgewater Community Healthcare NHS Foundation Trust for Wigan, Warrington, Halton, St Helen's, Bolton (children's services) and Oldham (children's services) CCG areas;
    - Bolton NHS Foundation Trust for Bolton CCG area (adults' services).
    - Salford Royal NHS Foundation Trust for Salford CCG area;
    - Stockport NHS Foundation Trust for Stockport CCG area; and
    - Tameside and Glossop Integrated Care NHS Foundation Trust for Tameside CCG area.

311. In Cheshire, which is to the south of the Manchester area served by CMFT and UHSM, major community services contracts are held by East Cheshire NHS Trust for Eastern Cheshire CCG area and Cheshire and Wirral Partnership NHS Foundation Trust for Western Cheshire CCG area.

312. [✂].[110] [✂].[111]

313. Given the lack of any past direct competition between CMFT and UHSM, and the large number of other community services providers in Greater Manchester and the surrounding area, the Trusts submit that there is no realistic prospect of an SLC in community services if the current contracting arrangements for these services were to continue.

10.2 Plans to establish a Manchester Local Care Organisation

314. As set out in Section 3.2.2, one of the three pillars of the Manchester Locality Plan, adopted by the City of Manchester's Health and Wellbeing Board, is the establishment of a Manchester Local Care Organisation (MLCO).

[110] [✂]
[111] [✂]

315. The plans for the MLCO reflect the broader plans for community health services in Greater Manchester. The Greater Manchester strategic plan for health and care services states that:

> "Greater Manchester has one of the highest rates of emergency hospital admission for conditions that would be better treated in the community. At any one time an estimated 2,500 patients are in an acute hospital bed in Greater Manchester, who could be treated at home or in a community setting, which would be preferable for the patient and more cost effective …
>
> "The community service models chosen within each of our localities varies depending on the objectives they are trying to achieve, but the essential characteristics of the models are the same. Health and social care providers will work collaboratively to provide care to a defined population (predominantly led by primary care). LCOs is a term developed at a Greater Manchester level to describe how across Greater Manchester, we will secure, in all parts of the conurbation, the principle features of a proactive, preventative, population health model, which delivers consistently high outcomes. The LCO and its member organisations will be collectively accountable for delivery."[112]

316. Services within the scope of the MLCO include community health services, social care services, GP primary care services, community mental health services and ambulance services. It also includes certain services that are currently provided in an acute setting, particularly those related to urgent care and management of long term conditions. The intention is to facilitate seamless transfers of care between hospital, community, primary and social care.[113]

317. CMFT and UHSM understand that due to the scope of the services involved, the length of the contract to be awarded, and the significant financial value of this contract, Manchester's CCGs plan to run a procurement process to select the provider (or providers) who will hold the MLCO contract.

318. The existing providers of community services in Manchester, including CMFT and UHSM, intend to bid for the MLCO contract. The precise governance arrangements for the consortium that would operate the MLCO, if their bid is successful, are still under discussion. However, the Trusts anticipate that it will take the form of a contractual joint venture between providers with each provider maintaining its own separate legal identity. As such, it may be necessary for one organisation to 'host' the MLCO contract with commissioners, and it is possible that the merged CMFT/UHSM will be put forward as the host organisation. However, the nature of any such arrangement is yet to be decided by the providers who will bid for the MLCO contract.

319. The planned merger between CMFT and UHSM will not lessen competition for the MLCO contract as both Trusts intend to participate in the MLCO consortium that will bid for the contract. This bidding process will, in any event, conclude prior to the CMA's review of this transaction.

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[112] GMCA and NHS in Greater Manchester, *Taking Charge of our Health and Social Care in Greater Manchester: The Plan*, December 2015, p.34-35 at Appendix 3.12.
[113] Further details on the MLCO are available at http://www.manchesterccgs.nhs.uk/the-lco-prospectus and in the MLCO Prospectus at Appendix 10.2.

320. Once the MLCO has been established, it is not anticipated that there will be any further separate tenders for community services contracts let by Manchester's CCGs as all community services will be commissioned through the MLCO. As a result, there would be no avenue for competition between a separate CMFT and UHSM beyond the MLCO contract.

321. Given these circumstances, there can be no realistic prospect of an SLC in relation to community health services.