CMA
Competition & Markets Authority

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

Notice of possible remedies under Rule 12 of the Competition and Markets Authority's rules of procedure for merger, market, and special reference groups

Introduction

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

2. The inquiry group has provisionally found that the merger may be expected to give rise to a substantial lessening of competition (SLC) in the provision of NHS elective and maternity services and NHS specialised services. The parties have submitted to us that the merger will result in a number of significant benefits to patients.[1]

3. This Notice sets out the actions that the inquiry group considers it might take for the purpose of remedying, mitigating or preventing the provisional SLC and any resulting adverse effects identified in the provisional findings, taking into account the benefits of the merger proposed by the parties.

[1] Please refer to the case page for the parties' benefits submission.

Remedies

Framework for considering remedies

4. Where the CMA concludes that a relevant merger situation has resulted, or may be expected to result, in an SLC, it is required to decide whether action should be taken to remedy, mitigate or prevent the SLC or any adverse effect resulting from the SLC.[2]

5. In deciding on a remedy, the CMA shall, in particular, have regard to the need to achieve as comprehensive a solution as is reasonable and practicable to remedy the SLC and any adverse effects resulting from it. The CMA will seek remedies that are effective in addressing the SLC and its resulting adverse effects and will then select the least costly and intrusive remedy that it considers to be effective.[3]

6. In merger inquiries, the CMA will generally prefer structural remedies, such as divestiture or prohibition, rather than behavioural remedies, because:

   (a) structural remedies are likely to deal with an SLC and its resulting adverse effects directly and comprehensively at source by restoring rivalry;

   (b) behavioural remedies may not have an effective impact on the SLC and its resulting adverse effects, and may create significant costly distortions in market outcomes; and

   (c) structural remedies do not normally require monitoring and enforcement once implemented.[4]

Possible remedies on which views are sought

7. Our preliminary view is that prohibition of the proposed merger transaction would be an effective remedy to prevent the provisional SLC and any resulting adverse effects, as it would prevent an SLC from arising in any of the areas we have provisionally identified.

8. We have also considered whether there are other less intrusive remedies that would also be likely to effectively and comprehensively address the provisional SLC and any resulting adverse effects.

[2] Merger Remedies: Competition Commission Guidelines (CC8), paragraph 1.6.
[3] CC8 paragraph 1.7.
[4] CC8 paragraph 2.14.

9. We have considered whether divestiture of those services or of the facilities necessary to deliver those services in which we have provisionally identified horizontal unilateral effects (ie partial divestiture) would be practicable. However, our preliminary view is that these services would not be easily separable from the rest of the parties' operations.

10. We also think, on a preliminary basis, that a behavioural remedy is unlikely to be an effective remedy to the SLC that we have provisionally identified.

11. At this stage, our preliminary view is that prohibiting the merger is likely to be the only effective remedy to the provisional SLC finding. However, prohibition could also prevent any relevant customer benefits (RCBs) from being realised as a result of the merger (see below).

Relevant customer benefits

Framework for considering RCBs

12. In deciding the question of remedies, the CMA may in particular have regard to the effects of any action on any RCBs arising from the merger.[5] In the context of the health sector and NHS mergers, RCBs relate to benefits to patients and/or commissioners.

13. RCBs are limited by the Act to benefits to relevant customers in the form of:

    (a) 'lower prices, higher quality or greater choice of goods or services in any market in the United Kingdom … or

    (b) greater innovation in relation to such goods or services'.[6]

14. The types of benefits that NHS providers have previously submitted (either to the Cooperation and Competition Panel, NHS Improvement,[7] the Office of Fair Trading/Competition Commission or the CMA) include:

    (a) higher-quality services through implementing a particular model of care;

    (b) higher-quality services through service reconfiguration;

[5] Section 36(4) of the Act, see also CC8, paragraph 1.14.
[6] Section 30(1)(a) of the Act, CC8, paragraph 1.14.
[7] Founded on 1 April 2016, NHS Improvement is an umbrella organisation bringing together Monitor, the NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team, and the Intensive Support Teams. NHS Improvement is the sector regulator for the provision of healthcare services in England. It oversees NHS foundation trusts, NHS trusts and independent providers of NHS-funded care.

(c) higher-quality services through increased consultant or staff cover;

(d) higher-quality services through access to equipment;

(e) greater innovation through research and development and greater ability to attract funding for research and development; and

(f) financial savings.[8]

15. The Act provides that a benefit is only an RCB if it accrues or is expected to accrue to relevant customers within the UK within a reasonable period from the merger and would be unlikely to accrue without the creation of that situation or a similar lessening of competition.[9]

16. According to its guidance, the CMA will consider whether it believes the benefits are likely to be realised. The merger parties will be expected to provide convincing evidence regarding the nature and scale of RCBs that they claim will result from the merger.[10]

17. The CMA will review implementation plans, and the more detailed and advanced these are, the more persuasive they are likely to be. The merger parties' incentives to implement the benefits will also be relevant to the likelihood of implementation.[11]

18. In determining whether the benefit is merger specific, the CMA will consider whether it was likely to occur in any event (eg if the benefit was in any event likely to arise through a commissioner-led reconfiguration) and whether the merger parties would have the ability and incentive to achieve the benefits independently or through arrangements, such as another merger, that do not give rise to competition issues.[12]

19. The CMA will normally take RCBs into account, as permitted by the Act, once it has decided on the existence of an SLC by considering the extent to which alternative remedies may preserve such benefits. In essence, RCBs that will be foregone due to the implementation of a particular remedy may be considered as costs of that remedy. The CMA may modify a remedy to ensure retention of an RCB or it may change its remedy selection, for instance it may

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[8] CMA guidance on the review of NHS mergers (CMA29), paragraph 7.13.
[9] Section 30(3) of the Act. see also CC8, paragraph 1.16.
[10] CC8, paragraph 1.17.
[11] CMA29, paragraph 7.18.
[12] CMA29, paragraph 7.17.

decide to implement a remedy other than prohibition or it may decide that no remedy is appropriate.[13]

Patient benefits arising from the merger

20. The parties claim that a number of specific patient benefits can be expected to arise as a result of the merger.

21. The benefits span a broad range of specialties and conditions, including:

    (a) Cardiology (the parties have proposed patient benefits arising in acute coronary syndrome, heart rhythm abnormalities and acute aortic surgery);

    (b) Vascular surgery;

    (c) stroke;

    (d) women's health (urgent gynaecological surgery and community midwifery);

    (e) Urology (patient access to core urology services, urology cancer services, kidney stone removal and urology seven day services);

    (f) General surgery;

    (g) Orthopaedics (elective orthopaedics and fractured neck of femur); and

    (h) Head and neck cancer surgery.

22. The benefits are diverse and include improved morbidity and mortality outcomes, reduced time to treatment and length of stay, fewer complications following surgery and more convenient patient access to services.

23. The parties have explained that the formulation of their benefits case has been underpinned by a strong process of clinical engagement, including the establishment of a Clinical Advisory Group and Clinical Working Groups to review service delivery models and advise on potential benefits.

24. The proposed service changes required to realise the proposed patient benefits are driven by a number of clinical developments, including greater clinical specialisation, workforce shortages, developments in medical treatment and a greater understanding of the relationship between patient volumes and outcomes.

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[13] CC8, paragraph 1.15.

25. The parties claim that the merger is key to realising these patient benefits, as neither party can individually deliver the proposed service changes required to realise the benefits due to the concentration of patient flows and scarce clinical expertise needed to effect such change.

26. The parties do not believe that any form of collaboration that falls short of a merger will be sufficient to realise the patient benefits, as the scale of change necessary to deliver the benefits would have a financial impact and bring risk to clinical service delivery that neither party, as separate, independent entities, would accept. The parties claim that this is evidenced by past failed attempts to work together to achieve service improvements as separate trusts.[14]

27. Further, the parties claim that only the merger (and not any other form of partnership) will enable them to make changes across multiple areas simultaneously, and provide a single, unified management structure to make the required changes and makes it far more likely for the proposed patient benefits to be sustained over time.

28. The parties are confident of implementing the changes required to realise the proposed patient benefits due to their past experience of effecting large-scale service changes involving significant impact on workforce, and their major project delivery experience.

29. The patient benefits proposed by the parties are summarised in Table 1 below.

[14] See provisional findings, paragraph 8.18.

Table 1: Summary of proposed patient benefits

Specialty	*Proposed service change*	*Patient benefits*	*Scale of benefit*
Acute coronary syndrome	Seven-day rota and centralisation of clinicians and patient flows in a dedicated unit	• Reduced time to treatment • Reduced length of stay • Improved mortality rates • Reduced waiting times for other patients	4,000 patients
Heart rhythm abnormalities	Seven-day rota and centralisation of clinicians and patient flows	• Reduced time to treatment • Reduced length of stay • Reduced risk of complications	430 patients
Acute aortic surgery	Seven-day rota and centralisation of clinicians and patient flows	• Improved mortality rates	50–100 patients
Vascular surgery	Centralisation of clinicians and patient flows at Manchester Royal Infirmary	• Reduced length of stay • Improved morbidity rates • Reduced risk of complications • Reduced tissue loss and amputation for diabetic foot patients	3,300 patients
Stroke	Seven-day rota	• Reduced length of larger stroke • Improved morbidity and mortality rates	900 patients
Urgent gynaecology surgery	Increase in dedicated surgery lists	• Reduced waiting time for surgery • Reduced length of stay • Reduced risk of escalation to emergency treatment	400 patients
Community midwifery	Improved information sharing and standardisation of training and governance	• Reduced risk of adverse patient outcomes	1,500 patients
Urology patient access	Pooled patient lists	• Choice of site for treatment	6,000 patients
Urology cancer surgery	Centralisation of clinicians and patient flows	• Improved health outcomes	400–500 patients
Kidney stone removal	Centralisation of clinicians and patient flows at Wythenshawe Hospital	• Reduced time to treatment	60 patients
Urology seven-day services	Seven-day rota	• Reduced time to treatment • Reduced length of stay	3,900 patients
General surgery	Centralisation of clinicians and patient flows at Manchester Royal Infirmary	• Reduced time to treatment • Reduced length of stay • Improved mortality rates • £10 million capital investment avoided	4,700 patients
Elective orthopaedics	Centralisation of clinicians and patient flows at Trafford General Hospital	• Reduced cancellations • Reduced time to treatment • Reduced length of stay	2,500 patients
Fractured neck of femur	Seven-day rota and centralisation of clinicians and patient flows in a dedicated unit	• Reduced time to treatment • Reduced length of stay • Improved mortality rates • Reduced risk of complications	550 patients
Head and neck cancer surgery	Seven-day rota and centralisation of clinicians and patient flows	• Reduced length of stay • Improved patient experience • Improved mortality rates	400 patients

Source: Submission on patient benefits, Table 4.4.

30. In addition to the benefits included in the parties' benefits submission, the parties claim that the merger will give rise to broader benefits, such as improved research and innovation opportunities and financial savings. For example, the parties expect material savings in the costs of organisational

leadership and resource use (due to the standardisation of clinical pathways and wider efficiencies through greater economies of scale).

31. Further, the parties claim that wider benefits will also arise from the merged trust's role in the broader healthcare landscape for Manchester. The City of Manchester Locality Plan, which includes the implementation of a single hospital service for the city, is intended to improve community-based care, standardise acute care pathways, and pool commissioning budgets across health and social care in Manchester, in order to support improved health outcomes.

32. The proposed merger has received widespread support including from clinicians, commissioners and NHS Improvement.

NHS Improvement's view on RCBs

33. Section 79 of the Health and Social Care Act 2012 (HSCA) requires NHS Improvement to provide advice on RCBs to the CMA in phase 1 as soon as reasonably practicable after receiving notification that the CMA is investigating a merger involving an NHS foundation trust.[15]

34. NHS Improvement's advice is not binding on the CMA. However, the CMA will place significant weight on NHS Improvement's advice, given NHS Improvement's role and expertise as sectoral regulator.[16]

35. In the event that the merging parties do not submit any RCBs during the phase 1 inquiry, they can make such submissions for the first time in phase 2, and the CMA will seek NHS Improvement's views regarding RCBs in phase 2.[17] In this case, the parties did not make a formal submission on RCBs during phase 1, but have now done so during phase 2, and we have received NHS Improvements' view on these RCBs.

36. NHS Improvement supports the strategic rationale for the merger, recognising that the merger could generate significant improvements to patients and that the parties are committed to achieving this.

37. NHS Improvement notes that the merged trust should have the capability, capacity and experience to deliver the merger successfully and contribute to the transformation of health care services for the people of Greater Manchester. Further, NHS Improvement thinks that the devolution of health and social care to Greater Manchester means that local bodies are well

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[15] See also CMA29, paragraph 7.5.
[16] CMA29, paragraph 7.6.
[17] CMA29, paragraph 8.6.

placed to oversee the changes taking place and ensure that the merged organisation delivers improvements for patients.

38. NHS Improvement considers that the parties have more work to do to ensure successful implementation of their strategic rationale, such as detailed post-merger integration planning, identification of clinical interdependencies across the hospitals related to any service relocations, and an assessment of the financial impact of the merger.

39. NHS Improvement also recognises that there are a number of implementation risks given the scale of the transaction, such as the need for the parties to effect significant cultural change among the merged workforce, and the need for significant investment in IT to enable the full realisation of the benefits.

40. In addition to local oversight, NHS Improvement will continue to work with the parties to manage these implementation risks (as part of its merger assurance process) and will hold the parties to account for delivery of the transaction and the implementation of changes for patients going forward.

41. With regard to the 15 proposed service changes outlined in the parties' benefits submission, NHS Improvement considers that the claimed benefits in 11 of the 15 specialties are likely to represent improvements for patients:

(a) Acute coronary syndrome.

(b) Heart rhythm abnormalities.

(c) Acute aortic surgery.

(d) Vascular surgery.

(e) Stroke.

(f) Urgent gynaecology surgery.

(g) Urology cancer surgery.

(h) Kidney stone removal.

(i) General surgery.

(j) Elective orthopaedics.

(k) Head and neck cancer surgery.

42. NHS Improvement notes that the number of patients likely to benefit from the improvements is likely to be a subset of the total number of patients expected to receive a particular service.

43. NHS Improvement acknowledges that the parties have undertaken planning work already. However, NHS Improvement considers that the parties have further work to do, as outlined in paragraph 38, to demonstrate that the improvements for patients are likely to be delivered within a reasonable time frame. NHS Improvement will assess the deliverability of the parties' plans through its merger assurance process.

44. NHS Improvement considers that the merger is the most effective way of enabling the parties to work together to ensure the implementation of the improvements for patients.[18] NHS Improvement accepts that it could be possible to achieve some of the service changes without a merger (eg joint recruitment and shared rotas). However, it thinks that a merger is the most effective method of implementing improvements at scale across Manchester.

45. The proposals set out in the benefits submission are examples of the wider opportunities created by the proposed merger, and the parties are in the process of developing plans for achieving improvements for patients across 75 services, including those proposals included in the benefits submission. NHS Improvement notes that the improvements for patients generated by the merger would be greater than those described in the parties' benefits submission, taking into account the wider opportunities being developed by the parties.

Our preliminary view on RCBs

46. Based on submissions from the parties and the views of NHS Improvement, our preliminary view is that a number of the patient benefits put forward by the parties may constitute RCBs. We will, however, carry out further investigation with the parties and work closely with NHS Improvement, in order to assess whether the patient benefits proposed by the parties can be identified as RCBs in accordance with the Act.

47. In the event that we find that the merger may be expected to result in an SLC and that prohibition of the merger is the only effective remedy to prevent the SLC and any resulting adverse effects, we will consider whether any RCBs

[18] NHS Improvement considers the proposals relating to Urology Cancer to be driven by commissioners and that the proposed service reconfiguration is likely to happen irrespective of whether the merger takes place.

identified outweigh the SLC and its adverse effects, such that no remedy may be appropriate.

48. At this stage, we invite views on:

(a) prohibiting the merger and the existence of any other effective remedies, whether structural or behavioural, to address the provisional SLC and any resulting adverse effects;

(b) whether the benefits proposed by the parties are RCBs as defined by the Act;

(c) the timing and relative certainty that the benefits will arise;

(d) the scale of the benefits;

(e) the extent to which the benefits will be passed on to patients (either directly or via commissioners);

(f) whether there are any other benefits not so far identified by the parties, which we should take into account, such as any further clinical benefits or financial savings likely to be generated by the merger;

(g) whether the benefits proposed by the parties outweigh the provisional SLC and any resulting adverse effects identified in the provisional findings; and

(h) any other matters raised in this Notice.

Next steps

49. Interested parties are requested to provide any views in writing, including any practicable alternative remedies they wish the CMA to consider, to the Project Manager on behalf of the Inquiry Group no later than **29 June 2017**.[19]

[19] This notice is given having regard to the provisional findings announced on 15 June 2017. The parties have until 7 July 2017 to respond to the provisional findings. The CMA's findings may alter in response to comments it receives on its provisional findings, in which case the CMA may consider other possible remedies, if appropriate.