NHS Improvement

Advice to the Competition and Markets Authority: Proposed merger of Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust

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NHS Improvement

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Summary

Central Manchester University Hospitals NHS Foundation Trust ('Central Manchester') and University Hospital of South Manchester NHS Foundation Trust ('South Manchester') (the 'parties') are proposing to merge on 1 October 2017. The merger must be approved by NHS Improvement[1] under its transaction assurance regime, and by the Competition and Markets Authority (CMA) under its merger review regime, before it can proceed.

This document provides advice from NHS Improvement to the CMA regarding the proposed merger. NHS Improvement supports the strategic rationale for the merger, recognising that there is further work for the parties to do to ensure successful implementation.

In line with the national context, the parties face challenges associated with increasing demand and financial constraints. In addition, Manchester commissioners have identified variations in quality of care and access to care for patients across the city as a significant problem contributing to poor health outcomes for some patients. Their response to these challenges involves changing how care is delivered throughout the city, including a proposal to create a Single Hospital Service.

NHS Improvement has assessed the strategic rationale for the merger as the first part of our overall assessment of the merger. At a strategic level, NHS Improvement is supportive of what the parties are trying to achieve for patients in Manchester. The strategy could generate significant improvements to the local health economy, and we find that the management teams at the organisations are very committed to achieving this.

Drawing on the strengths of the existing management teams, the merged trust should have the capability, capacity and experience to deliver the merger successfully and contribute to the transformation of healthcare services for the people of Greater Manchester. In addition, the local autonomy and responsibility resulting from the Greater Manchester devolution programme means that local bodies are well-placed to oversee the changes taking place and ensure that the merged trust delivers improvements for patients.

There are a number of risks that the parties will need to manage as they move forward and a number of key areas of work remain outstanding. NHS Improvement

[1] Since 1 April 2016, Monitor and the NHS Trust Development Authority have been operating as a single integrated organisation known as NHS Improvement. This document is published in exercise of functions conferred on Monitor by the Health and Social Care Act 2012.

will test the plans to address these risks and complete the detailed work on the financial case and integration planning during July and August. NHS Improvement's approval for the transaction will be contingent on the parties demonstrating that they can deliver it successfully in accordance with our guidance. NHS Improvement will hold the parties to account for delivery of the transaction and implementation of changes for patients going forward.

The parties have set out a number of specific proposals in their benefits submission to the CMA as examples of the wider opportunities created by the proposed merger. Our advice on these proposals is set out in this document. From the proposals we have identified the improvements which will arise for patients and set these out so that the CMA can take these into account in its analysis. We are aware that the parties are in the process of developing plans for achieving improvements for patients across approximately 75 service areas, including the 15 described in the benefits submission.

Our assessment of the proposals is that:

- Eleven of the 15 proposals are likely to represent improvements for patients.
- The parties have more work to do to show that the 11 improvements for patients are likely to be delivered within a reasonable timeframe. Some aspects of the proposals appear to be deliverable in the first year of the merger based on the parties' emerging plans. Other aspects will take longer to design and implement (mainly those requiring centralisation of services). There is important work to be done to identify clinical interdependencies and costs before a final decision is made about whether and how to implement these aspects of the proposals.
- Some of the improvements for patients could also be achieved through means other than the merger. However, in our view the merger will facilitate the delivery of improvements.

1. Introduction

This document presents advice from NHS Improvement to the CMA regarding the proposed merger of Central Manchester and South Manchester, including the NHS context in which the merger plan arises, our view of the parties' strategic rationale for the merger and our assessment of the potential benefits for patients. Specifically, we set out:

- Section 1: Information about the parties, the decision to merge, and the regulatory regimes that apply to the proposed merger
- Section 2: The national context in which the proposed merger is taking place
- Section 3: A description of the parties' strategic rationale for the merger, and NHS Improvement's view of the strategic rationale at this stage
- Section 4: A description of the parties' proposals to deliver benefits to patients as a result of the merger, and NHS Improvement's advice regarding the proposed benefits
- Appendix A: Specific advice on the improvements that are likely to arise from the proposals that the parties put forward as part of their patient benefit submission.

1.1. The parties

Central Manchester is a foundation trust operating in the Manchester and Trafford local authority areas. The turnover of Central Manchester in 2015/16 was about £967 million and it has around 1600 beds. Central Manchester provides services from three main sites. The main site is approximately 1.5 miles south of Manchester city centre and is the location of Manchester Royal Infirmary, St Mary's Hospital, Manchester Royal Eye Hospital, Royal Manchester Children's Hospital, and University Dental Hospital. The other two sites are Trafford General Hospital and Altrincham Hospital, which are both located in the Trafford local authority area south of Manchester city centre. Central Manchester also runs adult community health services in Central Manchester, children's community health services across North, Central and South Manchester and a small amount of private patient services.

Central Manchester provides a full range of district general hospital services as well as specialised services. Specialised services offered by Central Manchester include

services for women, babies and families, children and young people, kidney and pancreas transplants, cancer, vascular, haematology and sickle cell disease and cardiology, including cardiothoracic surgery.

South Manchester is a foundation trust operating from two sites in the Manchester local authority area. The turnover of South Manchester in 2015/16 was around £437 million and it has around 915 beds. It provides services at Wythenshawe Hospital and Withington Community Hospital as well as community-based health services in the South Manchester area. Wythenshawe Hospital and Withington Community Hospital are located approximately 8 miles and 5 miles, respectively, south of Manchester city centre.

South Manchester offers a full range of district general hospital services as well as specialised services. Specialised services offered by South Manchester include cardiology and cardiothoracic surgery, heart and lung transplantation, respiratory conditions, burns and plastics, and cancer.

1.2. The decision to merge

On 22 July 2016 Central Manchester, South Manchester and Pennine Acute Hospitals NHS Trust outlined their intention to implement a two stage process to create a new NHS foundation trust in the City of Manchester. As described further in Section 3, this followed a series of reports commissioned by the Manchester Health and Wellbeing Board that included a proposal for a single Manchester hospital service to deliver acute services. The proposal was to deliver a new acute trust in the City of Manchester encompassing Central Manchester, South Manchester and North Manchester General Hospital (NMGH) which is currently part of Pennine Acute Hospitals NHS Trust.

The first stage of the proposal involves merging Central Manchester and South Manchester to form a new foundation trust. The parties intend to complete this stage by 1 October 2017.[2] The second stage involves transferring NMGH services and assets from Pennine Acute Hospitals NHS Trust into the new foundation trust which the parties hope to achieve by April 2019. The CMA is currently reviewing the proposed merger of Central Manchester and South Manchester (the first stage of the proposal).

1.3. The CMA merger review process

The CMA has a function to review mergers involving NHS foundation trusts when they fall within its jurisdiction to ensure they do not have adverse effects on patients by reducing competition between providers. The CMA merger review process allows for both the effects on competition and the potential benefits of

[2] Subject to the necessary regulatory approvals.

mergers to be taken into account to determine what is in the overall best interests of patients.

On 9 February 2017, the CMA announced that it had opened a Phase 1 investigation of the proposed merger of the parties and that it had received a request from the parties to fast track the investigation for an in-depth investigation at Phase 2.[3]

As well as notifying NHS Improvement of the merger investigation, the CMA indicated that it would welcome advice and ongoing assistance from NHS Improvement regarding our assessment of the merger.

Under section 79(5) of the Health and Social Care Act 2012 ('the 2012 Act'), as soon as reasonably practicable after receiving such a notification from the CMA, NHS Improvement[4] is required to provide the CMA with advice on:

- the effect of the merger on benefits[5] (relevant customer benefits),[6] for people who use healthcare services provided for the purposes of the NHS and
- such other matters relating to the merger as NHS Improvement considers appropriate.

Since the parties requested a fast track to Phase 2, they did not make a formal submission on relevant patient benefits for the purposes of the CMA's phase 1 investigation. Therefore, NHS Improvement advised the CMA that it was not yet able to take a view on what impact the anticipated merger may have on any relevant patient benefits for the purposes of the CMA's Phase 1 decision. NHS Improvement offered to provide advice and assistance to the CMA on relevant patient benefits or any other matters during Phase 2 of the investigation.

On 27 February 2017 the CMA referred the anticipated merger between the parties for an in-depth Phase 2 investigation under its fast-track procedure. On 28 March 2017, the parties provided a submission on relevant patient benefits for consideration by NHS Improvement and the CMA during the CMA's Phase 2 investigation.

[3] Fast track reference cases are those where the parties accept that the test for reference is met (and agree to waive their normal procedural rights during Phase 1). The CMA will not be required to undergo all the normal procedural steps and the overall time taken from formal notification to a decision to refer to Phase 2 is accelerated significantly.
[4] The 2012 Act refers to Monitor but for consistency we refer to NHS Improvement.
[5] As defined in section 30(1)(a) of the Enterprise Act 2002.
[6] To note, in this document we use the term 'relevant patient benefits' instead of 'relevant customer benefits' but with the same meaning.

1.4. The role of NHS Improvement in transactions

In addition to a review by the CMA, mergers and other proposed transactions in the NHS may be subject to an assurance review by NHS Improvement. An assurance review takes place where:

- A proposed transaction could significantly alter the risk profile of a foundation trust (the review is part of NHS Improvement's broader responsibilities to ensure foundation trusts comply with the governance and Continuity of Service conditions of their provider licence).
- The transaction is a "statutory transaction" which includes a merger or acquisition involving one or more foundation trusts, and separations and dissolutions of foundation trusts; NHS Improvement has a statutory role in approving transactions which are defined as statutory transactions.

In line with these responsibilities, the NHS Improvement board will consider whether to approve the parties' proposal to merge after NHS Improvement has completed a transaction risk rating assurance review commensurate to the level of risk involved. The proposed merger has been considered to be high risk given the size of the foundation trust that would result from the merger. Therefore the merger is subject to a full scope transaction review in which NHS Improvement will look at four domains: the strategic rationale, the transaction execution, finance and quality. The financial impact of the transaction will be examined as part of this review.

NHS Improvement's assurance work on the merger is at an early stage. The parties submitted a full business case on 31 March 2017 and at this stage we have not reached a view on the overall risk rating for the merger. We have not yet received the parties' final integration plan and therefore have not been able to consider how developed the plan is or how aligned it is to delivering the potential improvements resulting from the merger. Further to this, we have not yet undertaken a detailed assessment to understand the potential financial impact of the merger.

We note that a number of key areas of work remain outstanding for the parties to complete during the course of NHS Improvement's assurance review. We are working with the parties to ensure timely and thorough completion of the process.

At this early stage, we are able to provide our view of the parties' strategic rationale for the merger. Our view is set out in Section 3 to help the CMA consider whether the parties have demonstrated that the merger represents a sound strategy to improve care for patients and address the challenges they face, and whether the parties appear capable of delivering this.

2. National context

The CMA's review of this merger takes place against the background of significant and well publicised operational and financial challenges in the NHS. In this section we describe some of those challenges, the regulatory response to them and the provider perspective. This is intended to assist the CMA in understanding the context in which the merger parties operate.

2.1. Current challenges faced by the NHS and the regulatory response

The demand for NHS services continues to increase. In both 2015/16 and 2016/17 (cost weighted) acute activity commissioned by clinical commissioning groups (CCGs) has grown at around 2.5% a year.[7] Providers and commissioners are under pressure to meet this increasing demand within government spending plans. The NHS is developing a number of system-level responses to meet demand on a financially sustainable basis, which are explained in the *NHS Five Year Forward View* and the subsequent next steps document.[8] [9] Some of these responses focus on prevention, some focus on shifting the pattern of care away from the hospital setting, others focus on operational productivity.

The system has developed in the following ways to enable the sector to focus on these current priorities:

- Sustainability and transformation partnerships (STPs) have been formed to bring together local providers, commissioners and local councils to facilitate planning at a regional level. The STPs are intended to be a key vehicle for agreement on the allocation of resources in the NHS.
- Financial control totals have been introduced, to be in effect for the years 2016/2017, 2017/2018 and 2018/2019, with a view to returning the provider sector to financial balance. Control totals reflect the minimum improvement in financial position that NHS Improvement expects each provider to achieve, taking into account their current financial position and

[7] Next steps on the NHS Five Year Forward View, p. 45. Available from: www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/.
[8] The Five Year Forward View is an evolving plan with a heavy emphasis on accountable care systems. Patient choice is to be preserved within these. The Five Year Forward View commits to "make good on the NHS' longstanding promise to give patients choice over where and how they receive care". NHS England has stated it is committed to a "major programme of work" to improve patient choice by 2020. Information on patient choice available from: www.england.nhs.uk/ourwork/pe/patient-choice/.
[9] Next steps on the NHS Five Year Forward View.

scope for efficiencies.[10] Providers have a range of incentives to deliver against their control totals.[11] In particular, a £1.8 billion Sustainability and Transformation Fund (STF) has been made available to providers. Providers will receive an allocated amount of STF funding if they achieve their financial control totals and perform against an agreed trajectory for certain waiting-time standards, including for A&E.

- In relation to operational productivity, NHS Improvement and NHS England are working with local partners to improve operational productivity to make the best use of resources and unlock more capacity.[12] A mandatory list of efficiency programmes for each CCG and trust in 2017/18 has been published.[13]

2.2. Provider perspective

In the acute provider sector increasing demand has coincided with a deterioration of the financial position across the board. As well as a forecast provider sector deficit, providers are collectively underperforming against several key national targets for A&E and elective care. The sustained focus on emergency care has meant a reduction in planned elective care, which in turn has resulted in a loss of income for providers.[14]

The system priorities described above mean that NHS Improvement, as regulator, and providers are focused on financial performance, A&E performance and operational productivity in particular.

In this landscape, providers are under pressure to secure the resources (funding and workforce) they need to provide services sustainably. We observe that:

[10] NHS Improvement (2016*), The Sustainability and Transformation Fund and financial control totals for 2016/17: methodology*.
[11] NHS England and NHS Improvement (2016), *Strengthening financial performance and accountability in 2016/17*, Available from: www.england.nhs.uk/wp-content/uploads/2016/07/strength-fincl-perfrmnc-accntblty-2016-17.pdf.
[12] Lord Carter's review (published in 2016) found evidence of unwarranted variations in productivity. NHS Improvement is leading the implementation of the recommendations of this review. More information on the review available from: www.gov.uk/government/news/review-shows-how-nhs-hospitals-can-save-money-and-improve-care.
[13] The Next Steps on the Five Year Forward View sets out 'The 10 point NHS efficiency plan', which covers areas where there are particularly large efficiency opportunities including, for example: freeing up bed capacity by reducing delayed transfers of care. Available from: www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/funding-and-efficiency/.
[14] In Q3 2016/17, the most recent reported financial results, the sector's financial position was £886 million in deficit. Source: Quarterly performance of the NHS provider sector: Quarter 3 2016/17. Available from: https://improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-3-1617/.

- A key focus of providers' efforts is securing funding through STPs which allow local systems to decide what services are needed, which providers will provide them and how. Key to this is the ability of providers to demonstrate they are capable of providing high quality, effective and efficient services.
- NHS Improvement's analysis of clinical workforce found that the supply of nurses, in particular, has failed to keep up with the rapid growth in demand for nurses.[15] We also found evidence of significant shortages of doctors, in particular of consultants, in some specialties.[16] The government is introducing seven-day services across the NHS by 2020, which adds to the resourcing challenges providers face.[17]

3. The strategic rationale for the merger

3.1. Devolution in Greater Manchester

The proposed merger is taking place in the context of significant change in Greater Manchester following a devolution agreement between the government and Greater Manchester. Devolution aimed to bring decision-making to local health and social care leaders to enable them to determine how best to allocate resources to improve care for the 3 million people who live in Greater Manchester.

Under the devolution programme, in April 2016, the Greater Manchester Health and Social Care Partnership took charge of the £6 billion health and social care budget for Greater Manchester. The partnership is made up of the 37 local authority and NHS organisations in Greater Manchester, plus representatives from primary care, NHS England, the community and voluntary sectors, Healthwatch, Greater Manchester Police and the Greater Manchester Fire and Rescue Service. Five-year strategies for health and care were developed for Greater Manchester.

Each local authority in Greater Manchester also developed plans for transforming services in their areas, known as locality plans.

[15] Following the Francis Report there has been an increase in the nurse-to-patient bed day ratio, which has increased the demand for nurses. Source: NHS Improvement (2016), *Evidence from NHS Improvement on clinical staff shortages – A workforce analysis*, February.
[16] NHS Improvement's report identified a number of reasons for shortages of doctors in some specialties, including: working conditions (especially emergency medicine) and the attractiveness of sub-specialisation appearing to have resulted in significant shortages for posts in acute general medicine.
[17] For information about seven-day services, see: www.gov.uk/government/collections/nhs-7-day-services and https://improvement.nhs.uk/resources/seven-day-services/.

Greater Manchester's plan features five areas that are targeted for transformational change:

1. A radical upgrade in population health prevention
2. Transforming community-based care and support
3. Standardising acute hospital care
4. Standardising clinical support and back office services
5. Enabling better care through innovation in organisational forms, commissioning, contracting and payment, information management and technology.

To take transformation in these areas forward, the City of Manchester's Locality Plan seeks to build health and social care on three pillars:

- a single commissioning function
- a single hospital service
- a single locality care organisation for out-of-hospital services.

The proposed merger is part one of the two-part proposed process to create a Single Hospital Service across the City of Manchester, as set out in section 1.2 above.

3.2. Challenges in Manchester

The Locality Plan for the City of Manchester aims to address a number of challenges across the city. Health outcomes for patients are in some cases poor compared to other parts of England, and, in line with the national context, hospitals are facing demand pressures.

Central Manchester and South Manchester have experienced high demand, which has impacted them in different ways. For example,[18]

- The number of adult admitted spells[19] has increased at South Manchester by 11% between 2013 and 2016. The number of adult admitted spells at Central Manchester has remained broadly constant over this period (the number of spells at Central Manchester was 0.5% lower in 2016 than in 2013). Waiting list sizes have increased, especially at South Manchester.

[18] The findings reported below are based on NHS Improvement's analysis of Hospital Episode Statistics data from NHS Digital.
[19] A spell is the stay in hospital from admission to discharge.

- South Manchester's performance in meeting referral to treatment (RTT) targets has declined from 95% in Q3 2013/14 to 83% in Q3 2016/17.[20] Central Manchester's s RTT performance declined from 92% to 91% over the same period.

- South Manchester's lower RTT performance coincides with pressures on A&E at South Manchester.[21] South Manchester has not achieved the 95% A&E target of patients being seen and admitted or discharged in under four hours in since October 2014 (in Q3 2016/17 its performance against the four hour standard was 87%). Central Manchester has been consistently performing just below the 95% target since August 2015 (before which Central Manchester's performance exceeded the target).

- Bed occupancy rates have been high in Manchester, especially at Central Manchester. Central Manchester's bed occupancy has consistently exceeded the recommended maximum of 85% as well as the national average over the past three financial years (2014/15 to 2016/17). South Manchester's bed occupancy has also remained high, with its average bed occupancy declining below 85% for only two quarters in the last three financial years.[22]

In addition, the Manchester Locality Plan identified problems including:

- different standards of care provided in different parts of the city
- duplication of some services and gaps in others, making it difficult for patients to access care
- trusts competing to attract staff with specialist skills
- expensive fixed assets that may be duplicated or not always used to optimal efficiency
- missed opportunities to collaborate in research and innovation
- different operational patient pathways and protocols used in different organisations, so a consistent care pathway is not delivered across the city.

[20] The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. The national target has been that 92% of people should spend less than 18 weeks waiting for treatment.
[21] The NHS Constitution sets out that a minimum of 95% of patients attending an A&E department in England must be seen, treated and admitted or discharged in under four hours (the four-hour target/standard).
[22] National Audit Office has noted that hospitals with average bed occupancy levels above 85% "can expect to have regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections". National Audit Office (2013), 'Emergency admissions to hospital: managing the demand', Report by the Comptroller and Auditor General, paragraph 1.21.

In January 2016, the Manchester Health and Wellbeing Board commissioned a review of the potential advantages of creating a Single Hospital Service for Manchester, one of the three pillars intended to address the challenges identified in the Locality Plan. The review had two stages: one to examine the possible benefits of a Single Hospital Service and a second stage to identify the best way to deliver a Single Hospital Service.

3.3. The parties' strategic rationale for the merger

Stage one of the Single Hospital Service review concluded that creating a Single Hospital Service across the city could lead to a number of improvements for patients. Stage two concluded that a merger would be the best way to achieve a Single Hospital Service.

The parties have said that the strategy behind the merger is primarily designed to eliminate unnecessary variations in quality and access to care and reduce duplication of services to improve care for patients across Manchester. The parties believe that a number of improvements (both clinical and non-clinical) will be delivered through the merger. The parties see a significant opportunity to improve outcomes and operational efficiency by reviewing and standardising care pathways, as well as applying operational productivity tools such as those identified in the GIRFT programme.[23] The parties believe that the increased scale of the organisation will enable:

- better quality of care, through increased clinical sub-specialisation[24] and more timely access to diagnoses and treatments through delivery of seven-day services, as well as creating some higher-volume centres to improve clinical outcomes
- improved patient experience with more co-ordinated care
- improved ability to recruit and retain high quality workforce and reduce reliance on bank and locum/agency staff
- increased financial and operational efficiency

[23] GIRFT is Getting It Right the First Time, a national programme led by clinicians to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice. It is a partnership between the NHS Royal National Orthopaedic Hospital Trust (RNOH), which first hosted the pilot programme, and NHS Improvement's Operational Productivity Directorate.

[24] A sub-specialty is a narrow field within a specialty of care and reflects a discrete body of knowledge, skills and competencies sufficiently distinct to justify its creation as separate to the main specialty. Sub-specialties are proposed by Royal Colleges and approved by the General Medical Council (GMC).A doctor can have sub-specialty training indicated against his or her name in the Specialist Register along with their main specialty if he or she satisfies the GMC that he or she has satisfactorily completed additional sub-specialty training. They would then be referred to as a sub-specialist, ie a specialist of a sub-specialty.

- greater focus on research and innovation, including improving access to clinical trials
- improved education and training.

These potential improvements are likely to have an impact across a much wider range of clinical services than the 15 services that the parties have identified as areas in which they would deliver relevant patient benefits for the purposes of the CMA review (see Section 4).

The parties have also said that a rationale for the merger is to overcome barriers that have led to failed or difficult attempts at service changes in the past. The parties have cited a history of failed service changes and reconfigurations, poor clinical relationships and the financial impact of losing a service, particularly a specialist service, as barriers to change. The parties believe that the merger will remove these barriers to delivering improvements by establishing a single accountable board which can drive through the necessary changes.

Finally, the parties have said that their rationale is strongly focused on a counterfactual scenario which identifies significant financial and operational issues for both organisations if they were to remain standalone, particularly for South Manchester. The parties say that this scenario would arise due to the individual organisations being unable to manage demand within their current capacity, leading to operational inefficiencies and an inability to deliver necessary cost improvement plans.

3.4. NHS Improvement's view of the strategic rationale and future work

In carrying out its assurance process, NHS Improvement's first step has been to assess the strategic rationale of the proposed merger. Our review is focused on whether there is a clear strategic rationale for the merger and whether the board has the capability, capacity and experience to deliver the strategy.

NHS Improvement supports the strategic rationale for the merger and what the parties are trying to achieve for patients in Manchester. The strategy could generate significant improvements to the local health economy, and we find that the management teams at the organisations are very committed to achieving this. Drawing on the strengths of the existing management teams the merged trust should have the capability, capacity and experience to deliver the merger successfully and contribute to the transformation of healthcare services for the people of Greater Manchester.

The parties are currently operationally stable and start from a relatively stable financial position with both trusts having exceeded their control totals for 2016/17. Integration delivery will be a key focus of the parties after the merger and the parties have demonstrated that this programme will be well-resourced. These factors help to build confidence in the parties' ability to continue their work plan for successful implementation of the merger. We also note the level of clinical engagement which has taken place to date has been very encouraging.

We recognise the transaction is a large undertaking for both parties and there are number of risks the parties will need to manage as they move forward. These risks include the uncertainty around the parties' ability to affect significant cultural change across the two organisations among clinicians and other staff groups, as well as understanding the IT investment essential to enabling the full transaction benefits to be realised.

Also, a number of key areas of work remain outstanding for the parties, including detailed integration planning and the identification of clinical interdependencies across the hospitals to understand what, if any, significant service relocation could be undertaken. The parties have more work to do to determine the financial impact of the transaction.

NHS Improvement will test the plans to address these risks and complete the detailed work on the financial case and integration planning during July and August. The parties recognise that there is still a lot to do to ensure the merger is successfully implemented. We are working with the parties to identify areas of focus and additional work that is needed for the transaction review.

4. The patient benefits case

The parties' patient benefits submission to the CMA describes proposed changes in 15 services that the parties expect will result in relevant patient benefits, as that term is defined under Section 30 of the Enterprise Act 2002 (the Enterprise Act) (see Section 4.1). While a merger may result in a number of changes that are good for patients, not all would constitute relevant patient benefits for the purpose of the Enterprise Act.

The proposals set out in the benefits submission to the CMA are examples of the wider opportunities created by the proposed merger. For example, some of the proposals explain how patient care could be improved as a result of the merger by providing greater access to specialist clinical input such as sub-specialty cardiology rotas and weekend stroke clinics. Others relate to sharing capacity and resources and creating higher volume hubs. We are aware that the parties are in the process of developing plans for achieving improvements for patients across as many as 75

services (including the 15 proposals in the benefits submission). Therefore, the improvements for patients would be greater than those described in the patient benefits submission.

4.1. The framework for assessing the proposals

NHS Improvement has a statutory duty under section 79(5) of the 2012 Act to provide advice to the CMA on the relevant patient benefits that arise from mergers involving NHS foundation trusts. This advice is provided in accordance with the statutory framework set out in the Enterprise Act.

NHS Improvement assesses whether the benefits put forward by the merger parties would be a relevant patient benefit by examining the following three questions:

- is the proposal likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?
- is the proposal likely to be realised within a reasonable period as a result of the merger?
- is the proposal unlikely to accrue without the merger or a similar lessening of competition?

Our advice on relevant patient benefits is one input into the decision to be taken by the CMA. The CMA has to decide whether the merger would be expected to lead to a substantial reduction in competition and patient choice. If the CMA finds such a reduction in competition, in the context of its Phase 2 review, it will consider whether there are any possible remedies and how any remedy would affect relevant patient benefits.

Further information on our approach to assessing merger benefits is set out in our guidance *Supporting NHS providers: guidance on merger benefits*.[25]

[25] www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers

4.2. The parties' proposals

The parties submitted that the merger would enable them to make a number of improvements which they said should be taken into account as relevant patient benefits. The proposals focus on patients who need services in the following specialties:

- cardiology, vascular and stroke services:
    - acute coronary syndrome
    - cardiac rhythm management
    - acute aortic surgery
    - vascular surgery
    - transient ischaemic attack (also known as a mini-stroke)
- women's health
    - urgent gynaecology surgery
    - community midwifery
- urology
    - urology day-case procedures
    - urology cancer services
    - kidney stone removal
    - urology inpatient services
- general surgery
- elective orthopaedics
- fractured neck of femur
- head and neck cancer services.

4.3. Assessment of the parties' proposals

In this section, we set out our assessment of the parties' proposals against the framework for analysing whether a proposal is a relevant patient benefit.

Our assessment is that:

- **Eleven of the 15 proposals are likely to represent improvements for patients.[26]**
- **The parties have more work to do to show that the 11 improvements for patients are likely to be delivered within a reasonable timeframe. Some aspects of the proposals appear to be deliverable in the first year of the merger based on the parties' emerging plans; other aspects will take longer to design and implement (mainly those requiring centralisation of services). There is important work to be done to identify clinical interdependencies and costs before a final decision is made about whether and how to implement these aspects of the proposals.**
- **Some of the 11 improvements for patients (such as the proposals for kidney stones and elective orthopaedics) could also be achieved through means other than the merger, such as service level agreements or reconfiguring existing capacity. However, in our view the merger will facilitate the delivery of 10 of the 11 improvements.[27]**

The submissions and evidence that the parties put forward in relation to the second and third elements[28] of the framework were similar across all 15 proposals. We therefore set out our advice in the following way:

- First, we summarise below our view of which proposals are likely to represent an improvement in quality, choice or innovation of services for patients or in value for money for commissioners. In Appendix A, we set out in detail our analysis of this element of the framework for each of those specific proposals that we found likely to represent an improvement for patients. This analysis aims to help the CMA understand how the proposal, if implemented, would be likely to result in improvements for patients.
- Second, we set out below our view of the likelihood that the parties would deliver the proposed improvements within a reasonable period; this view is

[26] Acute coronary syndrome, heart rhythm abnormalities, acute aortic surgery, stroke, vascular surgery, transient ischaemic attack (mini-stroke), urgent gynaecology surgery, kidney stone removal, urology cancer surgical services, general surgery, elective orthopaedics, and head and neck cancer surgery.
[27] Urology cancer is the one exception, as described further below.
[28] Is the proposal likely to be delivered within a reasonable period as a result of the merger, and is the proposal unlikely to accrue without the merger or a similar lessening of competition?

applicable across the proposals for which we found likely improvements for patients.

- Third, we set out below our view of whether the proposed improvements are unlikely to accrue without the merger or a similar lessening of competition; this view is applicable across the proposals for which we found likely improvements for patients (with one exception for urology cancer, as explained below).

4.3.1. Is each proposal likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?

In our view, 11 of the 15 proposals are likely to result in improvements for patients by:

- **providing more timely and effective care through combining workforces to increase the availability of sub-specialist consultants and access to services on the weekends:** this is the case with acute coronary syndrome, heart rhythm abnormalities, acute aortic surgery, and stroke proposals
- **providing more timely and effective care through sharing capacity and resources to provide dedicated surgical lists for urgent patients, increase treatment options available and ring fence elective care**: urgent gynaecology, kidney stones treatment, elective orthopaedics, respectively.
- **providing more effective care through creating higher volume hubs which have been shown to produce better patient outcomes and survivorship:** vascular, head and neck cancer, general surgery, urology cancer.

In most cases, the parties were unable to precisely identify the number of patients likely to experience the improvements identified above. We generally found that the number of patients likely to experience the improvements is a subset of the total number of patients expected to receive the particular service.

We found that four of the 15 proposals either did not represent improvements for patients or were insufficiently advanced to assess them under the framework. These were: community midwives, urology day-case surgery, urology inpatient services, and fractured neck of femur.

4.3.2. Is each proposal likely to be delivered within a reasonable timeframe?

With respect to each of those services in which we found a likely improvement for patients, we then considered whether the parties had demonstrated that the proposal was likely to be delivered in a reasonable timeframe.

For each of the 15 proposals the parties have provided us with project initiation documents as well as plans which set out the project milestones, planned timings and delivery dates. For their proposed head and neck cancer, acute coronary syndrome and heart rhythm abnormalities improvements the parties have provided indicative rotas. The parties have also provided a draft integration plan (which covers the wider transaction, including corporate integration, workforce and communication and engagement with staff) and information about the engagement with clinicians, staff, GPs and patient groups that they have done so far.

Although the parties have done a great deal of work already, in our view, to ensure the proposals are implemented successfully they will need to undertake the planning work that is described in their current integration plan. In the coming months, as their integration plan develops, NHS Improvement will be able to assess the deliverability of improvements through the merger assurance process. We would expect the parties to set out, for example:

- clinical interdependencies involved in each proposal, particularly where services are to be moved, and how these will be managed
- how the parties will instil cultural change
- the costs of the proposals (there are current high level estimates in the full business case).

While there is still work to be done, some aspects of the proposals appear to be deliverable in the first year of the merger given the focus and quality of leadership and planning underway and the steps in planning the parties have identified so far. These include proposals to provide greater access by implementing sub-specialist rotas in cardiology, cardiac surgery and head and neck cancer, introducing seven-day or out-of-hours working in cardiology and stroke, and sharing capacity and resources to create dedicated surgery lists for urgent gynaecology patients and increasing access to lithotripsy services for kidney stones patients. A key to delivering these parts of the proposals will be successful engagement with staff regarding how the changes will be implemented. Improving pathways from local hospitals for cardiology patients would also appear to be achievable within the first year with a robust plan for engagement and education with local hospitals.

In contrast, other aspects of the proposals would appear to require much more work to show that they are likely to be delivered in a reasonable timeframe. This is true, for example, for parts of the acute coronary syndrome, heart rhythm proposals, acute aortic surgery proposals that would seek to consolidate cardiac services on a single site. The parties have not yet identified the sites, determined how they will create additional capacity at those sites if needed, and identified the clinical interdependencies that will need to be managed. The parties have said, however, that identifying different levels of clinical interdependencies that may be affected by all proposals is an important part of their planning.

4.3.3. Is the proposal unlikely to be achieved without the merger or a similar lessening of competition?

The parties have said that they could not achieve certain improvements, such as seven-day sub-specialist rotas, independently because this would require recruiting additional consultants and staff, and the cost would not be justified by current patient volumes. In some cases, they add that national workforce shortages in certain specialties would prevent them from making these improvements on their own.

The parties have also said that they cannot make the proposed changes through joint working arrangements (short of a merger) because their past history of poor clinical working relationships and financial incentives to retain revenue demonstrate that these agreements are rarely successful or take too long to put in place. The parties have also said that putting in co-operation agreements across a large number of services would be too complex and time-consuming and a merger is needed to achieve this across a large number of services.

It should be possible to achieve some of these improvements without a merger, and other organisations have done so through recruitment, including joint appointments, shared rotas, implementing commissioning decisions or other arrangements. For example, a hospital can enter into an arrangement to share use of another hospital's facilities while using its own staff,[29] or hospitals may be able to ring fence elective care at a single site that also provides trauma care if they are able to reconfigure non-elective and elective capacity.

However, in this particular case, NHS Improvement's assessment is that a merger appears to be the most effective way to achieve the improvements at scale across the city. In our view, the parties are more likely to work together to ensure delivery of these improvements across the city with the merger than in the absence of the merger.

[29] Eg in this case for kidney stones patients.

We note that the proposals for general surgery are commissioner driven and are likely to happen even without the merger. Manchester Royal Infirmary of Central Manchester was designated as one of four 'hub' hospitals (along with Royal Oldham Hospital, Salford Royal Hospital, and Stepping Hill Hospital) to provide emergency general surgery and high risk general surgery services in four sectors covering General Manchester. South Manchester did not receive this designation. Manchester Royal Infirmary will be the hub hospital for the sector covering Manchester and Trafford. As a result of the reconfiguration, emergency and high risk general surgery patients currently presenting at each South Manchester hospital site will in future be directly transported to Central Manchester's Manchester Royal Infirmary. The change is expected to be fully implemented in August 2018.

We understand from the parties that to implement the commissioners' plan to consolidate emergency and high risk general surgery in the absence of the merger would cost approximately £19.4 million.[30] However, the parties believe that through the merger they will be able to implement the plan for approximately £10.3 million. The parties believe that they can achieve these savings through better use of the merged trust's estates which would allow the parties to create capacity to accommodate patients moving out of the Manchester Royal Infirmary site to allow for the additional emergency general surgery and colorectal patients from South Manchester.

While the parties have significant further planning to do to find the additional capacity required to implement the programme and the implementation costs are therefore not final, in our view the parties are likely to be able to deliver the improvements of the programme more quickly and with less cost through opportunities created by the merger.

The proposals relating to urology cancer are also commissioner driven and the reconfiguration is likely to happen even without the merger. The parties said that if they merge, they are each less likely to challenge the commissioners' decision to consolidate services onto a single site. However, we do not accept this as a reason for finding the urology cancer proposal to be dependent on the merger.

[30] The changes to general surgery are part of Healthier Together, a programme for health and social care reform across Greater Manchester.

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