Competition & Markets Authority

Anticipated merger between Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust

Provisional findings report

Notified: 15 June 2017

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The Competition and Markets Authority has excluded from this published version of the provisional findings report information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [✂]. Some numbers have been replaced by a range. These are shown in square brackets. Non-sensitive wording is also indicated in square brackets.

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A: Terms of reference and conduct of the inquiry
B: Industry background and regulation in the NHS
C: Analytical method and detailed analysis of NHS elective and maternity specialties

Glossary

Summary

1. The Competition and Markets Authority (CMA) has provisionally found that the anticipated merger between Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) (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.

2. However, the parties to the merger, CMFT and UHSM (the parties), have submitted to us that the merger will result in a number of significant benefits to patients (which they submitted amount to relevant customer benefits (RCBs)[1]). Where we conclude that an anticipated merger may be expected to give rise to an SLC, we are required to consider whether and, if so, what remedies might be appropriate. When considering possible remedies to an anticipated merger, we will take into account whether any RCBs might be expected to accrue within a reasonable period as a result of the merger and, if so, whether these benefits are unlikely to accrue absent the merger or without a similar lessening of competition. If no remedy can be found which does not prejudice RCBs, and we believe that the RCBs outweigh the adverse effects of the SLC, we will look to clear the merger.

3. We will carry out this assessment in the next stage of our inquiry. In doing so we will place significant weight on any advice from NHS Improvement. NHS Improvement has informed us it is supportive of what the parties are trying to achieve for patients in Manchester. It has told us that the merger will facilitate the delivery of certain improvements for patients (including delivering improvements more quickly and, for at least one proposed improvement, with less cost than without a merger) and that NHS Improvement will hold the parties to account for delivery of the transaction and implementation of changes for patients.

Background

4. On 27 February 2017, the CMA, in exercise of its duty under section 33(1) of the Enterprise Act 2002 (the Act), referred the anticipated merger between CMFT and UHSM for further investigation and report by a group of CMA panel members (the Inquiry Group). The Inquiry Group must decide:

[1] Within the meaning of section 30 of the Enterprise Act 2002.

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

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

5. CMFT and UHSM are both major acute, teaching and research hospital trusts located in Greater Manchester. CMFT provides services from five hospitals on its Oxford Road site in the city of Manchester as well as from Trafford General and Altrincham hospitals (both in Trafford). UHSM provides services from its Wythenshawe and Withington hospitals (both in south Manchester). Both parties provide a range of NHS elective and non-elective (including emergency care in A&E departments) services, more specialised services and community services.

6. The role of the CMA is to examine the impact that a merger between two hospital trusts could have on competition. In particular, we examine the adverse effects on patients and/or commissioners arising from a loss of competition and the consequences this may have for the quality of healthcare services provided, and the benefits of a merger for patients and commissioners.[2]

7. We are required to publish our final report by 13 August 2017.

Jurisdiction

8. We have provisionally found that the merger will result in the creation of a relevant merger situation within the meaning of the Act, and therefore that we have jurisdiction to review it.

Regulation and policy in the NHS

9. The parties provide their services in an environment of considerable regulation and regulatory oversight. Competition in the NHS is only one of a number of factors which influence the quality of services for patients and it is not the basic organising principle for the provision of NHS services. More important are considerations of regulation and policy.

10. Because of this, we have considered the policy framework for patient choice and competition within the NHS, in the context of recent policy developments in the NHS. CMFT and UHSM are public bodies providing a public service;

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[2] *CMA guidance on the review of NHS mergers (CMA29)*, paragraph 1.7.

namely health services that are free at the point of delivery. In many instances the payment they receive for the services that they provide is regulated. The regulations and recommended standards that providers face cover many facets of their operations including the quality and safety of patient care, which services they can or must offer, which medicines are approved for use, the pricing of medicines and the salaries of some staff. Provider exit from financial failure is uncommon and collaboration between providers to supply some services is commonplace. Because of these and other factors, we have been acutely aware that many of the normal conditions and dynamics of competition between suppliers that we see in other industries are not present in the NHS.

11. Furthermore, we have recognised the financial pressures on the NHS, and that the recent focus by national bodies (NHS England, NHS Improvement and the Care Quality Commission (CQC)) on greater collaboration between providers and commissioners to address these pressures in local health economies, particularly as elaborated in the *Five Year Forward View* and implemented through the regional Sustainability and Transformation Plans (STPs), has reduced the role of competition.

12. Although we believe that the role of competition has been reduced in recent years, we believe that there is a possibility that in all areas of our inquiry CMFT and UHSM may have competed. Patient choice of first outpatient appointments in England for routine NHS elective treatments supported by the payment mechanisms incentivises providers of NHS services ('NHS providers') to compete for patients. Commissioners selecting which NHS providers should be awarded contracts to provide NHS specialised or community services also raises the possibility that CMFT and UHSM competed for these contracts. Finally, that some patients select which A&E department they present themselves to, coupled with providers being paid according to the number of patients that they treat, also introduces the possibility of competition.

13. This merger takes place against a backdrop of considerable reorganisation of healthcare commissioning and provision in Greater Manchester and in the city of Manchester itself. The health and social care budget was devolved to Greater Manchester in 2015. The plans for health and social care in Greater Manchester are wide-ranging. We have had regard for the plans of Greater Manchester in our provisional findings and have spoken to those involved in that planning.

14. The parties submitted that their rationale for the merger was part of the broader strategy for health and social care services in Manchester, and that it was requested by commissioners due to their frustration with the parties' poor

track record of collaboration. A merger between the parties was recommended by an independent review commissioned to assess the prospect of a single hospital service in Manchester.

Market definition

15. The purpose of market definition in a merger inquiry is to provide a framework for the analysis of the competitive effects of the merger.

16. Consistent with our practice in previous hospital cases, we have adopted the following segmentations for defining relevant product markets in relation to this merger:

    (a) each clinical specialty is considered a separate market;

    (b) within each specialty, the following are considered as separate markets:

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

        (ii) community and hospital-based care; and

        (iii) elective and non-elective care;[3] and

    (c) private and NHS-funded services are also considered separately from each other, with the delineations at (a) and (b) being applicable to both private and NHS-funded services.[4]

17. We have not found it necessary in this case to define the geographic market precisely. We have found that the parties attract patients from within the city of Manchester, the borough of Trafford and some parts of the surrounding areas.

Counterfactual

18. Following the devolution of health and social care in Greater Manchester, several reform programmes are underway which could affect the merging parties in the near future. To allow us to assess the merger's impact on competition, we considered what would have been most likely to have happened to the services provided by the parties in the absence of the merger.

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[3] The category of elective care has a large number of clinical specialties within it.
[4] We encourage readers to refer to the glossary for the definition of terms used throughout this report, including outpatient, inpatient, day-case, elective, non-elective and community care.

19. We have carefully considered the following factors when reaching our provisional view on the most likely counterfactual to the merger:

    (a) UHSM's forecast financial performance over the next two years absent the merger;

    (b) the proposed single contract for acute hospital services in Manchester;

    (c) individual planned reconfigurations of services by Manchester commissioners;

    (d) the establishment of a Local Care Organisation in Manchester; and

    (e) potential specialist service reconfigurations by NHS England.

20. A number of Greater Manchester-wide healthcare service reconfigurations are planned or in progress. On the basis of the information available to us we have provisionally concluded that the oesophageal and gastric cancer services, and general surgery, reconfigurations (part of the *Healthier Together* programme) will take place in the near future with or without the merger. We have provisionally concluded that other possible service reconfigurations are not sufficiently certain (in terms of the extent to which they may impact competition, and when) to be taken into account in the counterfactual.

21. Nor did we receive strong evidence that the extent and timing of any impact on competition of the other factors listed in paragraph 19 above were sufficiently certain to be taken into account in the counterfactual.

22. We have therefore provisionally decided to adopt a counterfactual in which the pre-merger conditions of competition will continue, except where impacted by the particular planned service reconfigurations in general surgery and oesophageal and gastric cancer services.

Competitive assessment

23. We assessed in detail how the merger might affect the quality of services in the following areas:

    (a) NHS elective and maternity services;

    (b) non-elective services;

    (c) specialised services; and

    (d) community services.

24. Our assessment has focused on the change that the merger brings about in the parties' incentives. The parties' ability to respond to incentives is currently restricted by their limited resources, notwithstanding the personal and professional commitment of their staff to quality care. We have recognised that competition is only one of a number of factors influencing the quality of care in hospitals, and that the parties' internal documents reflect that.

NHS elective and maternity services

25. We considered the extent to which the parties are close competitors in the provision of NHS elective and maternity services. Such services are typically planned or scheduled in advance and usually require a referral from a GP or other primary care provider.

26. We have considered the evidence from patient surveys on choice and found that the survey evidence indicates that the single biggest factor in a patient's choice decision is the location of the hospital. Since the parties are geographically proximate to each other we believe that in order to attract patients they need to compete more strongly on other factors of quality.

27. We have examined how the parties might respond to patient demand. The parties' internal documents have several references to competition between them and we believe provide evidence that the parties are competing in the provision of NHS elective and maternity services. This includes references in strategy documents setting out each party's strategy for the next few years in particular clinical services. Available capacity gives some indication of the parties' ability and incentive to compete. If the parties are capacity constrained they will have little ability or incentive to compete for additional patients. We have found that the parties face some capacity constraints but we believe there is scope to treat further patients in some specialties thus preserving some incentive to compete.

28. We used GP referral data to get an indication as to whether the parties are close alternatives to each other for certain clinical specialties. We also took into consideration the parties' arguments on (among other factors) their differing strengths in sub-specialties within a clinical specialty category, recent reconfigurations, specific patient pathways that are in place and the presence of specialist treatment centres.

29. Based on the evidence discussed above we have provisionally found that the merger may be expected to give rise to horizontal unilateral effects in 18 NHS elective and maternity services. Therefore, we have provisionally found that the merger may be expected to result in an SLC in NHS elective and maternity services.

NHS non-elective services

30. NHS non-elective services is unplanned care that can be provided on an urgent or emergency basis. Our assessment focused on patients who self-present to A&E departments and receive some treatment there. We did not find evidence that the parties compete closely to provide non-elective services, and we found that the parties' capacity constraints limit their incentives to attract additional patients. We also identified alternative providers of non-elective services which patients could choose to go to rather than the parties.

31. We have provisionally found that the merger may not be expected to give rise to an SLC in relation to NHS non-elective services.

NHS specialised services

32. We assessed the extent to which the parties compete to provide NHS specialised services, which are commissioned at a city, sub-regional, regional or national level.

33. We particularly considered the process used to determine which NHS providers will have the right to supply NHS specialised services. We believe that NHS England and/or the Greater Manchester Health and Social Care Partnership (GMHSCP) might reduce the number of providers holding specialised services contracts, through a reconfiguration of those services. This provides for the possibility that competition (in anticipation of bidding to be awarded such services) would be reduced or lost as a result of the merger. We have provisionally found that the merger would lead to a reduction in the number of credible providers of certain specialised services from two to one in three cardiothoracic services and from three to two in in one specialised cardiothoracic service and one specialised vascular disease service. Accordingly, we have provisionally found that the merger may be expected to give rise to horizontal unilateral effects in four cardiothoracic services and one specialised vascular disease service in Greater Manchester.

34. We closely examined whether NHS England (as commissioner of, and contractual counterparty for, certain NHS specialised services) may possess countervailing buyer power to prevent a worsening of quality from arising in specialised services. We provisionally consider that the buyer power held by NHS England (and, by extension, the GMHSCP, which is the body responsible for procuring some specialised services in Greater Manchester) is insufficient to fully mitigate the effects of the merger in these specialised services.

35. We have provisionally found that the merger may be expected to give rise to an SLC in NHS specialised services in Greater Manchester.

Community services

36. We considered the impact of the merger on competition in the provision of community health services. We found evidence that the parties have not been in active competition with each other for community health services contracts and patients, and that they are not likely to be in competition in the near future. We have provisionally found that the merger may not be expected to give rise to an SLC in community services.

Provisional conclusions

37. Key commissioners with which we spoke in Greater Manchester were all supportive of the merger, and stressed to us the need for local NHS providers to work more closely with each other to tackle the health challenges in Greater Manchester with or without the merger. We consider that the influence of recent regulatory and policy measures has restricted the ability of the parties to compete at this moment in time. In particular, we have placed weight on the *Five Year Forward View* and the subsequent STPs which have provided greater focus on collaboration in the provision of acute services, particularly elective services.

38. In relation to NHS elective and maternity services, this dampening of the competitive dynamic between CMFT and UHSM may be exacerbated by the capacity constraints of the parties and the financial constraints on UHSM although the evidence on the latter is not clear.

39. In relation to NHS specialised services, we also accept that NHS England is likely to possess a degree of buyer power but we currently do not believe that buyer power would be sufficient to prevent an SLC from arising.

40. Taking these considerations into account, we provisionally find that the overall adverse effect resulting from an SLC in NHS elective and maternity services and NHS specialised services will be smaller than would be the case if the parties had a greater degree of regulatory, financial and clinical flexibility to compete vigorously on the quality of their services. We will take this into account when we consider remedies and RCBs.

Provisional findings

1. The reference

1.1 On 27 February 2017, the CMA in exercise of its duty under section 33(1) of the Enterprise Act 2002 (the Act) referred the anticipated merger between CMFT and UHSM for further investigation and report by the Inquiry Group.

1.2 In exercise of its duty under section 36(1) of the Act the CMA must decide:

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

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

1.3 The Inquiry Group's terms of reference are in Appendix A. The Inquiry Group is required to publish its final report by 13 August 2017.

1.4 This document, together with its appendices, constitutes the Inquiry Group's provisional findings, published and notified to CMFT and UHSM in line with the CMA's rules of procedure.[5] Further information relevant to this inquiry, including non-confidential versions of the submissions received from CMFT and UHSM, as well as summaries of evidence received in oral hearings, can be found on the CMA's website.[6]

1.5 Throughout this document CMFT and UHSM are referred to collectively as 'the parties'.

2. The parties to the merger and other providers

Central Manchester University Hospitals NHS Foundation Trust

2.1 CMFT is a large NHS foundation trust providing NHS acute services, teaching and research in the city of Manchester and Trafford area in Greater Manchester. CMFT is the largest acute foundation trust by revenue, and the

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[5] Rules of procedure for merger, market and special reference groups, (CMA17), Rule 11.
[6] Central Manchester University Hospitals / University Hospital of South Manchester merger inquiry case page.

largest provider of specialised services, in Greater Manchester.[7] Indeed, it is one of the largest foundation trusts in England (based on bed numbers).[8]

2.2 CMFT has around 1,600 beds and approximately 12,300 whole-time equivalent employees (as at end of March 2016).[9] It provides:

(a) district general hospital services including elective and non-elective services;

(b) specialised services for women, babies and families, children and young people, ophthalmology, kidney and pancreas transplants, haematology and sickle cell disease;

(c) adult community health services in the central Manchester area;

(d) children's community health services across the north, central and south Manchester areas; and

(e) a small amount of private patient services.[10]

2.3 Moreover, as a teaching hospital, CMFT carries out a significant amount of medical research and is a member of the Manchester Academic Health Science Centre.[11,12]

2.4 It provides these services across a number of sites and hospitals. Its hospitals are:

(a) Manchester Royal Infirmary, a large teaching hospital that provides emergency care, elective care and tertiary care services. It is the specialist regional centre for kidney and pancreas transplants, haematology, cardiothoracic surgery and cardiology;

(b) Royal Manchester Children's Hospital, a specialist children's hospital;

(c) Saint Mary's Hospital, a specialist hospital providing services for women and babies, including genetics;

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[7] Parties' phase 1 submission, paragraph 51.
[8] See NHS England: Bed Availability and Occupancy Data – Overnight.
[9] Parties' phase 1 submission, paragraph 47.
[10] Parties' phase 1 submission, paragraph 48.
[11] Parties' phase 1 submission, paragraph 48.
[12] The Manchester Academic Health Science Centre is a partnership between The University of Manchester and six NHS organisations, providing clinical and research leadership and helping healthcare organisations to benefit from research and innovation to drive improvements in care.

(d) Manchester Royal Eye Hospital, a specialist eye hospital;

(e) University Dental Hospital of Manchester, a specialist dental hospital;

(f) Trafford General Hospital, which provides inpatient, day-case and outpatient elective care services;[13] and

(g) Altrincham Hospital, which provides outpatient and diagnostic services.[14]

2.5 CMFT's constituent hospitals, other than Trafford General Hospital, Altrincham Hospital and the University Dental Hospital of Manchester[15] are located on a single site (the 'Oxford Road site') approximately 1.5 miles south of Manchester city centre (see Figure 1).[16]

2.6 CMFT was formed as an NHS trust in 2001 through the merger of Central Manchester Healthcare NHS Trust and Manchester Children's Hospital NHS Trust. It acquired foundation trust status in 2009. In 2012 it acquired Trafford Healthcare NHS Trust in April 2012 (which comprised the Trafford General and Altrincham hospitals).

2.7 CMFT's main commissioners of NHS acute services are:

(a) NHS England, through its North West Commissioning Hub;

(b) Manchester Clinical Commissioning Group (CCG);[17] and

(c) Trafford CCG.[18]

2.8 CMFT is rated 'Good' by the CQC.[19,20] CMFT is placed in the second out of a possible four segments under the NHS Improvement Single Oversight

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[13] Trafford General was the UK's first NHS hospital, opened by Aneurin Bevan in July 1948.
[14] Parties' phase 1 submission, paragraphs 45 and 46.
[15] Trafford General Hospital and Altrincham Hospital are located in the Trafford local authority area. The University Dental Hospital of Manchester is located on the Manchester University Campus, a short distance from CMFT's main site and also on Oxford Road.
[16] Parties' phase 1 submission, paragraph 47.
[17] Manchester CCG was created in April 2017, combining North Manchester, Central Manchester and South Manchester CCGs. See paragraphs 8.15 and 8.16.
[18] Parties' phase 1 submission, paragraph 49.
[19] Parties' phase 1 submission, paragraph 50.
[20] The CQC is the independent regulator of health and adult social care services in England. All providers of such services are required to register with the CQC. The CQC monitors, inspects and regulates health and adult social care services to make sure that they meet fundamental standards of quality and safety. It provides a rating of Trusts by placing them in one of four categories. In 2015/16, the CQC rated just 1% of trusts as Outstanding; 44% as Good; 49% as Requires Improvement; and 6% as Inadequate.

Framework (where the first segment is strongest and the fourth weakest).[21,22] This determines the amount of support required.

2.9 CMFT recorded revenue of approximately £1 billion and a trading surplus of £56.4 million in the year ended 31 March 2017 (in contrast to a trading deficit of £18.5 million in the year ended 31 March 2016). CMFT's 2017/18 operational plan for the year ended 31 March 2018 forecasts a surplus of £10.7 million (excluding non-operating income), which includes receipt of £20.2 million from the Sustainability and Transformation Fund.[23,24]

University Hospital of South Manchester NHS Foundation Trust

2.10 UHSM is a NHS foundation trust providing NHS acute services, teaching and research in south Manchester. UHSM is the fourth largest provider of acute services by revenue and the fourth largest provider of specialised services in Greater Manchester.[25]

2.11 In the year ended 31 March 2016 (latest available), UHSM had approximately 915 beds and around 5,500 employees.[26] It provides:

(a) district general hospital services including elective and non-elective services;

(b) specialised services, including cardiology and cardiothoracic surgery, heart and lung transplantation, respiratory conditions, burns and plastics, cancer and breast care services; and

(c) community-based health services in the south Manchester area.[27]

2.12 UHSM, like CMFT, is a teaching hospital and is a member of the Manchester Academic Health Science Centre.[28]

2.13 UHSM provides NHS acute services from Wythenshawe Hospital and Withington Community Hospital, which are located approximately 8 miles and 5 miles south of Manchester city centre respectively (see Figure 1).[29] Wythenshawe Hospital is a teaching hospital that provides emergency care,

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[21] Parties' phase 1 submission, paragraph 50.
[22] NHS Improvement is responsible for monitoring NHS trusts and NHS foundation trusts, and it uses its Single Oversight Framework to fulfil this obligation. See from paragraph 99 of Appendix B.
[23] Parties' phase 1 submission, paragraph 52.
[24] The Sustainability and Transformation Fund supports NHS providers in deficit. The distribution of funding is calculated by NHS Improvement and then agreed with NHS England. See paragraph 4.24 below.
[25] Parties' phase 1 submission, paragraph 58
[26] Parties' phase 1 submission, paragraph 54.
[27] Parties' phase 1 submission, paragraph 55.
[28] Parties' phase 1 submission, paragraph 55.
[29] Parties' phase 1 submission, paragraph 54.

elective care and tertiary care services. It is the specialist regional centre for burns and plastic surgery and heart and lung transplants. Withington Community Hospital offers outpatient services for a range of specialties, planned surgical services for adults on a day-case basis, and diagnostic services.

2.14 UHSM's main commissioners of NHS services are:

(a) NHS England, through its North West Commissioning Hub;

(b) Manchester CCG; and

(c) Trafford CCG.[30]

2.15 UHSM is rated 'Requires Improvement' by the CQC, which carried out a planned inspection on 26 to 29 January 2016.[31] UHSM has been in breach of its NHS Improvement licence conditions since May 2014, which reflects challenges it has experienced in its financial and operational performance in recent years.[32] NHS Improvement places it in segment three (out of four segments) in its segmentation process to determine support needed under its Single Oversight Framework.[33]

2.16 UHSM recorded revenue of £437 million and a deficit of £5.8 million (against a planned surplus of £0.2 million) in the year ended 31 March 2016 (latest available). The deficit was driven by a relatively high level of debt servicing as a result of UHSM's private finance initiative (PFI) scheme[34] and historically low levels of liquidity.[35]

2.17 UHSM's Wythenshawe site is a little over 7 miles from UHSM's Oxford Road site, 8 miles from Trafford General Hospital and 4 miles to Altrincham hospital. UHSM's Withington site is a little over 3 miles from CMFT's Oxford Road site, 10 miles from Trafford General Hospital and 9 miles from Altrincham Hospital.

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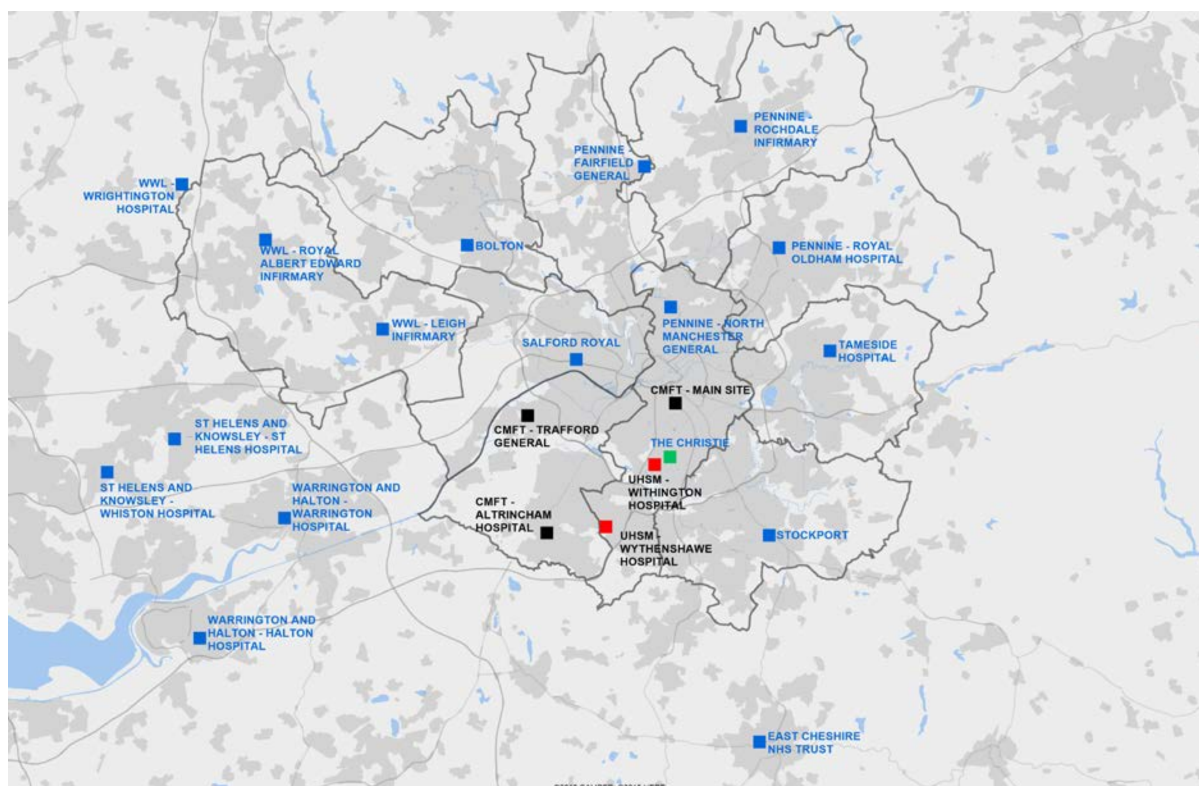
[30] Parties' phase 1 submission, paragraph 56.
[31] Parties' phase 1 submission, paragraph 57.
[32] Most providers of NHS services are required to hold a licence (the provider licence) from NHS Improvement. Licence holders must comply with the conditions of their licence, in order to provide NHS services. NHS Improvement monitors compliance with those conditions.
[33] Parties' phase 1 submission, paragraph 57.
[34] The PFI is a form of partnership between the public and private sectors in which a group of private companies contracts to provide public facilities, often public buildings, such as schools or hospitals. The Trust has a 35-year PFI scheme for two buildings at Wythenshawe Hospital, which expires in 2033.
[35] Parties' phase 1 submission, paragraph 58.

Other providers of NHS acute services in Greater Manchester

2.18 Figure 1 shows the close proximity of a number of other providers of NHS acute services in Greater Manchester. The competitive constraint these providers impose on the parties is a key component of our competitive assesment. This section briefly describes those closest to CMFT and UHSM both in terms of geographic proximity and in terms of breadth of provision of NHS acute services.

Figure 1: Hospitals in Greater Manchester (and nearby)



Source: The parties.

Salford Royal NHS Foundation Trust

2.19 Salford Royal NHS Foundation Trust (Salford Royal) is a district general hospital providing NHS acute and community services and is a teaching hospital. The trust provides a wide range of elective and emergency care as well as some specialised services, including for the treatment of disorders of the brain, renal system, spine and those with intestinal failure conditions. Salford Royal employs around 7,000 staff across all of its NHS acute and community services. It is 6 miles from CMFT (Oxford Road), 3 miles from CMFT (Trafford General) and 7 miles from UHSM (Wythenshawe).

2.20 The CQC has rated Salford Royal as 'Outstanding'. Its total income in the 2016/2017 financial year was around £520 million.

Pennine Acute Hospitals NHS Trust

2.21 Pennine Acute Hospitals NHS Trust (Pennine Acute) provides a range of elective and emergency services and some specialised services. It operates from four main sites: North Manchester General Hospital; The Royal Oldham Hospital; Rochdale Infirmary; and Fairfield General Hospital. The closest of these to the parties, geographically, is North Manchester General Hospital which lies a little over 5 miles to the north of CMFT (Oxford Road site), around 7 miles from CMFT (Trafford General) and 9 miles from UHSM (Wythenshawe).

2.22 The CQC has rated Pennine Acute as 'Inadequate'. Its total income in the 2016/2017 financial year was around £588 million.

Stockport NHS Foundation Trust

2.23 Stockport NHS Foundation Trust (Stockport) provides NHS acute services from Stepping Hill Hospital. Stepping Hill Hospital provides emergency care and a comprehensive range of elective and non-elective services, including for children and young people, and a range of outpatient and diagnostic imaging services. Stepping Hill Hospital is 7 miles from CMFT (Oxford Road), around 11 miles from CMFT (Trafford General) and 7 miles from UHSM (Wythenshawe). It also operates the Devonshire Centre for neuro-rehabilitation (community and mental health services) and the Meadows Palliative Care Centre.

2.24 The CQC rated Stockport 'Requires improvement'. Its total income in the 2016/2017 financial year was around £303 million.

The Christie NHS Foundation Trust

2.25 The Christie NHS Foundation Trust (The Christie) is a specialist cancer centre within 4 miles of CMFT (Oxford Road), 6 miles from CMFT (Trafford General), a little over 5 miles from UHSM (Wythenshawe) and a little over a mile from UHSM (Withington hospital).

2.26 It is the largest cancer treatment centre in Europe. The Christie provides chemotherapy, radiotherapy, surgical, diagnostic and non-elective patient care services. The Christie operates satellite treatment centres at hospital sites in Salford, Oldham, Macclesfield, Wigan, Bolton. The Christie is a major cancer research centre and a member of the Manchester Academic Health Science Research Centre.

2.27 The CQC has rated the Christie as 'Outstanding'. Its total income in the 2016/2017 financial year was around £268 million.

Tameside and Glossop Integrated Care Foundation Trust

2.28 Tameside and Glossop Integrated Care Foundation Trust (Tameside) provides a range of non-elective (including A&E) and elective services. It lies around 7 miles from CMFT (Oxford Road), 13 miles from CMFT (Trafford General) and 11 miles from UHSM (Wythenshawe).

2.29 The CQC rated Tameside 'Good'. It was taken out of special measures in 2015. Its total income in the 2016/2017 financial year was around £212 million.

3. Industry background and regulatory framework

3.1 This merger inquiry concerns the provision of certain NHS services in England.[36] Appendix B has a detailed overview of the provision of NHS services in England and the regulatory framework under which those services are provided. Further, Annex B to Appendix B sets out the principles and rules of competition in the NHS as they pertain to the commissioning of services. Industry-specific terms used in this report are defined in the glossary.

Regulation of NHS acute services

3.2 In this section, we describe the institutional bodies, the regulatory and other mechanisms in place to safeguard and support the improvement of the quality, performance, finance and leadership of NHS acute services.

Institutional responsibilities within the regulatory framework

3.3 The main institutions regulating the NHS in England are described in greater detail in Appendix B. Below we briefly describe the role these bodies play in the regulation of NHS acute providers in England.

The Department of Health

3.4 The Department of Health, led by the Secretary of State for Health, is responsible for the NHS, public health and social care in England. Among

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[36] Health is a devolved matter and since the merger and its effects are restricted to England we do not set out the regulatory framework for Scotland, Wales or Northern Ireland.

other duties, it develops policy, introduces legislation and allocates funding from HM Treasury to the NHS.

NHS England

3.5 NHS England is responsible for setting the priorities and direction of the NHS and improving health and social care outcomes for people in England. NHS England has a statutory duty[37] to exercise its functions with a view to securing continuous improvement in the quality of services.[38] It is required to promote autonomy and choice within the NHS.[39] NHS England is also the commissioner of primary healthcare services (ie medical services provided by general practitioners (GPs), dental practices, community pharmacies and high street optometrists) and specialised tertiary healthcare services (ie services provided in more specialised medical centres). Finally, NHS England is responsible for overseeing the operation of CCGs.

NHS Improvement

3.6 NHS Improvement is an umbrella body which brings together Monitor and the NHS Trust Development Authority, whose statutory functions have continued. NHS Improvement, through Monitor, authorises and regulates NHS foundation trusts, sets prices for NHS services (the National Tariff) and supports commissioners to maintain service continuity. NHS Improvement, through the NHS Trust Development Authority, oversees NHS trusts in England, including taking such steps as it considers necessary and appropriate to assist and support NHS trusts to ensure continuous improvement in the quality of the provision and the financial sustainability of NHS services.

3.7 In this report, we use both 'Monitor' and 'NHS Improvement' and, separately, 'NHS Trust Development Authority' and 'NHS Improvement' interchangeably.

Care Quality Commission

3.8 The CQC is an independent regulator of standards in health and adult care in England. It monitors, inspects and regulates services to make sure that

[37] Section 3E of the NHS Act 2006.
[38] Continuous improvement in quality refers to either the prevention, diagnosis or treatment of illness or the protection or improvement of public health.
[39] Section 13I and 13F (respectively) of the NHS Act 2006.

they are safe, effective, caring, responsive to patient needs and that providers are well led.

3.9 A key part of what the CQC does is to carry out unannounced inspections of acute hospitals (and other providers). Following an inspection, the CQC gives a ratings on a four-point scale. The ratings are 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'. CQC inspection reports are published.

Clinical Commissioning Groups

3.10 CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. There are 209 CCGs across England. CCGs commission most secondary care services (ie medical services provided by specialists or consultants in a particular field of medicine, whether in a hospital or community setting).[40]

Healthwatch England

3.11 Healthwatch England is responsible for representing the public's view on healthcare by gathering views on health and social care at both local and national levels and feeding these views into local health commissioning plans. Every local authority in England has a Healthwatch.

3.12 Healthwatch Manchester is the local Healthwatch for the city of Manchester.

Health and Wellbeing Boards

3.13 Health and Wellbeing Boards (HWBs) are statutory organisations established under the HSCA 2012. They promote cooperation from leaders in the health and social care system to improve the health and wellbeing of their local population and reduce health inequalities. The boards, which sit within local government authorities, bring together bodies from the NHS, public health and local government, to plan how to meet local health and social care needs, and to commission services accordingly.

3.14 The Manchester HWB (MHWB) is chaired by the leader of Manchester City Council and includes elected representatives from Manchester City Council, as well as representatives from Manchester CCG, CMFT, UHSM and Pennine Acute, and other commissioners and providers of health and social

[40] Community health services is a term used to describe a diverse range of services that are provided to patients in the home, in health centres, schools, community buildings or in small local hospitals. Services include health visiting, school nursing, community nursing, nutrition and dietetics, occupational therapy, speech and language therapy and diabetes care.

care services in Manchester. The MHWB is responsible for overseeing the delivery of the Manchester Locality Plan.

Commissioning in Greater Manchester

3.15 Commissioning and provision of NHS services in Manchester has gone through, and is going through, considerable change. On 25 February 2015, the 37 NHS organisations and local authorities in Greater Manchester signed an agreement with the government to devolve health and social care expenditure in Greater Manchester, following the political devolution agreement which had been made the previous year.[41] As a result, the GMHSCP assumed control over the region's health and social care budget, which amounts to approximately £6 billion per year. The GMHSCP operates through a single governance arrangement headed by a Strategic Partnership Board which oversees the delivery of a strategic plan relating to health and social care in Greater Manchester. [42] CMFT and UHSM as members of the partnership share responsibility for the delivery of the strategic plan. If the parties merge, responsibility will pass to the new, merged, trust.

3.16 Manchester is the only city in England to have health and social care devolved to it.

3.17 In July 2015, health commissioners in Greater Manchester agreed to adopt the *Healthier Together* transformation programme, a blueprint for local commissioning and provision across all facets of healthcare and social care in Greater Manchester, one aspect of which was a plan to consolidate acute hospital services in Greater Manchester into integrated 'single services'. The *Healthier Together* programme highlighted some of the poor health outcomes in Greater Manchester and the variability in those outcomes across the city.

3.18 As a part of the *Healthier Together* programme, each of the commissioning areas in Greater Manchester produced a locality plan in order to implement the aims of the *Healthier Together* programme in their local area. In November 2015, the MHWB adopted the City of Manchester Locality Plan, which set out the overall vision to improve health and social care in

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[41] On 3 November 2014, the Chancellor of the Exchequer and leaders of the Greater Manchester Combined Authority (GMCA) signed an agreement devolving new powers and responsibilities to Greater Manchester.
[42] The GMHSCP is a body comprised of the 37 NHS organisations and local authorities in Greater Manchester, as well as representatives from primary care, NHS England, the community and voluntary sectors, Healthwatch, Greater Manchester Police and the Greater Manchester Fire and Rescue Service. CMFT and UHSM are both members of the GMHSCP.

Manchester given the ambitions in the *Healthier Together* programme. The City of Manchester Locality Plan has three pillars:

(a) A single commissioning system that combines the health and social care commissioning responsibilities held by the three Manchester CCGs (now merged) and Manchester City Council.

(b) A Local Care Organisation (LCO) to deliver community-based health and social care services.

(c) A Single Manchester Hospital Service that delivers acute services to consistent standards and quality across Manchester.

3.19 With regard to the third of these, the MHWB commissioned the Manchester Single Hospital Service Review to assess the benefits of this plan. The review was led by Sir Jonathan Michael and conducted in two stages:

(a) First, to assess whether closer collaborative working between NHS providers in the city of Manchester would deliver benefits in quality of care, patient experience, workforce recruitment and retention, and in research and innovation.[43]

(b) Second, to assess what the best organisational and governance arrangements would need to be in order to successfully deliver the Single Hospital Service in the city.[44]

3.20 Sir Jonathan concluded that closer collaborative working between CMFT, UHSM and Pennine Acute's North Manchester General Hospital would deliver benefits to patients and to the local health economy and that the best way to achieve the benefits would be via a merger.

3.21 In December 2015 the GMHSCP published its five year plan, *Taking charge of our health and social care.*[45] This five-year plan was built from the ten locality plans and it was developed with input from NHS England, NHS Improvement and the CQC.

3.22 Devolution of health and social care to Greater Manchester bodies has not involved any legislative or regulatory change. NHS England, the ten local CCGs and the ten local authorities have retained their statutory commissioning functions. However, NHS England has delegated the internal responsibility for the operational management of the delivery of the NHS

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[43] Sir Jonathan Michael (2016), *Manchester Single Hospital Service Review: stage one report*.
[44] Sir Jonathan Michael (2016), *Manchester Single Hospital Service Review: stage two report*.
[45] GMHSCP (2015), *The Five Year Plan*.

Constitution and NHS Mandate to the Greater Manchester Chief Officer (GMCO) as its employee. The GMCO, through a Joint Commissioning Board, is responsible for the following commissioning functions:

(a) Some specialised commissioning services.

(b) Primary care (apart from GP services) and secondary dental care services.

(c) Public health related services.

3.23 Further, a memorandum of understanding between the GMHSCP and NHS England confirms that commissioning will take place at a Greater Manchester level where this achieves best outcomes for local residents.

4. The policy environment, patient choice and competition

Introduction

4.1 Over the past 15 years or so, various UK governments have gradually introduced policies impacting upon the nature and scope of patient choice and competition in the provision of NHS services in England. The main initiatives are listed below.

- 2003: block contracts were largely replaced with Payment by Results (PbR), an activity-based system that reimburses providers for the work that they carry out at an agreed national price (the National Tariff). This was designed to incentivise providers to attract patients;[46,47]

- 2003: NHS foundation trusts established. Foundation trusts typically have greater operational autonomy than NHS trusts, for example they are able to retain and reinvest any surpluses that they make.

- 2004: some NHS elective care could be provided by the independent sector, and the first foundation trusts were announced;[48]

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[46] See Department of Health (November 2012), A simple guide to Payment by Results, and Appendix B, paragraph 61.
[47] Block contracts are contracts between a commissioner and a provider which pays a provider a fixed amount of money in return for the provision of specified services. The payments therefore are not dependent on the number of patients treated although the contracts may be capitated. Block contracts have not been completely replaced – CMFT, for example, has a block contract with Trafford CCG – but PbR is the predominate form of provider payment for elective services.
[48] NHS foundation trusts have greater financial freedom, thereby increasing their incentive and ability to compete.

- 2006: the principle of patient choice was introduced to a limited extent. Patients could choose from a list of four or five hospitals;
- 2006: 'Choose and book' electronic booking system was introduced – patients could book the place, date and time for their own first outpatient appointment online or by phone;
- 2007: Principles and rules of competition were issued by the Department of Health in respect to procurement, cooperation and collusion, conduct of individual organisations, and mergers and vertical integration.
- 2008: 'free choice' was introduced which allowed any patient in England to choose any relevant provider in England for their first outpatient appointment;
- 2009: the right of patient choice was enshrined in the NHS Constitution;[49]
- 2012: the Any Qualified Provider (AQP) system was established, under which qualified providers have contracts with commissioners giving them the right to provide certain NHS services, and to be on the list of providers which can be chosen by patients for those services; and
- 2013: the Procurement, Patient Choice and Competition Regulations came into effect replacing the 2007 principles and rules of competition.

4.2 Today in England, patients have the right to choose any provider in England that has been commissioned by a CCG or NHS England of their first outpatient appointment for NHS elective services. This is enshrined in the NHS Constitution (2009). Patients generally choose a provider with their GP based on information and recommendations given by their GP.

4.3 Patient choice of provider of NHS elective services is facilitated by the AQP regime. Under AQP, where a provider meets the criteria for provision of NHS elective services, a commissioner must include that provider on the lists of providers, from which patients and GPs can then choose a provider for their first outpatient appointment via the e-Referral booking system (which has superseded the Choose and Book system).

4.4 The NHS Choice Framework sets out the range of choices that patients should expect to be offered in the NHS services that they use. Patient choice

[49] Patients are entitled to choose: (a) any provider that has been commissioned by a CCG or NHS England to provide that service; and (b) the clinical team that will be in charge of the treatment within the patient's chosen provider. See Appendix B, Industry Background, paragraph 146 and ff.

is underpinned by supporting infrastructure, including the NHS e-Referral Service, a secure and free NHS appointment booking service, which allows patients to book their first outpatient appointment at a hospital or clinic of their choice, and NHS Choices, which provides performance information on providers to assist patients in selecting an appropriate provider. Patients will have a variety of information on which to base their choice decision. Some information will come from their GP but other sources of information include the NHS Choices website and the CQC (as well as from more informal sources such as the experience of friends). Information available to patients typically includes:

(a) average waiting times for specific treatments from the time of a GP referral;

(b) CQC ratings of the hospitals and trusts;

(c) patient ratings and comments;[50]

(d) some clinical related outcome indicators (for example, 90-day mortality rates);

(e) overall infection rates;

(f) number of procedures performed in the trust;

(g) how well a ward's staffing level requirements are being met;

(h) whether the staff within a trust would recommend their own trust; and

(i) average time spent in hospital.[51]

4.5 If a patient chooses a particular provider for their first outpatient appointment, that provider will be paid via the PbR system. PbR is an activity-based system that reimburses providers for the work that they carry out at an agreed national price (the National Tariff), thereby allowing money to 'follow the patient' to the patient's chosen provider.

4.6 Competition between providers can in theory take place when patients choose (advised by, and perhaps together with, their GP) between them for routine elective services and (except where they arrive by ambulance) for non-elective services. Choice of provider is therefore a vital mechanism to encourage competition between providers. Providers of NHS elective

[50] From standard surveys such as the trusts' 'friends and family' surveys and from comments and ratings by users of NHS Choices.
[51] NHS Choices.

services are incentivised to maintain and improve the quality of their services in order to attract patient referrals and the income that treating additional patients brings. Within this policy and regulatory environment the key planks are the PbR and AQP regimes.

4.7 Unlike price or quantity, many aspects of quality cannot be set directly. The quality of a product or service is the outcome of many different decisions which will involve trading off different factors. For example, the decision not to fill a nursing vacancy is made by trading off the possible effect on quality of care and the impact on the cost of providing care. The priorities that determine how these decisions are made will affect individual aspects of the hospital's quality, such as the ratio of nurses to patients, as well as feeding into the hospital's overall reputation.

4.8 The effect of competition would be to focus these decisions such that account is taken of the factors that matter to patients and GPs. In this way, competition between hospitals might lead them to make spending decisions in a way that best reflects the factors that matter to patients and their GPs.

4.9 Competition between providers can also take place when commissioning entities (CCGs or NHS England, for example) choose with which provider(s) to enter into contracts for the provision of services to patients. By way of example, competition of this kind may occur in relation to specialised services contracts tendered by NHS England. The principles and rules that apply to the procurement of these services are set out in Annex B to Appendix B.[52]

4.10 Therefore, for many services – and especially routine elective services – competition between providers is inextricably linked to patient choice. As well as incentivising providers to improve services to the benefit of patients, the principle of patient choice is intended to empower patients to select the provider that best meets their needs. Our inquiry, therefore, has focused closely on how the merger may affect patient choice, as well as how it may affect commissioners' choices when they are selecting who is to provide NHS services.

4.11 However, the effectiveness of choice (whether by patients, their GPs or commissioners) as a driver of competition and improvements by providers is inextricably tied to the incentives and ability of providers to respond. We have assessed these incentives on providers within the context of the

[52] Despite being largely tertiary services, there are some specialised services in which providers compete for the right to supply them but once providers are in place patients can exercise choice between them. The parties told us that these are endocrinology services, HIV services and cancer services (albeit there is no patient choice following diagnosis).

regulatory and policy environments in which the parties currently operate. The main recent policy developments relevant to our inquiry are set out below.

Recent policy developments

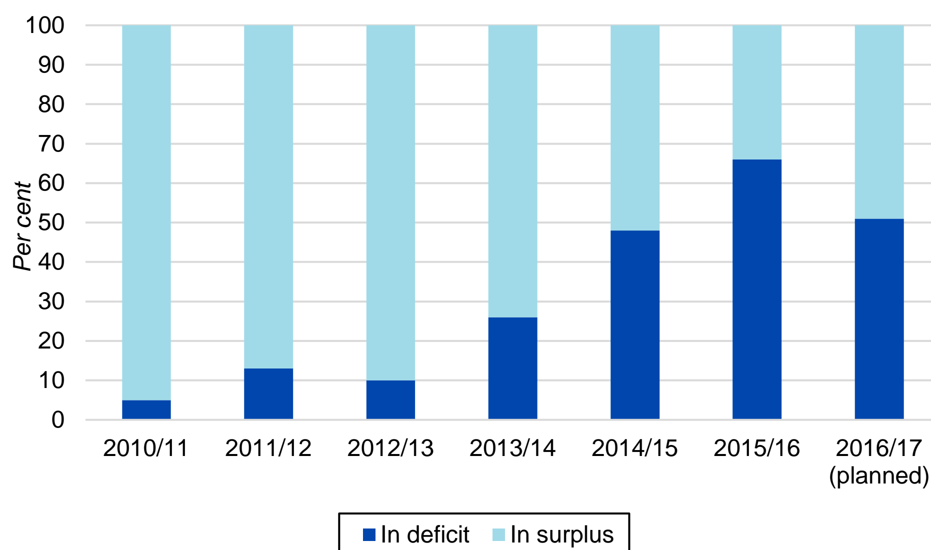
4.12 Acute healthcare provision in England is undergoing a period of change because of a variety of pressures on the NHS. There is increasing demand for NHS acute services, in part driven by longer lifespans and a growing population. Technological developments have improved patient care but some treatments but can be expensive. There is also a greater degree today of clinical specialisation than ever before, which requires a minimum critical scale to support it. Integration with other parts of the public health and social care system is required to deliver effective care to many patients.

4.13 We have heard from the parties and third parties in our inquiry that recent budgetary pressures within the NHS has meant that there has been a recent shift in the outlook of NHS providers, regulators and government alike, toward tighter financial management, stricter regulatory oversight and a reduced emphasis on autonomy for NHS and foundation trusts.

4.14 The budgetary pressures have been significant. The *Five Year Forward View* (see paragraph 4.17 below) estimated that in an environment of growing demand and the absence of further efficiency improvements, the NHS would face a budget shortfall of around £30 billion by 2020/21.[53] The King's Fund has found that the proportion of trusts in England in deficit has risen sharply from 5% in 2010/11 to an expected level of 50% in 2016/17 (having gone as high as 66% in 2015/16) (Figure 2).

[53] *Five Year Forward View,* paragraph 13.

Figure 2: Proportion of NHS provider trusts in England in deficit and surplus, 2010/11 to 2016/17



Source: The King's Fund based on data from Monitor, NHS Trust Development Authority and Department of Health (2009/10–2011/12), National Audit Office (2012/13–2015/16), NHS Improvement (2016/17)
Note: The underlying data include NHS ambulance, hospital, community and mental health service trusts in England. Around three-quarters of these trusts are acute hospital trusts.

4.15 The National Audit Office (NAO) examined the finances of the NHS last year and reported that:

(a) 'in 2015-16 trusts' balance of net current assets, showing how much capital trusts are generating and using, was negative for the first time. This suggests trusts are finding it difficult to finance their day-to-day operations'; and

(b) 'Trusts' performance against important NHS access targets has worsened… We [the NAO] found an association between trusts' financial performance and trusts' overall Care Quality Commission rating (which does not include measures of actual financial performance). The trusts that achieved lower quality ratings also reported poorer average financial performance. We found that the five trusts rated 'outstanding' between December 2013 and August 2016 had a net deficit equal to 0.02% of their total income in 2015-16. The 14 trusts rated "inadequate" had a net deficit equal to 10.4% of their total income in 2015-16'.[54]

4.16 As a consequence of the budget and other pressures (described above), there have been some national policy developments to help providers and commissioners address these pressures. This section discusses the more

[54] NAO, Financial Sustainability of the NHS, November 2016.

recent and pertinent of these for our inquiry. We start with the *Five Year Forward View*.

Five Year Forward View

4.17 The *Five Year Forward View* was developed by NHS England, the CQC, Public Health England and NHS Improvement and was published in October 2014. It is the key current policy document and provides a platform for many of the changes occurring across all levels in the NHS in England today.

4.18 The *Five Year Forward View* called for a greater focus on the prevention of ill health and improvement of public health and greater integration of health and social care, to meet the changing needs of patients and to improve the sustainability of services. One of its key proposals was the development of new models of care to remove the divide between primary care, community services and hospitals, and health and social care, which acts as a barrier to coordinated healthcare services. The new models of care are based on organisational forms proposed by the Dalton Review, a review undertaken by Sir David Dalton, to examine new options and opportunities for NHS providers. The proposed new models of care are set out in Appendix B.[55] The *Five Year Forward View* set out the implementation of new care models as one way to release some of the financial pressures on the NHS.[56]

4.19 Between January and September 2015, 50 vanguards across England were selected by NHS England to lead the development of these new care models and act as the blueprints for the NHS in England moving forward.[57] These vanguard organisations, which have reorganised arrangements between them, are ongoing.

4.20 A follow-up document, *Next Steps on the Five Year Forward View*, published in March 2017, reviewed the progress made since the launch of the *NHS Five Year Forward View* in October 2014 and set out a series of steps for the NHS to deliver a better, more joined-up and more responsive service. These steps included providing more care outside of a hospital setting to take the strain off urgent and emergency care, greater investment in primary care

[55] See paragraph 154 and ff.
[56] The report says that to achieve a 2-3% net efficiency gain each year would require investment in new care models since these could help make some providers more efficient and could help moderate demand increases.
[57] See NHS England: Vanguards.

and greater integration of the commissioning and provision of health and social care.[58]

4.21 The focus of the *Five Year Forward View* is on a greater level of collaboration between providers of NHS services in order to meet today's challenges in the NHS (paragraphs 4.12 to 4.14). Although collaboration does not need to be between providers of the same type of services[59] the report sets out that patient care might be improved in some instances if providers were to collaborate. This could be, for example, by establishing care networks.

Sustainability and Transformation Plans

4.22 STPs were introduced by NHS England and NHS Improvement to help ensure that health and social care services were built around the needs of local populations. This was achieved by requiring 44 regions or geographical footprints across England to produce a multi-year STP, demonstrating how each region would develop high-quality, sustainable health and social care services over the next five years. They are a key mechanism for delivering the Five Year Forward View.

4.23 The five-year strategy to improve health and social care in Greater Manchester was adopted as the region's STP in December 2015. It includes a number of initiatives to improve health and social care in Greater Manchester, including:

(a) an upgrade of the region's approach to prevention, early intervention and self-care;

(b) integrating primary, community, acute, social and third sector care through the development of LCOs;

(c) standardisation of acute care pathways and reorganisation of service provision;

(d) streamlining of back office support; and

(e) pooling commissioning budgets for health, care and support services in each locality.

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[58] *Next Steps on the Five Year Forward View* called for trusts to do more to tackle variation in clinical quality, which is one of the rationales for the *Healthier Together* programme.
[59] For example, primary care providers might combine with acute hospitals to provide better integrated care.

4.24 NHS England has created a Sustainability and Transformation Fund (STF) to assist with restoring financial sustainability across the NHS provider sector, and to support local areas in delivering their STPs. The STF stands at £2.1 billion for the financial year ending 31 March 2017.[60] Payments from the fund depend on whether providers meet their financial control totals (below) and whether providers meet other performance targets for certain waiting time standards. If they do not meet performance targets they will be required to agree an improvement plan with NHS Improvement. An NHS provider may face a withdrawal of STF payment. From April 2017, STPs have become the single application and approval process for accessing NHS transformation funding.

4.25 Within Manchester the parties submitted that a funding package of around £27 million has been agreed (which can be increased to a maximum of around £43 million) for transaction, transformation and restructuring costs in regard to the single hospital service programme. This funding will be dependent on the specific objectives being met. The parties also submitted that Sustainability funding of around £30 million per year for the merged trust is identified to the parties from the formula used by NHS Improvement, in distributing the funding agreed for restoring financial sustainability across the provider sector. This funding is directly linked to delivery trajectories of specific performance objectives (specific to each party). The parties understand that discussions are at an advanced stage, for control over this funding to be held by the GMHSCP in consultation with NHS Improvement. The parties told us that this is one way NHS Improvement and the GMHSCP can ensure that the merged trust will maintain and drive up quality.

Accountable care systems

4.26 Accountable care systems (ACSs) are intended to be an evolved version of an STP, which provide fully integrated care at a local level and take collective responsibility for resources and public health in return for greater control over the operations of the local health system. Candidates for ACS status are likely to include successful vanguards, devolution areas, and STPs that have been working towards the ACS goal. This includes Greater Manchester.

[60] The Fund consists of a £1.8 billion sustainability strand for providers (mainly of acute emergency care) and £0.3 billion for transformation.

Financial control totals

4.27 Financial control totals were introduced by NHS England and NHS Improvement in the financial year ended 31 March 2017. The control total regime comprises one of a wider set of measures to strengthen the financial and operational performance of NHS providers.[61]

4.28 Financial control totals, once agreed between providers and NHS Improvement, are the minimum level of financial performance that NHS provider boards must deliver, and for which they will be held directly accountable, thus providing a degree of financial constraint on providers. Providers that agree and meet their financial control totals are able to access the STF.

4.29 CMFT's audited annual accounts for the year ended 31 March 2017 report a trading surplus of £56.4 million (excluding non-operating income), which exceeded the control total agreed with NHS Improvement, and includes receipt of £48.8 million from the STF.

4.30 UHSM is forecasting achievement of its surplus of £0.4 million for the year ended 31 March 2017, which is consistent with the control total agreed with NHS Improvement, and includes receipt of £8.3 million from the STF.[62]

4.31 The parties submitted that the effect of the control totals regime is to constrain the autonomy of NHS providers, and their ability to independently 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 totals entail in relation to overall decision-making are also accompanied by specific initiatives that constrain NHS providers' autonomy in areas like spending on agency pay and other areas of expenditure and delivering cost savings in procurement. They submitted that the strategic autonomy of NHS providers is further constrained by the extreme difficulties faced by NHS providers in accessing capital to implement any new strategies.[63]

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[61] See NHS England news story (21 July 2016): NHS action to strengthen trusts' and CCGs' financial and operational performance for 2016/17.
[62] Parties' phase 1 submission, paragraph 66.
[63] Parties' phase 1 submission, paragraph 148.

Carter report into operational productivity

4.32 To help policy makers and providers in the current financial environment, in February 2016, Lord Carter of Coles reported to the Department of Health on what could be done to improve operational efficiency in acute hospitals in England in order to save the NHS £5 billion each year by 2020/21.[64] Following the Carter report, NHS Improvement and NHS England are working with local partners to improve operational productivity to make the best use of resources and free some capacity. A mandatory list of efficiency programmes for each CCG and NHS provider in 2017/18 has been published. The efficiency programmes are a mechanism to ensure that NHS providers meet their financial control totals.[65]

Views of third parties

4.33 NHS England said that patient choice has not worked in the way it was originally intended to in the NHS, and that it is increasingly using system management and collaboration rather than competition to manage the NHS at the local health economy level.[66]

4.34 Likewise, Sir Jonathan Michael told us that the NHS has moved away from competition as a driver for improvement.

Summary

4.35 NHS providers are experiencing significant financial challenges, driven by a number of factors. We have heard from the parties and seen some evidence that budget deficits adversely impact on an NHS provider's day-to-day performance. Regulators and policy makers have introduced a range of measures to respond to the challenges being faced by NHS providers. The most significant policy developments for the purpose of our inquiry are the *Five Year Forward View*, STPs and financial control totals. We consider that the consequence of these policies has been, in general, to encourage greater levels of collaboration and collective responsibility in the provision of NHS acute services within local health economies, and a reduced emphasis on competition. These recent policy developments have constrained the independence of foundation trusts, such as CMFT and UHSM, making them less effective as autonomous competitors. Nevertheless, we do not view

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[64] Operational productivity and performance in English NHS acute hospitals: unwarranted variations.
[65] NHS Improvement advice to the CMA. See the '10 point efficiency plan' in Next Steps on the Five Year Forward View.
[66] Greater Manchester is an example of a population at the local health economy level.

these policy developments as eliminating competition in the NHS in general, nor as we describe below, specifically as between the parties.

5. The merger and its rationale

Background

5.1 This merger takes place against a backdrop of considerable reorganisation of healthcare commissioning and provision in Greater Manchester.[67]

5.2 The parties submitted that they intended ultimately to merge CMFT, UHSM and Pennine Acute's North Manchester General Hospital. This, they told us, would occur in two stages. The first stage involves bringing together CMFT and UHSM. It is this transaction which we are investigating in this inquiry. CMFT and UHSM plan to be dissolved as trusts and, in their place, a new foundation trust will be created into which the assets and liabilities of CMFT and UHSM will be transferred. This requires regulatory approval of NHS Improvement. That approval process is ongoing at the time of our inquiry.

The rationale

5.3 The parties submitted that their rationale for the merger was linked to, and indeed a part of, the broader strategy for health and social care services in the city of Manchester, which we have described above in paragraphs starting at 4.1.[68]

5.4 In particular, the *City of Manchester Locality Plan* noted 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

[67] This has been discussed in paragraphs 3.15–3.23 above.
[68] Parties' phase 1 submission, paragraph 35.

focus for acute hospital care, or for the relationship between providers and commissioners.[69]

5.5 The *City of Manchester Locality Plan* called for a single hospital service, and the *Manchester Single Hospital Review* examined a number of different organisational arrangements which might be used to implement this. Following the Review's recommendations, on 22 July 2016 CMFT, UHSM and Pennine Acute proposed a merger between CMFT, UHSM and North Manchester General Hospital.[70]

5.6 The parties submitted that creating a single hospital service within the city of Manchester could improve the quality of care to patients, create opportunities to improve recruitment and retention of staff, and the ability to deliver financial and operational efficiencies.[71] Indeed, as a part of our inquiry the parties have submitted to us a number of claimed clinical benefits to patients that they say would arise as a direct result of the merger. The parties have agreed a number of strategic objectives for the new trust. These include, among other objectives, to:

(a) improve patient safety, clinical quality and outcomes (especially through eliminating unnecessary variation in care and to improve upwards the standardisation of care); and

(b) ensure financial stability (through a series of financial savings).

5.7 We have been struck in our inquiry by the widespread support of the merger of those NHS-related bodies who we have spoken to including the GMHSCP, CCGs, NHS England, and other providers. We have also been struck by the enthusiasm and support for the merger of each party's clinical staff we have met. They have all cited the benefits of the merger to patients as their reason for supporting the merger.

5.8 NHS Improvement has told us that the merger will facilitate the delivery of improvements for patients (including delivering improvements more quickly and, for at least one proposed improvement, with less cost than without a merger) and that NHS Improvement will hold the parties to account for delivery of the transaction and implementation of changes for patients going forward.

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[69] Manchester Locality Plan, November 2016, p55.
[70] The report of CMFT, UHSM and PAHT on arrangements to implement the recommendations of the Single Hospital Service Review, 22 July 2016.
[71] Full Business Case, March 2017.

6. Jurisdiction

6.1 A relevant merger situation is created if two or more enterprises cease to be distinct and either the share of supply or turnover test set out in the Act is satisfied.

6.2 Section 79 of HSCA 2012 clarifies that, where the activities of two or more trusts cease to be distinct and at least one is a foundation trust, this is to be treated as a case in which two or more enterprises cease to be distinct for the purpose of Part 3 of the Act. The parties submitted that they planned for the merger to involve the dissolution of UHSM and CMFT, their property and activities to be brought under a common new foundation trust. The parties would therefore be brought under common ownership whereas they were previously distinct.

6.3 We therefore provisionally consider that arrangements are in progress or contemplation which, if carried into effect, will result in enterprises ceasing to be distinct.

6.4 The turnover test will be satisfied where the value of the turnover in the UK of the business being taken over exceeds £70 million.[72] By virtue of section 28 of the Act, in the case of a merger, rather than acquisition, both parties' UK turnover needs to exceed £70 million.[73] Accordingly, the second limb of the relevant merger situation test is satisfied and there is no need to consider separately the share of supply test.

6.5 For the reasons given above, we are satisfied that the merger between the parties will, if carried into effect, result in the creation of a relevant merger situation. We therefore have provisionally concluded that we have jurisdiction to consider whether the creation of that situation may be expected to result in an SLC within any market or markets in the UK for goods and services.

7. Market definition

7.1 The CMA's Merger Assessment Guidelines state that the purpose of market definition in a merger inquiry is to provide a framework for the analysis of the competitive effects of a merger. Market definition is a useful analytical tool,

[72] Section 23(1)(b) of the Act. Note that the applicable turnover is that relating to the business year preceding the date when the phase 1 reference decision was made: see Enterprise Act 2002 (Merger Fees and Determination of Turnover) Order 2003, SI 2003/1370, article 11(2)(b).
[73] Section 28(1)(b) of the Act.

but not an end in itself, and identifying the relevant market involves an element of judgement.[74]

7.2 The boundaries of the market do not determine the outcome of our analysis of the competitive effects of a merger in a mechanistic way. In assessing whether a merger may give rise to an SLC, we may take into account constraints outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others.[75]

7.3 The Merger Assessment Guidelines also note that, in practice, the analysis underpinning the identification of the market or markets and the assessment of the competitive effects of a merger overlap, with many of the factors affecting market definition being relevant to the assessment of competitive effects and vice versa. Therefore, market definition and the assessment of competitive effects should not be viewed as distinct analyses.[76]

7.4 In the remainder of this section, we address the relevant markets in which the effects of the merger should be assessed. First, we address the appropriate product and geographic markets and, second, we present our provisional conclusion on market definition.

Product market

7.5 The CMA has previously adopted the following segmentations for defining relevant product markets in relation to mergers of NHS hospitals,[77] broadly in line with those identified in the NHS Merger Guidance:[78]

(a) each specialty is considered a separate market;

(b) within each specialty, the following are considered as separate markets:

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

(ii) community and hospital-based care; and

(iii) elective and non-elective care; and

[74] *Merger Assessment Guidelines (CC2/OFT1254)*, paragraphs 5.2.1 & 5.2.2.
[75] *Merger Assessment Guidelines*, paragraph 5.2.2.
[76] *Merger Assessment Guidelines*, paragraph 5.1.1.
[77] See *A report on the anticipated merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust (Ashford and St Peter's/Royal Surrey County)*, paragraph 5.49.
[78] *NHS Merger Guidance*, paragraph 6.38.

(c) private and NHS-funded services are also considered separately from each other, with the delineations at (a) and (b) being applicable to both private and NHS-funded services.

7.6 The parties expressed doubts about separately defining markets for outpatient, day-case and inpatient activity, given the way in which patients access these services, suggesting 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 parties also expressed doubts about whether each specialty is a separate product market. We address these concerns below. We also address the constraints at sub-specialty level below.[79]

Outpatient, day-case and inpatient activity

7.7 Outpatient care includes first and follow-up consultant appointments, as well as diagnostic treatments that do not require admission.

7.8 Admitted patients may be day-case or inpatient. A day-case is where a patient is admitted electively during the course of a day with the intention of receiving care, but does not require the use of a hospital bed overnight and returns home as scheduled.[80] Inpatient treatments require patients to be admitted to hospital and involve an overnight stay.

Parties' views

7.9 The parties raised concerns about the possibility of defining outpatient, day-case and inpatient treatments each as separate markets. The parties submitted that, at the time at which the patient was being referred, neither the patient nor their referring GP know what package of services would be consumed by the patient (including whether the patient would be admitted for day-case or elective inpatient services). Further, the ratio of patients admitted for treatment compared with those referred for outpatient appointments was low. The parties submitted that all patients who were referred for treatment faced the possibility of being admitted for treatment at the time the patient, together with their GP, was choosing their provider. The

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[79] *NHS Merger Guidance*, paragraph 6.38, notes that where there are limits to supply-side substitution within specialties, we may take into account constraints at sub-specialty level in our competitive assessment.
[80] Health & Social Care Information Centre, *A coded classification of patients who have been admitted to a Hospital Provider Spell*.

parties submitted that this meant all patients took into account the quality of outpatient and inpatient services offered by each provider.[81]

7.10 The parties submitted that in light of the above points 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 could then be assessed with reference to their ability to offer different types of treatment.[82]

7.11 The parties submitted arguments relating to whether each specialty was a separate product market:[83]

(a) There were specialties where services (for example, Anaesthetics) would be supplied to patients only as part of their treatment in another specialty, and specialties where a patient was only very rarely referred directly to that specialty by their GP (for example, Speech and Language Therapy or Transplantation Surgery). Patients were generally not separately accessing services in these specialties.

(b) It may be appropriate to group certain specialties together where patients with similar conditions were being recorded by each party as being referred to different specialties (suggested examples were Obstetrics and Midwife Episodes, and Oral Surgery and Maxillo-Facial Surgery).

Our assessment

Demand-side considerations

7.12 We consider that, from a demand-side perspective, outpatient and either day-case or inpatient services are not substitutable, because of the different services offered in each setting, and because the setting in which it is most appropriate for a patient to be treated can depend on that patient's condition. However, day-case and inpatient services may have some similarities in some specialties and it may be the acuity of the patient's condition that determines which service is received, or potentially differences between hospitals in how particular treatments are provided.

7.13 With respect to the parties' submissions on the determinants of patient choice we note that in choosing a provider, there is scope for patients to

[81] Parties' phase 1 submission, paragraphs 196–204.
[82] Parties' phase 1 submission, paragraph 167.
[83] Parties' initial phase 2 submission, paragraphs 21 & 22.

exercise choice based on the quality of outpatient, day-case and/or inpatient services. However, the extent to which patients or their GPs (acting on their patients' behalf) choose a provider based on (potential) future treatment is likely to vary by specialty. Some specialties are outpatient only, and for others admission as a day-case or inpatient may be less likely.

7.14 The CMA's patient survey in the *Ashford and St Peter's/Royal Surrey County* inquiry found that patients were evenly split as to whether or not they had expected at the time of their initial referral that they would subsequently need treatment or surgery. The survey also found that the quality of outpatient services is more important than the quality of future treatment to some patients in choosing a provider, while the quality of day-case and inpatient services was more important for other patients.[84]

7.15 We take from this evidence that there is scope for patients who anticipate follow-up inpatient (or day-case) treatment to possess and respond to different preferences over their treatment location compared with those who expect to receive only outpatient treatment. Even where the set of providers is the same across each of the treatment settings, some providers may have a better reputation or better quality offer for outpatient treatment than for their other services, or patients may weight locational convenience and quality measures differently depending on their expected treatment needs.[85] Although patient choice is limited to first outpatient referrals, the exercise of patient choice affects all parts of the patient pathway, and generates scope for hospitals to compete against one another in relation to outpatient, day-case and inpatient services.[86]

Supply-side considerations

7.16 We consider that, from a supply-side perspective, inpatient providers are readily capable of providing both day-case and outpatient services. Day-case-only providers are readily capable of providing outpatient services, but not inpatient services, because of the facilities and expertise required. Similarly, outpatient-only providers are not readily able to provide day-case or inpatient services. In summary, we consider there to be asymmetric constraints among different providers of inpatient, day-case and outpatient care for each specialty.

[84] *Ashford and St Peter's/Royal Surrey County*, paragraphs 6.38–6.40.
[85] In this specific case the set of providers is not the same across all treatment settings. For example, Care UK is a significant provider of outpatient-only services across a range of specialties in Greater Manchester. See Appendix C for further details.
[86] The implications of this for our analysis of GP referral data are discussed further at paragraph 10.46 and in Appendix C.

7.17 Providers of inpatient care generally compete with a wider set of providers, including day-case-only and outpatient-only providers, in the provision of day-case and/or outpatient care. However, this is unlikely to be the case across the full range of day-case and outpatient treatments, where day-case-only and outpatient-only providers cannot provide certain services. This may be because some day-case activity may have to take place at inpatient providers because of the equipment or capability required, and patients attend outpatient appointments at the provider at which their inpatient or day-case treatment has taken or will take place.

7.18 In our analysis, we distinguish between outpatient, day-case and inpatient services where this is possible and take into account the extent of competition that the parties face from each other and other providers.

Specialty and sub-specialty level

7.19 Each specialty is considered to be a separate product market since:

(a) on the demand side, patients and referring GPs will only choose treatments that are relevant to the diagnosed condition or symptoms; and

(b) on the supply side, different sub-specialty services can generally be aggregated into a broader product market at the specialty level: providers have the ability and incentive quickly (generally within a year) to shift capacity between these different services depending on demand for each, and the same providers compete to supply these services.[87]

7.20 Where the conditions of competition are the same, certain specialties may be grouped together.[88] Where certain specialties are clearly identifiable as primarily supporting treatment in another specialty, we take this into account in our competitive assessment.[89]

7.21 The NHS Merger Guidance notes that, where there are limits to supply-side substitution within specialties, the CMA may take into account constraints at sub-specialty level in its competitive effects assessment.[90]

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[87] *Merger Assessment Guidelines*, paragraph 5.2.17.
[88] For example Obstetrics and Midwifery Services have been grouped together as Maternity services (paragraph 175 of Appendix C). For Oral Surgery and Maxillofacial Surgery we have examined this both together and separately (paragraphs 92–96 of Appendix C).
[89] See paragraph 10.60 below in relation to Chemical Pathology. The same consideration applies to Anaesthetics but given the CMA's Phase 1 decision that there was no realistic prospect of an SLC finding in Anaesthetics it is not discussed further in these Provisional Findings.
[90] *NHS Merger Guidance*, paragraph 6.38.

7.22 We note that there may be limits to supply-side substitution within specialties, because providers may not have the ability or incentive to provide certain sub-specialty treatments. For example, a provider may be unable to undertake a complex treatment because it lacks the appropriate equipment.

7.23 Commissioning arrangements may also limit the extent to which providers can offer certain sub-specialty level treatments. In this regard, specialised services (some of which are provided by the parties and third parties nearby) are a subset of more complex treatments within a specialty, which providers can only offer if they are commissioned to do so by NHS England. Accordingly, the commissioning of these services places limits on supply-side substitution within a specialty.

7.24 Since not all providers have the ability or incentive to offer all treatments within a specialty, for the reasons set out above, the extent to which providers compete with each other for these treatments differs. We take this into account in the competitive assessment.[91]

Geographic market

NHS Merger Guidance

7.25 The NHS Merger Guidance states that, in publicly funded healthcare services, the relevant geographic market may be based on the locations of providers and will be informed by an assessment of the willingness of patients to travel for consultation or treatment, the 'catchment area'.[92]

7.26 Both parties are located in Greater Manchester, with both having sites in the city of Manchester, while CMFT also has sites in the borough of Trafford.

Parties' views

7.27 The parties submitted that they competed in Greater Manchester and Cheshire. They submitted results of catchment area analysis indicating that CMFT attracted 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 and 14 minutes' drive-time of Altrincham Hospital. UHSM attracted 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.

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[91] See paragraph 10.57 below, and Appendix C, paragraphs 50 and ff.
[92] *NHS Merger Guidance*, paragraph 6.40.

Our approach

7.28 For our primary analysis of elective services we have used data on actual GP referral patterns to provide an insight into patient's or their GP's preferences, rather than restricting analysis to a specified geographic area. We have also used catchment areas to support our analysis, as discussed below.

7.29 For non-elective services (including A&E) we have considered other providers located within Greater Manchester, taking into account travel distance and travel time in considering potential alternatives.

7.30 In relation to competition for contracts to provide specialised services and community services we have not needed to define a geographic market, but to inform our assessment have looked at the geographic scope of relevant contracts, and previous bidding for contracts, where information is available.

Catchment areas

7.31 We have carried out some specialty-level catchment area (and share of supply) analysis, to supplement our analysis of GP referral data.[93] For this purpose, we calculated catchment areas corresponding to the area from which 80% of patients travel.

Provisional conclusions on the relevant markets

7.32 Regarding the product market, we provisionally conclude the following:[94]

(a) 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. We take this into account in the competitive assessment.

(b) Within each specialty (with some specific exceptions), the following were considered as separate markets:

(i) outpatient, day-case and inpatient activity. Given the existence of asymmetric constraints among different providers, for each specialty, inpatient, day-case and outpatient care are considered to be distinct product markets;

[93] See Appendix C, paragraph 20 and table 4.
[94] *NHS Merger Guidance*, paragraph 6.38.

(ii) community and hospital-based care; and

(iii) elective and non-elective care.

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

7.33 Regarding the geographic market, we provisionally conclude that the parties compete in the city of Manchester, the metropolitan borough of Trafford, and parts of the surrounding area, but have not needed to take a more precise approach than this.

8. The counterfactual

Framework for our analysis

8.1 In order to assess whether the merger may be expected to result in an SLC, we are required to consider the competitive situation without the merger. This situation is referred to as the counterfactual.[95]

8.2 The counterfactual sets out the most likely competitive situation absent the merger based on the evidence available to us. It is affected by the extent to which events and their consequences are foreseeable in terms of their nature, timing and competitive effect, enabling us to predict with some confidence the most likely outcome.[96] We note that when making the competitive assessment we may consider a merger within the context of certain events or circumstances even if those events or circumstances are not sufficiently certain to include in the counterfactual. In this case we recognise that there are some ongoing changes in the Manchester health economy which currently carry significant levels of uncertainty, in particular concerning the timing and/or impact of any change on competition. However, where appropriate, we have taken account of these developments in our competitive assessment (in the provision of community services[97]). We may also take them into account in our RCB assessment, if relevant, in the next stage of our inquiry.

8.3 We may examine several possible scenarios affecting the conditions for competition absent the merger, one of which may be the continuation of the

[95] *Merger Assessment Guidelines*, paragraph 4.3.1.
[96] *Merger Assessment Guidelines*, paragraph 4.3.2.
[97] See paragraph 13.15 and ff.

pre-merger situation, but ultimately, only the most likely scenario will be selected as the counterfactual.[98]

8.4 We typically incorporate into the counterfactual only those aspects of scenarios that appear likely on the basis of the facts available to us and the extent of our ability to foresee future developments.[99] An approximate time frame of two years is being used in this merger inquiry.[100]

8.5 Against this framework, and in light of the parties' views and those provided by relevant third parties, we have considered the following factors when reaching our provisional view on the most likely counterfactual to the merger:

(a) UHSM's forecast financial performance over the next two years absent the merger;

(b) the proposed single contract for acute hospital services in Manchester;

(c) individual planned reconfigurations of services by Manchester commissioners;

(d) the establishment of a Local Care Organisation in Manchester; and

(e) potential specialist service reconfigurations by NHS England.

Parties' views

8.6 The parties have told us that there are four key points that they wished us to consider in relation to the counterfactual:

(a) UHSM's future ability to compete with CMFT given the financial pressures on UHSM and the impact on its ability to maintain its existing portfolio of specialised services in the light of planned service reconfigurations.

(b) The Commissioners' stated plans, in the lead up to the parties' merger decision, for a single contract for acute services in the city of Manchester.

[98] *Merger Assessment Guidelines*, paragraph 4.3.6.
[99] *Merger Assessment Guidelines*, paragraph 4.3.6.
[100] We have chosen two years since the foreseeable period used in our counterfactual assessment can sometimes be relatively short (*Merger Assessment Guidelines,* paragraph 4.3.2). By analogy, often the CMA's starting point for considering entry by a rival as a mitigating force in its substantial lessening of competition assessment is within two years, although this is tempered by the characteristics and dynamics of the market in question (*Merger Assessment Guidelines,* paragraph 5.8.11).

(c) The impact on competition between CMFT and UHSM in certain routine elective care specialties and specialised services of planned service reconfigurations, which would result in either CMFT or UHSM ceasing to supply certain services.[101]

(d) The impact on competition between CMFT and UHSM in community services of the Manchester CCG's intention to establish a LCO responsible for out-of-hospital care services in the city of Manchester.

8.7 Neither of the parties have claimed that they would exit the market if the merger does not take place.

Ability to maintain existing services because of financial performance

The parties' submissions on UHSM's financial position

8.8 The parties submitted that given UHSM's recent 'requires improvement' rating by the CQC and its comparatively weaker financial performance, its ability to provide a strong competitive constraint on CMFT (and other providers of NHS services) could be expected to decline if the merger did not proceed.[102]

8.9 The parties told us that prior to the decision to merge with CMFT, UHSM's relationships with other health and social care bodies in Greater Manchester and national NHS bodies were poor. The parties told us this was reflected in the reviews of board governance at UHSM dating from 2014 and 2015.[103] They said that since the decision to merge with CMFT, UHSM had been able to repair these relationships and secure the support needed to improve its position. For example, UHSM recently agreed with NHS Improvement a financial control total for 2016/17, which was achieved with support from local CCGs and NHS England, and resulted in UHSM receiving £8.3 million of STF money. UHSM told us that this has significantly improved its cash position.[104] However, the parties submitted, if the merger did not proceed, recent support for UHSM from commissioners would reduce, which would have an adverse impact on UHSM's financial position.[105]

[101] This includes elective care specialties for which the GMHSCP has devolved responsibility over and those for NHS England retains responsibility for.
[102] Parties' phase 1 submission, paragraph 109.
[103] Parties' phase 1 submission, paragraph 110.
[104] Parties' phase 1 submission, paragraph 110.
[105] Parties' phase 1 submission, paragraph 111.

8.10 The parties told us that if UHSM were to lose certain specialised services, this would further degrade UHSM's financial position, and also affect its attractiveness as an employer for clinicians and as a destination for patients.[106] For example, the transfer of high-risk general surgery from UHSM to CMFT under the *Healthier Together* programme could undermine UHSM's ability to maintain its specialised services in burns and vascular surgery, further worsening UHSM's financial position. As at May 2017 UHSM had a financial gap of £32.5 million for 2017/18, of which risk-assessed cost improvements accounted for £14.7 million, which leaves UHSM facing an £18 million deficit. The parties told us that UHSM faced considerable liquidity problems.

Our assessment of UHSM's financial position

8.11 The parties told us the extent of the financial pressures on UHSM was as follows:

(a) UHSM has been in financial deficit in all but two years since 2011/12;

(b) UHSM has been in breach of its NHS Improvement licence conditions since May 2014;[107] and

(c) NHS Improvement currently exercises oversight to ensure that UHSM's finances do not deteriorate further.

8.12 We note that UHSM's forward plan makes no reference to any services ceasing (other than due to the Greater Manchester service reconfigurations discussed below[108]). The plan states that the UHSM board confirmed that its strategic objectives and priorities for 2017-19 remain broadly the same as for 2016-17, and forecasts that UHSM's overall revenues will increase. Indeed, the parties have not argued that UHSM would cease to provide particular services as a direct result of these financial pressures, or that it would exit the market, rather, the parties believe that the financial pressures on UHSM will affect the quality of its services going forward.

8.13 Given that the parties have not supplied to us any details of any services ceasing, or being likely to cease, as a result of the financial pressures on UHSM, we do not, at this stage, accept that a cessation of some services or

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[106] Parties' phase 1 submission, paragraph 111.
[107] Parties' phase 1 submission, paragraph 109. We note that at the time UHSM agreed to take action in a number of areas to improve its finances and how it is run including the appointment of a turnaround director (Monitor press release (1 May 2014): Monitor takes action to improve finances of a foundation trust in Manchester).
[108] See paragraph 8.29 and ff.

a service-level reconfiguration as a result of financial pressure is likely to result in the near future absent the merger.

8.14 With respect to UHSM becoming a weaker competitor over time as a result of a worsening financial position, we note that, on the one hand, intervention by NHS Improvement is designed to strengthen and improve financial performance[109] and, on the other hand, that the NAO (above) found some link between poor financial performance and worsening clinical performance. However, the parties have not supplied us with compelling evidence that intervention by NHS Improvement would be unlikely to prevent, or significantly mitigate, any deterioration in UHSM's clinical performance that may result from its financial position. Accordingly, it is therefore unclear whether, when and the extent to which, UHSM's competitiveness may have declined absent the merger. We did not consider it necessary to speculate on this matter as we were satisfied that there was enough evidence to support our provisional view that absent the merger, UHSM would have continued to operate offering a similar range of services with a broadly similar competitive intensity that it currently does.

Single contract for acute hospital services in Manchester

Parties' submissions on the proposed single contract

8.15 Under the *City of Manchester Locality Plan*, the Manchester CCGs intended to establish a single commissioning system that would combine the health and care commissioning responsibilities held by them and Manchester City Council.[110,111]

8.16 This single commissioning function was established as Manchester Health and Care Commissioning (MHCC) on 1 April 2017, and was formed through a partnership of Manchester CCG and Manchester City Council. It will commission health, adult social care and public health services, including acute healthcare services.

8.17 The parties told us that absent the merger, commissioners would implement a single acute services contract within the city of Manchester. Therefore, the parties submitted that even if the merger does not go ahead there will be

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[109] See, for example, NHS Improvement (2016), *Single Oversight Framework*.
[110] The three Manchester CCGs merged on 1 April 2017 to form Manchester CCG.
[111] Parties' phase 1 submission, paragraph 82.

only one provider of each acute service within the city of Manchester and the merger will not represent a lessening of competition.[112]

8.18 We note that there have been efforts in the past to consolidate the provision of some services between the parties. According to the parties, there had been at least 17 separate initiatives to improve services involving CMFT and UHSM over the past decade or so. These had included both commissioner-led service reconfigurations and efforts to establish collaborative arrangements for the provision of services between the parties. These efforts had all been delayed, compromised or abandoned. The parties told us that of these 17 initiatives:

(a) eight were abandoned before achieving any significant change in service provision;

(b) seven delivered service improvements but with significant delays in implementation; and

(c) two delivered new models of service provision, but with significant compromises that resulted in lost opportunities to improve patient outcomes.[113]

8.19 The parties told us that the way in which a single contract for acute services would be implemented had not been set out by the CCGs, but the parties believed that such an arrangement would take the form of either CMFT or UHSM taking the role of lead provider, and the other party acting as a sub-contractor. Both CMFT and UHSM would retain their independent identities and their ability to separately contract with other commissioners for other services (for example, with NHS England for specialised services).[114]

8.20 The parties told us that under these proposed arrangements, patients would continue to be able to choose between CMFT and UHSM for routine elective care services, but the ability of the subcontracting party 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.[115] Thus, the parties believed that this would mean competition between CMFT and UHSM could be expected to reduce without the merger.

[112] Parties' phase 1 submission, paragraph 86.
[113] Parties' phase 1 submission, paragraph 86.
[114] Parties' phase 1 submission, paragraph 106.
[115] Parties' phase 1 submission, paragraph 107.

Third party views on the proposed single contract

8.21 The GMHSCP agreed that absent the merger, reform could be attempted through a contracting model. It confirmed that one form which an acute service could take under a single-contract model would be one provider taking primary responsibility for a service with other provider(s) playing a support role, perhaps as a subcontractor. The GMHSCP also told us that there were no firm alternative arrangements or plans in place in the event the merger did not go ahead.

8.22 While the structure of the single contract for acute services was yet to be determined, the MHCC told us that, assuming CMFT and UHSM merge:

(a) current bilateral contracts between the parties would remain in place until April 2018;

(b) the detailed plan for acute services would be developed in the financial year to 31 March 2018;[116] and

(c) a new single contract for acute services in Manchester would become effective from 1 April 2018.

8.23 In relation to what would happen if the merger did not proceed, MHCC told us that improvement for patients would be more limited, slower to implement and less effective. This impacted both upon the quality of hospital services as well as effective pathway coordination and patient flow between hospital and community service.

8.24 With regard to specialised services, we asked NHS England what would happen if the merger did not proceed. It told us that some service reconfigurations would go ahead regardless.

Our assessment of the proposed single contract

8.25 MHCC made clear to us that it intends to implement a single contract for acute hospital services in Manchester, in the absence of the merger. However, there is considerable uncertainty about what form this single hospital contract would take, as no detailed plans have yet been made regarding it.[117] Moreover, since no detailed plans have been made the timing of any single hospital contract is also uncertain.

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[116] Providers have the same respective contract schedules for 2017/18.
[117] Whether detailed plans for a commissioner-led single contract will need to be made is dependent on the outcome of this merger.

8.26 We note that the history of previous attempts to put in place collaborative arrangements for individual services between the parties under their extant governance arrangements suggest that it would be difficult to negotiate a single contract covering multiple, or all, acute services. There is therefore a possibility that a single contract would not be created, or that it would take a substantial amount of time and management resources to create it.

8.27 However, even if a single contract for acute hospital services in Manchester would be established in the absence of the merger, we consider that the extent of any impact of a single contract on competition between the parties (across different specialties and within individual specialties), and the timing of any such impact, is unclear. Depending on its design, a single contract could lessen competition between the parties. Alternatively, it could mean that the parties compete for lead provider status in the supply of particular services, or that they compete in other ways to provide a larger share of the services which have been commissioned.

8.28 We currently consider that there is substantial uncertainty around the form and timing of the emergence of a single hospital contract. This uncertainty includes the extent to which a single contract in Manchester would impact on competition between the parties (if at all), and the timing of any single hospital contract being put into place and having an impact on competition. At this stage, we consider that there is insufficient evidence on which to provisionally conclude that, absent the merger, a single hospital contract is likely to be introduced within the near future and is likely to materially weaken or remove the current competitive dynamic between the parties. We have, therefore, provisionally decided not to accept this reconfiguration as a part of the counterfactual to the merger.

Service reconfiguration plans for Greater Manchester

8.29 In addition to the proposed single contract for acute hospital services, the parties told us that there were a number of service reconfigurations underway to address the structure of some service provision across Greater Manchester.[118] These are commissioner-led programmes and concern: oesophageal and gastric (OG) cancer services; general surgery; urology cancer services; and a range of other services.

8.30 There have been some service reconfigurations involving the parties that have already been completed, for example, gynaecological cancer surgery was reconfigured onto two sites (CMFT and The Christie) in 2014. UHSM

[118] Parties' phase 1 submission, paragraph 115.

now only provides benign endometrial cancer surgery at Wythenshawe Hospital. We have provisionally decided to take these reconfigurations into account as part of the counterfactual to the merger.

8.31 Below we discuss the proposed reconfigurations.

Oesophageal and gastric cancer services

8.32 In October 2016, Salford Royal was appointed lead provider for OG cancer services for Greater Manchester. Under the previous arrangements, CMFT, UHSM and Salford Royal each provided these services.[119]

8.33 The GMHSCP told us that commissioners had agreed the reconfiguration of OG cancer services to establish a single service for Greater Manchester which will be led by Salford Royal, which it expected to commence in October 2017.

8.34 NHS England told us that the failure of the merger to go ahead would not affect the reconfiguration of OG cancer.

8.35 We believe that it is likely that this service reconfiguration will take place, with or without the merger, and that Salford Royal will become the lead provider for oesophageal and gastric cancer services for Greater Manchester with these services no longer being provided by either CMFT or UHSM. We have, therefore, provisionally decided to take this reconfiguration into account in the counterfactual to the merger.

General surgery

8.36 MHCC told us that a reconfiguration of general surgery was part of the *Healthier Together* programme whereby CCGs in Greater Manchester decided to implement a single service model across Greater Manchester. This reconfiguration had been approved by commissioners and was at the implementation phase.

8.37 The parties told us that under this programme, emergency and high-risk general surgery would be consolidated at four sites in Greater Manchester, including CMFT. UHSM would no longer deliver these services.[120]

8.38 The parties have told us that:

[119] Parties' phase 1 submission, paragraph 116.
[120] Parties' phase 1 submission, paragraph 116.

(a) all colorectal cancer patients would now have their surgery at Manchester Royal Infirmary; and

(b) all emergency general surgery patients requiring an admission would now be admitted to Manchester Royal Infirmary (not just those defined as high risk).

8.39 The benefits submission from the main parties also states that critical care services would be maintained at both Manchester Royal Infirmary and Wythenshawe Hospital.[121]

8.40 UHSM told us that these changes would occur irrespective of the merger. UHSM's Operational Plan for 2017-19 provides that the first stage of the *Healthier Together* programme's implementation would be the transfer of high-risk elective general surgery inpatients from UHSM to CMFT from April 2017. CMFT told us that the merger would not impact the planned reconfiguration of general surgery.

8.41 We accept that it is likely that this reconfiguration will go ahead, with the result that that all colorectal cancer patients will now have their surgery at CMFT's Manchester Royal Infirmary hospital and all emergency general surgery patients requiring an admission will now be admitted to Manchester Royal Infirmary (not just those defined as high risk). We have, therefore, provisionally decided to take this reconfiguration into account in the counterfactual to the merger.

Urology cancer services

8.42 There are currently five trusts providing Urology cancer services in Greater Manchester (CMFT; UHSM; Salford Royal; The Christie; and Stockport). The parties told us that these would be consolidated on two sites, one site for kidney and bladder cancer surgery and another site for prostate cancer surgery.[122]

8.43 UHSM anticipated that it would be asked to be the lead provider for the urology cancer service and to provide kidney and bladder cancer surgery from Wythenshawe Hospital, with The Christie providing prostate cancer surgery under a subcontract from UHSM. Based on 2015/16 data an additional 524 bladder cancer and kidney cancer operations would be performed at Wythenshawe Hospital once the reconfiguration was complete.

[121] Parties' benefits submission on patient benefits, paragraphs 373 & 374.
[122] Parties' phase 1 submission, paragraph 116.

8.44 CMFT told us that it expected it would lose all urological cancer surgery and associated costs and income with or without the merger.

8.45 The GMHSCP told us that, with respect to urological cancer surgery, the recommendation to commissioners was that UHSM and The Christie were to provide the Greater Manchester service. However, the GMHSCP also told us that decisions on urology cancer services had been subject to challenge in the past by Greater Manchester providers including both CMFT and UHSM and that if the merger did not take place, the ability to cover rotas might be more challenging and, without a change in focus from the parties, might threaten the leadership UHSM was able to provide to the single urological cancer service.

8.46 NHS England told us that the failure of the merger to go ahead would not affect the urology cancer service reconfiguration.

8.47 We currently consider that there is substantial uncertainty as to whether this proposed reconfiguration will proceed. There is further uncertainty concerning the timing of the proposed reconfiguration. At this stage, we consider that there is insufficient evidence on which to provisionally conclude that, absent the merger, this reconfiguration is likely to occur within the near future and is likely to materially weaken or remove the current competitive dynamic between the parties in respect to this service. We have, therefore, provisionally decided not to accept this reconfiguration as a part of the counterfactual to the merger. We anticipate that in advance of our Final Report further information about this reconfiguration will become available which may, in particular, lead to us revisiting this provisional conclusion.

Other services

8.48 The parties also submitted that reconfigurations were being considered in benign urology, musculoskeletal and orthopaedic, paediatric surgery and vascular services.

8.49 For each of these services the parties told us that the reconfiguration of services had not yet started. Moreover, for each the GMHSCP told us that the reconfigurations were at an early stage and no firm implementation plans were in place.

8.50 For vascular services, the parties told us that the merger would largely achieve the commissioner’s intentions in terms of service consolidation (ie to bring these services in Greater Manchester into line with the national service specification issued by NHS England), but given the ongoing compliance issues with the NHS England service specification such a consolidation

would likely be attempted in the absence of the merger.[123] The GMHSCP told us that the reconfiguration proposals were yet to be developed but it was probable that the reconfiguration would entail specialist surgery being consolidated into one provider. NHS England told us that if the merger did not go ahead it would not affect its plan for a reconfiguration to take place for this service.

8.51 For vascular services as well as for benign urology, musculoskeletal and orthopaedic service and paediatric surgery the proposed reconfigurations are at an early stage and proposals are yet to be developed. For this reason there is substantial uncertainty as to whether these proposed reconfigurations will proceed, and if they do proceed, as to their timing and who will be selected as providers of these services. At this stage, we consider that there is insufficient evidence on which to provisionally conclude that, absent the merger, these reconfigurations will occur within the near future and are likely to materially weaken or remove the current competitive dynamic between the parties. We have, therefore, provisionally decided not to accept any of these reconfigurations as a part of the counterfactual to the merger.

The establishment of the Local Care Organisation

8.52 The establishment of the Manchester LCO is intended to provide a greater proportion of health and social care to Greater Manchester residents in a community setting. The LCO is an organisation that will house its member organisations who include community, social care, acute, some mental health services providers and a full range of third sector providers. The LCO as an entity will hold a contract for the delivery of community services in the city of Manchester. By having a diverse range of membership the LCO will be better placed than existing community service providers to integrate health and social care in order to deliver a more effective service to patients.

8.53 The GMHSCP told us that the LCOs were fundamental to the delivery of the Greater Manchester strategy 'Taking Charge'.[124]

8.54 The GMHSCP told us that it anticipated that following the procurement process and agreement of a provider, mobilisation would begin and the new model would be up and running for 1 April 2018. The GMHSCP told us that the development of the LCO sat alongside the creation of a single contract for acute hospital services and should the merger not proceed, it might pose a major block to the LCO's success.

[123] Parties' phase 1 submission, paragraph 116
[124] See GMCA, The five-year vision for Greater Manchester.

8.55 The three Manchester CCGs (now Manchester CCG) and the Manchester City Council (together MHCC) have developed an LCO Prospectus as the initial stage of a procurement process. The LCO Prospectus sets out the timeline for the LCO as a full award from April 2018.[125] A competitive tendering process for the LCO is underway (the contract value for the services is around £6 billion over ten years).

8.56 Of relevance to the counterfactual consideration is that while the contract for the establishment of the LCO in Manchester is currently out to tender, how it will be implemented, including the services included in it, has not been set out and remains uncertain.

8.57 We therefore provisionally consider that there is substantial uncertainty as to the extent to which, and when, the proposed establishment of the LCO will impact on the parties and we have therefore provisionally decided not to accept it as part of the counterfactual to the merger.

Specialised services reconfiguration plans for Greater Manchester and the North West region

8.58 NHS England is beginning to adopt a 'place-based commissioning' approach to specialised services.[126] In Greater Manchester, where the process of devolution is already quite far advanced, this has led to major changes in the commissioning of specialised services. Services for which NHS England considers the area across which a provider should cover is quite local – in this case within Greater Manchester (formally, these are classified as being tier 1 services) – have been devolved to the Chief Officer of the GMHSCP.[127]

8.59 Responsibility for Tiers 2-4 specialised services remains with NHS England. There are no overlaps between the parties in relation to Tiers 3-4 specialised services. In relation to Tier 2 services, NHS England told us that there were planned service reconfigurations for complex gynaecology services (Severe Endometriosis, Urogenital and Anorectal Conditions, Congenital Gynaecological Anomalies, and Urinary Fistulae).

8.60 According to NHS England, national service specifications were currently being reviewed for these complex gynaecological services. NHS England considered as likely that the new service specifications for these would drive a reduction in the number of providers that were able to achieve volumes of

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[125] Manchester Local Care Organisation Prospectus 2017.
[126] Place-based commissioning focuses on embedding commissioning in systems of care based around local health economies. See The King's Fund (2015), Ham and Alderwick, *Place-based systems of care*.
[127] See paragraph 12.3 for an explanation of the system of tiers of specialised services.

activity to meet minimum standards. In that case, an intervention by NHS England to consolidate services would be required.

8.61 We recognise that plans are underway for the provision of certain specialised services to be reconfigured in Greater Manchester (tier 1) and the North West (tier 2). However, we have not been provided with evidence of the extent to which, absent the merger, these reconfigurations are likely to impact particular services provided by the parties in the near future. We therefore expect that the parties would continue to provide broadly similar specialised services absent the merger. At this stage, we consider that there is insufficient evidence on which to provisionally conclude that, absent the merger, these NHS England led reconfigurations are likely to materially weaken or remove the current competitive dynamic between the parties. We have, therefore, provisionally decided not to accept these reconfigurations as a part of the counterfactual to the merger.

Provisional conclusion on the counterfactual

8.62 We have provisionally decided to adopt a counterfactual in which the pre-merger conditions of competition will continue except where they are impacted by the particular planned service reconfigurations in general surgery and OG cancer services.

9. Introduction to our competitive assessment

9.1 Within the provisions of the Act, the CMA has jurisdiction over mergers involving NHS foundation trusts. The role of the CMA in this context is to examine the impact that a merger between two such trusts may be expected to have on competition, and the consequences this may have for the quality of healthcare services provided to patients.[128]

9.2 During the course of our inquiry, in line with our issues statement,[129] we have examined whether the merger may be expected to result in an SLC in the provision of:

(a) NHS elective and maternity services;

(b) NHS non-elective services;

(c) NHS specialised services; and/or

[128] *NHS Merger Guidance*, paragraph 1.7.
[129] CMA issues statement.

(d) community services.

9.3 We have also examined whether any SLC that may be expected to result from the merger would lead to 'hospital-wide' effects that go beyond the elective and maternity services in which the primary effects of any lessening of competition may arise. These areas of inquiry are discussed below.

9.4 Patient choice helps to incentivise providers to make decisions that affect quality in a way that best reflects the factors that matter most to patients and GPs. Mergers between providers of NHS services may dampen this incentive if they serve to remove a significant alternative for patients and thereby significantly reduce the competitive constraints on the merging providers. This could result in the quality of the merged trust's offering not being as good as it otherwise would be.[130] We have examined whether this merger would be likely to remove an important alternative for patients with regard to both NHS elective and maternity services, and NHS non-elective services. In regard to how we have examined any change in the parties' incentives to compete for patients that the merger may bring about, we have not found it necessary to distinguish whether the choice of first outpatient appointments was made mainly by the patient or the GP.

9.5 Mergers may also reduce choice for commissioners when they wish to tender a contract for the provision of a certain service which, in turn, could dampen providers' incentives to drive up quality or innovation in that service. We have examined whether this merger would be likely to remove an important alternative for commissioners with regard to both NHS specialised services and community services.

9.6 With these two broad effects a merger may harm competition if it removes an important provider, resulting in a reduced incentive for the merged provider to maintain and provide better quality services to patients and value for money for commissioners. This effect is sometimes known as a 'horizontal unilateral effect' and we use that terminology throughout this provisional findings report. We have not found it necessary in this inquiry to investigate whether the merger would lessen competition and harm patients and/or commissioners in any other way, nor have we seen any evidence nor have any third parties suggested to us that we should.

9.7 The parties to this inquiry are public bodies providing a public service; namely health services which are free at the point of delivery. We have been acutely aware that many of the normal conditions and dynamics of

[130] *NHS Merger Guidance*, paragraph 1.5.

competition between suppliers that we see in other industries do not apply in this case. Some of the most prominent characteristics of the industry in this regard are:

(a) NHS providers are subject to a restrictive regulatory environment. The regulations and recommended standards that providers face cover many facets of their operations including the quality and safety of patient care, which services they can or must offer, which medicines are approved for use, the pricing of medicines and the salaries of some staff.

(b) The people who receive care do not pay for their treatment at the point of delivery and therefore providers cannot use price as a way to ration demand.

(c) Many of the NHS services provided in a hospital setting are subject to the National Tariff such that commissioners pay a regulated price.[131] Therefore, in the majority of instances, the money that the hospitals receive for the services that they provide is not negotiated but rather set centrally by a regulator which may or may not reflect CMFT's and UHSM's cost base.

(d) The NHS as a system is allocated a fixed, externally determined (by government) sum of money with which to commission and provide health services.

(e) Providers of NHS services do not typically exit the market due to financial or operational difficulties, although providers can exit some services and, in extreme circumstances, may face a managed failure process with NHS Improvement.

(f) Collaboration and collective responsibility across providers to supply NHS services are common features of the industry.

9.8 In assessing the merger we have considered a broad range of information including examining the internal documents of the parties, received views and evidence from third parties such as commissioners, regulators and other providers, and assessed the performance indicators of the parties, particular aspects of the regulatory environment and some quantitative data (for example, patient referral data in our analysis of NHS elective and maternity services). The specific pieces of information and how we have used them are discussed in greater depth in the competitive assessment of each area

[131] See Appendix B, paragraph 63 and ff.

below. We appointed an external clinical adviser for the purpose of advising us on aspects of our analysis regarding specific clinical services.

9.9 Moreover, as emphasised earlier in these Provisional Findings we have taken into account the recent developments in NHS policy and the broader financial environment in which providers are operating.[132] In particular, we believe that these have, in general, encouraged a significantly reduced emphasis on the role of competition in NHS service provision and a weakened ability of providers to compete at the current time.

9.10 We were conscious that the CMA's phase 1 investigation found that there was no realistic prospect of an SLC as a result of the merger in the provision of services to private patients and in relation to seven overlapping NHS elective specialties.[133] No party has made submissions to us on these particular services and we did not investigate these further.[134]

Third party views

9.11 As part of our inquiry we invited views from a variety of third parties. We received submissions from commissioners, providers, patients, Manchester City Council and Unite (a union).

9.12 The large majority of the third parties who contacted us had no concerns about the merger, and indeed several (including, but not solely, Manchester City Council and Manchester CCG) were supportive of the merger, citing its benefits to patients.

9.13 Nonetheless, some third parties did raise concerns about the merger. Some of these were not relevant to our inquiry: for example, an NHS provider raised concerns that the merged trust would be better positioned to recruit staff at the expense of other NHS providers. Other concerns reflected potentially pro-competitive outcomes of the merger, such as the merged trust's ability to offer a broader set of services, or its ability to attract more patients. However, some concerns about the merger did relate to ways in which it might lessen competition. Several third parties were concerned about the merger's impact on patients' travel times, patient choice and the parties' incentives to reduce capacity post-merger. We have taken third parties' views into account in our competitive assessment (below), where relevant. Other comments, like the impact on travel times for patients, will be

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[132] See paragraph 4.12 and ff above.
[133] The specialties are anaesthetics, palliative medicine, anticoagulant services, medical oncology, clinical oncology, gynaecological oncology and interventional radiology.
[134] We set out our proposed approach to assessing these overlaps between the parties in our issues statement.

considered when we assess the parties’ case for patient benefits (see paragraph 14.1 and ff).

10. The effect on competition in NHS elective and maternity services

Role of competition in NHS elective and maternity services

Introduction

10.1 We have examined what role competition plays in the provision of NHS elective and maternity services. We started our assessment of the role of competition in NHS elective and maternity services by looking at the demand side, particularly evidence on patients’ choice for their provider of elective treatments. We have also considered the relevant academic literature on the relationship between patient choice and quality. These two pieces of information give us some insight to how demand for these services might operate. Then we reviewed internal documents from CMFT and UHSM, their capacity constraints, how the parties have behaved in relation to some recent events, and their benchmarking activities all of which give us some insight to how the supply of NHS elective and maternity services might operate.

Parties’ submissions

10.2 The parties submitted that competition played a minor role in their overall strategic and operational decisions. They submitted to us that competition might have a role in NHS acute services, but it was not the basic organising principle for these services. The limited role for competition in the NHS was complemented by extensive administrative regulatory mechanisms that constrained the ability of providers to ‘flex’ their offer in response to ‘market’ conditions.[135] The parties believed 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 all played a more important role than competition in influencing acute trust decision-making and performance.[136] The parties also told us that there was now an increased emphasis on centralised management, and a reduced emphasis on provider autonomy. Examples of this are the introduction of

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[135] Parties’ phase 1 submission, paragraph 127.
[136] Parties’ phase 1 submission, paragraph 136.

control totals, STPs, and a single oversight framework that did not distinguish between foundation trusts and non-foundation trusts. There was therefore a reduced emphasis on competition between providers.[137]

Evidence on the demand for NHS elective services

10.3 In the main, hospitals will increase their revenues in NHS elective and maternity services by treating more patients. In theory, providers are motivated to compete on quality in order to attract patient referrals and hence income. Competition therefore is likely to impact on those decisions that affect the quality aspects which matter most to patients and GPs. Further information on the nature of competition in the NHS is set out in paragraphs 4.1 and ff, and in Appendix B.

Patient surveys

10.4 We have looked at the evidence on patient choice, in particular what proportion of patients exercise their right to choose and the key determinants affecting that choice. In doing so we were conscious that the patient's GP may be influential in the choice of provider. But even if in some instances the GP is effectively choosing the provider on behalf of their patient NHS providers will still, in theory, have an incentive compete for those referrals.

10.5 Surveys of patients on choice provide a reasonably consistent picture of patient choice. Each year a survey of patients regarding the exercise of their choice of their first outpatient appointment is carried out.[138] The 2015 survey (the latest available) indicates that patient choice was operating to some extent within the NHS – 40% of surveyed patients recalled being offered a choice of hospital or clinic to go to for their first outpatient appointment.[139] Although this is broadly consistent with national surveys of patients undertaken in previous years by the Department of Health we note that since 2010 there has been some decline in the proportion of patients reporting that they were offered choice (from around 50% to 40% in 2015).[140] The national surveys are also consistent with surveys of patients undertaken by the CMA for previous merger cases (albeit using different survey questions and techniques). In 2015 the CMA found that around half of the patients surveyed were aware that they had choice of provider for their first outpatient

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[137] See paragraph 4.12 and ff above.
[138] While it used to be conducted by the Department of Health, it is now carried out jointly by NHS Improvement and NHS England.
[139] See NHS Improvement and NHE England outpatient appointments summary, July 2015.
[140] For example, in 2010 the Department of Health found that 49% of patients could recall being offered a choice of provider for their first outpatient appointment and 47% said that they were not offered choice.

appointment for an elective treatment.[141] The CMA made the same finding (of around half of the relevant patient pool were aware of their right to choose) in 2013.[142]

10.6 In its 2015 survey the CMA found that a hospital's proximity to the patient's home is a key driver of patient choice (and for GPs).[143] Again, this was consistent with the national survey. In 2010 the Department of Health found the most important factor for patients when exercising choice was whether the hospital was located near to their home (38% of respondents). Other factors were personal experience of the hospital (12% of respondents), waiting times (10%), good previous experience (6%), public transport access (5%) and quality of care (5%). In the CMA surveys, the CMA found that the factors important to patients when exercising choice, after the location of the hospital, were clinical expertise of consultants, quality of nursing care, clinical outcomes, quality of aftercare, waiting times, convenience of appointment times and previous experience.

10.7 The King's Fund, in 2010, asked patients and GPs to rate different factors in order of importance which showed that cleanliness, standard of care and the facilities were the most important factors on average.[144] Closeness to home or work were somewhat important but were ranked eighth in order of importance to patients, although we also note that almost 70% of patients in that survey did choose their local hospital.

10.8 In our view, the available evidence summarised above indicates that the location of the hospital is the most important factor to patients. Although we do not have survey results specific to patients in Greater Manchester we are not aware of any reason why these results would not also be broadly applicable to patients in Greater Manchester.[145]

10.9 We also believe that, notwithstanding the importance to patients of the location of the hospital when making their choice, the closer together two hospitals are located, the greater the likely importance of other factors (such as service quality) that patients (or their GPs) take into account. On this basis, we note that CMFT and UHSM are located near to each other in a metropolitan area with a large population and therefore it might be the case

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[141] *Ashford and St Peter's/Royal Surrey County*, paragraph 6.28.
[142] *A report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust (Bournemouth/Poole)*, paragraph 6.92.
[143] GfK (2015), Research Report on the Ashford and St Peter's Hospitals and Royal Surrey County Hospitals Merger Inquiry.
[144] The King's Fund (2010), Dixon, Robertson, Appleby, Burge, Devlin and Magee, *Patient choice: how patients choose and how providers respond*.
[145] We considered conducting our own survey in this inquiry but given existing surveys of patients were available to us we decided to use these instead of incurring the considerable cost of conducting our own.

that in order to attract elective and maternity services referral they would need to have a high-quality service offering over-and-above convenience of location. A loss of competition might therefore dampen the parties' incentive to maintain these high-quality standards.

Studies of patient choice and hospital quality

10.10 In *Ashford and St Peter's Hospitals/Royal Surrey County* the CMA reviewed the literature from academic studies which examined the prevalence of patient choice and the link between patient choice and quality (whether clinical quality or some other measure of quality in a hospital's offering).[146] Some of the studies found that patients and referring GPs did respond to changes in mortality rates in hospitals when making their choice decision.[147] Another study found that a hospital's good performance on quality factors such as waiting times and infection rates, mortality rates and CQC ratings made it more likely that patients would choose it rather than another hospital, although distance remained the predominant factor.[148]

Evidence on the supply of NHS elective and maternity services

10.11 We have examined how competition between the parties might respond to demand and changes in patient choice decisions. In particular we have considered the array of factors that NHS providers' managers take into account when considering the quality of services offered, including the relative profitability of different elective specialties, capacity constraints and the parties' benchmarking activities.

10.12 We have also considered the evidence on competition between the parties from the supply side by using their internal documents, the academic literature, their response to recent events and third party views.

Parties' internal documents and management decisions

10.13 We note that competition among NHS providers of elective and maternity services is almost always in relation to quality, rather than price. This is because the majority of prices for services are determined centrally in accordance with set tariffs. The quality of a product or service is the outcome of many different decisions that are made at different levels across a hospital trust. These decisions are taken by clinicians and managers and may involve trade-offs. For example, a decision to invest a part of the trust's finite

[146] *Ashford and St Peter's/Royal Surrey County*, Appendix H.
[147] *Ashford and St Peter's/Royal Surrey County*, Appendix H, paragraphs 47, 50 and 52.
[148] *Ashford and St Peter's/Royal Surrey County*, Appendix H, paragraph 53.

resources in one clinical area (whether staff, equipment or physical space) is likely to involve a trade-off with a possible investment in another clinical area which may affect the quality of care provided in both clinical areas. This is notwithstanding that the individual NHS clinical and other staff involved in these services are personally and professionally committed to providing the highest possible quality of care for their patients. There is clearly a wide range of factors that NHS providers' managers need to take into account when making their decisions. Examples of these factors include: demands in the local health economy; available funding; best clinical practices including from the Royal Colleges; technological improvement; the ability to recruit staff; legislative and regulatory requirements on the trusts; and CQC findings.

10.14 The plethora of relevant factors collectively provide incentives for NHS providers to behave and operate in certain ways irrespective of the signals that they receive from the demand side (ie what decision patients are making when choosing where to be treated). Our inquiry has been focused on whether the merger may be expected to substantially lessen competition and the incentives on the parties to improve or sustain service quality. Such a change in incentives would be to the detriment of patients.

10.15 In considering the role of competition in the provision of NHS elective and maternity services we have examined what the parties themselves have said in their internal documents and what others have said.

10.16 The parties have told us that their internal documents corroborated their overall view of competition, which was not that competition had no role in NHS elective and maternity services, but that its role was less significant than other factors such as regulation, commissioning policies and government policies (from paragraph 4.1 above). Indeed, the parties told us that competition-related references were found in only a small number of their strategic and operational papers (such as board reports and business cases) which was entirely consistent with the small role for competition. The parties said that out of 82 CMFT and UHSM business cases that were submitted to their board or management board, only seven discussed competition-related matters. The bulk (around 60) discussed instead the need to respond to regulatory requirements or the need to meet demand via additional capacity.[149]

[149] The parties also told us that Monitor, in its Guidance for the Annual Planning Review, 2014/15 and its Strategy Development Toolkit, encouraged trusts to undertake competitor assessments. We do not find this argument convincing, not least because we have found that the comments in the parties' internal documents are consistent with our own analysis of where the parties are close competitors.

10.17 We accept that regulation and capacity constraints might determine trust behaviour more than competition. But consideration of factors, such as regulation and capacity constraints, is not necessarily to the exclusion of considering competition. There is some support for this proposition in the parties' internal documents, particularly in business plans and strategy documents where one would expect any considerations of the competitive environment to be discussed if it is relevant. For example, a CMFT surgery business plan notes that 'the main competitor for our services is UHSM at present especially in the area of UGI [upper gastrointestinal] and vascular work' and that CMFT faces 'significant competition from UHSM' for designation as a vascular centre.

10.18 UHSM's strategic plan said that 'our main competitor for most key specialties is CMFT'. Further in the same strategic plan, UHSM said 'our most important local competitors are CMFT and Stockport, with some services competing with Pennine Acute Trust'. UHSM's strategy document for Withington Community Hospital in 2015 discusses competition and competitors in its market analysis, including CMFT.

10.19 We believe that the internal documents do indicate that CMFT and UHSM do compete against other for patients in NHS elective and maternity services. Further references to the parties' internal documents are made when we discuss some of the specific clinical specialties, below.

Capacity to compete

10.20 Whether the parties have an incentive and the ability to compete will in part depend on whether they have, or can create, sufficient capacity to treat additional patients in some of the specialties where they overlap.[150]

10.21 The parties submitted that there is no single measure of capacity that can be used to assess a trust's ability to treat additional patients, and that any of a number of factors may, at a particular point in time, be a binding constraint. For example, the parties will look at the number of available beds, theatre utilisation and whether the diagnostic and other support services are available when considering capacity. The parties submitted that the best way to assess their ability to treat more patients is to look at outcome measures, and that for routine elective care the main such measure is Referral-to-treatment (RTT) waiting times.[151] Providers work to a regulatory standard of

[150] Or to seek to maintain existing patient volumes in the face of competitive pressures from other trusts.
[151] RTT measures the time it takes for a patient to receive treatment once they have been referred into the acute hospital system. It is used to measure a key waiting time target set for NHS providers.

commencing the treatment of 92% of routine elective care patients within 18 weeks.

10.22 The parties submitted that, against this standard, CMFT is currently treating 91.6% of patients within 18 weeks, while UHSM is currently treating 83.3% of patients within that time, although performance varies significantly at each according to specialty. The parties submitted that the RTT data indicates that UHSM has limited ability to compete for additional routine elective care referrals in most specialties due to its inability to commence treatment for any additional patients within the 18 week RTT requirement. The parties submitted that this was particularly the case for surgical specialties, whereas UHSM may have some scope for treating additional patients in some medical specialties.[152]

10.23 We note that CMFT's overall performance has been consistently above the 92% target in recent years. Also, CMFT is currently exceeding the target for a significant number of specialties.

10.24 We note that capacity measures based on bed occupancy rates also indicate the existence of capacity pressures. The parties' evidence indicated that both have operated with bed occupancy rates consistently above the 85% recommended operational standard in recent years. However, we observe that this standard is not a binding constraint on the trusts, nor on individual specialties, and that there will be elective specialties and treatment settings (eg outpatient treatments) for which it is not a relevant factor.

10.25 We note that capacity is variable to some extent, especially over longer time horizons, rather than rigidly fixed. In general, a hospital can unlock potential capacity by reducing length of stay and managing beds more effectively, or by innovating. If paid for additional activity, providers have an incentive to achieve such efficiencies. CMFT's internal capacity planning presentation notes 'There remains opportunities across all Divisions to reduce length of stay'. Looking ahead, initiatives to increase ambulatory care, redesign discharge pathways, and increase delivery of out-of-hospital care should all provide opportunities to reduce demand for beds, and so improve patient flow and capacity pressures. We also consider that the parties may be able to switch existing capacity between specialties if there are sufficient financial incentives to do so, allowing waiting times to vary between services accordingly. Indeed, flexing capacity between specialties is one of the main

[152] Surgical specialties are clinical specialty treatments which require surgery (eg aspects of Cardiology, Plastic Surgery and Vascular Surgery) whereas medical specialties are treatments which do not (eg aspects of General Medicine, Rheumatology, Dermatology).

ways that the parties can manage their capacity constraints in the short term.

10.26 We acknowledge that the parties face capacity constraints arising from sustained national and local demand trends. However, we believe that there is scope for the parties to accommodate additional patients in some elective and maternity services (albeit not across the board), such that incentives can exist to attract additional patient referrals. Nevertheless, the capacity pressures to which the parties are subject may dilute these incentives.

Relative profitability of NHS elective and maternity services

10.27 The parties did not provide us figures on revenue, cost allocations and profitability by clinical specialty from either party. Both parties told us that this is because they do not hold financial information in this way, nor do they make specialty-specific decisions based on profitability considerations. The parties told us that when they make decisions on specialties they will instead take into account commissioner and regulatory requirements such as meeting core CQC standards and waiting time targets.

10.28 The parties told us that there are two key reasons why they do not use service line financial reporting in their decision making. First, the National Tariff changes annually.[153] The parties told us that some of these changes can be substantial and this makes specialty-level decision making based on financial considerations difficult.[154] Second, the parties told us that any financial estimation at elective specialty level will be flawed. They said that a clinical specialty will be devoting some of its resources to elective treatments and some to non-elective treatments. Depending on the demand at any particular time, a specialty may give up some of its beds and physical ward space to another specialty or, conversely, require some resourcing from another part of the hospital. Because this is an ongoing dynamic within a hospital, and many services are interdependent (including with support services), financial analysis loses some of its precision and, therefore, usefulness.

10.29 We have seen internal documents from UHSM regarding the development and better utilisation of Withington Community Hospital (which provides NHS elective services). While profitability of the hospital was taken into account in

[153] NHS Improvement has recently moved to biennial tariffs.
[154] The parties submitted a report by PWC which found in 2012 that 40% of tariff prices had changed by more than 10% each year and that this undermined confidence of providers and commissioners making it difficult for them to respond to price signals. PWC (2012), *An evaluation of the reimbursement system for NHS-funded care: Report for Monitor*.

this strategy document, it was not at specialty level but rather at the site level.

10.30 We consider that it is instructive that neither CMFT nor UHSM hold and use financial information at the specialty level. It is probative that they are not making specialty-level decisions based on whether a particular elective service is profitable. Therefore, in this inquiry we have not placed weight on whether the profitability of particular elective services currently incentivise the parties to compete against each other for NHS elective or maternity referrals.

Benchmarking

10.31 During our main party hearings with CMFT and UHSM we discussed benchmarking and how the parties monitored performance of other NHS providers and used that information to improve their own performance. This may be an indicator of competition between providers.

10.32 The parties told us that they benchmark:

(a) between different operating divisions or units internally;

(b) against national performance outcomes;

(c) against Shelford Group peers (for CMFT);[155] and

(d) against other acute trusts in Greater Manchester and the North West.

10.33 From the evidence that we have seen, including examples of various benchmarking reports, it seems that the parties benchmark against a range of providers, not just those in Manchester. We have seen that they benchmark on specific clinical outcomes and general indicators of performance (for example, results of the Friends and Family Test, the CQC inpatient survey and meeting various regulatory targets on waiting times). While this is consistent with a commitment to achieving clinical excellence, it is also consistent with the parties competing on the quality of their services. However, even if the parties' benchmarking were an indicator of competition for referrals, we have not seen from the benchmarking reports provided to us that they have particularly focused on each other.

[155] The Shelford Group comprises ten major NHS acute trusts that provide tertiary healthcare services. Its members include CMFT, University Hospitals Birmingham, University College London Hospitals, Sheffield Teaching Hospitals, Oxford University Hospitals, Newcastle-Upon-Tyne Hospitals, King's College Hospital, Imperial College Healthcare, Guy's and St Thomas', and Cambridge University Hospitals

Studies of patient choice and hospital quality

10.34 As with the demand side considerations, we have noted the literature from academic studies in relation to supply side consideration. Some studies found that the introduction of patient choice and competition in the NHS can lead to improvements in hospital quality, suggesting that competition can play a role in improving quality over and above that of regulation.[156]

10.35 Other studies have indicated that a system of patient choice supported by PbR is itself not sufficient to drive improvements in hospital care. In 2012 PWC, in a report for Monitor, said that 'the pricing system is a lever to drive improvements in quality. It does this through enabling patient choice (in the case of PbR) and rewarding providers for making improvements to quality. Without sufficient information on patient outcomes, the pricing system will not create appropriate incentives that consistently reward providers for quality improvements.'[157] NHS England and NHS Improvement also noted that patient choice may not be solely sufficient for NHS providers to improve aspects of their offering, such as waiting times. They jointly said last year that 'survey evidence shows that progress towards achieving meaningful choice has stalled. A radical upgrade of choice is now needed across the whole of the NHS in England, and in particular, concerted action is required to improve patient choice in elective services to help deliver the RTT waiting times standard.' [158]

How the parties behaved in response to certain events

10.36 In order to gauge how they considered competition, patient choice and competitors in some of their decision-making, or to gauge the impact of certain events on their own hospitals, we asked the parties about instances of:

(a) CMFT or UHSM starting or stopping the provision of any clinical services;

(b) any third party provider in the local area starting or stopping the provision of any clinical services;

[156] *Ashford and St Peter's/Royal Surrey County*, Appendix H, paragraphs 67–73 provide a review of the relevant literature.
[157] PWC (2012), *An evaluation of the reimbursement system for NHS-funded care: Report for Monitor*.
[158] NHS England and NHS Improvement (2016), *Securing meaningful choice for patients: CCG planning and improvement guide*.

(c) any major disruption to services or event causing a significant impact on the public's perception of the quality of services offered (for example, an MRSA outbreak);

(d) changes to the National Tariff;

(e) NHS Improvement's introduction of control totals;

(f) the boards of each party considering the single hospital service in Manchester.

CMFT or UHSM starting or stopping the provision of any clinical services

10.37 CMFT told us that it had not started to provide any new clinical service since 2012 although it did acquire Trafford Healthcare NHS Trust in April 2012 (and therefore expanded). Nor has CMFT discontinued any major services since 2012.

10.38 UHSM, in contrast, has started to provide some new clinical services since 2012. Many of these were not elective and maternity services and some were an expansion of an existing service. In this case, we were unable to find any examples of UHSM entering an elective service which would provide any insight on the role of competition in how it makes service-level operational decisions or how that entry event impacted on neighbouring providers.[159]

Any third party provider in the local area starting or stopping the provision of any clinical services

10.39 Spire Healthcare has recently (in January 2017) opened a new hospital in central Manchester, in between CMFT's Oxford Road site and UHSM's Wythenshawe hospital. This hospital is, in effect, a relocation of Spire Healthcare's previous hospital at Whalley Range, around 2 miles away. As with the previous hospital, the new Spire Healthcare hospital offers a small range of NHS elective treatments. Both CMFT and UHSM told us that this has had very little impact on their patient numbers and operations.[160]

[159] UHSM did provide examples where it stopped providing some services but these have been commissioner-led reconfigurations and UHSM told us that competition in these services played no role in the decision.
[160] Since the hospital has only recently opened we are unable to see what has happened to GP referral volumes in our data.

Major disruptions

10.40 Neither party said that it had experienced a major disruption to a service which in its view would cause a significant impact on the public's perception of the quality of services offered. UHSM said that in May 2014 Monitor took action against it as a result of the trust breaching the financial sustainability provision of its licence. CMFT told us that the CQC rated it as 'Good' last year which did not result in any material change to its patient volumes.

Changes to the National Tariff and the introduction of control totals

10.41 From the board documents submitted to us, neither party considered the implications on its competitive standing, or the competitive dynamic in Greater Manchester, as a result of the externally imposed changes to the National Tariff or in NHS Improvement's introduction of control totals.[161]

Implications of a single hospital service

10.42 In regard to the parties considering a single contract for acute hospital services, some CMFT internal documents say that maintaining the current competitive environment will present a risk against the delivery of priorities of developing a collaborative approach in exceeding commissioner standards including on clinical outcomes and access, and in maintaining financial stability in the city of Manchester. In the main, CMFT's internal documents on the single hospital service discussed either the process of its own merger with UHSM and/or the improvements to patient care that could be made following a merger. We have not seen reference in the considerable number of documents submitted about CMFT benefiting from a reduction in competition.[162]

10.43 Likewise, UHSM documents also focus on improvements to patient care that could be made following a merger. We have not seen reference in the considerable number of documents submitted about UHSM benefiting from a reduction in competition.

Views of third parties on the role of competition

10.44 The MHWB, in developing its idea for a single hospital service, said:

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[161] For the purpose of exploring how the trusts made decisions in the face of these external events we used the National Tariff of 2016 to come into effect in 2017/18 and the control totals for 2016/17.
[162] It is worth noting that many of these documents were produced concurrently with CMFT engaging in merger discussions with UHSM and some documents make reference to the CMA merger review process. It may be that some document authors were mindful that the documents would be submitted to the CMA.

> … the main hospital services that are used by residents of Manchester are provided by three different provider organisations (Pennine Acute Hospitals NHS Trust (PAT), Central Manchester University Hospitals NHS FT (CMFT), and University Hospitals of South Manchester NHS FT (UHSM)). Previous national policy has encouraged provider organisations to compete and the structure of contracts, payment mechanisms and competitive tendering processes has made it difficult for the Trusts to behave in any other way. This approach has resulted in duplication of services, and has created barriers that stop Trusts working together to improve services for local people… Opportunities to work together to improve patient care or enhance research and innovation are missed.

10.45 Sir Jonathan Michael, in his first report, said that there was a need for a single hospital service model to improve the quality and consistency of services provided to patients. He did not think that the era of competition between hospital services in Manchester had delivered the requisite improvement and that it was necessary to focus on a collaborative approach to tackle some of the challenges that health and social care services in Manchester were finding.[163] When we spoke to Sir Jonathan he told us that the NHS was moving away from competition as a driver for improvement. This was the result of a number of factors including the absence of a meaningful market or of a failure regime in the NHS and recognition that collaboration rather than competition was likely to make best use of limited resources in an era of tight budget restraints.

Closeness of competition in NHS elective and maternity services

Analytical approach

10.46 Our analysis included an assessment of NHS referral data based on the Hospital Episode Statistics (HES). Using parties' shares of referrals from each referrer (usually a GP practice) to either CMFT or UHSM (which we call the 'anchor hospital'), we were able to estimate the share of referrals which would go to each alternative provider if in a hypothetical scenario the anchor hospital became unavailable.[164] The referral analysis provides a starting point for our assessment of the closeness of competition between acute

[163] Sir Jonathan Michael (2016), *Manchester Single Hospital Service Review: stage one report.*
[164] To give a numerical example, if a particular GP practice refers patients to four hospitals (A, B, C, and D) and it sent 60 referrals to A, 30 to B, 15 to C, and five to D, then the referral analysis anchored on hospital A would reallocate 36 (or 60%) of A's referrals to B, 18 (30%) to C, and 6 (10%) to D. This would suggest that B and C are likely to be important alternatives to A for patients at that GP practice.

trusts, and provides some insight into the choices available to patients at each referrer.

10.47 We took the following approach to assessing closeness of competition in NHS elective and maternity services, which is fully set out in Appendix C. We:

(a) identified the services in which the parties overlap on a clinical specialty level;[165]

(b) omitted from any further analysis clinical specialties where the parties' share of referrals reallocated to the other party was under 40% for both parties;[166]

(c) excluded from further analysis those specialties for which the vast majority (over 90%) of the parties' outpatient referrals are derived from sources that do not involve patient choice of provider (such as referrals from another consultant, or referrals from an A&E department);

(d) examined whether the parties appeared to have different areas of sub-specialisation within a clinical specialty, which might mean that they are not close alternatives for each other for that clinical specialty; and

(e) conducted a detailed review of the remaining specialties, including taking into account (among other factors) recent reconfigurations, specific patient pathways and the presence of specialist treatment centres. We have worked with our clinical adviser on these.

Analysis of inpatients and day-cases

10.48 In addition to our analysis of outpatient referrals, we conducted a referral analysis for inpatients and day-cases, despite these patients not having a direct choice of provider for admitted care (where they are either admitted at

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[165] In order to balance the need to filter out 'overlaps' which are falsely identified due to coding errors, whilst not filtering out genuine overlaps in low-volume specialties, we considered the parties to overlap in a specialty and treatment setting if, in either 2014/15 or 2015/16, both parties recorded at least 100 outpatient episodes per year, or both parties recorded at least 50 day-case admissions per year, or both parties recorded at least 50 inpatient admissions per year.

[166] In some previous cases the CMA has applied an initial filtering threshold of 30%. However, we are mindful that our findings in this case that recent policy developments have encouraged greater levels of collaboration in the provision of NHS acute services which have reduced the emphasis on the role of competition within the NHS. Also, previous CMA cases have not identified an SLC in regard to clinical specialties in which reallocated referrals are below 40% to the other merger party. We also looked at what difference moving from 30% to 40% in this case and the effect was to filter out two additional specialties: trauma and orthopaedics; and infectious diseases. In this inquiry the latter would be cleared on other grounds in any case.

the hospital where they had their first outpatient appointment or referred by the outpatient consultant onto another provider).

10.49 Because of the lack of direct choice by patients of their treatment setting, using referral analysis on an inpatient or day-case referrals may be less directly informative than employing that analysis on outpatient referrals. However, that is not to say that the referral analysis is not relevant. We have previously found that patients have been evenly split as to whether they had expected at the time of their initial referral that they would subsequently need treatment or surgery.[167]

10.50 Where patients do expect follow-on treatment, patients and their GPs will take into account the possibility that they will be admitted when making their initial choice of provider for their outpatient appointment, and so will assess the quality of both outpatient and inpatient services offered by each provider in taking their initial decision. Therefore, some patients and their GPs may indirectly choose their provider of inpatient or day-case treatment. As such, an analysis of the patterns of first outpatient referrals would take into account, to some extent, patients' preferences across both outpatient and admitted patient services in that specialty to the extent that patients are choosing on the possibility of follow-on treatment, but would not be able to separate out those patients who choose solely on the basis of considerations related to the quality of outpatient services.[168]

10.51 Combined with the fact that, from a supply-side perspective, the conditions of competition may differ across different treatment settings, due to asymmetric constraints among different providers of inpatient, day-case and outpatient care for each specialty, and the presence of providers that are only active in outpatient and not inpatient or day-case in some specialties, we believe that it is appropriate to use referral data to analyse inpatient and day-case referrals.

10.52 However, in recognition that patient choice directly to an inpatient or day-case treatment setting is not possible, we also examined the parties' and third parties' volume of admissions and shares of inpatient and day-case activity (within an 80% catchment area).

[167] In *Ashford and St Peter's/Royal Surrey County*, the CMA's patient survey found that 44% of surveyed patients at the Ashford and St Peter's and Royal Surrey County trusts thought it was very likely or quite likely that they would subsequently need treatment or surgery. The evidence from the patient survey suggests that the quality of outpatient services is more important than the quality of future treatment to some patients in choosing a provider, while the quality of day-case and inpatient services is more important for other patients. See *Ashford and St Peter's/Royal Surrey County*, paragraphs 6.36–6.40.
[168] In other words, we cannot see inpatient choices separate from outpatient choices, for example.

10.53 A full description of how we have undertaken this analysis is in Appendix C.

Results of our analysis

The parties' overlaps

10.54 In 2015/16, CMFT provided services in 84 clinical specialties, UHSM in 56. Of these, we have found that the parties overlap in at least one treatment setting (that is, inpatient, day-case, or outpatient) for 34 clinical specialties.[169] Excluding those specialties which did not have at least 40% of their referrals reallocated to the other merger party left 31 specialties for us to assess.

Referral sources and sub-specialisation

10.55 We considered that competition concerns were unlikely to arise in specialties where a low proportion of first outpatient referrals (fewer than 10%) came from sources that involve patient choice. We found that the specialties Cardiac Surgery, Dietetics, Infectious Diseases, Neonatology and Occupational Therapy could all be disregarded for further review on this basis.

10.56 Speech and Language Therapy showed that it had a low proportion of first outpatient referrals from sources that involve patient choice (around 14%) and that these referrals are nearly all to UHSM. The parties submitted that GPs may make direct referrals to the Speech and Language Therapy service at UHSM, but that there is no equivalent direct access at CMFT. Speech and Language Therapy is generally accessed by patients as part of a broader programme of treatment, and so are generally not subject to direct referrals by GPs or patient choice. We have therefore disregarded Speech and Language Therapy for further review in our inquiry.

10.57 We also examined whether the overlaps between CMFT and UHSM were limited to the extent that they provide different sub-specialty treatments and procedures within each specialty. The parties submitted that they did not wholly overlap in the treatments and services within the following specialties: Vascular Surgery; Oral Surgery and Maxillo-Facial Surgery; Plastic Surgery; Pain Management; Clinical Haematology; Diabetic Medicine; Respiratory Medicine; Paediatrics, Paediatric Surgery, and Paediatric Urology; Geriatric

[169] We have not included in our inquiry those clinical services in which the CMA's phase 1 investigation found that there was no realistic prospect of an SLC finding in the clinical specialties Anaesthetics, Palliative Medicine, Anticoagulant services, Medical Oncology, Clinical Oncology, Gynaecological Oncology and Interventional Radiology.

Medicine; and Gynaecology. The lowest level of commonality between CMFT and UHSM was in Respiratory Medicine where CMFT treated around 40% of the same treatment spells as did UHSM. However, we could not rule out potential competition concerns arising at these levels of overlap and therefore all of these specialties remained in the list of specialties for closer review.

10.58 We therefore conducted a detailed review of the merger's impact on competition between the parties in the 25 specialties listed in Table 1.

Table 1: Clinical specialties SLC consideration

Specialty
Audiology
Cardiology
Chemical pathology
Clinical haematology
Dermatology
Diabetic medicine
Ear, nose, throat
Gastroenterology
General medicine
General surgery
Geriatric medicine
Gynaecology
Maternity
Oral surgery
Orthodontics
Paediatrics
Paediatric cardiology
Paediatric urology
Pain management
Plastic surgery
Physiotherapy
Respiratory medicine
Rheumatology
Urology
Vascular surgery

Source: CMA referral data analysis.

Our detailed review of individual specialties

Specialties in which we provisionally find no horizontal unilateral effects in any treatment setting

Audiology

10.59 We were able to confirm the parties' submission that many acute trusts in Greater Manchester provide Audiology services despite only CMFT, UHSM and St Helens and Knowsley Teaching Hospitals NHS Trust recording any activity in the Audiology specialty in the HES data. This would lead the referral analysis to understate the extent to which the parties would be constrained by third party providers in the market for Audiology services. The results of the GP-only referral analysis for outpatient Audiology suggests that the parties will continue to face strong competitive constraints from Specsavers Healthcare Group. This is supported by the parties' internal documents.[170] We therefore provisionally find that the merger is unlikely to give rise to horizontal unilateral effects in Audiology.

Chemical Pathology

10.60 Chemical Pathology is a service that supports other clinical services in a hospital that rely on biochemistry diagnostics. Providing diagnostic services support to other services in the hospital accounts for the majority of the work of the specialty, although a small volume of work may also be carried out for outpatients. There is little competition for patients in Chemical Pathology services, as the majority of pathology is done 'behind the scenes' in support of other specialties, and it is unlikely to be the basis on which patients would make their decision about the hospital to attend for their main elective treatment. We therefore provisionally find that the merger is unlikely to give rise to horizontal unilateral effects in Chemical Pathology.

Dermatology

10.61 The parties submitted that in 2015, South Manchester CCG, Central Manchester CCG and Trafford CCG changed Dermatology services so that only cancer-related Dermatology referrals were made to CMFT and UHSM, and all other Dermatology referrals were made to a community-based

[170] In addition, the 2014 CMFT surgery business plan identifies other local NHS providers as competitors for a variety of sub-specialisms (and notes that community-based trusts are seen as more accessible for patients), with no particular mention of UHSM. It also says that private providers are competitors for hearing aids for non-complex patients ('notably Specsavers'). For some services (implantable devices and auditory verbal therapy mentoring) it explicitly states that its only competitors are non-local.

provider. Therefore, historical referral numbers and patterns, including those dating from 2015/16, were no longer relevant to an assessment of the effect of the merger on this specialty.

10.62 Although the data do not distinguish between cancer and non-cancer related Dermatology, we were able to confirm that Salford Royal offers skin cancer clinics and cancer-related Dermatology services.[171] The referral analysis indicated that, historically, Salford Royal was the closest third-party competitor to the parties for Dermatology. On this basis, we believe that Salford Royal is likely to continue to provide a significant competitive constraint to the parties with respect to cancer-related Dermatology referrals. Furthermore, to the extent that benign Dermatology referrals have been successfully redirected by commissioners to community providers, this suggests that community providers may provide a material constraint to the parties and other acute providers with respect to benign Dermatology referrals. Therefore, we provisionally find that the merger is unlikely to give rise to horizontal unilateral effects in Dermatology.

Orthodontics

10.63 For Orthodontics hospital treatments, the parties submitted that referrals for adult treatment are not subject to the usual rules on patient choice. Funding requests for treatment in Orthodontics must be approved by local commissioners, who will specify the treatment provider where treatment is approved.

10.64 Given that patient choice does not apply to Orthodontics there is limited scope for providers to compete and we therefore provisionally find that the merger is unlikely to give rise to horizontal unilateral effects in Orthodontics.

Paediatric Cardiology

10.65 Paediatric Cardiology relates to the treatment of diseases and abnormalities of the heart in children. The CMA observed that UHSM only recorded [0–500] Paediatric Cardiology outpatient episodes across the two years 2014/15 and 2015/16, compared with [4,000–5,000] for CMFT. In other words, UHSM provided around [5–10]% of the parties' combined outpatient Paediatric Cardiology episodes. As a result, we believe that the merger may only give rise to a small increment to CMFT's episodes in this specialty and

[171] NHS Choices website: Salford Royal–Dermatology; Salford Royal leaflet: Skin cancer nurse specialist and multi-disciplinary team.

therefore provisionally find that the merger is unlikely to give rise to horizontal unilateral effects in Paediatric Cardiology.

Plastic Surgery

10.66 UHSM is a regional specialist centre for Plastic Surgery, which is closely related to its specialist Burns and Breast Surgery services that are not offered by CMFT. In addition, the outpatient appointments for Plastic Surgery at CMFT are due to an outpatient clinic being run at CMFT by a UHSM plastic surgeon, and CMFT does not have independent access to a consultant workforce in this specialty. CMFT does not provide any inpatient Plastic Surgery services.

10.67 In addition to the parties' submission that UHSM is a regional specialist centre for Plastic Surgery, the CMA observed that CMFT only recorded [0–500] episodes for outpatient Plastic Surgery, over the two years 2014/15 to 2015/16, compared with [12,000–13,000] episodes for UHSM. In other words, CMFT provided fewer than [0–5]% of the parties' combined outpatient Plastic Surgery episodes. As a result, we believe that the merger may only give rise to a small increment to UHSM's outpatient episodes in this specialty and therefore we provisionally find that the merger is unlikely to give rise to horizontal unilateral effects in outpatient Plastic Surgery.

Physiotherapy

10.68 The results of our referral analysis show that the shares of reallocated referrals from each party to the other in outpatient Physiotherapy is relatively low. Our analysis suggests that the parties will continue to face strong competitive constraints, particularly from Care UK.

10.69 We therefore provisionally find that the merger is unlikely to give rise to horizontal unilateral effects in Physiotherapy.

Specialties in which we provisionally find horizontal unilateral effects in at least one treatment setting

10.70 We have carefully considered the available evidence for each of the remaining clinical specialties in which the parties overlap in at least one treatment setting and not discussed or otherwise filtered out as noted in paragraphs 10.46 to 10.53 above. This includes the competitive constraints on the parties from other trusts. Our analysis of these is set out in detail in Appendix C. A summary of our provisional finding on each specialty is below.

Cardiology

10.71 The parties submitted that a proportion of Cardiology patients are from referral sources other than GPs (and so no patient choice will apply). We have taken this into account in our analysis. This has already been taken into account (paragraph 10.55).

10.72 The referral analysis suggests that the parties are close competitors (more than a 40% share of reallocated referrals) across most treatment settings for Cardiology. The parties have high combined shares (more than a 40% share of admissions) in each of their catchment areas for inpatients but a relatively low combined share (around or less than 40% share of admissions) for day-cases, in both catchment areas.

10.73 We provisionally find that the merger may be expected to give rise to horizontal unilateral effects in all treatment settings for Cardiology.

Clinical Haematology

10.74 CMFT offers a number of specialist services relating to bone marrow transplantation, sickle cell disease and thalassaemia, which are not available at UHSM.

10.75 The parties told us that in some instances a pathology laboratory at a hospital examining a blood sample sent from a GP practice will identify that a patient requires urgent secondary treatment and there will be no right of patient choice in those instances.

10.76 We note that patient choice does apply to other patients of Clinical Haematology and, moreover, the parties have not indicated what proportion of patients will require urgent secondary treatment.

10.77 The referral analysis suggests that the parties provide strong constraints on each other (over a 40% share of reallocated referrals), and that CMFT in particular provides a very strong constraint on UHSM. We have not found it necessary to examine share of appointments and admissions since the parties overlap only in outpatient services.

10.78 We therefore provisionally find that the merger may be expected to give rise to horizontal unilateral effects in outpatient Clinical Haematology.

Diabetic Medicine

10.79 CMFT is a renal centre, and is likely to see diabetic patients with renal failure. Therefore, many patients referred to CMFT for treatment in this

specialty may not be suitable for treatment at UHSM. However, because of the data available to us it was not possible for us to analyse differences in the parties' treatment offerings. Nevertheless, the presence of the specialist renal centre and the renal diabetes clinics at CMFT means that CMFT's share of reallocated UHSM referrals is likely to be overstated.[172]

10.80 The referral analysis suggests that the parties are close competitors (more than a 40% share of reallocated referrals), and that CMFT provides a particularly strong constraint on UHSM (more than 70% of reallocated referrals), although this may be partly due to the presence of diabetic patients requiring renal treatment that could only attend CMFT or Salford Royal.

10.81 We provisionally find that the merger may be expected to give rise to horizontal unilateral effects in outpatient Diabetic Medicine but will take into account the parties' submissions on the specialist renal centre when we consider the magnitude of the adverse effect of any SLC finding.[173]

Ear, Nose and Throat (ENT)

10.82 The parties told us that the majority of ENT referrals are from consultants, not GPs (thereby indicating that patient choice does not play a role for these patients). This has already been taken into account (paragraph 10.55).

10.83 The referral analysis indicates that the parties are close competitors for day-cases, but also that they appear to face a wide range of competitors for inpatients and outpatients, with Care UK being a particularly significant competitor for outpatients. For day-cases, the parties' combined shares are high (over 70% of day-case admissions in the area around UHSM).

10.84 There is limited corroboration of these results in the parties' internal documents. The 2014 CMFT surgery business plan anticipates centralisation in Head & Neck surgery in the coming years, and profiles one of its competitors as UHSM, along with Pennine Acute and Salford Royal.

10.85 We therefore provisionally find that the merger may be expected to give rise to horizontal unilateral effects in day-case ENT.

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[172] We can take this into account, if necessary, in the next stage of our inquiry when we assess remedy options and RCBs.
[173] See paragraph 15.9 and ff.

Gastroenterology

10.86 The parties submitted that a significant proportion of activity in Gastroenterology can relate to referrals for endoscopies. However, not all endoscopies relate to patients receiving treatment within the Gastroenterology specialty, which can result in endoscopies being inconsistently coded to different specialties at different trusts. Similarly, most gastroenterologists are still general physicians with a special interest in Gastroenterology, and still participate in General Medical provision. Therefore, there may be a risk of different coding practices at CMFT, UHSM, and other acute trusts in Greater Manchester between Gastroenterology and General Surgery, and between Gastroenterology and General Medicine.

10.87 The parties further submitted that CMFT is a bowel cancer screening centre for Greater Manchester. This means that a proportion of referrals that are made to CMFT, which are for screening purposes, could not be made to other trusts. This will have the effect of inflating CMFT's share of Gastroenterology referrals at each GP practice, and its apparent strength as a competitor to other trusts, including UHSM.

10.88 However, neither the parties nor we are able to adjust the data to address the possibility of miscoding. We have excluded in our analysis patients who have gone via the bowel cancer screening centre. That referral analysis indicates that CMFT provides a particularly strong constraint on UHSM (around 60% or more of reallocated referrals), and that UHSM provides a strong constraint on CMFT (around a 40% share of reallocated referrals or more) for day-cases and outpatients. In addition, CMFT and UHSM have high combined shares of appointments and admissions in inpatient and day-case treatment settings.

10.89 On the basis of the referral analysis, supplemented by the analysis of share of appointments and admissions, we provisionally find that the merger may be expected to give rise to horizontal unilateral effects in each treatment setting for Gastroenterology.

General Medicine

10.90 The parties submitted that the vast majority of admissions in General Medicine at both trusts was non-elective in nature. Therefore, a large proportion of patients have not been exercising choice in General Medicine and the scope for competition is very limited indeed. While we consider that this is true for admitted patients, there are patients who will be exercising choice for outpatient appointments (but who may not go on to be admitted). We are not persuaded from the evidence available that in this specialty the

non-elective nature of a large proportion of admitted patients will necessarily protect elective patients from a reduction in quality.

10.91 The results of our referral analysis suggest that CMFT provides a strong, but asymmetric, constraint on UHSM in outpatient General Medicine. Therefore, we provisionally find that the merger may be expected to give rise to horizontal unilateral effects in outpatient General Medicine.

10.92 However, we note that CMFT attracts more patients than UHSM. In 2014/15 and 2015/16, there were around [5,000–6,000] elective outpatient appointments at CMFT and around [500–1,000] at UHSM (ie UHSM provided around [10–20]% of the parties' combined activity).[174]

General Surgery

10.93 The parties noted that there is a degree of differentiation between the services at the two trusts. The CMFT consultants who provide renal transplant and renal failure related surgery (which is not carried out at UHSM) also perform some 'general surgery' procedures (such as parathyroidectomy and other endocrine surgery) on both patients with and without renal failure. The parties submitted that referrals for renal failure related surgery are from across the region, and Salford Royal is the only other provider of renal failure related surgery.

10.94 In addition, the parties noted that our analysis using historical referral data will not pick up the reconfigurations in OG cancer services and emergency and high risk General Surgery, and as a result overstate the closeness between CMFT and UHSM. We have accepted these reconfigurations in the counterfactual to the merger.[175]

10.95 CMFT's relevant business plan notes that UHSM is the main competitor for its surgical services, 'especially in the area of UGI [upper gastrointestinal]" surgery. Other references in the parties' internal documents suggest that the patients have alternatives to the merger parties, at least in other parts of General Surgery (Appendix C, paragraph 67).

10.96 We have noted that the General Surgery category houses a range of services broader than those subject to reconfigurations. Given the results of our referral analysis and that CMFT's internal documents indicate that the parties are close competitors, we provisionally find that the merger may be

[174] See Table 2 in Appendix C.
[175] See paragraphs 8.32–8.41.

expected to give rise to horizontal unilateral effects in day-case General Surgery.

Geriatric Medicine

10.97 UHSM's Geriatric Medicine services is more extensive than CMFT's, with more services offered in relation to falls and Parkinson's Disease

10.98 The referral analysis shows that the parties are close competitors (around a 60% share of reallocated referrals).

10.99 We therefore provisionally find that the merger may be expected to give rise to horizontal unilateral effects in outpatient Geriatric Medicine.

Gynaecology

10.100 St Mary's Hospital in CMFT is a major specialist centre for Gynaecology services, providing specialist services that are not available at UHSM, such as reproductive medicine services. UHSM only provides routine Gynaecology services to its local catchment.[176]

10.101 Our analysis shows that nearly all of UHSM's inpatient and day-case Gynaecology activity involved treatments that were also performed at CMFT, but only around [50–60]% of CMFT's inpatient and day-case gynaecology activity involved treatments that were performed at UHSM. Our referral analysis using only treatments common to both parties indicates that UHSM is not a strong constraint on CMFT but CMFT places a very strong constraint on UHSM, particularly for day-cases.

10.102 The parties have high combined shares (more than a 40% share of admissions) in the catchment area around UHSM for inpatient and day-case settings but not in the catchment area around CMFT.

10.103 We therefore provisionally find that the merger may be expected to give rise to horizontal unilateral effects in Gynaecology.

Maternity

10.104 The parties submitted that relatively few women enter the Maternity pathway of care by way of a GP referral. Only 16% of CMFT's and 22% of UHSM's

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[176] The parties further submitted that the difference in services was reflected in the source of referrals for Gynaecology at each Trust. In 2015/16, around 90% of referrals for first outpatient appointments in Gynaecology at UHSM came from GPs, while this was the case for less than 40% of referrals for first outpatient appointments in Gynaecology at CMFT.

first outpatient Maternity appointments come from a GP referral. In Manchester, most women are booked into hospital via their antenatal care provider, typically a community midwifery service.

10.105 We have taken this into account. Our referral analysis suggests that UHSM is a significant competitor for CMFT, but CMFT also faces a similar constraint from Pennine Acute. In contrast, CMFT provides a very strong constraint on UHSM (more than a 70% share of reallocated referrals). The parties have a high combined share (more than a 40% share of admissions) in each of their catchment areas for inpatients.

10.106 We therefore provisionally find that the merger may be expected to give rise to horizontal unilateral effects in inpatient and outpatient Maternity.

Oral Surgery

10.107 For this specialty we have used share of appointments and admissions rather than GP referral data since patients receiving Oral Surgery are not referred by a GP. The parties told us that University Dental Hospital of Manchester in CMFT performs a large volume of specialist activity that could not be undertaken at UHSM.[177] The parties submitted that referrals in Greater Manchester are also processed by the triage centre. Referrals are assessed by a clinician who will determine, from the information provided by the dentist, the appropriate setting for any treatment. However, the parties acknowledged that where the triaging clinician determines that a hospital setting is appropriate, then patients will be offered a choice of provider.

10.108 Given that patient choice applies here, and that the parties have a high combined share (over 70% of appointments and admissions in each inpatient, outpatient and day-case treatment setting with high increments of over 20% in all instances) we provisionally find that the merger may be expected to give rise to horizontal unilateral effects in inpatient and day-case Oral Surgery.

Paediatrics

10.109 Our analysis showed that nearly all of UHSM's inpatient and day-case Paediatrics activity involved treatments that were also provided at CMFT, but only around 72% of CMFT's inpatient and day-case activity in this specialty involved treatments that were performed at UHSM. Our referral analysis on

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[177] The parties submitted that, in 2015/16, around 75% of referrals to UHSM in these two specialties were from GPs, while around 50% of referrals to CMFT were from GPs. The large proportion of non-GP referrals to CMFT is indicative of referrals being made from other providers where specialised care is needed for patients.

those treatments common to both parties indicated that CMFT and UHSM are close competitors.

10.110 The parties have high combined shares (more than a 40% share of admissions) in UHSM's catchment areas for inpatients and day-cases, and for inpatients and day-cases in CMFT's catchment area. However, UHSM's high shares of inpatient Paediatrics are likely due to its incorrect coding of Well Babies and Neonatology to the Paediatrics specialty.

10.111 Given the high combined shares, we provisionally find that the merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient Paediatrics.

Paediatric Urology

10.112 Royal Manchester Children's Hospital in CMFT is a regional specialist centre for children's services. UHSM delivers non-specialist services for its immediate catchment. In addition, children under two years old that require surgery must be treated at a specialist centre like CMFT, and are unable to be treated at UHSM.

10.113 The parties informed the CMA that UHSM identified a coding error whereby activity that should have been coded to Paediatric Urology was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

10.114 Our referral analysis on the re-coded basis suggests that CMFT provides a very strong constraint (more than a 90% share of reallocated referrals) on UHSM's Paediatric Urology service, for both day-cases and outpatients. UHSM also appears to place a strong constraint on CMFT (more than a 50% share of reallocated referrals). The parties have a very high combined share (more than 80% of appointments and admissions) in each of their catchment areas for day-cases.

10.115 On the basis of this analysis we provisionally find that the merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient Paediatric Urology.

Pain Management

10.116 The referral analysis indicates that the parties are close competitors for outpatients, and that UHSM is a strong competitor for CMFT's day-case patients. It also suggests that Salford Royal is a significant competitor to both parties.

10.117 UHSM offers a chronic Pain Management service, and CMFT does not.

10.118 The parties stated that there is a coding issue in the data provided to us such that some Pain Management patients may be undergoing treatment at their first appointment with a consultant and coded as day-case activity instead of outpatient activity. To account for this, the CMA grouped the first day-case appointments with other first outpatient appointments, and repeated the referral analysis. The results suggest that Salford Royal will continue to provide some competitive constraint on the merged entity. However, CMFT and UHSM have a high combined share of appointments and admissions in the UHSM catchment area (of around [70–80]% in the day-case treatment setting and around [70–80]% in the outpatient treatment setting) with increments of around [20–30]%.

10.119 On the basis of the referral analysis, supplemented by the analysis of share of appointments and admissions, we provisionally find that the merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient Pain Management.

Respiratory Medicine

10.120 UHSM is a specialist centre for Respiratory Medicine, and includes the North West Lung Centre, which provides services across the North West. Specialist services at UHSM in this area cover a range of conditions and treatment areas, including allergy, asthma, bronchiectasis, cystic fibrosis, lung transplantation and a sleep service. Patients that are referred to UHSM for specialised services could not be treated at CMFT. Our analysis showed that all of CMFT's inpatient and day-case Respiratory Medicine activity involved treatments that were also provided at UHSM, but only around 43% of UHSM's inpatient and day-case activity in this specialty involved treatments that were performed at CMFT.

10.121 Referral analysis limited to treatments in day-case Respiratory Medicine that both CMFT and UHSM provide indicate that the parties are close competitors. The parties have a high combined share (more than a 40% share of admissions) in CMFT's catchment for day-cases. An UHSM internal document identifies CMFT as it closest competitor in Respiratory Medicine.

10.122 We therefore provisionally find that the merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient Respiratory Medicine.

Rheumatology

10.123 The referral analysis shows that the parties are close competitors (around 40% share or more of reallocated referrals). The parties have a high combined share (more than around a 40% share of admissions) in each of their catchment areas for day-cases.

10.124 We therefore provisionally find that the merger may be expected to give rise to horizontal unilateral effects in day-case Rheumatology.

Urology

10.125 The parties stated that there is a coding issue in the data provided to us such that some Urology patients referred to CMFT, UHSM and other providers may be undergoing treatment at their first appointment with a consultant and coded as day-case activity instead of outpatient activity. To account for this possibility, we grouped the first day-case appointments with other first outpatient appointments, and repeated the referral analysis. The results suggest that the parties may be closer competitors for outpatients than implied by the outpatient-only results.

10.126 Internal documents from both parties indicate that they are close competitors in this specialty.

10.127 We therefore provisionally find that the merger may be expected to give rise to horizontal unilateral effects in inpatient and day-case Urology.

Vascular Surgery

10.128 The parties submitted that there will be a reconfiguration of Vascular Surgery services to give a single Vascular Surgery service in Manchester. This is discussed as a part of the counterfactual to the merger (see paragraphs 8.50 to 8.51) where we have provisionally found that the proposed reconfiguration is not sufficiently certain to be taken into account as a part of the counterfactual to the merger.

10.129 The parties also told us that CMFT is the Greater Manchester provider of complex endovascular services, a sub-specialism within Vascular Surgery, which is not provided at UHSM. In addition, a proportion of referrals for Vascular Surgery at CMFT will be related to CMFT's status as a specialist renal centre. These referrals are unlikely to be able to switch to UHSM.

10.130 The results of our referral analysis (on clinical activities common to both CMFT and UHSM) indicates that the parties are close alternatives for patients. Likewise, the 2014 CMFT surgery business plan identifies UHSM

as the 'main competitor' which strategically aspires 'to be a leading centre for vascular surgery in GM and investment in the service is evident'. Pennine Acute is also described as a competitor, but its threat 'is considered minimal given their infrastructure and ability to sustain the service in line with national standards and service specification.' UHSM and Pennine Acute are also identified as competitors for Carotid Artery, Aortic Aneurysm and Lower Leg By-Pass surgery. However, Varicose Veins is an area in which there are multiple providers on the market.

10.131 We therefore provisionally find that the merger may be expected to give rise to horizontal unilateral effects in each treatment setting for Vascular Surgery.

Countervailing factors

10.132 With regard to buyer power, the CMA's NHS Mergers Guidance says that:

> when looking at whether the commissioners would be likely to have the ability to prevent the merged provider from reducing quality or increasing price in respect of those specialties where it was less constrained by a competitor, we will consider whether in these circumstances the commissioner would be able easily to switch (or threaten to switch) its demand to another provider or otherwise constrain the merged provider. We would be looking at whether the commissioners could act to prevent a decrease in quality or increase in price at the margins, in particular in an area where, for example, the merging providers both provided services of a high quality, at levels over and above key regulatory requirements or in areas where the merged provider would not consider a decrease in quality such that it lost Commissioning for Quality and Innovation (CQUIN) payments or fell below a quality regulatory threshold to be a significant issue.[178]

10.133 We have not been presented with any evidence of countervailing buyer power in regard to NHS elective and maternity services in this case.

10.134 Nor have we been presented with evidence of entry by a third party provider which may prevent an SLC from arising as a result of the merger. The parties submitted to us that barriers to entry into a clinical specialty include a combination of getting the right infrastructure, the right staff and commissioner approval. What infrastructure and equipment is required will

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[178] *NHS Merger Guidance*, paragraph 6.81.

vary by specialty (for example, radiotherapy requires specially constructed bunkers and expensive capital equipment). They told us that obtaining commissioner approval might represent a significant barrier to entry.

Provisional conclusions on competition in NHS elective and maternity services

10.135 We have looked carefully at the role played by competition in the provision of NHS elective and maternity services. We have found that surveys of patients indicate that the location of hospital is the single most important factor in a patient's choice of hospital, although not the only important factor. Given the close proximity of the parties, we believe that it is likely that some of those other important factors have greater prominence in patients' decision making when choosing between the two parties.

10.136 The internal documents from CMFT and UHSM have provided us with some insight that the parties have competed for patients and have considered, to some extent, the competitive environment when formulating their strategies. We particularly note that it is in the strategy documents that the parties discuss competition. The evidence on capacity constraints is that the parties face some capacity constraints but we believe that there is scope for the parties to accommodate additional patients in some elective services.

10.137 Our view of the evidence is that competition does play a role in the provision of NHS elective and maternity services.

10.138 On the basis of the evidence available to us, we have provisionally found that CMFT and UHSM are close alternatives to each other for 18 elective and maternity services (paragraphs 10.59 to 10.131) (Table 2) and that horizontal unilateral effects could be expected to result from the merger. By product market, we have provisionally found that within those 18 clinical specialties horizontal unilateral effects arise in 34 product markets (ie by inpatient, day-case or outpatient treatment setting).

Table 2: Clinical specialties where the merger may be expected to give rise to horizontal unilateral effects

Specialty
Cardiology
Clinical haematology
Diabetic medicine
Ear, nose, throat
Gastroenterology
General medicine
General surgery
Geriatric medicine
Gynaecology
Maternity
Oral surgery
Paediatrics
Paediatric urology
Pain management
Respiratory medicine
Rheumatology
Urology
Vascular surgery

10.139 We note that a substantial number of patients are served by the parties within these 18 NHS elective and maternity services, and that these services account for a significant proportion of the parties' total income, which are consistent with the parties being incentivised to compete concerning these services. The average annual number of appointments and admissions affected by the 18 elective and maternity services range from around 45,000 in the inpatient treatment setting to around 690,000 in the outpatient treatment setting (Table 48, Appendix C).[179] Even after making allowance for the fact that, as noted above, in some treatment settings or clinical specialties the overlap does not occur across the whole setting or specialty, the patient numbers and appointments involved are substantial.

10.140 The 18 NHS elective and maternity services account for at least 10% of CMFT's total revenue and 14% of UHSM's total revenue (and around 37% and 43% of CMFT's and UHSM's NHS elective and maternity services only income respectively). Even allowing for the data limitations described in

[179] We have aggregated figures for CMFT and UHSM and averaged them over two years. Outpatient figures include first outpatient appointments (as well as follow-up outpatient treatments) and therefore will include appointments of patients who then go on to receive treatments in a day-case or inpatient setting.

Appendix C we have found that the 18 NHS elective and maternity services account for a substantial proportion of the elective income of each party.[180]

10.141 Taken together with the evidence on closeness of competition between the parties in these specialties, we have therefore provisionally concluded that the merger may be expected to give rise to an SLC in the provision of NHS elective and maternity services.

10.142 In addition to the clinical specialty-level competition effects, there may also be effects across the whole hospital that are likely to arise as a result of the merger. These effects are fairly broad in nature, but are capable of influencing patients' and GPs' choice of hospital for any given elective service. For example, given that we have provisionally found that the merger may be expected to give rise to horizontal unilateral effects in 18 elective and maternity services, we have considered whether some aspects of quality which are common across all of the hospitals within CMFT or UHSM (rather than associated only with one particular elective service) are also likely to be worsened as a result of the merger.[181]

10.143 In view of our provisional findings in respect of NHS elective and maternity services and in respect of specialised services (below), and given our analysis of other features of the competitive environment in which the parties operate, we have not found it necessary to reach any provisional conclusion on whether the merger may be expected to give rise to hospital-wide effects.

11. The effect on competition in NHS non-elective services

11.1 We have examined whether CMFT and UHSM have competed for patients in NHS non-elective treatments and, if so, whether the merger may be expected to give rise to an SLC in NHS non-elective services.

11.2 Non-elective services are not planned in advance and there is no statutory right for the patient to choose a provider as there is for NHS elective services. However, when someone takes themselves to an A&E department they may choose which one to attend. For example, someone who has suffered a broken arm in Manchester may choose to be taken to CMFT or to UHSM. For the avoidance of doubt, we do not consider that choice or a

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[180] Our reasons for this are set out in paragraphs 198 and 199 of Appendix C.
[181] The Cooperation and Competition Panel found that some hospital trusts had reacted to competitive pressure by improving non-specialty specific quality attributes like introducing directly bookable services to GPs, increasing opening hours, introducing an infection control team to work across departments and operating a shuttle bus to take patients between hospital sites. Cooperation and Competition Panel, Inside the black box: How competition between hospitals improves quality and integration of services, July 2012.

competitive dynamic exists for patients who are taken to an A&E department by ambulance. We have focused our examination on those patients who self-presented to the A&E department and received some treatment once there.

11.3 Both parties provide non-elective services. CMFT has an A&E department offering a 24-hour service as well as a walk-in centre for minor injuries or illness at the Manchester Royal Infirmary. It also has a Paediatric Emergency Department offering a 24-hour service at Manchester Royal Children's Hospital (located next to Manchester Royal Infirmary) and an urgent care centre (for non-elective but non-life threatening conditions) at Trafford General Hospital. CMFT provides emergency dental and eye care to non-elective patients at its dedicated sites.[182] UHSM has an A&E department offering a 24-hour service at Wythenshawe Hospital.

11.4 In the financial year ending in March 2016, around [256,000–257,000] patients attended the various centres for non-elective services provided by CMFT. However, taking into account only those patients who attended CMFT's A&E department at Manchester Royal Infirmary, it treated around [103,000–104,000] patients. Of these, around 30% were admitted for further treatment. During the same period, about [92,000–93,000] patients attended UHSM's A&E department, of which about 32% were admitted.

11.5 We have considered in our inquiry whether the merger may be expected to give rise to an SLC in NHS non-elective services which could be to the detriment of patients through a lowering of some aspect of quality. We have also considered whether the merger would impact on commissioner choice in the event of any future A&E reconfiguration.

Competition in NHS non-elective services

The parties' submissions

11.6 The parties submitted that they did not compete for non-elective patients.[183] Further, the parties said that even in a hypothetical environment of competition for these patients, they would have neither the ability nor the incentive to compete for them. According to the parties, one of the goals of healthcare policy in relation to non-elective care was to minimise hospital admissions by providing the most effective primary and community-based care to ensure that people were cared for in their own home or as close to

[182] Manchester Royal Eye Hospital and University Dental Hospital of Manchester respectively.
[183] Parties' initial phase 2 submission, paragraph 96.

home as possible. Pressures on A&E services meant that CMFT, UHSM, NHS commissioners, and others in the local health economy did as much as possible to encourage people to seek care in settings other than A&E wherever possible. This included out-of-hours GP services, community pharmacies, urgent care centres, walk-in centres and other facilities.[184]

11.7 The parties told us that non-elective care, involving the admission of a patient through A&E, did not involve patient choice given the urgent and unplanned nature of the care that was being provided.[185] The parties' view was that those patients that self-presented at A&E with a major illness or injury were unlikely to be exercising choice. These patients required care urgently and were likely to be in pain. Their priority would be to attend their nearest A&E.

11.8 In regard to patients with a minor injury, not suited to A&E treatment, the parties submitted that those patients that were self-presenting at A&E were more likely to exercise choice. However, for these patients, choice extended beyond A&E departments and might include walk-in centres, urgent care centres, GP services, out-of-hours GP services, pharmacies, and NHS 111 services. The parties told us that it was not possible to envisage a situation in which the parties were competing for more A&E self-presenters who required A&E treatment that did not also have the effect of attracting more A&E self-presenters who needed a minor injuries/illness service. Such an outcome would be seen as undesirable by commissioners, and create significant tension between the trust and its commissioners.

11.9 The parties did not believe that, even if there was a financial incentive to attract additional A&E patients (which the parties did not believe is the case), it would be possible to implement an acceptable strategy that aimed to attract additional A&E patients outside peak demand periods and not during peak periods.[186]

11.10 Moreover, a significant proportion of A&E attendances resulted in a non-elective admission at both CMFT and UHSM (30% and 32%, respectively). According to the parties, this meant that the parties' capacity to treat additional non-elective patients is not only a function of the capacity of their A&E departments, but also the availability of beds within their hospitals to

[184] Publicity material aimed at deterring patients from inappropriate A&E attendances can be found on the following websites: Choose Well Manchester; CMFT: A&E - Not the Place for Toothache!; North West Ambulance Service: #Team999 Campaign; and Greater Manchester Local Pharmaceutical Committee: Stay Well This Winter (2016/17).
[185] Parties' initial phase 2 submission, paragraph 30.
[186] Parties' initial phase 2 submission, paragraph 92.

admit these patients. This beds issue is a constraint regardless of whether the patient arrives at A&E inside or outside peak demand periods in the A&E department.

11.11 The parties submitted that bed occupancy levels were high at both trusts. In Quarter 3 of 2016/17, bed occupancy at UHSM was 84.1% and at CMFT it was 93.1%.[187] The NAO suggested that hospitals with average occupancy levels in excess of 85% could expect to have regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections,[188] while the Department of Health also said that occupancy of greater than 85% was a cause for concern.[189] These high levels of bed occupancy mean that there is a further disincentive to attract additional non-elective care patients.

11.12 The parties also made relevant submissions on financial incentives.[190] They told us that the marginal rate emergency rule (see paragraph 12.24 below) reduces the incentives to treat additional patients after the threshold volume. In addition, those non-elective patients who are admitted will be taking a bed that could otherwise be used for an elective care patient where there is no marginal rate rule. All else being equal, the elective care patient is likely to be more financially attractive than the non-elective patient.

11.13 Moreover, the parties said that there was no experience in the NHS of acute trusts competing for contracts to supply A&E services. The commissioning intentions set out by Manchester CCGs did not set out any intention to hold a competitive tender process for the provision of A&E or non-elective services.

Our analysis

Evidence of competition

11.14 In considering competition between the parties in non-elective services, we have looked at the evidence on whether patients exercise choice between A&E departments, whether the parties consider the implications of competition in their management decisions and whether the parties have the ability and incentive to attempt to attract additional patients to their A&E departments. We have also looked at what alternatives for patients exist in the local area.

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[187] NHS England statistics: Bed Availability and Occupancy Data – Overnight
[188] NAO (24 February 2000), *Inpatient Admissions and Bed management in NHS acute hospitals*.
[189] See Department of Health Annual Report 2002, paragraph 5.9: The National Beds Inquiry.
[190] Parties' initial phase 2 submission, paragraph 95.

11.15 Although improving the quality of A&E departments could be expected to increase the volume of patients at the margins by appealing to those patients who have choice, the time-critical nature of emergency and urgent treatment means that those A&E patients who have choice will typically be less able than other patients to consider hospitals' quality. We also note that some of the relevant information for patients to make an effective choice – such as waiting times – might change frequently throughout the day and week.

11.16 We have looked at the data on whether patients do attend the closest A&E to their home as one possible way to ascertain whether they are exercising any meaningful choice. The parties submitted that around three-quarters of self-presenting patients who attended CMFT's Manchester Royal Infirmary A&E Department went to their closest A&E. We found that around the same proportion of self-presenting patients attending UHSM's Wythenshawe A&E department had also gone to their closest A&E.[191] We note that the data relied on patients' home postcodes to indicate whether they went to their nearest A&E but some people will suffer an accident or incident away from their home (which may be more prevalent for CMFT given its central location).[192] Further, some patients will know that their nearest hospital's medical facilities are less well suited to them (for example, if they have a recurring condition).

11.17 We have not seen evidence that either CMFT or UHSM has a strategic goal to improve the quality of its A&E department for the purpose of increasing patient volumes (and therefore revenues). Indeed, UHSM is in the process of expanding its A&E capacity and so in this inquiry we have been able to explore the reasons for that.

11.18 Last year the UHSM board approved a £14.9 million investment to expand and improve its A&E department. The main rationale for this, as set out in its business case, was 'to cope with current demand and predicted levels of growth in emergency activity between now and 2023/24, and to meet the additional requirements placed on UHSM as a result of changes to emergency services at Trafford General Hospital under the "New Health Deal for Trafford"'. The development works started in August 2016 and are expected to be completed by autumn 2018. Overall, the expansion is

[191] Using A&E HES data, we calculated drive-times from patients' residence postcodes to the relevant A&Es. Using distance travelled produces similar results.
[192] The parties submitted that for CMFT the location of the patient's incident was recorded in only 11% of instances and therefore they are unable to determine whether patients went to the closest A&E to their accident incident location.

expected to allow UHSM to accommodate demand up to 2023/24 forecast, which is estimated to reach about 105,000 patients a year.

11.19 Although expansion of the A&E department at Wythenshawe hospital will strengthen UHSM's ability and incentive to compete for non-elective patients in an environment of such competition, there is no indication in the internal documents that we have seen that competition for these patients played any role in the expansion decision.

Ability and incentive to compete

11.20 We have considered the parties' ability and incentive to compete for additional A&E patients by considering whether it is financially attractive for them to do so and whether they would have the capacity to treat additional patients if they could attract more. In our inquiry, we have not seen any evidence of the parties competing for non-elective patients. Indeed, there is some evidence suggesting that the parties have been proactive in dissuading people from coming to their A&E departments if they do not need to.[193]

11.21 Non-elective service revenue is paid on a per patient basis, so the greater the number of patients the greater the trust's revenue. The payment to trusts for A&E services is subject to the 'marginal rate emergency tariff', under which commissioners set an absolute baseline level of funding for emergency admissions for each provider. Providers are then paid the full tariff rate for each patient treated to that level but then, if they go beyond the absolute baseline level they are paid 70% of the tariff rate for each additional patient treated.[194] This funding formula dampens trusts' incentives to go beyond their baseline level.[195] It is worth noting that the 'marginal rate emergency tariff' is not calculated on the basis of total attendances to A&E

[193] For example, UHSM's website informs people that 'Accident and Emergency should only be used in extreme circumstances. Please only visit Accident and Emergency if it's a serious or life threatening situation. If you access Accident and Emergency inappropriately, you may be turned away and directed to another NHS service.'
[194] 2016/17 National Tariff Payment System, paragraph 166.
[195] The marginal tariff has recently been changed from the previous level (of 30% of the tariff rate). In considering the change to the rate, Monitor and NHS England said 'the rule was intended to give acute providers an incentive to collaborate with other parties in the local health economy to manage demand for avoidable emergency admissions and to treat patients in the most appropriate setting. Providers may achieve these aims, for example, by deploying best clinical practice in their A&E departments (such as 7-day consultant cover) and linking with other providers, such as social workers and GPs, to avoid as many preventable emergency admissions as possible'. Monitor and NHS England (December 2013), Monitor and NHS England's review of the marginal rate rule, p2.

but rather to the number of patients who are admitted to the hospital once they have been clinically assessed.[196]

11.22 UHSM has exceeded the baseline for each of the past three years.[197] CMFT submitted that no rebates were applied in 2014/15 and 2015/16 and that no projected rebate was expected in 2016/17 (that is, CMFT would receive the full tariff).[198] Neither CMFT nor UHSM produces profit and loss analysis for A&E (the parties told us that this was because they did not take decisions regarding A&E according to financial incentives).

11.23 We considered whether the parties have capacity to provide services to additional non-elective patients. There are two elements to this:

(a) the parties' capacity to treat additional patients at their A&E departments; and

(b) the parties' capacity to provide services to additional patients that would be admitted, after attending the A&E.

11.24 Over the past three years there has been an 11% increase in admissions to CMFT via its A&E department and a 13% increase at UHSM. We note that UHSM is investing to expand its A&E capacity (see paragraph 11.18 above). The planned changes in physical capacity are shown below in Table 3.

Table 3: Current and future capacity available at UHSM A&E department

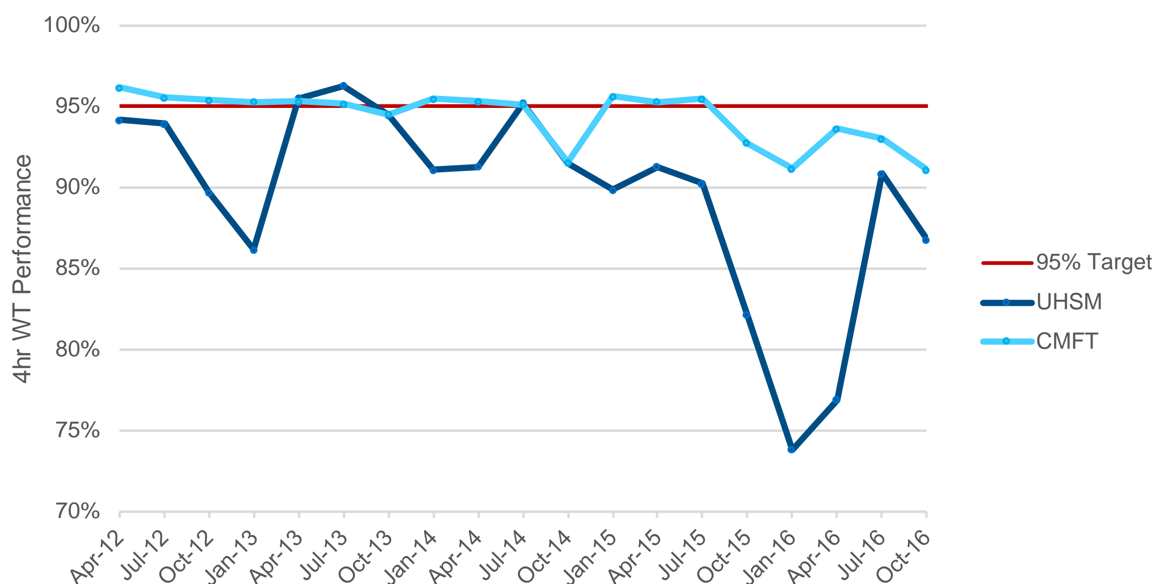
Current capacity	*New capacity*
Major cases – 12 cubicles	Major cases – 26 cubicles
Minor cases – 6 cubicles	Minor cases – 12 cubicles
Resuscitation – 6 cubicles	Resuscitation – 7+1 cubicles
Clinical Decision Ward – 12 beds	Clinical Decision Ward – 12 beds
Paediatrics – 7 cubicles	Paediatrics – 9 cubicles

Source: UHSM ED Business Case (Table 2).

11.25 UHSM's performance against the 4-hour target indicates that it has been capacity constrained for at least the past 5 years (figure 3). By contrast, CMFT's performance against the 4-hour waiting time target suggests that its A&E department has been capacity constrained since 2015.

[196] NHS Improvement (2016), Guidance for Commissioners on the marginal rate emergency rule and 30-day readmission rule.
[197] UHSM submitted that in 2015/16, its non-elective income amounted to £88.1 million (excluded excess bed days) and it exceeded the threshold by £700,000.
[198] CMFT submitted that its 2015/16 baseline for non-elective admissions was £82.068 million.

Figure 3: Parties' performance against 4-hour waiting time target in A&E over the quarter



Source: CMA analysis.

11.26 We note that in one CMFT paper CMFT raised a concern that more patients will attend its A&E department, damaging its A&E performance. This indicates that CMFT is not incentivised to take on many more patients. The document says:

> Geographic exposure of CMFT to neighbouring local health systems is profound – unplanned changes to emergency patient flows could quickly de-stabilise hospital capacity, which is reliant on operating close to saturation point to deliver multiple bottom-line requirements.

11.27 We also note the parties' submissions on bed occupancy rates, and the likelihood that this may be more of a constraint on non-elective admissions incentives than it may be for some elective specialties.

11.28 We have also considered whether the parties would have an incentive to compete to be a local emergency centre. This may arise if commissioners have plans to reconfigure A&E services in their area, reducing the number of providers, and existing A&E providers are spurred to compete to retain their A&E services.[199] However, we have been told by the commissioner that there are no plans to reconfigure A&E or any A&E service in the Manchester

[199] This possibility has been considered previously by the Co-operation and Competition Panel. See, for example, Monitor (2013), *Merger of parts of University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust*; and Monitor (2013), *Merger of Royal Free London NHS Foundation Trust with Barnet and Chase Farm Hospitals NHS Trust*.

CCG area, and therefore we do not view the merger as reducing choice to commissioners.

Other providers

11.29 We also note that even if NHS providers in the local area competed for non-elective patients, besides the merger parties there are other providers in the area (Table 4). In particular, both Salford Royal and Stockport (at Stepping Hill) are of a similar distance (if not closer) to one of the parties than the parties are to each other and treat around the same number of patients in their A&E departments as does UHSM at Wythenshawe. Therefore, it seems that to the extent that any local patients wish to choose which A&E department they attend they are likely to have a broader choice of providers than just CMFT and UHSM.

Table 4: Type I A&E departments in Greater Manchester, by distance from the parties and volume of activity (2015/16)*

	From CMFT		*From UHSM*		*Admissions in FY 2015/16*
To	*Miles*	*Drive-time (mins)*	*Miles*	*Drive-time (mins)*	
CMFT (Manchester Royal Infirmary)	-	-	8.4	22	[103,000–104,000]
UHSM (Wythenshawe Hospital)	8.0	22	-	-	[92,000–93,000]
Salford Royal	5.4	16	10.4	22	[98,000–99,000]
North Manchester General Hospital†	5.0	19	11.7	33	-
Royal Oldham Hospital†	9.3	28	17.9	30	-
Stepping Hill Hospital (Stockport)	7.4	25	8.4	22	[92,000–93,000]
Fairfield General Hospital†	12.6	34	25.2	38	-
Royal Bolton Hospital	14.2	29	19.1	31	[109,000–110,000]
Tameside Hospital	7.4	24	14.5	26	[82,000–83,000]
Wrightington, Wigan and Leigh NHS FT (RAI)	24.4	42	27.5	42	[85,000–86,000]

Source: The parties' distance data, Google Maps and the HES data.
* There are four types of A&E departments in the HES data: Type 1 departments are 24-hour, consultant-led emergency departments with full resuscitation facilities and designated accommodation for the reception of A&E patients; Type 2 departments are single specialty (eg paediatrics, ophthalmology, dental), consultant-led A&E services; Type 3 departments are other types of A&E or minor injuries units; and Type 4 departments are NHS walk-in centres.
† Pennine Acute Hospitals NHS Trust (Pennine) manages these A&E departments. From the HES dataset we only observe admissions at trust level. Overall, Pennine saw [252,000–253,000] A&E patients during financial year 2015/16.
Note: The parties submitted drive-time information in their phase 1 submission (see Tables 7.1 and 7.2). Distance information has been recovered using Google Maps. When Google Maps identified alternatives routes for each journey, the minimum distance has been selected.

11.30 Similarly, for patients with minor injuries, we have found that there are a number of providers of healthcare services suitable for dealing with minor injuries and illness in Greater Manchester (of a similar kind to CMFT's urgent care centre and walk-in centre).[200]

[200] According to NHS Choice there are over ten walk-in and urgent care centres in the area (in particular, the City Health Centre walk-in centre located in the city centre about 1.7 miles from Manchester Royal Infirmary). Also, these centres are likely to offer similar services to GP practices and pharmacies.

Provisional conclusions on competition in NHS non-elective services

11.31 Our provisional view is that the parties do not compete closely in the provision of NHS non-elective services. We have found some evidence that the parties have less incentive to attract patients for non-elective services than they do for elective services, and that the pressure on the parties' to meet A&E targets limit the scope for competition between them. We note that besides CMFT and UHSM, patients also have a choice of other Manchester A&E providers, in particular Salford Royal and Stockport (at Stepping Hill).

11.32 We have been told by Manchester CCG that there are no plans to reconfigure A&E in the Central Manchester CCG area, and therefore we do not view the merger as reducing choice to commissioners.

11.33 We therefore provisionally find that the merger may not be expected to give rise to an SLC in the provision of NHS non-elective services.

12. The effect on competition in NHS specialised services

12.1 In this section, we consider the theory of harm related to the expected impact of the merger on competition to provide NHS specialised services, and in particular the process used to determine which providers will have the right to supply NHS specialised services.

12.2 Specialised services refer to services in respect of rare, cost-intensive, or complex conditions as specified in NHS England's 'Manual of Prescribed Specialised Services'. Specialised services are generally commissioned directly by NHS England. However, for certain specialised services decisions relating specifically to Greater Manchester, commissioning is devolved.[201]

12.3 The geographical footprint within which specialised services are commissioned varies according to the rarity of the condition, due to the need to achieve critical mass in the volume of treatments necessary to be clinically and financially sustainable. Specialised services are allocated to one of four 'tiers' according to the geographic footprints across which they are commissioned. In this context, Tier 1 relates to Greater Manchester; Tier 2 to the North West; Tier 3 to the North of England; and Tier 4 to services commissioned on a national basis. The number of providers appointed within

[201] See paragraph 3.15 and ff above.

the relevant geographic commissioning footprint can vary (ie there is often more than one).

12.4 Providers of a specialised service will typically have had to invest in developing the expertise of their clinical staff, and in specialised equipment and facilities, in each case to provide the specialised service. Having done so, they have an incentive to maximise the number of patients they treat, subject to any capacity constraints or reduced incentives resulting from the tariff payments for treatment being unattractive. Competition to provide a particular specialised service can take the form of a competitive tendering process or some other procurement process, including a commissioner-led designation process. To compete, rival trusts might develop the expertise of the clinical staff, including through maximising the number of specialised treatments undertaken, and investing in equipment in anticipation of a possible reconfiguration of a specialised service. A loss of competition therefore might result in a reduction in the quality associated with the provision of specialised services, such as investment in equipment, developing staff expertise or some other factor of quality.

Parties' views

12.5 The parties provide a wide range of specialised services (CMFT supplies 89 specialised services; UHSM supplies 31) under contracts in place with NHS England. In the financial year ended 31 March 2016, CMFT's revenues from these services were £339 million, accounting for 35% of its total revenues. UHSM's revenues from specialised services in the same period were £140 million, accounting for 32% of its total revenues.[202]

12.6 The parties submitted that their merger did not give rise to an SLC in relation to any of the specialised services in which they overlapped.

12.7 The parties submitted that where an anticipated reconfiguration would reduce the number of suppliers to a single supplier, then any competitive process in the lead-up to the reconfiguration decision will be a one-off event. They submitted that while the merger may result in the loss of a once-only competitive process, this is very different to losing a competitive process that would occur repeatedly in the future.

12.8 The parties also submitted that if services are producing sub-optimal quality outcomes as a result of problems with the current structure of the supply side of the market, then the improvement in quality that could be anticipated

[202] Parties' phase 1 submission, paragraphs 301 & 302.

in the lead-up to a reconfiguration decision is likely to be small or non-existent. Where service improvement is dependent on reducing the number of suppliers, this cannot be delivered by the suppliers acting individually.Commissioning of specialised services.

12.9 The trend in medicine to have more specialist treatments translates into an increase in the minimum catchment populations required in many specialties. This in turn leads to a reduction in the optimal number of providers of a specialised service. NHS England told us that within the last few years it had reconfigured and reduced the number of providers in some specialised services, and planned to do so for other services in the future where this can achieve better outcomes.

12.10 The advanced nature of the devolution process in Greater Manchester has implications for the commissioning of specialised services in Greater Manchester. Future commissioning decisions for Tier 1 services, for which the appropriate planning population is Greater Manchester, have been devolved to the Chief Officer of the GMHSCP.

Competition for contracts to provide specialised services

12.11 We have focused our analysis on those specialised services which the parties both currently provide (actual competition). This is because there are significant entry barriers to initiating the provision of a specific specialised service, hence competitive constraints in the form of potential competition are expected to be weak (see barriers to entry, below).

12.12 NHS England told us that it uses formal competitive tenders when reconfiguring specialised services infrequently. It told us that assessment of provider capabilities was done on a case-by-case basis when commissioning for individual services, and that services might be commissioned using a negotiated process. As an example, the reconfiguration of OG cancer services in Greater Manchester in 2014 (described in paragraphs 8.32 to 8.35 above) involved a competitive tender. Although Salford Royal won the tender, CMFT and UHSM both competed against each other and against Salford Royal to provide this service.

12.13 Incumbent providers may invest in the quality of their services, including equipment and staff expertise, in order to be well-placed to retain provider status at the stage of future commissioning reconfigurations (where the commissioner may seek to reduce the number of providers). The theory of harm is that where the parties are both current providers, and there are few others, the merger will remove the competitive constraint between the parties and reduce incentives to invest in quality that would exist when a

service reconfiguration reducing the number of providers of specialised services is anticipated. Given the apparent general trend of commissioning fewer specialised services providers we did not consider it necessary for there to be a known and planned specific reconfiguration for this competitive incentive and consequent potential merger effect to exist.

Overlaps between the parties

12.14 There is no overlap between the parties in the provision of Tier 3 and Tier 4 services.

12.15 The parties overlap in relation to a limited number of Tier 2 services (five 'service specifications' within two 'service groups'). They overlap with respect to four specialised services in Complex Gynaecology, and also in Endocrinology services.

12.16 The parties overlap in relation to a larger number of Tier 1 specialised services commissioned on the basis of a Greater Manchester footprint. Overlaps exist within:

(a) Specialised Cardiothoracic services;

(b) HIV services;

(c) Neonatal Critical Care;

(d) Specialised Immunology and allergy services;

(e) Specialised Cancer services;

(f) Specialised Colorectal services; and

(g) Specialised Vascular services.

Evidence from the parties' internal documents

12.17 Specialised services account for an important proportion of each party's overall revenues, and strategies to retain specialised services feature in each of their internal strategy and planning documents, as do threats from specialised services competitors.

CMFT

12.18 Manchester Royal Infirmary's Division of Surgery Business plans note with respect to 'Designation as Vascular Centre':

> Continue to work strategically across GM to best position the MRI as the major arterial centre
>
> Prepare for any tender process
>
> Ramp up team for bid process and review national spec gap
>
> Risk: … Significant competition from UHSM.
>
> Resource requirements: Investment in hybrid theatre and associated staffing resource … plus dedicated resource to pull together any tender packs.

12.19 In its 'Competitive Analysis Overview' the same document noted:

> … our local competitors are also investing and trying to secure their services such as UHSM purchasing a Da Vinci robot.

12.20 CMFT's Strategic Plan for 2014/15 – 2018/19 included the statement:

> Competition for specialised services exists in relation to a number of specialist services such as vascular surgery, cardiac services and cancer surgery.

UHSM

12.21 UHSM's Strategic Plan Document for 2014-19 includes a detailed analysis of its competitive positioning in relation to specialised services in the context of anticipated reconfiguration. It noted:

> Specialist services are safest and best for patients when they are delivered by centres with high throughput, excellent teams, and which have access to all the support services they need for the whole patient journey. This will lead to a consolidation of specialist services across the country into a smaller number of units, and UHSM will be well placed to meet these needs. NHS England is actively progressing this consolidation.

12.22 With respect to 'Strategic risks and mitigations' the same document noted:

> Risk: NHS England specialist consolidation
>
> a. Cardiac
>
> b. Vascular
>
> c. Trauma L1 and major emergency

d. Breast surgery Burns and plastics.

Mitigation:

Develop partnerships with providers

Develop increased sub-specialisation

Meet NHS England specifications to position well during any procurement.

NHS England's views and future role of the GMHSCP

12.23 Where NHS England is the commissioner of a specialised service there are no other possible commissioners, and NHS England sees itself as holding a strong negotiating position in terms of its ability to monitor outcomes and hold providers to account for the quality of their services. In addition to ongoing dialogue with providers, it has levers it can use to influence service quality. These include withholding payment until issues are resolved, or threatening to move a service to another provider. It told the CMA that its monopsony position more than counters any market power of providers of specialised services.

12.24 With respect to previous reconfigurations, NHS England explained that it attempted a 'market intervention' (a type of reconfiguration) a few years ago for Urological Cancer services, with a view to reducing the number of providers. NHS England explained that at the latter stages of its tender award process it was subject to legal challenge from one of the providers and was unable to finalise the contracts award. We note that this example provides support for the idea that there is competitive rivalry between providers to retain services.

12.25 NHS England stated that it was unlikely to run new competitive tenders in Greater Manchester in the foreseeable future, due to the devolution of health and social care to Greater Manchester. NHS England planned to work closely with the GMHSCP, which it expected to favour a more collaborative approach to service reorganisations.

12.26 NHS England told the CMA that it was not concerned about the merger.

12.27 The GMHSCP confirmed that commissioning responsibility for Tier 1 specialised services had been delegated to its Chief Officer by NHS England. The GMHSCP confirmed that it saw value in commissioners continuing to have some choice in terms of which Greater Manchester

hospitals take on specific services, and noted some of the specific strengths of different trusts located in Greater Manchester.

Competitive assessment of overlap services

Approach taken

12.28 For those specialised services where the parties are both current providers, we considered the extent of the remaining post-merger constraint from other providers. We excluded from further consideration services where there would remain at least three currently active providers other than the parties as we judged that these would provide sufficient competition after the merger. For the remaining specialised services we considered the strength of any remaining constraints, and other factors potentially relevant to the parties' incentives to alter their strategies relative to the counterfactual including the amount of total revenue available for the relevant service.

Services with a Greater Manchester (Tier 1) commissioning footprint

12.29 After examining the number of competitors for each specialised service, the service specifications requiring further consideration are listed in Table 5.

Table 5: Tier 1 overlaps for detailed consideration

Service group	*Service specification*
Specialised Cardiothoracic services	Electrophysiology and ablation
Specialised Cardiothoracic services	Cardiac surgery
Specialised Cardiothoracic services	Primary percutaneous coronary intervention
Specialised Cardiothoracic services	Implantable cardioverter defibrillator & cardiac resynchronisation therapy
Specialised Vascular disease	Vascular service
Specialised Immunology and allergy	Specialised allergy services
Specialised colorectal	Transanal endoscopic microsurgery
Specialised colorectal	Faecal incontinence

12.30 We consider each service group in turn below.

Specialised Cardiothoracic services

12.31 In Specialised Cardiothoracic services, there are four areas of overlap between the parties, listed in Table 5 above. The parties are the only providers for three of these services in Greater Manchester. Implantable Cardioverter Defibrillator and Cardiac Resynchronisation Therapy is also

provided by Pennine Acute. Total Greater Manchester turnover for these four Specialised Cardiothoracic services is around £42 million.

12.32 NHS England told us that Public Health England had undertaken a review of Specialised Cardiology in the North West. NHS England was considering the recommendations, which might lead to service reconfiguration in a number of these services, which would likely lead to a reduction in the number of appointed providers. NHS England stated that in a city the size of Greater Manchester there was usually only one provider of Specialised Cardiology services.

12.33 Absent the merger we would expect the parties to compete to retain their specialised services in the event of future reconfiguration. There are very limited constraints from other providers. Accordingly, we have provisionally found that the merger may be expected to give rise to horizontal unilateral effects in the four Specialised Cardiothoracic services listed in Table 5 above.

Specialised Vascular disease services

12.34 The parties are two of the three current providers of Specialised Vascular disease services for adults in Greater Manchester, the other being Pennine Acute. Total Greater Manchester turnover is £3.6 million.

12.35 NHS England told us that it was not sustainable to have three providers of this service in Greater Manchester due to a minimum volume required to deliver a good service. It also explained that Vascular Surgery was very dependent on Interventional Radiology, and that there were not enough interventional radiologists in Greater Manchester to support three services at three sites. NHS England told us that the Greater Manchester review of this service would reduce the number of providers from three, to either two or one, in order to achieve a service model that was sustainable from a workforce and patient volume perspective.

12.36 Absent the merger, the CMA would expect the parties to compete to retain their specialised services in the event of future reconfiguration. This view is specifically supported by the content of the internal documents quoted above in paragraphs 12.18 to 12.22. There is only a limited constraint from other Greater Manchester providers. Accordingly, we have provisionally found that the merger may be expected to give rise to horizontal unilateral effects in Specialised Vascular disease, specifically vascular service.

Immunology and allergy

12.37 The parties are two of the three current providers of Specialised Allergy services in Greater Manchester, the other being Salford Royal.

12.38 NHS England told us that consideration was being given as to whether consolidation was required to secure the sustainability of Immunology and Allergy services. Hence it is possible that there might be a reduction in the number of providers in the future.

12.39 Both CMFT and Salford Royal provide both Specialised Immunology and Specialised Allergy services (which collectively comprise the relevant service group), whereas UHSM only provides Specialised Allergy services. This may limit the prospective competitiveness of UHSM in a reconfiguration scenario if it was considered preferable to have the services co-located.

12.40 The value of specialised allergy services in revenue terms is small (below £600,000) relative to the parties' overall specialised services activity. This may limit the parties' incentives to focus on and alter their strategy in this area, either in response to potential reconfiguration or as a result of the merger.

12.41 For these reasons we have provisionally found that the merger may not be expected to give rise to horizontal unilateral effects in any Immunology and allergy services.

Specialised Colorectal services

12.42 The parties overlap in relation to two Specialised Colorectal services,[203] for which they are the only current providers in Greater Manchester. According to NHS England, consolidation is required to meet national standards in Transanal Endoscopic Microsurgery. There is not enough volume at either site given the current configuration to meet requirements.

12.43 The parties submitted that Salford Royal also provides two (different) Specialised Colorectal services, and argued that its expertise in Specialised Colorectal services, as well as other specialised intestinal services, meant that it would be a ready alternative for commissioners in the event that they were dissatisfied with services at the merged trust.

12.44 Available data suggests that the value of the overlap Specialised Colorectal services in revenue terms is small (below £300,000) relative to the parties'

[203] Transanal endoscopic microsurgery and faecal incontinence.

overall specialised services activity. This may limit the parties' incentives to focus on and alter their strategy in this area, either in response to potential reconfiguration or as a result of the merger.

12.45 For these reasons we have provisionally found that the merger may not be expected to give rise to horizontal unilateral effects in any Specialised Colorectal services.

Services with a North West (Tier 2) commissioning footprint

12.46 The only Tier 2 service which would have fewer than three other providers after the merger was Urinary Fistulae service specification (in the Complex Gynaecology services group).

12.47 The parties overlap in four specialised Complex Gynaecology services. For most there are at least three other current providers in the North West. However, for the Urinary Fistulae service, other than the parties the only providers are Salford Royal and the Wirral University Teaching Hospital NHS Foundation Trust.

12.48 NHS England told us that national service specifications were currently being reviewed for Complex Gynaecology services. It was likely that new service specifications would drive a reduction in the number of providers that were able to achieve volumes of activity to meet minimum standards, prompting a reconfiguration.

12.49 For three of the four overlap services in this service group the parties face competition from at least three other Tier 2 providers in the North West. For the Urinary Fistulae service there are two other providers, one of which is also located in Greater Manchester (Salford Royal). Hence the parties seem likely to face continued competitive constraints in the period prior to any prospective reconfiguration. For these reasons the we provisionally find the merger may not be expected to give rise to horizontal unilateral effects in relation to Urinary Fistulae services (nor specialised Complex Gynaecology services more generally).

Countervailing buyer power

12.50 As noted in paragraph 10.31 above, a customer has countervailing buyer power when it has the negotiating strength to limit a provider's ability to raise prices or lower quality. NHS England said that it held a strong monopsony position in specialised services. It conducts annual assessments of the provision of these services and monitors the outcomes of the various services. In this exercise all specialised services providers report their

performance against the key standards within the service specifications and if there are gaps the provider and NHS England agree an action plan for improvement.

12.51 By way of an example, UHSM told us that in 2011 NHS England commissioned a highly specialised service that had not been offered before, ECMO (Extracorporeal Membrane Oxygenation Services). In 2016 NHS England ran a re-designation process which resulted in UHSM making a number of improvements to the governance of that service in order that UHSM better met NHS England's requirements. UHSM also told us that NHS England required all trusts to sign up to a CQUIN target in order to improve acute intensive care units.

12.52 NHS England also told us that it monitored performance on quality through benchmarking and to encourage the spread of best practice by having clinicians from different trusts visiting each other and passing on advice. Moreover, NHS England said that it could go into trusts and support them to improve their quality if need be.

12.53 In some circumstances, NHS England can suspend the provision of services if it considers that the services are unsafe to patients. NHS England told us that in practice this was quite rare since quality-related issues were almost always resolved through a process of dialogue with the provider (and withholding payment if necessary).

12.54 We provisionally consider that NHS England (and, by extension, the GHSCP as regards Tier 1 specialised services) does have some buyer power. However, even though NHS England can scope its service specifications and intervene on quality grounds, if necessary, it may not be able to prevent some decline in service quality following the merger, especially if the existing quality standards are higher than the specified minimum. We have also noted that one option that NHS England has to maintain high-quality services for patients, albeit an option used only exceptionally, is to remove that service from a provider and to award it to another provider. We think that the merger will remove that option from NHS England in some specialised services, or make it less useful, where other trusts in Greater Manchester are not as suitable alternatives to one of the parties as the other is.

12.55 For the reasons noted above, we provisionally consider that the buyer power held by NHS England (and, by extension, the GMHSCP) is insufficient to mitigate fully the horizontal unilateral effects we have provisionally found in NHS specialised services.

Barriers to entry

12.56 NHS England told us that barriers to entry were very high in the provision of specialised services. The barriers included the lack of relevant expertise which would allow NHS England to award someone a contract, clinical interdependencies with the specialised service which some other providers will not have (for example, heart transplants require a minimum level of cardiac surgery expertise and a cardiac intensive treatment unit), and a demonstrable record of performance to satisfy NHS England. Because of these barriers, NHS England said that there were strong incumbency advantages in the provision of specialised services and that competition between providers was muted.

12.57 NHS England told us that entry barriers included interdependencies between different services,[204] and the likely need for investment in equipment and capability given the complexity of the services.

12.58 We provisionally consider that barriers to entry into the provision of specialised services are high.

Provisional conclusion on the impact of the merger on NHS specialised services

12.59 We have provisionally found that the merger may be expected give rise to horizontal unilateral effects by eliminating competition between CMFT and UHSM in a number of specialised services in Greater Manchester, namely Specialised Cardiothoracic services and Specialised Vascular disease services. We note that these services together account for over £45 million in the parties' income or almost 10% of their income from all specialised service contracts. We consider this to be substantial.

12.60 Whilst we accept that NHS England and the GMHSCP as commissioners would be likely to possess a degree of buyer power which could mitigate the potential impact of the merger on quality, we nevertheless have provisionally found that the merger may be expected to give rise to an SLC in NHS specialised services.

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[204] A prospective entrant may need to enter several services simultaneously, or build up capability in those other services.

13. The effect on competition in community services

Background

13.1 In this section, we consider the impact of the merger on competition in the provision of community health services. Community health services are services provided in residential and community settings. They cover a diverse range of services including health visiting, community nursing, mental health services and occupational therapy.

13.2 Typically, community services are commissioned by CCGs and are provided through a combination of:

(a) high-value contracts for a broad range of community health services in each CCG. These contracts are typically held by specialist community health trusts, acute trusts, mental health trusts and private providers; and

(b) a large number of lower-value contracts for individual community health services held by a larger range of providers.

13.3 We consider both competition for contracts, and (to the extent relevant) competition for patients.

Parties' views

13.4 Both parties are providers of a range of community services within Greater Manchester. In the financial year ended 31 March 2016, CMFT's revenues from these services were £64.5 million, and UHSM's revenues were £16.2 million. This corresponds to a community services share of total revenues of about 7% for CMFT, and about 4% for UHSM.

13.5 The parties submitted that if the current model of community services were to continue in the future, their merger would not give rise to an SLC in community services as a result of a reduction in either patient choice or competition for community services contracts. However, the parties submitted that in any event the establishment of an LCO by Manchester CCG will remove any potential for competition between CMFT and UHSM in the provision of these services.[205]

[205] Parties' initial phase 2 submission, paragraph 320.

Commissioning and provision of community services

13.6 The biggest commissioners of community services in Greater Manchester are the CCGs, although Manchester City Council also commissions some services. High-value block contracts for the delivery of adult and children's community services make up the majority of CCG-commissioned services. They are awarded to a single provider, which may in turn use subcontracting to deliver the contract's services.

13.7 The main community services contracts held by CMFT are Central Manchester CCG's broad adult services contract, and a contract for children's services covering South, Central and North Manchester CCGs. The main contract held by UHSM is South Manchester CCG's broad adult services contract. Community services are provided by CMFT and UHSM under one-year contracts which have typically been rolled over each year.

13.8 Contracts to provide community services to other CCGs in Greater Manchester are held by a range of providers, including local acute trusts and two specialist community health trusts.

Implementation of LCOs

13.9 Greater Manchester commissioning bodies plan to establish ten LCOs for the ten CCGs, including the merged Manchester CCG, aiming to transform the way community care is delivered. The Manchester LCO will be commissioned by MHCC through a single comprehensive contract, based upon a 'whole budget' for the city's population.[206] The LCO will both provide community services and subcontract them with health and social care providing organisations.

13.10 The outcome of the LCO tender has yet to be announced.

Competition for community services contracts

13.11 If, absent the merger, the parties would be strong competitors for future community services contract awards, with few strong rivals, then the merger could:

(a) reduce the available pool of competitive bidders; and

[206] See paragraph 8.52 and ff.

(b) deliver worse tender outcomes (in terms of price and/or quality) for commissioners.

13.12 We first analysed evidence from previous competitive tenders in order to assess whether the parties have tended to compete (bid) against each other. Second, we considered the context of forthcoming commissioning of LCOs, the parties' likely positioning and the remaining range of other providers.

Evidence from previous commissioning processes

13.13 Since 2010 there have been no community services tenders in which CMFT and UHSM have offered competing bids. There have been a number of occasions when the parties have submitted joint bids, including in the tender for Trafford CCG's broad ranging community services contract in 2012.[207] In the case of the Trafford contract, the parties told us that a joint bid 'made sense for the patients for those services' given the location of the Trafford community relative to the parties' main sites.

13.14 The available evidence suggests that the parties were not previously in active competition with each other for community services contracts.

Competition for LCO status

13.15 The parties have entered the Manchester LCO tender process as part of a consortium of existing local community services providers. This is consistent with their previous tendering activity, and the CMA has seen no evidence to indicate that the parties would have offered (or been part of) competing Manchester LCO bids in the absence of the merger.

13.16 With respect to the appointment of other LCOs by commissioners across Greater Manchester, there is no evidence that the parties would have submitted competing bids were they to enter into these wider commissioning processes. Further, there are a range of other existing community services providers who would be likely to provide competition in this process, including the various acute trusts and specialist community trusts which currently hold the major CCG contracts.

13.17 With respect to the subcontracting of individual services from LCOs to other providers, to the extent that the parties could potentially compete in the

[207] The Trafford CCG contract was awarded to Pennine Care NHS Foundation Trust. Other tenders in which the parties submitted joint bids were (i) commissioning of sexual health services in Manchester; and (ii) commissioning of sexual health services across Stockport, Tameside and Trafford.

counterfactual, the CMA anticipates that there would be a range of other potential providers.

Provisional conclusion on competition for contracts

13.18 In relation to competition for community services contracts, including for appointment to LCO status, we have provisionally found that the merger may not be expected to result in an SLC in relation to competition for community services.

Competition for patients

13.19 In principle, there can be competition between providers for community services patients if CCGs commission services through AQP contracts. Under this model a CCG would commission services from every provider that demonstrates they are qualified to offer the service, and patients would have the option to choose between providers. However, in Greater Manchester, for the vast majority of services, community services are commissioned for a specific catchment area from a single provider.

13.20 The parties told us that CMFT offered just one community service under an AQP contract, and UHSM none, although there might be exceptional circumstances where they treated a resident from outside the relevant CCG area. Manchester CCG told us that AQP contracts in Manchester were currently in use for a small number of services,[208] for which there were a large number of providers in Greater Manchester.

13.21 Based on the evidence available, we have provisionally found that the merger may not be expected to give rise to an SLC with respect to any competition for community services patients.

14. Patient benefits

14.1 The parties have submitted to us that the merger would result in RCBs to patients. RCBs are defined in section 30 of the Act as:

> (1) For the purposes of this Part a benefit is a relevant customer benefit if—
>
> (a) it is a benefit to relevant customers in the form of—

[208] Audiology, Non-obstetric ultrasound, and MRI – head and neck.

(i) lower prices, higher quality or greater choice of goods or services in any market in the United Kingdom (whether or not the market or markets in which the substantial lessening of competition concerned … may occur); or

(ii) greater innovation in relation to such goods or services; and

(b) the decision-making authority believes …

(3) … that—

(a) the benefit may be expected to accrue within a reasonable period as a result of the creation of the relevant merger situation concerned; and

(b) the benefit is unlikely to accrue without the creation of that situation or a similar lessening of competition.

14.2 The parties have submitted that, as a result of the merger, RCBs would arise in 15 clinical areas, which are summarised in our Remedies Notice, accompanying this report. In addition, the parties' full submission on the benefits arising from the merger is published on the case page of our website.

14.3 In the event that we find that the merger may be expected to give rise to an SLC we are required by the Act to consider whether action should be taken to remedy, mitigate or prevent the SLC concerned or any adverse effect that has resulted from, or may be expected to result from, that SLC.[209] When considering possible remedies to an anticipated merger, we will take into account whether any RCBs might be expected to accrue within a reasonable period as a result of the merger and, if so, whether these benefits are unlikely to accrue absent the merger or without a similar lessening of competition. If no remedy can be found which does not prejudice RCBs, and we believe that the RCBs outweigh the adverse effects of the SLC, we may decide to clear the merger.

14.4 We refer readers to our Remedies Notice for further details as well as regarding how to make representations about the purported patient benefits.

[209] *NHS Merger Guidance*, paragraph 8.4.

15. Overall provisional conclusions

NHS elective and maternity services

15.1 We have been mindful of the regulatory environment in which the parties operate and of the recent policy changes which have impacted on the parties and reduced the role of competition in the provision of NHS elective and maternity services (paragraphs 4.1 to 4.35).

15.2 We have considered how competition between CMFT and UHSM might work and the role of competition in the provision of NHS elective and maternity services (paragraphs 10.1 to 10.45). In considering the role of competition, we have looked at both the demand side (paragraphs 10.3 and ff) and the supply side (paragraphs 10.11 and ff) as well third party comment (paragraphs 10.44 and 10.45).

15.3 We have provisionally found that the merger will give rise to horizontal unilateral effects in 18 NHS elective and maternity services (Table 6) and therefore we have provisionally found that the merger may be expected to result in an SLC in NHS elective and maternity services.

Table 6: Clinical specialties where the merger may be expected to give rise to horizontal unilateral effects

Specialty
Cardiology
Clinical haematology
Diabetic medicine
Ear, nose, throat
Gastroenterology
General medicine
General surgery
Geriatric medicine
Gynaecology
Maternity
Oral surgery
Paediatrics
Paediatric urology
Pain management
Respiratory medicine
Rheumatology
Urology
Vascular surgery

NHS non-elective services

15.4 We have provisionally found that the merger may not be expected to result in an SLC in non-elective services.

NHS specialised services

15.5 We assessed the extent to which the parties compete to provide NHS specialised services (paragraphs 12.28 to 12.49). We have provisionally found that the merger would lead to a reduction in the number of providers of certain specialised services from two to one in three Specialised Cardiothoracic services and from three to two in one Specialised Cardiothoracic service and one Specialised Vascular disease service.

15.6 We closely examined whether NHS England (as commissioner) may possess countervailing buyer power. We provisionally consider that the buyer power held by NHS England (and, by extension, the GMHSCP) is insufficient to fully mitigate the SLC in NHS specialised services (paragraphs 12.50 to 12.55).

15.7 We have provisionally found that the merger may be expected to give rise to an SLC in NHS specialised services in Greater Manchester.

Community services

15.8 We have provisionally found that the merger may not be expected to result in an SLC in the provision of community services.

The overall adverse effect of our SLC findings

NHS elective and maternity services

15.9 For NHS elective and maternity services, competition does not occur on price, and accordingly it has not been possible to quantify the magnitude of any harm that may derive from any SLC in NHS elective and maternity services. However, our assessment has been informed by a number of qualitative factors concerning the nature of competition between NHS foundation trusts in general, and specifically as between the parties.

15.10 For NHS elective and maternity services, although both CMFT and UHSM's internal documents do suggest that they have competed for elective and maternity services, those documents also suggest that competition-related considerations are not the predominant factor in their decision-making.

15.11 We are keenly aware that NHS commissioners and providers are facing significant challenges, particular in terms of finance and capacity. We have received evidence that this lies behind recent policy decisions that emphasise the role of collaboration amongst providers and between providers and commissioners in each local health economy. During our inquiry we have been struck by the degree to which commissioners and providers in Manchester have coalesced around these recent central policies of the NHS in forming their local plans (for example, the *City of Manchester Locality Plan*). Recent initiatives such as NHS Improvement's control totals have had a significant effect on the way trusts are managed and operated. *The Five Year Forward View* called, amongst other things, for greater integration of health and social care, and proposed for providers and commissioners to develop new ways of delivering effective care to patients and the local STPs are the key mechanisms to deliver that ambition in the local health economies throughout England. In Greater Manchester, the STP sets out a number of initiatives, involving acute providers delivering services in closer collaboration and partnership with each other which particularly impact elective services. Taken together with other recent policy developments, we believe that the overall consequence has been, in general, to encourage greater levels of collaboration and collective responsibility in the provision of NHS acute services, in particular, the provision of NHS elective and maternity services.

15.12 We have examined this closely in our inquiry. We have spoken to key commissioners in Greater Manchester – the GMHSCP, Manchester CCG and Manchester City Council – all of whom have stressed to us that, with or without a merger between CMFT and UHSM, it will be necessary to find a way for local providers to work more closely with each other to tackle the health challenges in Greater Manchester. We have also spoken to Sir Jonathan Michael, who led the review of the single hospital service within the Manchester Locality Plan, who also stressed to us the need for closer collaboration in Manchester in order to realise certain benefits to patients. The plans in place in Greater Manchester – the *Healthier Together* programme and the City of Manchester Locality Plan – are a part of the local STP to make the *The Five Year Forward View* ambitions a reality in Greater Manchester.

15.13 Taking all of these considerations into account, we provisionally believe that, whilst the merger may be expected to give rise to an SLC in NHS elective and maternity services, any adverse effect resulting from such SLC is likely to be smaller than would be the case if the parties had a greater degree of regulatory, financial and clinical flexibility to compete vigorously on the price or quality of their services.

NHS specialised services

15.14 We have provisionally found an SLC in NHS specialised services, in particular in Specialised Cardiothoracic and Specialised Vascular disease services.

15.15 We believe that some of the regulatory and policy factors that dampen the parties' incentive to compete in NHS elective and maternity services also dampen the parties' incentives to compete in specialised services.

15.16 We have also taken into account the factors that were relevant particularly to specialised services, namely the extent of any buyer power NHS England or the GMHSCP may possess. Although we consider that, to the extent such bodies have buyer power, it will not be sufficient to prevent an SLC from arising, we nevertheless accept that NHS England and the GMHSCP are likely to have a degree of buyer power which will lessen the effect of that SLC. We also note that the value of the Specialised Vascular disease services where we have provisionally found a horizontal unilateral effect is low.

15.17 Further, the detriment arising from a substantial lessening of competition may be time limited insofar as competition between CMFT and UHSM might be extinguished if the reconfigurations take place in those specialties where

the parties are the only two providers (Electrophysiology and Ablation, Cardiac Surgery and Primary Percutaneous Coronary Intervention services). We are also conscious that the rationale for any re-configuration by either NHS England or the GMHSCP is that greater specialisation among a smaller number of providers (including a single provider) might better optimise quality, efficiency and patient welfare in the provision of specialised services.

15.18 Taking these considerations in the round, we provisionally believe that whilst the merger may be expected to give rise to an SLC in specialised services, any adverse effect resulting from such SLC is likely to be smaller than would be the case if NHS England did not possess a degree of buyer power the parties had a greater degree of regulatory, financial and clinical flexibility to compete vigorously on the price or quality of their services.

Overall provisional conclusion

15.19 We provisionally find an SLC in NHS elective and maternity services and NHS specialised services, and that the overall adverse effect resulting from any such SLC is likely to be smaller than would be the case if the parties had a greater degree of regulatory, financial and clinical flexibility to compete vigorously on the quality of their services.

15.20 We will take into account the magnitude of the detriment deriving from the SLC that we have provisionally found in the next stage of our inquiry when assessing the parties' claims concerning the patient benefits that may result from the merger.