Response to Provisional Findings

Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust

1. This submission by Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester (UHSM) responds to the CMA's Provisional Findings on the proposed merger of the two Trusts.

2. In summary, CMFT and UHSM believe that the CMA's provisional findings provide a high quality, thoughtful analysis and discussion of the issues. The Trusts are pleased that many of the points made in their submissions are reflected in these findings. However, the Trusts also have concerns that the provisional findings do not always acknowledge arguments made by the Trusts (and as a result these contributions do not seem to have been considered by the Panel), and in other areas the Panel's understanding of the arguments being made by the Trusts is incorrect.

3. In some cases, these omissions or misunderstandings are not material to the overall conclusions drawn by the Panel, and as a result, this submission only makes passing reference to these issues (or does not refer to them at all). However, in other cases, the Trusts believe that a lack of consideration, or misunderstanding, of the arguments put by the Trusts has resulted in wider SLC findings than is warranted by the evidence.

4. Consistent with this approach, there are two main areas of focus in this submission: (i) market definition for routine elective care and maternity services; and (ii) evidence in relation to specific routine elective care specialties. The final part of this submission contains a small number of miscellaneous comments on the provisional findings that the Panel may wish to address in its Final Report.

Market definition for routine elective care services

5. From the outset of this review, the Trusts have made numerous points regarding the CMA's approach to defining the market for routine elective care services. The CMA, in its working papers and provisional findings, have acknowledged several (but not all) of the arguments that have been made, and have made some adjustments to its approach as a result. The Trusts appreciate the progress that has been made in this regard.

6. That said, the Trusts believe that significant weaknesses remain in the CMA's approach to market definition, and the adjustments made by the CMA (in terms of reviewing shares of supply across catchment areas) do not mitigate the underlying concerns that have been raised. The overall impact of the CMA's approach is that it has found SLCs in four specialties (Urology, General Surgery, ENT and Rheumatology), where the Trusts do not believe this is justified.

7. The Trusts appreciate that the Panel and staff team may believe that they have heard, and addressed, the arguments set out by the Trusts on market definition. Nevertheless, the discussion of these issues in the Panel's provisional findings does not give the Trusts

confidence that this is the case, and hence these issues are discussed further below in this response to provisional findings.[1]

Demand-side perspective on market definition

8. The CMA's assessment of market definition, in paragraph 7.12 of the provisional findings states that, "from a demand-side perspective, outpatient and either day-case or inpatient services are not substitutable".

9. The CMA has been using this formulation of words to describe its demand-side approach to market definition in NHS acute trusts mergers for some time. Indeed, the CMA's formulation of these words pre-dates the point at which arguments began to be put to it (in the Ashford & St Peter's / Royal Surrey merger review) about the patient pathway (from first consultant outpatient appointment to diagnosis and then treatment), and the implications of this for assessing how market definition (and competition) should be viewed in routine elective care.[2]

10. The CMA does not appear to have seriously re-thought its approach to how it defines the product market since this patient pathway issue was first raised. The unfortunate appearance is that the CMA is relying on the existing formulation of the product market as a means of making a complex issue analytically tractable, and is retrofitting the evidence on the patient pathway into its preferred analytical approach. The Trusts in no way wish to infer any doubts about the professionalism or integrity of the Panel or staff team. It is simply that the lack of sufficient attention to this issue, and engagement with the issues raised by the Trusts, is creating an unfortunate impression.

11. The starting point for the CMA's assessment of the appropriate definition of the market for routine elective care services from a demand-side perspective is that:
    - a patient is referred, by their GP, to an acute services provider for a first outpatient appointment with a consultant in the specialty that appears most relevant to their needs;
    - diagnosis takes place and, where required, the patient is treated; and
    - treatment, which will be specific to the needs of each patient, may be provided in an outpatient, day-case or inpatient setting.

12. The point about treatment being specific to the needs of each patient is important because fundamentally patients are not able to substitute between different treatments, regardless of whether these different treatments are provided in the same, or a different, care setting. However, a literal reading of the CMA's statement above (i.e. "from a demand-side perspective, outpatient and either day-case or inpatient services are not substitutable") is that patients can substitute between treatments so long as it is in the same care setting.[3]

[1] Our concerns about the CMA's understanding of the arguments that have been put to it by the Trusts are amplified by the wording at paragraph 17 of Appendix C of the Provisional Findings. This states that "Contrary to the parties' assertion, neither patients nor their referring GPs know what type of treatment they are going to receive at the point of referral …". This lack of knowledge about the type of treatment that patients will receive when being referred, however, has been central to the Trusts submissions on market definition from the very start of this review. The Trusts are unsure as to how the CMA could have reached the conclusion that their view was the exact opposite to the point the Trusts have repeatedly made.

[2] Prior to these arguments being put to the CMA, there appears to have been an implicit assumption on the CMA's part that patients were directly referred from their GP to one of these different care settings.

[3] In fact, patients may be able to receive the same treatment in different settings at different providers. As set out in the Trusts' response to the working papers, an example of this is Rheumatology where UHSM is in the process of shifting joint injections from a day-case to an outpatient setting. The implications of treatments shifting between care settings are discussed further below.

13. The lack of substitutability between treatments is clarified in paragraph 7.19, but the wording used by the CMA still creates an impression that patients cannot choose between care settings, but are referred directly to a care setting within which they have the ability to choose between providers. As set out above, this does not an accurate reflection of the patient pathway, but this underlying impression seems to govern the CMA's overall approach to assessing how competition (and market definition) works in these services.

Patient survey evidence relevant to market definition

14. The provisional findings, at paragraphs 7.14 and 7.15, discuss the implications of the patient survey carried out in its review of the proposed merger between Ashford & St Peter's Hospitals and Royal Surrey County Hospital. Two results are highlighted: first, different patients have different expectations about whether they would need treatment or surgery; and second, different patients assign different degrees of importance to the quality of outpatient services compared with day case and/or inpatient services when choosing their provider.

15. The CMA appears to conclude in paragraph 7.15 (although the wording is not entirely clear) that this variation in expectations and preferences allows routine elective care providers to respond by offering a stronger service in particular care settings as a means of competing more strongly for patients that require care in those settings.

16. There is, however, no reference to the CMA having any evidence that providers actually pursue strategies along these lines. To the extent that there is evidence in this review of competitively driven strategies in routine elective care (such as the Trusts' internal documents) there is nothing that supports the idea that providers are competing by differentiating the strength of their offering across different care settings within the same specialty. All of the evidence on competition points to providers competing for all patients within a specialty regardless of the setting in which they will be treated. This lack of evidence on competitive strategies needs to be weighed alongside the GP referral analysis and taken into account in the inferences the CMA is drawing from the latter.

17. Moreover, the Trusts do not believe that the survey evidence actually supports the conclusion that the CMA has drawn. The provisional findings state that the survey evidence points to patients being 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. There is no information in the patient survey that indicates whether these expectations were accurate. Further, while surgery is provided on either a day-case or inpatient basis, treatment is provided in outpatient, day-case and inpatient settings. That is, a patient's expectation of treatment cannot be equated with an expectation of the setting in which they will receive care.

18. All in all, the absence of any strategies on the part of providers to differentiate the strength of their offering across care settings within a single specialty is readily explainable by the fact that there appears to be a very low likelihood that those patients that might actually be influenced in their choice of provider – due to its strength in a particular care setting within a specialty – will actually end up receiving treatment in that care setting even if they choose to be referred to that provider. The lack of this linkage means there would be no pay-off to providers from pursuing this strategy.

19. It also goes, almost without saying, that such sophistication in the pursuit of a competitive strategy on the part of providers of NHS acute services goes way beyond anything that has been seen in the internal strategies of these providers.

Supply-side perspective on market definition

20. The CMA in paragraphs 7.16 to 7.24 sets out its supply-side perspective on market definition. In paragraphs 7.19 to 7.24 it discusses specialty and sub-specialty level aspects of market definition. It is worth noting that the reasoning set out in paragraphs 7.19 to 7.24 is more relevant to the grouping of treatments into separate care settings (i.e. outpatient, day-case and inpatient) than the discussion in paragraphs 7.12 and 7.13.

21. In paragraphs 7.16 to 7.18, the CMA discusses the ability of providers that are active within different care settings within a specialty to competitively constrain other providers. It states that "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".

22. The critical piece of evidence on this point in this merger review, however, is that there are, in effect, no day-case only or outpatient-only providers in Greater Manchester. The Trusts drew the CMA's attention to Care UK's (now InHealth's) presence in the market, and its offer of a complete care pathway to patients in all of the specialties in which it provides services, in their response to the CMA's working papers.

23. This information, however, is not reflected in the discussion of this issue in paragraphs 19 and 20 of Appendix C of the Provisional Findings. As set out in the response to the working papers, the InHealth (formerly Care UK) business has set partnership arrangements with other providers, such as BMI and Pennine Acute Hospitals NHS Trust, which provide inpatient services for those patients who are initially referred to Care UK, and who require an admission. In this way, the partnership between Care UK and BMI and Pennine Acute forms a joint offer to patients across the entire care pathway.[4]

24. Given the lack of supply-side differentiation between providers, there is no supply-side justification for segmenting the provision of treatment services into separate outpatient, day-case and inpatient markets.

Interpreting the variation between GP referral analysis results and shares of supply across care settings within a specialty

25. As set out above, there is no evidence from a demand-side or supply-side perspective in Greater Manchester that justifies segmenting routine elective care treatment services into separate outpatient, day-case and inpatient markets.

26. The Trusts appreciate, however, that the results of the GP referral analysis vary across outpatient, day-case and inpatient settings. The CMA has interpreted this variation as a difference in competitive strength across providers in different care settings within the

[4] The Trusts appreciate that there may be other parts of England where there are, for example, Independent Sector Treatment Centres (ISTCs) that do not necessarily make the same kind of offer an integrated service across the care pathway that is made by InHealth (formerly Care UK) and its partnered providers of inpatient services. (The Trusts are unsighted on how these arrangements work for ISTCs in other parts of England.) However, such considerations are not relevant to the question of the appropriate market definition for this particular merger review.

same specialty. Hence it has made SLC findings in four specialties in day-case or inpatient settings where it has not found an SLC in that specialty in outpatient services.

27. There are, however, at least four reasons why diversion figures arising from the GP referral analysis (and shares of supply) could be higher in day-case and/or inpatient settings compared with first outpatient appointments in the same specialty.

- First, there may be differences between providers in the care setting in which certain treatments are administered to patients. For example, as noted in the Trusts' response to the CMA's working papers, UHSM is in the process of transferring joint injections in Rheumatology from a day-case to an outpatient setting. Looking at the resulting effect on the data through a competition lens, it would lead to the conclusion that UHSM is a relatively strong competitor in this specialty in day-case treatment just because of decision about how it provides a treatment to patients. (An analysis based on referrals for first outpatient appointments would not be affected by this type of shifts in treatment because additional appointments in outpatient settings are not included in the analysis.) More generally, there continues to be innovation in patient treatment that allows more and more patients to have treatment in day-case, rather than inpatient, settings. The adoption of these innovations, however, will not be uniform, which will lead to misleading conclusions being drawn about the competitive strength of different providers when this is based on day-case or inpatient data.

- Second, there may be a degree of random variation in the results of the GP referral analysis at day-case and inpatient levels compared with the analysis of first outpatient appointments due to the smaller number of events that are being analysed. For example, the Trusts had 34,458 OPFA spells in the Cardiology speciality for 2015/16. Of those 16,308 were used for the referral analysis calculation. There were only 2,134 spells for elective admitted care, of which 1,814 spells are used for the referral analysis calculation. That is, 11% of the number of spells available for the OPFA calculation are available for the inpatient elective analysis.[5]

- Third, differences in the underlying health characteristics of the local population that is predominantly served by each Trust could drive differing admission rates for treatment, and thus an appearance of different competitive strengths.[6] There could also be differences in clinical approaches between Trusts that have this effect.

- Finally, the GP referral analysis when applied to day-cases and inpatients is based on all referrals, not just referrals from GP practices (as this is the only data that is available in relation to day-case and inpatient spells). That is, a wider, less precise dataset is used for the analysis of GP referrals at the day-case and inpatient level compared with outpatients.

[5] To note, this is one year of data and the referral analysis undertaken by the CMA and Trusts relies upon two years of data. However, the ratio of elective inpatient care to outpatient first appointment activity is expected to be very similar over the two-year period.

[6] For example, patients whose treatment may be deliverable in a day case setting under general anaesthesia may, because of their individual general health or circumstances, may not meet the requirements for discharge home the same day. (These requirements include support at home, lack of major risk factors, having someone at home able to communicate in an emerging emergency scenario.) The prevalence of these types of patients will vary from area to area and will affect the extent to which patients who otherwise are receiving the same treatment are cared for in a day-case or inpatient setting.

28. Finally, the CMA has said that it acknowledges the potential problems with the GP referral analysis at the day-case and inpatient level, and as a result, is using a cross-check based on shares of supply.[7] Analysing shares of supply does not, however, mitigate the fundamental problems that are set out above. In particular, if there is no link between patients' expectation about the care setting in which treatment will be provided, the care setting in which treatment is *actually* provided, and patients' choice of provider in response to preferences about the quality of services in different treatment settings, then the share of supply information is going to be just as meaningless as the GP referral analysis for reaching conclusions about competition in different care segments. This point was made by the Trusts in their response to the working papers, but there is no reference or response to this in the provisional findings.

29. The appropriate conclusion is that providers compete in an undifferentiated fashion of patient referrals, and this is best analysed through applying the GP referral analysis to first outpatient appointments. There is insufficient robust evidence to let the CMA form an expectation of an SLC in any specialty in day-case and/or inpatient services where this not also an SLC finding in outpatient services.

30. As set out in paragraph 10.50 of provisional findings, "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". The Trusts' view is that in the absence of any indication of an SLC from this source of evidence (Outpatient data), other evidence in relation to separate day-case and inpatient services is insufficiently robust to allow the Panel to form the expectation required to reach an SLC finding.

31. Consistent with this, the Trusts strongly believe that the Panel should, in reaching their final decision, shift away from their provisional SLC findings in relation to five markets in four specialties, namely:
    - day-case General Surgery services;
    - day-case and inpatient Urology services;
    - day-case ENT services; and
    - day-case Rheumatology services.

Routine elective care and maternity services

32. This section sets out comments on the analysis of individual specialties in the Provisional Findings in addition to the discussion in the previous section, which had particular implications for General Surgery, Urology, ENT and Rheumatology.

33. *Rheumatology*: Paragraph 53 of Appendix C states that the parties have not provided a submission on why CMT appears to only be able to perform around 60% of UHSM's activity in Rheumatology. However, at paragraph 48 in our response to the working papers we did offer a potential explanation: "For example, in Rheumatology, when joint injections take place on the ward, these are likely to be coded as a day-case activity. However, at UHSM this service is now moving to specific joint injection clinics, which are not only better for patients, but would also be coded as outpatient follow-up appointments. As a result of this change, UHSM's share of day-case activity in a segment will fall, without their being

[7] The justification provided at 10.49 of provisional findings for applying the GP referral analysis to day-case and inpatient services is, however, unconvincing, and the reference to the patient survey results in this paragraph is irrelevant to the matter at hand.

any change in how patients are referred or the choices patients are making between acute trusts."

34. *Vascular surgery*: Appendix C of the provisional findings does not explain how the CMA has separated the data used to reach a provisional finding in this speciality from the data that will also be coded here for the four sub-specialities in the specialist market definition. If this data is not separated, then the data related to specialist activity is also potentially coded to this TFC. Further, at paragraph 78 of Appendix C, the CMA says that "reconfiguration to a single service would no longer have any independent incentive to attract patients". The Trusts do not understand the conclusion in this sentence – if there is only one provider in the counterfactual, then of course there is no competition from the other Trust to attract patients because it no longer offers the service and no longer competes in it.

35. *Paediatric Urology*: most GP practices that make referrals into this specialty, particularly those GP practices that refer to CMFT, only refer patients to a single provider (i.e. to CMFT). More than 50% of referrals to CMFT in this specialty come from this type of GP practice. As a result, the GP referral analysis is based on a much smaller number of GP practices that refer to multiple providers. However, the CMA is effectively extrapolating inferences about GP/patient preferences from a small number of GP practices to the entire set of referrals in this specialty. The robustness of the GP referral analysis particularly comes into question in this situation.

36. *Maternity*: The CMA does not seem to have taken account of the Trusts' submissions in respect of this speciality. That is, that only a small percentage of activity is a GP referral, and so the HES data is less likely to provide insight into how mothers might choose between providers. Further, the CMA does not refer to the payment mechanism for Maternity (which the Trusts' have previously explained) which differs significantly to other elective care (i.e. providers are reimbursed for the entire pathway and so the delivery itself is simply the conclusion of the pathway, and not a separate product segment as suggested by the CMA's analysis of Inpatient activity). At paragraph 176, the CMA also does not seem to have referred to the Trusts' submission that 21.8% of women coming from a UHSM postcode are likely to have been medically directed to receive care at CMFT's St Mary's Hospital. That is, around 1/5th of activity suggested to 'choose' CMFT instead of UHSM are in fact subject to medical directions rather than choice of provider and the referral analysis would be likely to significantly reduce if this factor was accommodated in the CMA's analysis.

37. *Geriatric Medicine*: the CMA's conclusion at paragraphs 173 and 174 of Appendix C is difficult to follow. It appears that the CMA has acknowledged the Trust's concern that competing providers are unlikely to accurately and consistently record to the Geriatric Medicine speciality, and so the range and strength of competitors is not likely to be represented in HES data. In this context the CMA's statement at paragraph 173 that "notwithstanding these concerns, the referral analysis suggests the parties are very close competitors…" is a statement of what the Trusts expect that the data will show, given that competitors are under-represented in the data. A share of supply analysis, using the same data, only confirms the same bias in the data i.e. all other NHS acute trusts will be providing significant amounts of geriatric care, but not coding it as such. Thus, the GP referral analysis and share of supply based on this TFC speciality are not robust data on which to form an expectation about the effect of the merger on competition for this patient cohort.

38. *Paediatrics*: paragraph 162 and FN 50 of Appendix C appear to conflate the description of two separate issues about coding of non-elective activity and a coding mistake at UHSM. As previously submitted, UHSM is aware (and is in the process of remedying) its coding related to Well Babies and Neonatology, which is incorrectly coded to the Paediatrics speciality for the period of the data used by the CMA. Well Babies and Neonatology specialities will have ADMIMETH codes 82 and 83 present, but Paediatrics will not have these codes present in any of its activity. Thus, it should be easy to remove 82 and 83 codes from Paediatrics and so resolve the issue of the CMA allocating incorrectly, what the NHS classifies as non-elective activity, to the Paediatrics elective inpatient category for the purpose of its analysis. We note, further, the adjustment of codes 82 and 83 in the Paediatrics speciality would have no impact on analysis in other areas, such as Maternity, where non-elective activity codes 82 and 83 might more appropriately be evaluated within a patient choice analysis. An analysis of Well Babies and Neonatology data is itself an unproductive exercise as Well Babies is just the code used for babies that stay with their mothers while their mother is receiving treatment, and Neonatology is not a speciality subject to patient choice (as previously accepted by the CMA).

39. *General Medicine*: the provisional finding of an SLC in outpatient services is based on 48.6% of UHSM referrals diverting to CMFT (with only 15% of General Medicine referrals to CMFT diverting to UHSM). This conclusion appears to be based on a total of 268 OPFA spells out of what start out as 4,732 OPFA spells (i.e. 6% of UHSM activity) because of the large number of GP practices that refer only to UHSM, and as a result, second preference providers cannot be identified at these GP practices. Given this, the analysis in relation to General Medicine is not robust, and it is difficult to see how the CMA can reasonably form an expectation of an SLC given this.

40. *Respiratory Medicine*: at paragraph 151 the CMA explains that around 43% of UHSM's inpatient and day-case procedures were also performed at CMFT. Then, at paragraph 152, the CMA explains that by only using data on common activity it shows that another specialist provider (Sheffield Teaching Hospital) does not show as strong a constraint on UHSM as it does when all activity is used. This is a logical outcome of removing the specialist UHSM activity where Sheffield is expected to be a strong competitor. Nevertheless, the finding of an SLC seems to rely on UHSM being able to differentiate its specialist and non-specialist Respiratory Medicine services. That is, it could allow non-specialised services to deteriorate as a result of the merger, while still having to maintain high quality specialised services for which it is constrained by Sheffield Teaching Hospital. Such an outcome is not consistent with the evidence on how services are managed at the specialty level.

41. *Gynaecology*: paragraph 185 and 186 at Appendix C sets out the same reasoning as discussed above in relation to Respiratory Medicine. Here, there is 55% shared HRG routes, and when the 45% of activity which appears to be specialist activity is taken out, CMFT and UHSM become closer competitors. This seems a very selective way of looking at the data. Another way of thinking about this could be that the fact that there is 45% of not shared activity suggest that the two Trusts are not close competitors at all and are actually providing quite different / complementary services as envisaged by Commissioners when commissioning specialist services from CMFT.

42. In conclusion, the Trusts would submit that the evidence in several specialties discussed above is not sufficiently robust to allow the Panel to form an expectation of an SLC in relation to these specialties. In addition to those specialties adversely affected by the

CMA's approach to market definition (i.e. ENT, Urology, Rheumatology and General Surgery), the Trusts are particularly concerned about the provisional SLC findings in relation to Geriatric Medicine, Paediatric Urology, General Medicine and Respiratory Medicine.

Comments on other matters addressed in the CMA's provisional findings

43. *Community Services* - Para 13.10: The provider consortium in which CMFT and UHSM are participating have been announced as the sole capable provider that has responded to the LCO tender.

44. *Urology Cancer* – Paras 8.42-8.47: as anticipated in the provisional findings, the results of the Urology Cancer reconfiguration decision have been formally notified to CMFT and UHSM. As anticipated, UHSM will be the lead provider of the kidney and bladder operative cancer service, while The Christie will be the lead provider of prostate cancer surgical service. The letter announcing this decision is attached. As set out in the Trusts' response to the Remedies Notice, however, the announcement of a reconfiguration decision by commissioners by no means ensures its later implementation. The history of service reconfiguration efforts in Manchester is a testament to this point. It will be the merger of CMFT and UHSM that will allow this reconfiguration to be successfully implemented, and hence the Trusts' submission that the benefits from this reconfiguration should be attributed to the merger.

45. *Single versus multi-site analysis* - paras 22 and 23 of Appendix C: the CMA refers to its rationale for a single site analysis. However, the appendix does not explain how this is consistent with the published guidance on retail mergers, which indicates that where a single site approach is taken then internal diversion needs to be allowed for if the parameters of competition vary between sites. MRI, Trafford and Altrincham all offer different services, as does Wythenshawe and Withington. An approach consistent with the Retail Merger guidance suggests that the GP referral calculations should be significantly lower for many services.