

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

Summary of final report

1 August 2017

1. The Competition and Markets Authority (CMA) has cleared the anticipated merger between Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) (the merger).
2. We have found that the merger may be expected to give rise to a substantial lessening of competition (SLC) in the provision of NHS elective and maternity services and NHS specialised services. In addition, we believe that prohibiting the merger is the only practicable and effective remedy. However, prohibition would result in the loss of substantial relevant customer benefits (RCBs) which may be expected to arise as a result of the merger. When balanced against the nature of the SLC we have found and the detriment to patients and commissioners which we expect to arise as a result of the merger, it is clear to us that the RCBs are likely to be more significant. We have therefore concluded that it would be disproportionate to prohibit the merger, and that it should be cleared.
3. In reaching this conclusion, we have placed significant weight on the advice of NHS Improvement, and the views of commissioners in Greater Manchester (including the Manchester Clinical Commissioning Group (the Manchester CCG) and the Greater Manchester Health and Social Care Partnership (the GMHSCP)).

Background

4. CMFT and UHSM (together the parties) are both major acute, teaching and research hospital trusts located in Greater Manchester. CMFT provides services from five hospitals on or near 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 services (including emergency care in A&E departments), more specialised services and community services.

5. The merger is subject to various approvals and oversight including from the trusts' own board and governors, national regulators and national and local commissioners. Our role in this broader process is to assess the merger's likely effects on patients and commissioners, examining the adverse effects arising from any SLC and the benefits of the merger. We have sought to ensure that the merger is in the overall interest of patients.¹ In performing our role we have engaged extensively with various relevant NHS bodies.
6. We are required to publish our final report by 13 August 2017.

Regulation and policy in the NHS

7. 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 we have found in this inquiry that it is not the basic organising principle for the provision of NHS services. More important are considerations such as the increasing demand for NHS services and greater degree of clinical specialisation being sought, and the regulatory, policy, and financial context within which such services are provided.
8. Because of this, we have particularly considered the interplay between (i) competition within the NHS, and (ii) the regulatory and policy framework for patient choice, in the context of recent policy developments in the NHS. CMFT and UHSM are public bodies providing a public service; 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 due to financial failure is uncommon and collaboration between providers to supply 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.

¹ [CMA guidance on the review of NHS mergers \(CMA29\)](#), paragraph 1.7.

9. Furthermore, we have recognised the financial pressures on the NHS (in the context of rising demand), and that the recent focus by national bodies (NHS England, NHS Improvement and the Care Quality Commission) on greater collaboration between providers and commissioners to address these pressures in local health economies, has reduced the role of competition. In particular, we have had regard to the vision for the NHS elaborated in the *Five Year Forward View* and implemented through the regional Sustainability and Transformation Plans.
10. Although we have found that the role of competition has been reduced in recent years, we believe that there is some evidence that CMFT and UHSM 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, in choosing which NHS providers to award specialised and community contracts to, can use competition between NHS providers to improve services. Finally, some patients can select which A&E department they present themselves to, which also introduces the possibility of competition, as providers are paid according to the number of emergency patients that they treat.
11. This merger takes place against a backdrop of considerable reorganisation of healthcare commissioning and service 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 to the plans for Greater Manchester, and for the city of Manchester, and have closely engaged throughout our inquiry with those involved in forming these plans.
12. The parties submitted that their rationale for the merger was part of the broader strategy for health and social care services in Manchester. The merger was requested by commissioners, at least in part due to their frustration with the parties' poor track record of collaboration, in combination with their desire to address the variation in health outcomes across Manchester. A merger between the parties was also recommended by an independent review commissioned to assess the prospect of a single hospital service in Manchester.

Market definition

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

14. 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.²
 - (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.³
15. 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

16. To allow us to assess the merger's impact on competition, we must first consider what would have been most likely to have happened to the services provided by the parties in the absence of the merger. 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.
17. We have considered the following factors in reaching our 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.

² Please refer to the glossary for the definition of terms used throughout this report, including outpatient, inpatient, day-case, elective, non-elective and community care.

³ The CMA's phase 1 decision found no realistic prospect of an SLC in the provision of services to private patients as a result of the merger, and we received no submissions in phase 2 of our inquiry suggesting we should have concerns in this area. We have therefore not investigated it further.

- (c) Individual planned reconfigurations of services by Manchester commissioners.
 - (d) The establishment of a Local Care Organisation in Manchester.
 - (e) Potential specialist service reconfigurations by NHS England.
18. 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 concluded that the oesophageal and gastric cancer services, general surgery, and urology cancer surgery reconfigurations (part of the *Healthier Together* programme) will take place in the near future with or without the merger. We have 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.
19. We did not receive strong evidence that the extent and timing of any impact on competition of the other factors listed in paragraph 17 above were sufficiently certain to be taken into account in the counterfactual.
20. We have therefore 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 oesophageal and gastric cancer services, general surgery, and urology cancer surgery.

Competitive assessment

21. We assessed in detail how the merger might affect the quality of services in the following areas:
- (a) NHS elective and maternity services;
 - (b) NHS specialised services;
 - (c) NHS non-elective services; and
 - (d) community services.
22. 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 recent developments have encouraged significantly reduced emphasis on the role of competition in NHS service provision and a weakened ability of providers to compete at the current time.

NHS elective and maternity services

23. 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.
24. 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. However, the parties' hospitals are located close to each other in a large metropolitan area and we therefore believe that in order to attract elective and maternity services referrals they need to have a high-quality service offering over-and-above convenience of location.
25. 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.
26. We used GP referral data to provide 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.
27. Based on the evidence discussed above, we have found that the merger may be expected to give rise to horizontal unilateral effects in 18 NHS elective and maternity services. Therefore, we have found that the merger may be expected to result in an SLC in NHS elective and maternity services.

NHS specialised services

28. 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.

29. 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 GMHSCP (which is the body responsible for procuring some specialised services in Greater Manchester) 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 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 one specialised cardiothoracic service and one specialised vascular disease service. Accordingly, we have 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.
30. We 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 consider that NHS England (and, by extension, the GMHSCP) has some buyer power, but that this is insufficient to fully mitigate the horizontal unilateral effects in these specialised services.
31. We have found that the merger may be expected to give rise to an SLC in NHS specialised services in Greater Manchester.

NHS non-elective services

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

Community services

34. 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.

35. We have found that the merger may not be expected to give rise to an SLC in community services.

Adverse effects of the SLC

36. We found that, for the SLC in NHS elective and maternity services and NHS specialised services, any adverse effect resulting from such SLC is likely to be significantly constrained by recent policy developments, the devolution of health and social care in Greater Manchester, increased regulatory oversight of the merging parties and the local investment agreements which will link the parties' transformation funding to financial and quality targets.
37. We also found that for NHS specialised services the adverse effects of the SLC were somewhat further constrained by the buyer power possessed by NHS England and the GMHSCP.
38. Taking all of these considerations in the round, we believe that any adverse effect resulting from the SLC we have identified is likely to be significantly constrained.

Remedies and relevant customer benefits

39. We considered that the only practicable and effective remedy to the SLC we identified would be to prohibit the merger, as partial divestiture would not be practicable and effective given the difficulty of divesting individual clinical services. Neither would behavioural remedies be practicable and effective, as any such remedy is unlikely to deal with the SLC and adverse effects at source and may not be effective in mitigating the SLC or its adverse effects.
40. It has been put to us, however, that this merger will give rise to potentially substantial benefits to patients and/or commissioners, which would be forgone if we prohibited it. To the extent any such benefits amount to RCBs within the meaning of the Enterprise Act 2002 (the Act), we are able to have regard to the effect of prohibition on the parties' ability to realise any RCBs, before deciding whether prohibiting the merger is an appropriate action to remedy the SLC and resulting adverse effects that we have found.
41. The parties have set out various potential benefits that may flow from the proposed merger, many of which may be associated with a merger between two large NHS trusts. We consider that these fall into the following broad categories:

- (a) A wide range of potential benefits (including those comprised in the parties' business and financial case for the merger), such as improved research and innovation opportunities; financial savings; an enhanced ability to recruit and retain key staff; the ability and incentive to effect change across a number of clinical and non-clinical services simultaneously and at considerable scale and pace; indirect benefits deriving from more efficient use of spare capacity and hospital resources; and enhancing the parties' role in the broader healthcare landscape for Greater Manchester.
 - (b) A total of approximately 75 distinct clinical service areas, in relation to which we understand the parties are developing specific plans for delivering improvements for patients.
 - (c) A sub-set comprising 15 of the 75 distinct clinical service areas, which the parties told us have been well developed following a rigorous and cautious selection process, and that have been submitted to NHS Improvement and us as giving rise to RCBs (the proposed RCBs), and in respect of which NHS Improvement has provided its views to us.
- 42. A number of bodies involved in the regulation and commissioning of NHS services in Manchester, including NHS England, Manchester CCG and the GMHSCP, supported the parties' submissions on benefits.
- 43. In this case, the parties have not claimed that the wide range of potential benefits, and the benefits associated with the 75 distinct clinical service areas (save for the proposed RCBs), amount to RCBs within the meaning of the Act. Nor has NHS Improvement's view (despite acknowledging the possibility of the merger giving rise to a wide range of potential benefits) provided us with sufficient confidence that any of these wider benefits amount to RCBs. Accordingly, we have not been able to conclude that such potential benefits amount to RCBs.
- 44. As a general consideration, we are aware that mergers between NHS providers are complex transactions involving institutionally diverse organisations facing heightened operational challenges, and significant regulatory and clinical pressures, to maintain quality and service levels whilst the merger process is ongoing. They can therefore raise significant delivery and implementation risks to the prompt realisation of benefits.
- 45. There are a number of factors that support the parties' plans for post-merger integration and realisation of benefits within a reasonable period from the merger, including the following considerations:

- (a) The experience of the management team that has been appointed to date to run the merged trust (in terms of prior experience of implementing large scale NHS mergers and service reconfigurations).
 - (b) The degree of planning that has been carried out so far by the parties in delivering the proposed RCBs (including the level of clinical engagement), which may be expected to assist in the delivery of other potential benefits.
 - (c) The regulatory oversight by NHS Improvement and others of the delivery of a quality service and of the merger benefits set out in the parties' business and financial case.
 - (d) The anticipated presence of strong financial incentives on the parties to deliver such merger benefits in the parties' investment agreements with the Manchester CCG and the GMHSCP.
46. We have taken into account these factors in our assessment of the likelihood of the proposed RCBs being implemented within a reasonable period of the merger.
47. We further believe that these factors make it more likely that some of the other various potential benefits will arise from the merger. We therefore consider that our assessment of the magnitude of the RCBs we have had regard to in our proportionality assessment is likely to understate the overall magnitude of benefits that could flow from this particular merger.
48. We have assessed in detail the 15 proposed RCBs submitted by the parties and, in doing so, we have given significant weight to the views of NHS Improvement.
49. We have concluded that there are 11 RCBs within the meaning of section 30 of the Act. These are likely to represent improvements in outcome for patients, may be expected to accrue within a reasonable period from the merger, and would be unlikely to accrue without the merger (or a similar lessening of competition):
- (a) Acute aortic surgery: improvements for patients with Type A aortic dissection currently being treated by CMFT or UHSM, and for patients currently being transferred to other centres. Further, the development of pathways and protocols between local hospitals and the merged trust would likely lead to improved clinical outcomes, including reduced mortality.
 - (b) Acute coronary syndrome: improvements for some heart attack patients through reduced time to diagnosis and treatment, resulting in more

patients receiving treatment in line with national and European guidance, and reduced anxiety for patients and their families while waiting for diagnosis.

- (c) Elective orthopaedics: improvements for some elective orthopaedic patients in the form of improved patient access, outcomes and experience.
- (d) Fractured neck of femur: improvements to patients in the form of reduced time to treatment and length of stay, resulting in reduced complication rates and reduced mortality and improved morbidity outcomes.
- (e) General surgery: more timely and less costly implementation of the proposed service reconfiguration, resulting in improved patient access to sub-specialist care and improved patient outcomes.
- (f) Head and neck cancer surgery: improved patient outcomes, access and experience.
- (g) Heart rhythm abnormalities: improvements for patients requiring non-elective implantation of pacemakers or non-elective defibrillator implant analysis in the form of reduced time to treatment or reduced time to defibrillator implant analysis. This will likely lead to reduced anxiety and reduced risk of complications due to prolonged immobilisation.
- (h) Kidney stone removal: reduced waiting time for lithotripsy services for some patients currently treated at CMFT, improved choice of day and time of treatment for patients currently treated at both CMFT and UHSM, and improved choice of treatment for some patients currently treated at CMFT.
- (i) Stroke: reduction in time that some mini-stroke patients wait for assessment, resulting in the reduced risk of a subsequent larger stroke.
- (j) Urgent gynaecology surgery: modest reductions in the time that some patients waited for urgent gynaecological surgery, resulting in reduced psychological distress, pain, risk of recurrence and risk of a patient's condition deteriorating to an emergency status.
- (k) Vascular surgery: reduced mortality as a result of the increased patient volumes treated at the centralised vascular hub at Manchester Royal Infirmary.

50. We have noted that further planning work is required concerning certain aspects of the proposed RCBs, in particular, regarding proposed site

consolidations and associated interdependencies. The parties submitted, and we agree, that such benefits may be expected to be delivered within a period of two years from the merger, which we considered to be a reasonable period given the nature of the claimed benefit.

Proportionality of prohibition

51. We have considered whether it would be proportionate to prohibit the merger, taking into account the nature of the SLC and the magnitude of its adverse effects, which prohibition would remedy, and the magnitude of the 11 RCBs that we have found, which would be forgone with prohibition.
52. We have found substantial beneficial effects on clinical outcomes and patient care from the RCBs associated with the merger. In assessing the magnitude of the RCBs, we have given material weight to the reduction in patient mortality and complications and the incidence of disease (morbidity), which we consider constitute extremely significant benefits. We also found that, for certain services, the merger was likely to improve patient access and patients' choice of location for treatment, and to improve the hospital experience for a significant number of patients.
53. We have considered the magnitude of the 11 RCBs that we have found, and balanced these against the nature of the SLC we have found and the magnitude of its adverse effects. Taking the above factors in the round, we consider that the adverse effect likely to result from the SLC in NHS elective and maternity services and NHS specialised services is, in the particular circumstances of this case, substantially lower than the beneficial impact of the RCBs that would be lost as a result of prohibition. In our judgement this is not a finely balanced conclusion.
54. Accordingly, we have decided to clear the merger.