

Central Manchester University Hospitals and University Hospital of South Manchester

A report on the anticipated merger between
Central Manchester University Hospitals NHS
Foundation Trust and University Hospital of
South Manchester NHS Foundation Trust

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The Competition and Markets Authority has excluded from this published version of the 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 Some numbers have been replaced by a range.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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- B: Industry background and regulation in the NHS
- C: Analytical method and detailed analysis of NHS elective and maternity specialties
- D: Past service improvement initiatives involving CMFT and UHSM

Glossary

Summary

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.
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.

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

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.

(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*

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.

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.

Findings

1. The reference

- 1.1 On 27 February 2017, the CMA in exercise of its duty under section 33(1) of 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).
- 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 findings, published and notified to CMFT and UHSM in line with the CMA's rules of procedure.⁴ 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.⁵

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 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 largest

⁴ Rules of procedure for merger, market and special reference groups, (CMA17), Rule 11.

⁵ [Central Manchester University Hospitals / University Hospital of South Manchester merger inquiry case page.](#)

provider of specialised services, in Greater Manchester.⁶ Indeed, it is one of the largest foundation trusts in England.⁷

2.2 CMFT has around 1,600 beds and approximately 12,300 whole-time equivalent employees (as at end of March 2016).⁸ 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.⁹

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.^{10,11}

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;

⁶ Parties' phase 1 submission, paragraph 51.

⁷ Based on bed numbers. See [NHS England: Bed Availability and Occupancy Data – Overnight](#).

⁸ Parties' phase 1 submission, paragraph 47.

⁹ Parties' phase 1 submission, paragraph 48.

¹⁰ Parties' phase 1 submission, paragraph 48.

¹¹ 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;¹² and
 - (g) Altrincham Hospital, which provides outpatient and diagnostic services.¹³
- 2.5 CMFT's constituent hospitals, other than Trafford General Hospital, Altrincham Hospital and the University Dental Hospital of Manchester¹⁴ are located on a single site (the 'Oxford Road site') approximately 1.5 miles south of Manchester city centre (see Figure 1).¹⁵
- 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 services are:
- (a) NHS England, through its North West Commissioning Hub;
 - (b) Manchester Clinical Commissioning Group (CCG);¹⁶ and
 - (c) Trafford CCG.¹⁷
- 2.8 CMFT is rated 'Good' by the Care Quality Commission (CQC).^{18,19} CMFT is placed in the second out of a possible four segments under the NHS Improvement [Single Oversight Framework](#) (where the first segment is

¹² Trafford General was the UK's first NHS hospital, opened by Aneurin Bevan in July 1948.

¹³ [Parties' phase 1 submission](#), paragraphs 45 and 46.

¹⁴ 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.

¹⁵ [Parties' phase 1 submission](#), paragraph 47.

¹⁶ Manchester CCG was created in April 2017, combining North Manchester, Central Manchester and South Manchester CCGs. See paragraphs 8.15 and 8.16.

¹⁷ [Parties' phase 1 submission](#), paragraph 49.

¹⁸ [Parties' phase 1 submission](#), paragraph 50.

¹⁹ 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.

strongest and the fourth weakest).^{20,21} 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.^{22,23}

University Hospital of South Manchester NHS Foundation Trust

- 2.10 UHSM is an NHS foundation trust providing NHS 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.²⁴
- 2.11 In the year ended 31 March 2016, UHSM had approximately 915 beds and around 5,500 employees.²⁵ 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.²⁶
- 2.12 UHSM, like CMFT, is a teaching hospital and is a member of the Manchester Academic Health Science Centre.²⁷
- 2.13 UHSM provides NHS 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).²⁸ Wythenshawe Hospital is a teaching hospital that provides emergency care, elective care

²⁰ Parties' phase 1 submission, paragraph 50.

²¹ 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 98 of Appendix B.

²² Parties' phase 1 submission, paragraph 52.

²³ 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.

²⁴ Parties' phase 1 submission, paragraph 58

²⁵ Parties' phase 1 submission, paragraph 54.

²⁶ Parties' phase 1 submission, paragraph 55.

²⁷ Parties' phase 1 submission, paragraph 55.

²⁸ Parties' phase 1 submission, paragraph 54.

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.²⁹
- 2.15 UHSM is rated 'Requires Improvement' by the CQC, which carried out a planned inspection on 26 to 29 January 2016.³⁰ 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.³¹ NHS Improvement places it in segment three (out of four segments) in its segmentation process to determine support needed under its Single Oversight Framework.³²
- 2.16 UHSM recorded revenue of £473 million and a deficit of £8.9 million against a planned surplus of £0.4 million in the year ended 31 March 2017. The deficit was driven by a relatively high level of debt servicing as a result of UHSM's private finance initiative (PFI) scheme³³ and historically low levels of liquidity.³⁴
- 2.17 UHSM's Wythenshawe site is a little over 7 miles from CMFT's Oxford Road site, 8 miles from Trafford General Hospital and 4 miles from 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.

²⁹ Parties' phase 1 submission, paragraph 56.

³⁰ Parties' phase 1 submission, paragraph 57.

³¹ 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.

³² Parties' phase 1 submission, paragraph 57.

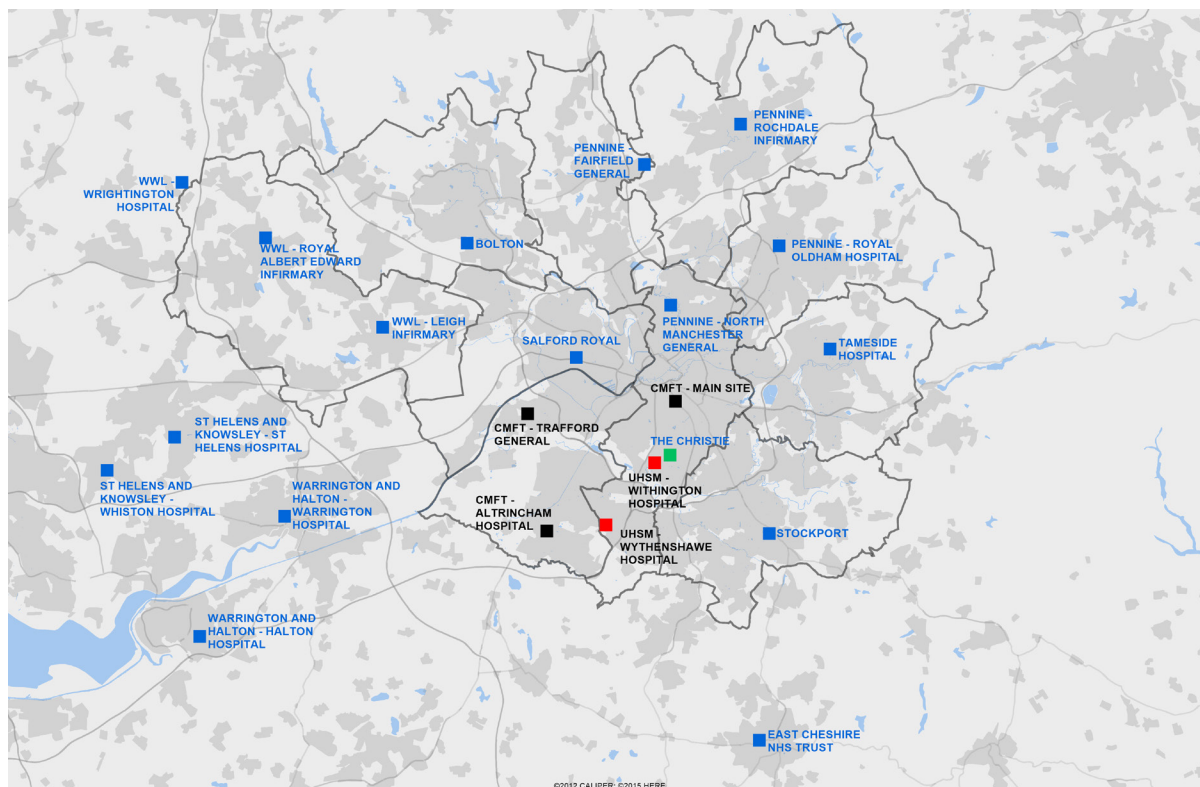
³³ The PFI is a form of partnership between the public and private sectors in which a group of private companies contracts to provide public facilities, often public buildings, such as schools or hospitals. The Trust has a 35-year PFI scheme for two buildings at Wythenshawe Hospital, which expires in 2033.

³⁴ Parties' phase 1 submission, paragraph 58.

Other providers of NHS hospital services in Greater Manchester

2.18 Figure 1 shows the close proximity of a number of other providers of NHS hospital services in Greater Manchester. The competitive constraint these providers impose on the parties is a key component of our competitive assessment. 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 hospital 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 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.³⁵ 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 2 to Appendix B sets out the principles and rules of competition in the NHS as they pertain to the commissioning of NHS services. Industry-specific terms used in this report are defined in the glossary.

Regulation of NHS hospital 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 hospital 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 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

³⁵ 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 duty³⁶ to exercise its functions with a view to securing continuous improvement in the quality of services.³⁷ It is required to promote autonomy and choice within the NHS.³⁸ 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 includes Monitor and the NHS Trust Development Authority. NHS Improvement, through Monitor, authorises and regulates NHS foundation trusts, sets prices for NHS services (through 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 they are safe, effective, caring, responsive to patient needs and that providers are well led.

³⁶ Section 3E of the [NHS Act 2006](#).

³⁷ Continuous improvement in quality refers to either the prevention, diagnosis or treatment of illness or the protection or improvement of public health.

³⁸ Section 13I and 13F (respectively) of the [NHS Act 2006](#).

- 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 rating 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).³⁹

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 Health and Social Care Act 2012 (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

³⁹ 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 *City of 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, 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.⁴⁰ 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.⁴¹ 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 NHS 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

⁴⁰ 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.

⁴¹ 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, led by Sir Jonathan Michael, was 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.⁴²
- (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.⁴³

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*.⁴⁴ 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

⁴² Sir Jonathan Michael (2016), *Manchester Single Hospital Service Review: stage one report*.

⁴³ Sir Jonathan Michael (2016), *Manchester Single Hospital Service Review: stage two report*.

⁴⁴ 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.^{45,46}
- 2004: first 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, which increases their incentive and ability to compete.
- 2004: some NHS elective care could be provided by the independent sector.

⁴⁵ See Department of Health (November 2012), [A simple guide to Payment by Results](#), and Appendix B, paragraph 61.

⁴⁶ 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.

- 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 of 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](#).⁴⁷
- 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.
- 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 for 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 secure and free e-Referral booking system⁴⁸ (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

⁴⁷ 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 following.

⁴⁸ See www.ebs.ncrs.nhs.uk/.

is underpinned by supporting infrastructure, including the e-Referral booking system 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;⁴⁹
- (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.⁵⁰

4.5 If a patient chooses a particular provider for their first outpatient appointment, that provider will be paid via the PbR system. As PbR is an activity-based system it allows 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 services are incentivised to maintain and improve the quality of their services in order to attract patient referrals and the income that treating additional

⁴⁹ From standard surveys such as the trusts' 'friends and family' surveys and from comments and ratings by users of [NHS Choices](#).

⁵⁰ [NHS Choices](#).

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 2 to Appendix B.⁵¹
- 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 regulatory and policy environments in which the parties currently operate.

⁵¹ 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).

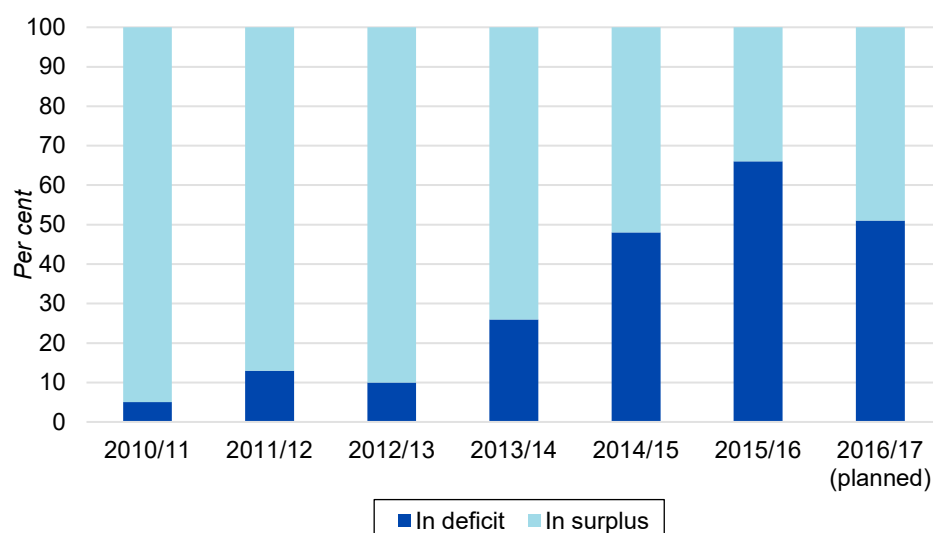
The main recent policy developments relevant to our inquiry are set out below.

Recent policy developments

- 4.12 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 services, in part driven by longer lifespans and a growing population. Technological developments have improved patient care but some treatments can be expensive. There is also a greater degree of clinical specialisation today 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 2020/21.⁵² 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 51% in 2016/17 (having gone as high as 66% in 2015/16) (Figure 2).

⁵² *Five Year Forward View*, paragraph 13.

Figure 2: Proportion of NHS 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'.⁵³

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

⁵³ NAO (November 2016), [Financial Sustainability of the NHS](#).

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 providers of NHS services. The proposed new models of care are set out in Appendix B.⁵⁴ 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.⁵⁵
- 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.⁵⁶ 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 *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

⁵⁴ See from paragraph 152.

⁵⁵ The report says that to achieve a 2 to 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.

⁵⁶ See [NHS England: Vanguards](#).

and greater integration of the commissioning and provision of health and social care.⁵⁷

- 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. Although collaboration does not need to be between providers of the same type of services⁵⁸ the report sets out that patient care might be improved in some instances if NHS providers were to collaborate. This could be, for example, by establishing care networks.

Sustainability and Transformation Plans

- 4.22 Sustainability and Transformation Plans (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.

⁵⁷ [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.

⁵⁸ 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 2017.⁵⁹ 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. The parties 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.
- 4.25 Following the devolution of control of £6 billion of health and social care funding to Greater Manchester, a £450 million Greater Manchester Transformation Fund was established. The GMHSCP told us that a funding package of around £43 million to support the Manchester Single Hospital Service had been agreed from this transformation fund (which is separate from the STF payment).⁶⁰ This funding will be distributed gradually between the financial years 2017/18 and 2020/21. It will support the costs of transforming and standardising the single hospital service, and it will be directly linked to delivery trajectories of performance objectives, which the GMHSCP told us will be more detailed and bespoke than those associated with the national STF funding.
- 4.26 The parties told us that control of these funds is one way NHS Improvement and the GMHSCP can ensure that the merged trust will maintain and drive up quality.

Accountable care systems

- 4.27 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

⁵⁹ The STF consists of a £1.8 billion sustainability strand for providers (mainly of acute emergency care) and £0.3 billion for transformation.

⁶⁰ Joint hearing with GMHSCP and NHSI. The funding is contingent on the CMA's approval of the merger.

STPs that have been working towards the ACS goal. This includes Greater Manchester.

Financial control totals

- 4.28 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
- 4.29 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.
- 4.30 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.
- 4.31 UHSM's audited annual accounts for the year ended 31 March 2017 report a retained surplus of £3.2 million (excluding exceptional losses), which exceeded the control total agreed with NHS Improvement, and includes receipt of £10.6 million from the STF.
- 4.32 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.⁶²

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 148.

Carter report into operational productivity

- 4.33 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 (the *Carter report*).⁶³ 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.⁶⁴

Views of third parties

- 4.34 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.⁶⁵
- 4.35 Likewise, Sir Jonathan Michael told us that the NHS has moved away from competition as a driver for improvement.

Summary of the policy environment, patient choice and competition

- 4.36 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 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

⁶³ [Operational productivity and performance in English NHS acute hospitals: unwarranted variations.](#)

⁶⁴ NHS Improvement advice to the CMA. See the '10 point efficiency plan' in [Next Steps on the Five Year Forward View.](#)

⁶⁵ 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.⁶⁶
- 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.⁶⁷
- 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 focus for acute hospital care, or for the relationship between providers and commissioners.⁶⁸

⁶⁶ This has been discussed in paragraphs 3.15–3.23 above.

⁶⁷ [Parties' phase 1 submission](#), paragraph 35.

⁶⁸ [Manchester Locality Plan](#), November 2016, p55.

- 5.5 The *City of Manchester Locality Plan* called for a single hospital service, and the *Manchester Single Hospital Review* (the 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.⁶⁹
- 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. 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 would plan to hold the parties to account for delivery of the transaction and implementation of changes for patients going forward.

⁶⁹ [The report of CMFT, UHSM and PAHT on arrangements to implement the recommendations of the Single Hospital Service Review](#), 22 July 2016.

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, which covers merger control. 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 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.⁷⁰ 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.⁷¹ 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 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, but not an end in itself, and identifying the relevant market involves an element of judgement.⁷²

⁷⁰ 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).

⁷¹ Section 28(1)(b) of the Act.

⁷² [Merger Assessment Guidelines \(CC2/OFT1254\)](#), paragraphs 5.2.1 and 5.2.2.

- 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.⁷³
- 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.⁷⁴
- 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 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,⁷⁵ broadly in line with those identified in the NHS Merger Guidance:⁷⁶
- (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
 - (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.

⁷³ [Merger Assessment Guidelines](#), paragraph 5.2.2.

⁷⁴ [Merger Assessment Guidelines](#), paragraph 5.1.1.

⁷⁵ 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.

⁷⁶ [CMA29](#), paragraph 6.38.

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.⁷⁷

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.⁷⁸ 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 parties submitted that this meant all patients took into account the quality of outpatient and inpatient services offered by each provider.⁷⁹

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

⁷⁷ CMA29, 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.

⁷⁸ Health & Social Care Information Centre, [A coded classification of patients who have been admitted to a Hospital Provider Spell](#).

⁷⁹ Parties’ phase 1 submission, paragraphs 196–204.

different providers in that specialty could then be assessed with reference to their ability to offer different types of treatment.⁸⁰

7.11 The parties submitted arguments relating to whether each specialty was a separate product market:⁸¹

(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, different treatments and treatment settings are generally not substitutable, as treatment will be specific to the clinical needs of each patient. Sometimes, the same treatment can be offered across different settings. However, generally patients' conditions mean that for a given patient, only one setting will be appropriate. For example, patients with more complex underlying conditions or co-morbidities may require an inpatient stay for a treatment that could usually be performed in a day-case or outpatient setting, in case of any complications.

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 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.

⁸⁰ Parties' phase 1 submission, paragraph 167.

⁸¹ Parties' initial phase 2 submission, paragraphs 21 and 22.

- 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 to be admitted to hospital for treatment or planned surgery.⁸² 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.⁸³
- 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.⁸⁴ 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.⁸⁵

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.
- 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

⁸² The survey question was 'At the time of your initial referral to the hospital, how likely did you think it was that you would be admitted to the hospital for planned surgery or treatment?' (*Ashford and St Peter's/Royal Surrey County survey report*, Question A9, p.17)

⁸³ *Ashford and St Peter's/Royal Surrey County*, paragraphs 6.38–6.40.

⁸⁴ 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.

⁸⁵ The implications of this for our analysis of GP referral data are discussed further at paragraph 10.49 and following, and in Appendix C.

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 There may be differences between providers in the care setting in which certain treatments are provided to patients. This can happen, for example, where one provider is an early-adopter of an innovation which allows a patient to be treated as a day-case patient, rather than as an inpatient. We have taken this into account in our competitive assessment where we have found evidence that this is taking place.
- 7.19 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

- 7.20 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.⁸⁶
- 7.21 Where the conditions of competition are the same, certain specialties may be grouped together.⁸⁷ Where certain specialties are clearly identifiable as primarily supporting treatment in another specialty, we take this into account in our competitive assessment.⁸⁸

⁸⁶ [Merger Assessment Guidelines](#), paragraph 5.2.17.

⁸⁷ For example, obstetrics and midwifery services have been grouped together as maternity services (paragraph 187 of Appendix C). For oral surgery and maxillo-facial surgery we have examined this both together and separately (paragraphs 100–104 of Appendix C).

⁸⁸ See paragraph 10.61 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.

- 7.22 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.⁸⁹
- 7.23 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.
- 7.24 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.
- 7.25 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.⁹⁰

Geographic market

NHS Merger Guidance

- 7.26 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’.⁹¹
- 7.27 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

- 7.28 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

⁸⁹ CMA29, paragraph 6.38.

⁹⁰ See paragraph 10.58 below, and Appendix C, paragraphs 57 and following.

⁹¹ CMA29, paragraph 6.40.

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.

Our approach

- 7.29 For our primary analysis of NHS elective services we have used data on actual GP referral patterns to provide an insight into patients' 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.
- 7.30 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.
- 7.31 In relation to competition for contracts to provide NHS 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

- 7.32 We have carried out some specialty-level catchment area (and share of supply) analysis, to supplement our analysis of GP referral data.⁹² For this purpose, we calculated catchment areas corresponding to the area from which 80% of patients travel.

Conclusions on the relevant markets

- 7.33 Regarding the product market, we conclude the following:⁹³
- (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.

⁹² See Appendix C, paragraph 22 and Table 4.

⁹³ CMA29, paragraph 6.38.

- (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;
 - (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.

7.34 Regarding the geographic market, we 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 first required to consider the competitive situation without the merger. This situation is referred to as the counterfactual.⁹⁴
- 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.⁹⁵ 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,

⁹⁴ [Merger Assessment Guidelines](#), paragraph 4.3.1.

⁹⁵ [Merger Assessment Guidelines](#), paragraph 4.3.2.

where appropriate, we have taken account of these developments in our competitive assessment⁹⁶ and, where relevant, in our RCB assessment (see Section 15).

- 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 pre-merger situation, but ultimately, only the most likely scenario will be selected as the counterfactual.⁹⁷
- 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.⁹⁸ We adopted an approximate time frame of two years for this merger inquiry.⁹⁹
- 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 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 an LCO 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

⁹⁶ For instance, see paragraphs 13.15 and following.

⁹⁷ [Merger Assessment Guidelines](#), paragraph 4.3.6.

⁹⁸ [Merger Assessment Guidelines](#), paragraph 4.3.6.

⁹⁹ 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).

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.
- (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.¹⁰⁰
- (d) The impact on competition between CMFT and UHSM in community services of the Manchester CCG's intention to establish an 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 hospital services) could be expected to decline if the merger did not proceed.¹⁰¹

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 2015.¹⁰² 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

¹⁰⁰ This includes elective care specialties for which the GMHSCP has devolved responsibility over and those for which NHS England retains responsibility.

¹⁰¹ [Parties' phase 1 submission](#), paragraph 109.

¹⁰² [Parties' phase 1 submission](#), paragraph 110.

position.¹⁰³ 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.¹⁰⁴

- 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.¹⁰⁵ 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;¹⁰⁶ 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 below¹⁰⁷). 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

¹⁰³ [Parties' phase 1 submission](#), paragraph 110.

¹⁰⁴ [Parties' phase 1 submission](#), paragraph 111.

¹⁰⁵ [Parties' phase 1 submission](#), paragraph 111.

¹⁰⁶ [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](#)).

¹⁰⁷ See paragraphs 8.29 and following.

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 accept that a cessation of some services or 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 performance¹⁰⁸ 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 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 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.^{109,110}
- 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 NHS hospital services.

¹⁰⁸ See, for example, NHS Improvement (2016), [Single Oversight Framework](#).

¹⁰⁹ The three Manchester CCGs merged on 1 April 2017 to form Manchester CCG.

¹¹⁰ [Parties' phase 1 submission](#), paragraph 82.

- 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 only one provider of each NHS acute service within the city of Manchester and the merger will not represent a lessening of competition.¹¹¹
- 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 are set out in Appendix D. 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.¹¹²
- 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).¹¹³
- 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

¹¹¹ Parties' phase 1 submission, paragraph 86.

¹¹² Parties' phase 1 submission, paragraph 86.

¹¹³ Parties' phase 1 submission, paragraph 106.

constrained.¹¹⁴ Thus, the parties believed that this would mean competition between CMFT and UHSM could be expected to reduce without the merger.

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 NHS hospital 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 NHS hospital services would be developed in the financial year to 31 March 2018;¹¹⁵ and
 - (c) a new single contract for NHS hospital 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 NHS hospital services in Manchester, in the absence of the merger. However, there is considerable uncertainty about what form this single

¹¹⁴ [Parties' phase 1 submission](#), paragraph 107.

¹¹⁵ Providers have the same respective contract schedules for 2017/18.

hospital contract would take, as no detailed plans have yet been made regarding it.¹¹⁶ Moreover, since no detailed plans have been made the timing of any single hospital contract is also uncertain.

- 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, NHS hospital 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 NHS 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. We consider that there is insufficient evidence on which to 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, 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 NHS 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.¹¹⁷ These are commissioner-led programmes and concern:

¹¹⁶ They told us that whether detailed plans for a commissioner-led single contract will need to be made is dependent on the outcome of this merger.

¹¹⁷ [Parties' phase 1 submission](#), paragraph 115.

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 now only provides benign endometrial cancer surgery at Wythenshawe Hospital. We have 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.¹¹⁸

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 OG cancer services for Greater Manchester with these services no longer being provided by either CMFT or UHSM. We have, therefore, decided to take this reconfiguration into account as part of 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.

¹¹⁸ [Parties' phase 1 submission](#), paragraph 116.

- 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.¹¹⁹
- 8.38 The parties have told us that:
- (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.¹²⁰
- 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 have their surgery at CMFT's Manchester Royal Infirmary hospital and all emergency general surgery patients requiring an admission will be admitted to Manchester Royal Infirmary (not just those defined as high risk). We have, therefore, 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.¹²¹

¹¹⁹ Parties' phase 1 submission, paragraph 116.

¹²⁰ Parties' benefits submission on patient benefits, paragraphs 373 and 374.

¹²¹ Parties' phase 1 submission, paragraph 116.

- 8.43 In our provisional findings we said that despite being told of a possible reconfiguration of this service there was at the time substantial uncertainty as to whether it would proceed. Since then, the results of the urology cancer reconfiguration decision have been formally notified to CMFT and UHSM. UHSM will be the lead provider for the urology cancer service and provide kidney and bladder cancer surgery from Wythenshawe Hospital, while The Christie will be the lead provider of prostate cancer surgery.¹²² 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.
- 8.44 CMFT will lose all urology cancer surgery and associated costs and income if the reconfiguration is implemented.
- 8.45 In their response to our provisional findings, the parties clarified that, in their view, the announcement of a reconfiguration decision by commissioners¹²³ does not ensure its later implementation, as evidenced by the history of failed service reconfiguration efforts in Manchester. In their view, the merger of CMFT and UHSM will allow this reconfiguration to be successfully implemented, and hence, in their view, the benefits from this reconfiguration (which they submitted as a proposed RCB) should be attributed to the merger.
- 8.46 The GMHSCP told us that, with respect to urology 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 implementing the reconfiguration might be more challenging.
- 8.47 NHS England told us that the failure of the merger to go ahead would not affect the urology cancer service reconfiguration.
- 8.48 Following the announcement that UHSM and The Christie are to provide the Greater Manchester urology cancer surgery service, we now believe that it is likely that this reconfiguration will go ahead, with the result that CMFT will no longer provide urology cancer surgery. We have, therefore, decided to take this reconfiguration into account as part of the counterfactual to the merger.

¹²² [Joint hearing with the GMHSCP and NHS Improvement.](#)

¹²³ [Joint hearing with the GMHSCP and NHS Improvement.](#)

Other services

- 8.49 The parties also submitted that reconfigurations were being considered in benign urology, musculoskeletal and orthopaedic, paediatric surgery and vascular services.
- 8.50 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.
- 8.51 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.¹²⁴ 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.
- 8.52 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. We consider that there is insufficient evidence on which to 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, decided not to accept any of these reconfigurations as a part of the counterfactual to the merger.

The establishment of the Local Care Organisation

- 8.53 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

¹²⁴ [Parties' phase 1 submission](#), paragraph 116.

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.

- 8.54 The GMHSCP told us that the LCOs were fundamental to the delivery of the Greater Manchester strategy 'Taking Charge'.¹²⁵
- 8.55 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 NHS hospital services and should the merger not proceed, it might pose a major block to the LCO's success.
- 8.56 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 2018.¹²⁶ A competitive tendering process for the LCO is underway (the contract value for the services is around £6 billion over ten years). The provider consortium in which CMFT and UHSM are participating has been announced as the sole capable provider that has responded to the LCO tender.
- 8.57 The parties submitted that once the LCO has been established, it is not anticipated that there will be any further separate tenders for community services contracts let by Manchester's CCGs as all community services will be commissioned through the LCO. The parties submit that, as a result, there would be no avenue for competition between a separate CMFT and UHSM beyond the LCO contract.
- 8.58 However, the details of how the LCO will function are still under development, and we consider that it remains unclear how the introduction of the LCO will affect competition between the parties. Some scope for competition may continue to exist outside the LCO, as the LCO Prospectus states that the LCO will have sub-contract arrangements in place with other providers. Within the framework of the LCO, there may be room for the parties to compete with each other; for example, better performance by one

¹²⁵ See [GMCA, The five-year vision for Greater Manchester](#).

¹²⁶ [Manchester Local Care Organisation Prospectus 2017](#).

provider could allow it to negotiate itself into a position to treat more patients, and to receive proportionately greater payments.

- 8.59 We therefore consider that there is substantial uncertainty as to the extent to which the proposed establishment of the LCO will impact on the parties and we have therefore 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

- 8.60 NHS England is beginning to adopt a 'place-based commissioning' approach to specialised services.¹²⁷ 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.¹²⁸
- 8.61 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).
- 8.62 According to NHS England, national service specifications were 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 activity to meet minimum standards. In that case, an intervention by NHS England to consolidate services would be required.
- 8.63 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

¹²⁷ 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*.

¹²⁸ See paragraph 11.3 for an explanation of the system of tiers of specialised services.

specialised services absent the merger. We consider that there is insufficient evidence on which to 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, decided not to accept these reconfigurations as a part of the counterfactual to the merger.

Conclusion on the counterfactual

8.64 We have 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, OG cancer, and urology cancer services.

9. Introduction to our competitive assessment

9.1 The HSCA 2012 clarifies that the CMA has jurisdiction over mergers involving NHS foundation trusts in accordance with the Act. 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 NHS services provided to patients.¹²⁹

9.2 During the course of our inquiry, in line with our issues statement,¹³⁰ 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 specialised services;
- (c) NHS non-elective services; and/or
- (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

¹²⁹ [CMA29](#), paragraph 1.7.

¹³⁰ [CMA issues statement](#).

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.¹³¹ The aspects of quality which may, in theory, be impacted by a reduction in competition include clinical factors such as infection rates, mortality rates, ratio of nurses or doctors to patients, equipment, best practice, and non-clinical factors such as waiting times, cleanliness and parking facilities.¹³² 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 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 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

¹³¹ CMA29, paragraph 1.5.

¹³² CMA29, paragraph 6.48.

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.¹³³ 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 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 this report we have taken into account the recent developments in NHS policy and the broader financial environment in which providers are operating.¹³⁴ In particular, we believe

¹³³ See Appendix B, paragraphs 63 and following.

¹³⁴ See paragraphs 4.12 and following, above.

that these have, in general, encouraged a significantly reduced emphasis on the role of competition in NHS acute service provision and a weakened ability of NHS 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.¹³⁵ No party has made submissions to us on these particular services and we did not investigate them further.¹³⁶

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.

¹³⁵ The specialties are anaesthetics, palliative medicine, anticoagulant services, medical oncology, clinical oncology, gynaecological oncology and interventional radiology.

¹³⁶ We set out our proposed approach to assessing these overlaps between the parties in our [issues statement](#).

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 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.¹³⁷ 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.¹³⁸ 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 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.¹³⁹

¹³⁷ [Parties' phase 1 submission](#), paragraph 127.

¹³⁸ [Parties' phase 1 submission](#), paragraph 136.

¹³⁹ See paragraphs 4.12 and following, above.

Evidence on the demand for NHS elective and maternity 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 Section 4, 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 to 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.¹⁴⁰ 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.¹⁴¹ 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).¹⁴² 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 appointment for an elective treatment.¹⁴³ The CMA made the same finding

¹⁴⁰ While it used to be conducted by the Department of Health, it is now carried out jointly by NHS Improvement and NHS England.

¹⁴¹ See [NHS Improvement and NHE England outpatient appointments summary, July 2015](#).

¹⁴² 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.

¹⁴³ [Ashford and St Peter's/Royal Surrey County](#), paragraph 6.28.

(of around half of the relevant patient pool were aware of their right to choose) in 2013.¹⁴⁴

- 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).¹⁴⁵ 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.¹⁴⁶ 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.¹⁴⁷
- 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. Therefore, in order to attract elective and maternity services referrals, we believe the parties would need to have a high-quality service offering over-and-above convenience of

¹⁴⁴ [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.

¹⁴⁵ GfK (2015), [Research Report on the Ashford and St Peter's Hospitals and Royal Surrey County Hospitals Merger Inquiry](#).

¹⁴⁶ The King's Fund (2010), Dixon, Robertson, Appleby, Burge, Devlin and Magee, [Patient choice: how patients choose and how providers respond](#).

¹⁴⁷ 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.

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).¹⁴⁸ Some of the studies found that patients and referring GPs did respond to changes in mortality rates in hospitals when making their choice decision.¹⁴⁹ 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.¹⁵⁰

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 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

¹⁴⁸ [Ashford and St Peter's/Royal Surrey County, Appendix H](#).

¹⁴⁹ [Ashford and St Peter's/Royal Surrey County, Appendix H](#), paragraphs 47, 50 and 52.

¹⁵⁰ [Ashford and St Peter's/Royal Surrey County, Appendix H](#), paragraph 53.

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 (see section 4, 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.¹⁵¹
- 10.17 We accept that regulation and capacity constraints might determine trust behaviour more than competition. But consideration of factors, such as

¹⁵¹ 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.

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 compete against each 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.¹⁵²
- 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.¹⁵³ Providers work to a regulatory standard of commencing the treatment of 92% of routine elective care patients within 18 weeks.

¹⁵² Or to seek to maintain existing patient volumes in the face of competitive pressures from other trusts.

¹⁵³ 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.

- 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.¹⁵⁴
- 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 ways that the parties can manage their capacity constraints in the short term.

¹⁵⁴ 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).

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.

Profitability of NHS elective and maternity services

10.27 The parties did not provide 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.¹⁵⁵ The parties told us that some of these changes can be substantial and this makes specialty-level decision making based on financial considerations difficult.¹⁵⁶ 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 this strategy document, it was not at specialty level but rather at the site level.

¹⁵⁵ NHS Improvement has recently moved to biennial tariffs.

¹⁵⁶ 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](#).

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);¹⁵⁷ 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.

¹⁵⁷ 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 considerations. 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.¹⁵⁸
- 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.’¹⁵⁹ 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.’¹⁶⁰

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;

¹⁵⁸ [Ashford and St Peter's/Royal Surrey County, Appendix H](#), paragraphs 67–73 provide a review of the relevant literature.

¹⁵⁹ PWC (2012), [An evaluation of the reimbursement system for NHS-funded care: Report for Monitor](#).

¹⁶⁰ 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; and
- (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.¹⁶¹

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.¹⁶²

¹⁶¹ 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.

¹⁶² 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.¹⁶³

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.¹⁶⁴
- 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:

¹⁶³ 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.

¹⁶⁴ 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 We note that the MHWB identified barriers to collaboration between the parties as a detrimental outcome from competition, and we have considered these below as part of our assessment of RCBs, in paragraphs 15.100 to 15.102.
- 10.46 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.¹⁶⁵ 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

- 10.47 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

¹⁶⁵ Sir Jonathan Michael (2016), [Manchester Single Hospital Service Review: stage one report](#).

would go to each alternative provider if in a hypothetical scenario the anchor hospital became unavailable.¹⁶⁶ The referral analysis provides a starting point for our assessment of the closeness of competition between acute trusts, and provides some insight into the choices available to patients at each referrer.

10.48 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;¹⁶⁷
- (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;¹⁶⁸
- (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.

¹⁶⁶ 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.

¹⁶⁷ 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.

¹⁶⁸ 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 hospital 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.

Analysis of inpatients and day-cases

- 10.49 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 the hospital where they had their first outpatient appointment or referred by the outpatient consultant onto another provider).
- 10.50 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.¹⁶⁹
- 10.51 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.¹⁷⁰
- 10.52 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.

¹⁶⁹ 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.

¹⁷⁰ In other words, we cannot see inpatient choices separate from outpatient choices, for example.

10.53 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).

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

Results of our analysis

The parties' overlaps

10.55 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 33 clinical specialties.¹⁷¹ Excluding those specialties which did not have at least 40% of their referrals reallocated to the other merger party¹⁷² left 30 specialties for us to assess.

Referral sources and sub-specialisation

10.56 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, neonatology and occupational therapy could all be disregarded for further review on this basis.¹⁷³

10.57 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 therefore disregarded speech and language therapy for further review in our inquiry.

¹⁷¹ 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.

¹⁷² The specialties of endocrinology, trauma and orthopaedics, and infectious diseases.

¹⁷³ We found infectious diseases could also be disregarded on this basis, but note that this specialty had already been excluded from further assessment as noted in footnote 172.

10.58 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: clinical haematology; diabetic medicine; geriatric medicine; gynaecology; oral surgery and maxillo-facial surgery (which we have considered together and separately); paediatrics; paediatric surgery; paediatric urology; pain management; plastic surgery; respiratory medicine and vascular surgery. 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.

10.59 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

<i>Specialty</i>
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.

Detailed review of individual specialties

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

Audiology

10.60 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.¹⁷⁴ We therefore find that the merger is unlikely to give rise to horizontal unilateral effects in audiology.

Chemical pathology

10.61 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 find that the merger is unlikely to give rise to horizontal unilateral effects in chemical pathology.

Dermatology

10.62 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 provider. Therefore, historical referral numbers and patterns, including those

¹⁷⁴ 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.

dating from 2015/16, were no longer relevant to an assessment of the effect of the merger on this specialty.

- 10.63 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.¹⁷⁵ 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 find that the merger is unlikely to give rise to horizontal unilateral effects in dermatology.

Orthodontics

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

Paediatric cardiology

- 10.66 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 therefore

¹⁷⁵ NHS Choices website: [Salford Royal–Dermatology](#); Salford Royal leaflet: [Skin cancer nurse specialist and multi-disciplinary team](#).

find that the merger is unlikely to give rise to horizontal unilateral effects in paediatric cardiology.¹⁷⁶

Plastic surgery

- 10.67 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.
- 10.68 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 find that the merger is unlikely to give rise to horizontal unilateral effects in outpatient plastic surgery.¹⁷⁷

Physiotherapy

- 10.69 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.
- 10.70 We therefore find that the merger is unlikely to give rise to horizontal unilateral effects in physiotherapy.

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

- 10.71 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, in which we were unable to rule out concerns through the filtering process and discussion in paragraphs 10.47 to 10.54 above. This includes the competitive constraints on the parties from other trusts. Our

¹⁷⁶ See Appendix C, paragraph 63(b).

¹⁷⁷ See Appendix C, paragraph 63(a).

analysis of these is set out in detail in Appendix C. A summary of our finding on each specialty is below.

Cardiology

- 10.72 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.
- 10.73 Internal documents indicate that the parties take some account of the competitive environment when making decisions. A UHSM operational plan says that UHSM intends to appoint a dedicated device consultant in cardiology to increase market share for device work. Similarly, a UHSM strategic document says that UHSM has seen a decline in cardiology market share (in 2013) which may be related to competition or to community pathways. The document identifies CMFT as UHSM's main competitor for secondary cardiology services (it reports that UHSM's market share was [20-30]% and CMFT's was [20-30]%; the next largest trust had a share of around [5-10]%).¹⁷⁸
- 10.74 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.
- 10.75 We find that the merger may be expected to give rise to horizontal unilateral effects in all treatment settings for cardiology.

Clinical haematology

- 10.76 CMFT offers a number of specialist services relating to bone marrow transplantation, sickle cell disease and thalassaemia, which are not available at UHSM.
- 10.77 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.

¹⁷⁸ Shares were based on inpatient activity for April to December 2013.

- 10.78 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.
- 10.79 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.
- 10.80 We therefore find that the merger may be expected to give rise to horizontal unilateral effects in outpatient clinical haematology.

Diabetic Medicine

- 10.81 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.
- 10.82 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.
- 10.83 We find that the merger may be expected to give rise to horizontal unilateral effects in outpatient diabetic medicine but we note the parties' submissions on the specialist renal centre which is relevant to the magnitude of the adverse effect of any SLC finding.¹⁷⁹

Ear, Nose and Throat (ENT)

- 10.84 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 10.56).

¹⁷⁹ See paragraph 14.4 and following.

- 10.85 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).
- 10.86 There is limited corroboration of these results in the parties' internal documents. The 2014 CMFT surgery business plan anticipates centralisation in head and neck surgery in the coming years, and profiles one of its competitors as UHSM, along with Pennine Acute and Salford Royal.
- 10.87 We therefore find that the merger may be expected to give rise to horizontal unilateral effects in day-case ENT.

Gastroenterology

- 10.88 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 medicine 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.
- 10.89 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.
- 10.90 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.

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

General medicine

10.92 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.

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

10.94 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).¹⁸⁰

General surgery

10.95 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.

10.96 In addition, the parties noted that our analysis using historical referral data will not pick up the reconfigurations in OG cancer services and emergency

¹⁸⁰ See Table 2 in Appendix C.

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.¹⁸¹

- 10.97 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 66).
- 10.98 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 find that the merger may be expected to give rise to horizontal unilateral effects in day-case general surgery.¹⁸²

Geriatric medicine

- 10.99 UHSM's geriatric medicine services are more extensive than CMFT's, with more services offered in relation to falls and Parkinson's Disease.
- 10.100 The referral analysis shows that the parties are close competitors (around a 60% share of reallocated referrals).¹⁸³
- 10.101 We therefore find that the merger may be expected to give rise to horizontal unilateral effects in outpatient geriatric medicine.

Gynaecology

- 10.102 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.¹⁸⁴
- 10.103 Our analysis shows that nearly all of UHSM's inpatient and day-case gynaecology activity involved treatments that were also performed at CMFT,

¹⁸¹ See paragraphs 8.32–8.41.

¹⁸² In contrast, the parties' shares of reallocated referrals was below our 40% threshold in other treatment settings for general surgery (albeit very close to this level for CMFT's inpatient activity).

¹⁸³ The parties raised a number of concerns about the reliability of the HES data for geriatric medicine, as this specialty may be particularly susceptible to different coding practices. However, for the reasons explained in Appendix C, we did not consider that there was a material risk of the referral analysis underestimating the extent of competitive constraints from third parties in this specialty.

¹⁸⁴ 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.

but only around 55% 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 for all care settings, and particularly for day-cases.

10.104 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.

10.105 We therefore find that the merger may be expected to give rise to horizontal unilateral effects in each treatment setting for gynaecology.

Maternity

10.106 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 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. We have taken this into account in our referral analysis.

10.107 A UHSM strategy document identifies CMFT as UHSM's main competitor in maternity and obstetrics. 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 an 80% 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.

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

Oral surgery

10.109 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.¹⁸⁵ The parties submitted that referrals in

¹⁸⁵ 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.

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.

- 10.110 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 find that the merger may be expected to give rise to horizontal unilateral effects in all treatment settings in oral surgery.

Paediatrics

- 10.111 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 those treatments common to both parties indicated that CMFT and UHSM are close competitors.
- 10.112 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.
- 10.113 Given the high combined shares, we find that the merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient paediatrics.

Paediatric urology

- 10.114 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.
- 10.115 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.

- 10.116 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.
- 10.117 On the basis of this analysis we find that the merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient paediatric urology.

Pain management

- 10.118 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.
- 10.119 UHSM offers a chronic pain management service, and CMFT does not.
- 10.120 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]%.
- 10.121 On the basis of the referral analysis, supplemented by the analysis of share of appointments and admissions, we find that the merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient pain management.

Respiratory medicine

- 10.122 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.

- 10.123 A UHSM strategic document says that UHSM's largest competitor in respiratory services is Pennine Acute but that CMFT is gaining market share and it particularly highlights CMFT as a competitor for allergy services.
- 10.124 Referral analysis limited to treatments in day-case respiratory medicine that both CMFT and UHSM provide indicates 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. A UHSM internal document identifies CMFT as its closest competitor in respiratory medicine.
- 10.125 We therefore find that the merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient respiratory medicine.

Rheumatology

- 10.126 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.¹⁸⁶
- 10.127 We therefore find that the merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient rheumatology.

Urology

- 10.128 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

¹⁸⁶ The parties submitted that the results of our referral analysis may be affected by UHSM transferring joint injections from a day-case to an outpatient setting. For the reasons set out in Appendix C, we believe that this would lead our analysis to underestimate the extent of UHSM's competitive constraint on CMFT, relative to the constraint from other third parties, for day-case rheumatology. We also believe that this would have no impact on our analysis with respect to outpatient rheumatology.

results suggest that the parties may be closer competitors for outpatients than implied by the outpatient-only results.

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

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

Vascular surgery

10.131 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 8.49 to 8.52) where we have found that the proposed reconfiguration is not sufficiently certain to be taken into account as a part of the counterfactual to the merger.

10.132 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.

10.133 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 bypass surgery. However, varicose veins is an area in which there are multiple providers on the market.

10.134 We therefore find that the merger may be expected to give rise to horizontal unilateral effects in each treatment setting for vascular surgery.

Countervailing factors

10.135 With regard to buyer power, the CMA's NHS Merger 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.¹⁸⁷

10.136 MHCC submitted that, following the merger of the three Manchester CCGs, it has buyer power. However, we consider that MHCC could not easily threaten to switch its demand to another provider, given the volume of patients treated by the parties and the limited spare capacity at the surrounding trusts.

10.137 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 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.

Conclusions on competition in NHS elective and maternity services

10.138 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.

¹⁸⁷ [CMA29](#), paragraph 6.81.

10.139 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.

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

10.141 On the basis of the evidence available to us, we have found that CMFT and UHSM are close alternatives to each other for 18 NHS elective and maternity services (paragraphs 10.60 to 10.134) (Table 2) and that horizontal unilateral effects could be expected to result from the merger. By product market, we have found that within those 18 clinical specialties horizontal unilateral effects may be expected to arise in 35 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

<i>Specialty</i>
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

10.142 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 (Appendix C, Table 49).¹⁸⁸ 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.

- 10.143 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 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.¹⁸⁹
- 10.144 Taken together with the evidence on closeness of competition between the parties in these specialties, we have therefore concluded that the merger may be expected to give rise to an SLC in the provision of NHS elective and maternity services.
- 10.145 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 would be fairly broad in nature, but could be capable of influencing patients' and GPs' choice of hospital for any given elective service. For example, given that we have found that the merger may be expected to give rise to horizontal unilateral effects in 18 NHS 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.¹⁹⁰
- 10.146 We have not received any evidence in this case to support a proposition that whole hospital harm is likely to arise as a result of the merger. The muted nature of adverse effects that we believe are likely to arise from our SLC finding – which is discussed in Section 14 – make it unlikely that factors such as infection rates, waiting times, the ratio of clinical staff to patients and the like will materially worsen across the whole trusts as a direct result of the

¹⁸⁸ 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.

¹⁸⁹ Our reasons for this are set out in paragraphs 208 to 215 of Appendix C.

¹⁹⁰ 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.

merger. We therefore have found that the merger will not result in any horizontal unilateral effect across the whole trusts (or any of their hospitals).

11. The effect on competition in NHS specialised services

- 11.1 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.
- 11.2 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 relating specifically to Greater Manchester, commissioning decisions are devolved.¹⁹¹
- 11.3 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 the relevant geographic commissioning footprint can vary (ie there is often more than one).
- 11.4 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

¹⁹¹ See paragraphs 3.15 and following, above.

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

- 11.5 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.¹⁹²
- 11.6 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.
- 11.7 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.
- 11.8 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 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

- 11.9 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.

¹⁹² [Parties' phase 1 submission](#), paragraphs 301 and 302.

11.10 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

11.11 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, from paragraph 11.56 below).

11.12 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.

11.13 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

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

- 11.15 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.
- 11.16 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

- 11.17 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

- 11.18 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.

11.19 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.

11.20 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

11.21 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.

11.22 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

- 11.23 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.
- 11.24 With respect to previous reconfigurations, NHS England explained that it attempted a 'market intervention' (a type of reconfiguration) a few years ago for urology 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 contract award. We note that this example provides support for the idea that there is competitive rivalry between providers to retain services.
- 11.25 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.
- 11.26 NHS England told us that it was not concerned about the merger.
- 11.27 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

- 11.28 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

11.29 After examining the number of competitors for each specialised service, the service specifications requiring further consideration are listed in Table 3.

Table 3: Tier 1 overlaps for detailed consideration

<i>Service group</i>	<i>Service specification</i>
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

11.30 We consider each service group in turn below.

Specialised cardiothoracic services

11.31 In specialised cardiothoracic services, there are four areas of overlap between the parties, listed in Table 3 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.

11.32 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.

11.33 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 found that the merger may be expected to give rise to horizontal unilateral effects in the four specialised cardiothoracic services listed in Table 3 above.

Specialised vascular disease services

- 11.34 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.
- 11.35 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.
- 11.36 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 11.18 to 11.22. There is only a limited constraint from other Greater Manchester providers. Accordingly, we have found that the merger may be expected to give rise to horizontal unilateral effects in one specialised vascular disease service, specifically vascular services.

Immunology and allergy

- 11.37 The parties are two of the three current providers of specialised allergy services in Greater Manchester, the other being Salford Royal.
- 11.38 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.
- 11.39 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.

- 11.40 The value of specialised allergy services in revenue terms is small (below £600,000) relative to the parties' overall specialised services activity. This may be expected to 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.
- 11.41 For these reasons we have found that the merger may not be expected to give rise to horizontal unilateral effects in any immunology and allergy services.

Specialised colorectal services

- 11.42 The parties overlap in relation to two specialised colorectal services,¹⁹³ 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.
- 11.43 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.
- 11.44 Available data suggests that the value of the overlap specialised colorectal services in revenue terms is small (below £300,000) relative to the parties' overall specialised services activity. This may be expected to 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.
- 11.45 For these reasons we have 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

- 11.46 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).
- 11.47 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

¹⁹³ Transanal endoscopic microsurgery and faecal incontinence.

providers are Salford Royal and the Wirral University Teaching Hospital NHS Foundation Trust.

- 11.48 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.
- 11.49 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 we 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

- 11.50 As noted in paragraph 10.135 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.
- 11.51 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.
- 11.52 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.

- 11.53 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).
- 11.54 We consider that NHS England (and, by extension, the GMHSCP 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.
- 11.55 For the reasons noted above, we 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 found in NHS specialised services. In Section 14 we take into account the existence of such buyer power in our assessment of the magnitude of the adverse effects resulting from the horizontal unilateral effects in NHS specialised services.

Barriers to entry

- 11.56 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.

- 11.57 NHS England told us that entry barriers included interdependencies between different services,¹⁹⁴ and the likely need for investment in equipment and capability given the complexity of the services.
- 11.58 We consider that barriers to entry into the provision of specialised services are high.

Conclusion on the impact of the merger on NHS specialised services

- 11.59 We have 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: four specialised cardiothoracic services and a specialised vascular disease service. 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.
- 11.60 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 found that the merger may be expected to give rise to an SLC in NHS specialised services.

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

- 12.1 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.
- 12.2 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 competitive dynamic exists for patients who are taken to an A&E department by ambulance. We have focused our examination on those patients who

¹⁹⁴ A prospective entrant may need to enter several services simultaneously, or build up capability in those other services.

self-presented to the A&E department and received some treatment once there.

- 12.3 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.¹⁹⁵ UHSM has an A&E department offering a 24-hour service at Wythenshawe Hospital.
- 12.4 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.
- 12.5 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

- 12.6 The parties submitted that they did not compete for non-elective patients.¹⁹⁶ 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 home as possible. Pressures on A&E services meant that CMFT, UHSM,

¹⁹⁵ Manchester Royal Eye Hospital and University Dental Hospital of Manchester respectively.

¹⁹⁶ [Parties' initial phase 2 submission](#), paragraph 96.

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.¹⁹⁷

- 12.7 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.¹⁹⁸ 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.
- 12.8 With 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.
- 12.9 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.¹⁹⁹
- 12.10 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 admit these patients. This beds issue is a constraint regardless of whether

¹⁹⁷ 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 \(2016/17\)](#).

¹⁹⁸ [Parties' initial phase 2 submission](#), paragraph 30.

¹⁹⁹ [Parties' initial phase 2 submission](#), paragraph 92.

the patient arrives at A&E inside or outside peak demand periods in the A&E department.

- 12.11 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%.²⁰⁰ 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,²⁰¹ while the Department of Health also said that occupancy of greater than 85% was a cause for concern.²⁰² These high levels of bed occupancy mean that there is a further disincentive to attract additional non-elective care patients.
- 12.12 The parties also made relevant submissions on financial incentives.²⁰³ They told us that the marginal rate emergency rule (see paragraph 12.21 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.
- 12.13 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

- 12.14 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.

²⁰⁰ NHS England statistics: [Bed Availability and Occupancy Data – Overnight](#)

²⁰¹ NAO (24 February 2000), *Inpatient Admissions and Bed management in NHS acute hospitals*.

²⁰² See Department of Health Annual Report 2002, paragraph 5.9: [The National Beds Inquiry](#).

²⁰³ [Parties' initial phase 2 submission](#), paragraph 95.

- 12.15 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.
- 12.16 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.²⁰⁴ 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).²⁰⁵ 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).
- 12.17 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.
- 12.18 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

²⁰⁴ Using A&E HES data, we calculated drive-times from patients' residence postcodes to the relevant A&Es. Using distance travelled produces similar results.

²⁰⁵ 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.

- 12.19 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

- 12.20 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.²⁰⁶
- 12.21 Non-elective service revenue is paid on a per patient basis, so the greater the number of emergency 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.²⁰⁷ This funding formula dampens trusts' incentives to go beyond their baseline level.²⁰⁸ It is worth noting that the 'marginal rate emergency tariff' is not calculated on the basis of total

²⁰⁶ 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.'

²⁰⁷ 2016/17 National Tariff Payment System, paragraph 166.

²⁰⁸ 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 seven-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.

attendances to A&E but rather to the number of emergency patients who are admitted to the hospital once they have been clinically assessed.²⁰⁹

12.22 UHSM has exceeded the baseline for each of the past three years.²¹⁰ 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).²¹¹ 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).

12.23 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.

12.24 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 12.18 above). The planned changes in physical capacity are shown below in Table 4.

Table 4: Current and future capacity available at UHSM A&E department

<i>Current capacity</i>	<i>New capacity</i>
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).

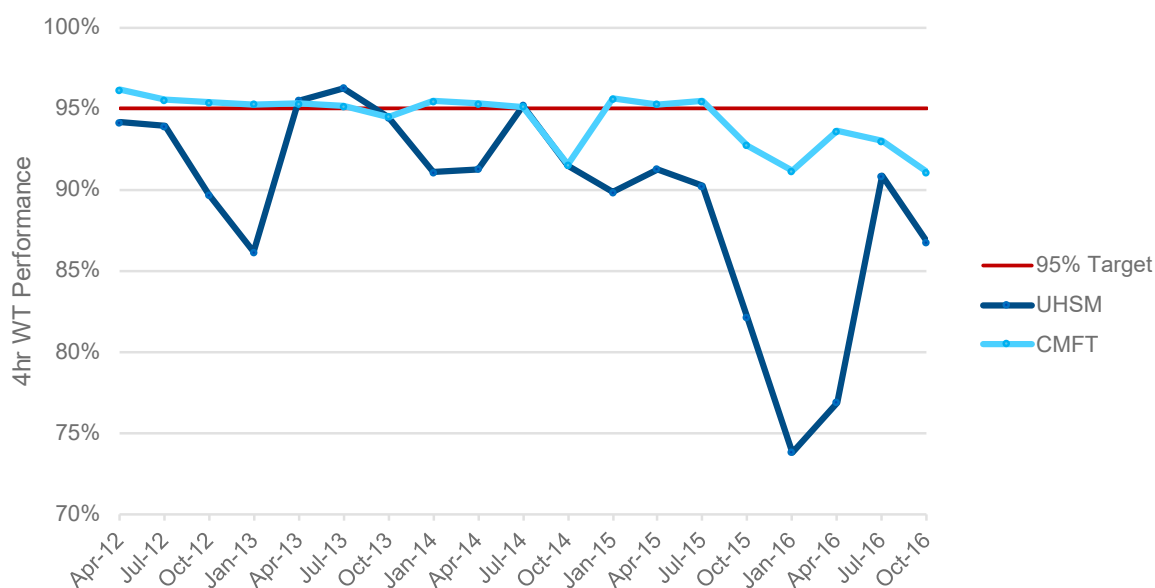
12.25 UHSM's performance against the 4-hour target indicates that it has been capacity constrained for at least the past five years (Figure 3). By contrast, CMFT's performance against the 4-hour waiting time target suggests that its A&E department has been capacity constrained since 2015.

²⁰⁹ NHS Improvement (2016), [Guidance for Commissioners on the marginal rate emergency rule and 30-day readmission rule](#).

²¹⁰ 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.

²¹¹ 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.

12.26 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.

12.27 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.

12.28 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.²¹² 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

²¹² 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

12.29 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 5). 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 emergency 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 5: Type I A&E departments in Greater Manchester, by distance from the parties and volume of activity (2015/16)*

To	From CMFT		From UHSM		Admissions in FY 2015/16
	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 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 of that submission). Distance information has been recovered using Google Maps. When Google Maps identified alternative routes for each journey, the minimum distance has been selected.

12.30 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).²¹³

²¹³ 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.

Conclusions on competition in NHS non-elective services

- 12.31 Our 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 limits 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).
- 12.32 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.
- 12.33 We therefore find that the merger may not be expected to give rise to an SLC in the provision of NHS non-elective 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.²¹⁴

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 In the year ended 31st March 2017, the main community services contracts held by CMFT were 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 was South Manchester CCG's²¹⁵ 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.

²¹⁴ [Parties' initial phase 2 submission](#), paragraph 320.

²¹⁵ On the 1st April 2017 South Manchester, Central Manchester and North Manchester CCGs merged to form Manchester CCG. See paragraphs 8.15 and 8.16.

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.²¹⁶ The LCO will both provide community services and subcontract them with health and social care providing organisations.
- 13.10 The provider consortium in which CMFT and UHSM are participating has been announced as the sole capable provider that has responded to the LCO tender.

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
 - (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 2012.²¹⁷ 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.

²¹⁶ See paragraphs 8.53 and following.

²¹⁷ 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.

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

Conclusion on competition for contracts

- 13.18 In relation to competition for community services contracts, including for appointment to LCO status, we have 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,²¹⁸ for which there were a large number of providers in Greater Manchester.

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

14. Overall conclusions on the SLC test

- 14.1 We have found that the merger may be expected to give rise to horizontal unilateral effects in the provision of 18 NHS elective and maternity services (Table 6), and therefore we have found that the merger may be expected to give rise to 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

<i>Specialty</i>
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

- 14.2 We have found that the merger may be expected to give rise to horizontal unilateral effects in the provisions of specialised cardiothoracic services and specialised vascular disease services, and therefore we have found that the merger may be expected to give rise to an SLC in the provision of NHS specialised services in Greater Manchester.

²¹⁸ Audiology, non-obstetric ultrasound, and MRI – head and neck.

- 14.3 We have found that the merger may not be expected to give rise to an SLC in the provision of NHS non-elective services or in community services.

The overall adverse effect of our SLC findings

NHS elective and maternity services

- 14.4 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. 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.
- 14.5 Although both CMFT and UHSM's internal documents do suggest that they have competed for NHS elective and maternity services, those documents also suggest that competition-related considerations are not the predominant factor in their decision-making.
- 14.6 In certain specialties (the parties submitted that vascular surgery, oral surgery and maxillo-facial surgery, pain management, clinical haematology, diabetic medicine, respiratory medicine, paediatrics, paediatric urology, geriatric medicine and gynaecology were relevant), sub-specialisation may overstate the extent and significance of the overlap between the parties within the specialties in which we found horizontal unilateral effects as a result of the merger.²¹⁹
- 14.7 We are keenly aware that NHS commissioners and providers are facing significant challenges, particularly 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. The local STPs are the key mechanisms to deliver that ambition in the local

²¹⁹ See paragraph 10.58 (above) and Appendix C, paragraphs 57–62.

health economies throughout England. In Greater Manchester, the STP sets out a number of initiatives, involving NHS 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 services, in particular, the provision of NHS elective and maternity services.

- 14.8 We have examined this closely in our inquiry. We have extensively consulted 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 *City of 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 vision for the NHS elaborated in *The Five Year Forward View* a reality in Greater Manchester.
- 14.9 NHS Improvement told us that they were developing a multi-tiered approach to oversight of the merged trust, which incorporated involvement with partners across the health system. This approach would involve:
- (a) monitoring integration milestones and how the system was performing against the NHS Improvement Single Oversight Framework;²²⁰
 - (b) regular review of trust-wide issues; and
 - (c) site based and functional oversight.
- 14.10 The GMHSCP and NHS Improvement told us that the oversight framework would not be limited to measuring the merged trust’s performance against national standards, but would aim to improve care across the merged trust to match best practice.
- 14.11 We also found that in order to access funding from the Greater Manchester Transformation Fund for the merger, the parties expect to sign an

²²⁰ NHS Improvement uses its Single Oversight Framework to identify where providers may benefit from or require improvement support to ultimately help providers attain, and maintain, CQC ratings of Good or Outstanding.

investment agreement with Manchester CCG, which will be bound in turn by an investment agreement with the GMHSCP. These local investment agreements are expected to include a series of deliverables (such as specific milestones, financial savings, performance targets, and benefits) which will be monitored on a quarterly basis. The GMHSCP told us that if performance, financial or activity targets were missed, a recovery plan would be put in place, and if the merged trust seriously underperformed, the GMHSCP could stop the funding for the merger.

- 14.12 We consider that this increased level of oversight of the trusts, combined with the financial penalties which could be enforced if quality at the trusts were to decline, is likely further to limit the scope for harm from the SLC.
- 14.13 Taking all of these considerations in the round, we 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 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.

NHS specialised services

- 14.14 We have found an SLC in NHS specialised services, in particular in four specialised cardiothoracic services and a specialised vascular disease service.
- 14.15 We believe that some of the regulatory and policy factors that dampen the parties' incentives to compete in NHS elective and maternity services also dampen the parties' incentives to compete in specialised services.
- 14.16 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,²²¹ 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 service where we have found a horizontal unilateral effect is low.
- 14.17 Further, the detriment arising from a substantial lessening of competition may be time limited insofar as competition between CMFT and UHSM might

²²¹ See paragraphs 11.50 and following, above.

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.

- 14.18 Taking these considerations in the round, we 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 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, and by the buyer power possessed by NHS England and the GMHSCP.

Overall conclusion on the SLC test

- 14.19 We find, in accordance with subsection 36(1) of the Act, that arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation and the creation of that situation may be expected to result in an SLC in NHS elective and maternity services and NHS specialised services, and that the overall adverse effect resulting from such SLC is likely to be significantly constrained.

- 14.20 We have taken into account the magnitude of the detriment deriving from the SLC that we have found in our assessment of proportionality of remedies, below.

15. Remedies and relevant customer benefits

Introduction

- 15.1 We have found that the merger may be expected to give rise to an SLC in the provision of NHS elective and maternity services and NHS specialised services.
- 15.2 We are therefore required to decide whether we or another body should take action to remedy, mitigate or prevent the SLC or adverse effect arising from

it and, if so, what action should be taken.²²² When we consider whether a remedy would be appropriate, we are required to have regard to the need to achieve as comprehensive a solution as is reasonable and practicable to the SLC and any adverse effects resulting from it.²²³ We will seek remedies that are effective in addressing the SLC and its resulting adverse effects and will then select the least costly and intrusive remedy that we consider to be effective, ensuring that no remedy is disproportionate to the SLC and its resulting adverse effects.²²⁴ We may have regard to the effect of any remedial action on any RCBs which could be expected to arise from the merger.²²⁵ We set out in paragraphs 15.9 to 15.25 the framework for considering RCBs.

- 15.3 It has been put to us that this merger will give rise to potentially substantial benefits to patients and/or commissioners by enabling the merged provider to deliver a better service than the two providers could offer separately. Even if a merger of NHS providers may be expected to result in an SLC, the benefits to patients may be significant. An action that remedies the SLC or addresses any adverse effect resulting from it, such as prohibiting the merger transaction, could be considered disproportionate if it denies patients and/or commissioners these benefits, which may outweigh the SLC and any resulting adverse effects. Insofar as these benefits amount to RCBs, the statutory framework allows us to take them into account when we decide whether any remedy is appropriate.
- 15.4 The parties have set out various potential benefits that may flow from the proposed merger. We have assessed these potential benefits, and the risks associated with their delivery and implementation arising from the merger and more generally.
- 15.5 In this case, the parties have not claimed that all of the various potential benefits amount to RCBs within the meaning of the Act. The parties have submitted that the merger would give rise to a number of benefits to patients, including proposed RCBs in 15 clinical service areas (the proposed RCBs). The parties claim that the proposed service changes in these 15 clinical service areas would result in significant clinical and non-clinical improvements for patients across Manchester, including improved morbidity outcomes and reduced mortality, reduced time to treatment and length of

²²² See section 36(2) of the Act and [Merger Remedies: Competition Commission Guidelines \(CC8\)](#), paragraph 1.6.

²²³ Section 36(3) of the Act.

²²⁴ [CC8](#), paragraph 1.7.

²²⁵ Section 36(4) of the Act, see also [CC8](#), paragraph 1.14.

stay, fewer complications following surgery, more convenient patient access to services and improved patient experience.

- 15.6 In reaching our decision on whether it is appropriate to remedy the SLC and its adverse effects, we have considered the views of the parties, clinicians, commissioners and views we have received from NHS Improvement on the parties' benefits submission.²²⁶
- 15.7 Our conclusions in relation to the 15 proposed RCBs have been summarised in Table 7.
- 15.8 This section is structured as follows:
- (a) Framework for considering RCBs.
 - (b) Assessment of remedy options.
 - (c) Potential benefits arising from the merger.
 - (d) Assessment of RCBs.
 - (e) Proportionality of prohibition.
 - (f) Conclusion.

Framework for considering RCBs

RCBs

- 15.9 According to its guidance, the CMA will normally take RCBs into account, as permitted by the Act, once it has decided on the existence of an SLC as a part of its consideration of remedies. The CMA will consider the extent to which alternative remedies may preserve such benefits. In essence, RCBs that will be forgone due to the implementation of a particular remedy may be considered as costs of that remedy. The CMA may modify a remedy to ensure retention of an RCB or it may change its remedy selection. For instance, it may decide to implement an alternative, effective, remedy other than prohibition of the merger transaction or it may decide that no remedy is appropriate.²²⁷ Clearly, prohibiting a merger will also prevent any RCBs from arising.

²²⁶ Please refer to the [case page](#) for the parties' written submissions, including their benefits submission, and NHS Improvement's views on the parties' benefits submission.

²²⁷ CC8, paragraph 1.15.

- 15.10 Only benefits that meet the conditions set out in section 30 of the Act can be considered RCBs.
- 15.11 Section 30(1)(a) of the Act requires the benefits to be ‘a benefit to relevant customers in the form of:
- (a) lower prices, higher quality or greater choice of goods or services in any market in the United Kingdom ... or
 - (b) greater innovation in relation to such goods or services’.²²⁸
- 15.12 Sections 30(1)(b)(ii) and 30(3) of the Act specify that a benefit is only an RCB if the CMA believes that:
- (a) ‘the benefit is expected to accrue to relevant customers within the UK within a reasonable period as a result of the creation of the relevant merger situation; and
 - (b) the benefit is unlikely to accrue without the creation of that situation or a similar lessening of competition’.²²⁹
- 15.13 Below we separate out the requirements of the Act into an analytical framework.

Types of benefits that may represent RCBs

- 15.14 The assessment of whether benefits claimed by merger parties constitute RCBs must be assessed on a case-by-case basis.²³⁰
- 15.15 The types of benefits that NHS providers have previously submitted in merger cases include:
- (a) higher-quality services through implementing a particular model of care;
 - (b) higher-quality services through service reconfiguration;
 - (c) higher-quality services through increased consultant or staff cover;
 - (d) higher-quality services through access to equipment;

²²⁸ See also [CC8](#), paragraph 1.14.

²²⁹ See also [CC8](#), paragraph 1.16.

²³⁰ [CMA29](#), paragraph 7.14.

- (e) greater innovation through research and development and greater ability to attract funding for research and development; and
- (f) financial savings.²³¹

15.16 In the context of the health sector and NHS mergers, ‘relevant customers’ include patients and/or commissioners.²³²

Is the benefit expected to accrue within a reasonable period?

15.17 According to its guidance, the CMA will consider whether it believes the benefits are likely to be realised. The merger parties will be expected to provide convincing evidence regarding the nature and scale of RCBs that they claim will result from the merger.²³³

15.18 The CMA will review implementation plans, and the more detailed and advanced these are, the more persuasive they are likely to be. The merger parties’ incentives to implement the benefits will also be relevant to the likelihood of implementation.²³⁴

15.19 The level of information required to demonstrate a benefit will vary on a case-by-case basis. For the more extensive benefit proposals, the CMA expects that the merger parties will have:

- (a) determined what the preferred proposal is and, where relevant, provided evidence for the need for change;
- (b) discussed plans with clinicians and relevant commissioners;
- (c) developed a model of care; and
- (d) produced an assessment of the clinical advantages (and any disadvantages) as well as a robust assessment of the financial or economic viability of the plans.²³⁵

15.20 The CMA may conclude that the benefit is expected to arise even if the merger parties have not completed the following steps:

- (a) Undertaken or started a public consultation.

²³¹ [CMA29](#), paragraph 7.13.

²³² See section 30(4) of the Act and [CMA29](#), paragraph 7.3.

²³³ [CC8](#), paragraph 1.17.

²³⁴ [CMA29](#), paragraph 7.18.

²³⁵ [CMA29](#), paragraph 7.20.

(b) Taken a firm decision to proceed.

(c) Implemented or started to implement the proposal.²³⁶

15.21 What is a reasonable period will vary on a case-by-case basis, depending, for example, on the nature of the proposed benefit and the circumstances of its implementation. For example, a large-scale building project or merger of a maternity or A&E service may reasonably require a longer implementation period – with benefits possibly not accruing to patients for a number of years – than a small project.²³⁷

Is the benefit unlikely to accrue without the merger or a similar lessening of competition?

15.22 In determining whether the benefit is merger specific, the CMA will consider whether it was likely to occur in any event (eg if the benefit was in any event likely to arise through a commissioner-led reconfiguration) and whether the merger parties would have the ability and incentive to achieve the benefits independently or through other arrangements, such as another merger or through collaboration, that do not themselves give rise to competition issues of a similar magnitude.²³⁸

Role of NHS Improvement in our assessment of RCBs

15.23 Section 79 of the HSCA requires NHS Improvement to provide advice on RCBs to the CMA in phase 1 as soon as reasonably practicable after receiving notification that the CMA is investigating a merger involving an NHS foundation trust.²³⁹

15.24 NHS Improvement's advice is not binding on the CMA. However, the CMA will place significant weight on NHS Improvement's advice, given NHS Improvement's role and expertise as sectoral regulator.²⁴⁰

15.25 In the event that the merging parties do not submit any RCBs during the phase 1 inquiry, they can make such submissions for the first time in phase 2, and the CMA will seek NHS Improvement's views regarding RCBs in phase 2.²⁴¹ In this case, the parties did not make a formal submission on

²³⁶ CMA29, paragraph 7.21.

²³⁷ CMA29, paragraph 7.16.

²³⁸ CMA29, paragraph 7.17.

²³⁹ CMA29, paragraph 7.5.

²⁴⁰ CMA29, paragraph 7.6.

²⁴¹ CMA29, paragraph 8.6.

RCBs during phase 1, but did so during phase 2, and we have received NHS Improvement's view on the proposed RCBs.²⁴²

Assessment of remedy options

15.26 In this section, we set out the various remedy options that we have considered and then conclude on the effectiveness of those options.

Assessment of effectiveness of prohibition

15.27 In the notice of possible remedies,²⁴³ we invited views on the prohibition of the merger as an appropriate remedy to prevent the provisional SLC and any resulting adverse effects. We received no submissions claiming that prohibition would be not be effective.

Assessment of effectiveness of other remedy options

15.28 We invited views on any other remedies, whether structural or behavioural, that would be practicable and effectively address the provisional SLC and any resulting adverse effects. In response, the parties agreed that there were no other remedies that would be effective and we did not receive any other proposals for an effective remedy other than prohibition of the merger.

15.29 For completeness, we have nonetheless considered whether there are structural remedies, other than prohibition of the merger, that would be likely to be practicable and effective in addressing the SLC and any resulting adverse effects.

15.30 We do not consider that the divestiture of those services which give rise to the SLC (ie partial divestiture) would be a practicable or effective solution to remedy the SLC and any resulting adverse effects:

- (a) In general, and as noted by NHS Improvement,²⁴⁴ individual clinical services or specialties are not easily separable from the rest of the merged parties' operations, reflecting the complex interdependency of clinical services or specialties provided in a district general hospital setting. Moreover, the location of where services are provided is important to patients. Therefore, we consider that the divestment of a particular service in isolation of other services may be infeasible and/or

²⁴² Please refer to the [case page](#) for NHS Improvement's views on the proposed benefits of the merger.

²⁴³ Please refer to the [case page](#) for the notice of possible remedies.

²⁴⁴ See NHS Improvement's view, on our [case page](#).

not in the best interests of patients. Further, in this particular case, the divestment of multiple services would be complex.

- (b) Partial divestiture would be subject to the risk that a suitable purchaser was not available or the parties would dispose to an inappropriate purchaser.
- (c) Partial divestiture would also be subject to the risk that the scope of the divestiture package would be too constrained or not appropriately configured to attract a suitable purchaser or would not allow a purchaser to operate as an effective competitor in the market.

15.31 We also do not consider that a behavioural remedy is a practicable or effective solution to remedy the SLC and the resulting adverse effects, 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 and adverse effects. It may also require monitoring and enforcement once implemented.

Conclusion on the effectiveness of the remedies assessed

15.32 Our view is that prohibition of the merger is the only remedy that would be practicable and effectively remedy, mitigate or prevent the SLC and resulting adverse effects. Prohibition would prevent the horizontal unilateral effects from arising in any of the areas we have identified as giving rise to the SLC, and prohibition is straightforward to implement, monitor and enforce.

15.33 Having established that there are no effective and practicable remedy options other than prohibition,²⁴⁵ we have focused our assessment of the proportionality of prohibition on whether the costs of prohibition are outweighed by its benefits. In particular, we have had regard to whether prohibition may result in RCBs being forgone and, if so, whether the loss of any RCBs would be disproportionate when balanced against the SLC and resulting adverse effects.²⁴⁶

Assessment of benefits

15.34 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

²⁴⁵ On this basis, we are not required to consider whether prohibition is the least costly and intrusive remedy we consider to be equally effective.

²⁴⁶ As this is an anticipated merger the non-RCB related costs of prohibition on the parties are negligible. To the extent that they arise, they are, in essence, avoidable and therefore we have not considered them in our assessment of the proportionality of prohibition. See [CC8](#), paragraph 1.10.

two large NHS trusts. We consider that these fall into the following broad categories:²⁴⁷

- (a) A wide range of potential benefits (including those comprised in the 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 capacity and hospital resources; and enhancing the parties' role in the broader healthcare landscape for Greater Manchester.
- (b) 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.

15.35 In the rest of this section, we discuss the wide range of potential benefits and the parties' specific plans in 75 distinct clinical service areas (other than the 15 proposed RCBs), third parties' views of such benefits, and the risks associated with the delivery and implementation of such benefits in general. We then discuss the 15 proposed RCBs.

Wide range of potential benefits

15.36 NHS Improvement has found, in general, that improvements in clinical service delivery and financial savings, similar to many of the wide range of potential benefits claimed by the parties, can be achieved through mergers between NHS providers.²⁴⁸

15.37 We note, in this regard, that the parties expect material savings in the costs of organisational leadership and resources used (due to the standardisation of clinical pathways and wider efficiencies through greater economies of scale, including from some of the proposed RCBs). We have not undertaken

²⁴⁷ See the Parties' submission on patient benefits, the Parties' summary of patient benefits, and NHS Improvement's view, on our [case page](#).

²⁴⁸ See NHS Improvement (May 2016), [Improvements NHS providers have achieved through mergers](#) and Aldwych Partners (May 2016), [Benefits from mergers: lessons from recent NHS transactions](#).

a detailed assessment of the financial impact of the merger, and we note that NHS Improvement is currently in the process of doing so. We expect that the parties would use such savings to improve existing services or to treat more patients.

- 15.38 The parties also claim that, where a number of services are interdependent, this may enable the merged trust to effect change across a number of clinical and non-clinical services simultaneously and at considerable scale and pace. In addition, the parties claim that the merger is not only likely to bring about a direct benefit to patients but also may give rise to potential indirect benefits to patients. For example, the parties submitted that, by introducing seven-day rotas providing increased access to some service areas, this is likely to provide a direct benefit to patients in one specialty (who are able to receive faster treatment), as well as indirect benefits to patients, potentially, in other specialties (for example, by freeing up capacity in one specialty, thereby reducing waiting times in other specialties).
- 15.39 Moreover, the parties claim that benefits will also arise from the merged trust's role in the broader healthcare landscape for Manchester (outlined in the *City of Manchester Locality Plan*) which includes the implementation of a single hospital service for the city, and is intended to improve community-based care, standardised acute care pathways, and pool commissioning budgets across health and social care in Manchester, in order to support improved health outcomes.²⁴⁹

Seventy-five separate service areas

- 15.40 We understand that as part of preparing for the merger, the parties are in the process of developing plans for achieving improvements for patients across approximately 75 distinct clinical service areas.²⁵⁰ For example, the parties submitted that in Respiratory Medicine, clinicians have developed a service improvement initiative which includes a streamlined lung cancer pathway which reduces the time to diagnosis and thoracic surgery, thereby increasing patient survival through earlier intervention.
- 15.41 The parties submitted that it was not possible to add further patient benefit cases to the overall case for the 15 proposed RCBs, given the time and resource to put these cases together. However, the parties submitted that the service change initiatives which have been identified, but not selected for inclusion in the patient benefits case as the 15 proposed RCBs, have been

²⁴⁹ Sir Jonathan Michael (2016), *Manchester Single Hospital Service Review: stage one report*.

²⁵⁰ NHS Improvement's advice to the CMA.

included in a wider package of initiatives to be developed and implemented following the merger.

Third party views

- 15.42 NHS Improvement told us that it supported the strategic rationale for the merger, recognising that the merger could generate significant improvements to patients and that the parties were committed to achieving this.
- 15.43 NHS Improvement noted that the merged trust should have the capability, capacity and experience to deliver the merger successfully and contribute to the transformation of healthcare services for the people of Greater Manchester. Further, NHS Improvement has advised that the devolution of health and social care to Greater Manchester meant that local bodies were well placed to oversee the changes taking place and ensure that the merged organisation delivered improvements for patients.
- 15.44 The GMHSCP told us that the merger would allow it to deliver its clinical services strategy faster, and that the merged trust would be able to provide a broader teaching experience and a more comprehensive combination of services, which would also make it more attractive as a research organisation. The GMHSCP also said that the merged trust would be better placed to meet the seven-day clinical standards by combining the parties' workforces.²⁵¹ The GMHSCP is also expecting financial savings from the merger.²⁵²
- 15.45 The MHCC told us that a much larger range and quantity of benefits could be achieved at a much quicker pace through the merger than if MHCC were to try to achieve the benefits of the single hospital service without it. MHCC also said that it expects the merger to generate savings.²⁵³
- 15.46 NHS England told us that the merger would make collaboration between the parties' hospitals easier, and that there are financial savings to be made from the merger by reducing management and infrastructure costs.²⁵⁴
- 15.47 Sir Jonathan Michael told us that the introduction of a single hospital service in Manchester (which he believed was best achieved through a merger between the parties) would allow for a wide range of clinical benefits (such as from standardised protocols and achieving critical mass) and financial

²⁵¹ Hearing with the GMHSCP.

²⁵² Joint hearing with the GMHSCP and NHS Improvement.

²⁵³ Hearing with the MHCC.

²⁵⁴ Hearing with NHS England.

savings.²⁵⁵ In his stage 1 report, Sir Jonathan Michael took eight clinical specialties as case studies (including infectious diseases, radiology, respiratory services, rheumatology, maternity services, critical care and secondary paediatrics – service areas which were not part of the 15 proposed RCBs put forward by the parties). Sir Jonathan found that a single hospital service would result in improvements to patients in each, as well as improvements to the local health economy.²⁵⁶

General considerations relating to implementation and merger specificity

- 15.48 In this case, the parties have not claimed that the wide range of potential benefits, and 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. However, we regard the possibility of such potential benefits as important context for our consideration of RCBs.
- 15.49 Before we assess whether each of the 15 proposed RCBs is an RCB within the meaning of section 30 of the Act, we have set out a number of considerations that are relevant to the merger transaction, the proposed RCBs and all of the various potential benefits.
- 15.50 These considerations relate to the risks to the delivery and implementation of benefits, the steps which have been taken to mitigate these risks, and the particular history between the parties in question that affect our assessment of whether the merger (rather than any other form of collaboration between the parties) will ensure effective implementation of the benefits.

Implementation

- 15.51 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.

²⁵⁵ Hearing with Sir Jonathan Michael.

²⁵⁶ Sir Jonathan Michael (2016), *Manchester Single Hospital Service Review: stage one report*. Sir Jonathan found that the improvements covered a broad range of areas comprising the quality of care to patients, patient experience, the trusts' workforce, financial and operational efficiency, research and innovation, and education and training.

They can therefore raise significant delivery and implementation risks to the prompt realisation of benefits.²⁵⁷

- 15.52 There are a number of general considerations concerning the risks to delivery and implementation of the various potential benefits claimed by the parties to arise from the merger, which are particularly relevant for our assessment of whether each of the proposed RCBs is an RCB within the meaning of the Act.
- 15.53 For instance, at the time of submitting its advice on patient benefits to us, NHS Improvement considered that the parties had more work to do to ensure successful implementation of their strategic rationale, such as detailed post-merger integration planning, identification of clinical interdependencies across the hospitals related to any service relocations, and an assessment of the financial impact of the merger.
- 15.54 NHS Improvement also recognised that there were a number of implementation risks given the scale of the transaction, such as the need for the parties to effect significant cultural change among the merged workforce, and the need for significant investment in IT to enable the full realisation of the proposed RCBs.
- 15.55 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 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 of service and of the merger benefits set out in the parties' business and financial case.

²⁵⁷ See NHS Improvement (May 2016), [Literature review: the experiences of healthcare providers in delivering merger objectives](#).

(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.

15.56 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. We further believe that these factors make it more likely that some of the other various potential benefits may 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.

Management and trust capability

15.57 NHS Improvement told us that drawing on the strengths of the existing management teams, the merged trust should have the capability, capacity and experience to deliver the merger successfully.

15.58 The parties told us that they had made a number of key appointments to the interim board of the merged trust and that these positions had been filled by candidates with significant experience of effecting large-scale change within the NHS and within the local health economy.

15.59 NHS Improvement told us that the merged trust would start from a relatively stable financial position, as both trusts had exceeded their control totals for the financial year ended 31 March 2017.

15.60 NHS Improvement also noted that the parties' post-merger integration programme was well resourced, and that both their operational and financial stability and resourcing helped to build confidence in the parties' ability to continue their work plan for successful implementation of the merger.

15.61 The parties told us that:

(a) there was a formal governance structure in place to hold executives of the merged trust to account for delivery of the integration plan; and

(b) a second Deputy Chief Executive had been introduced to the leadership structure for the proposed new trust, who would have dedicated responsibility for integration.

15.62 The parties have experience of successfully implementing significant change projects:

- (a) CMFT's acquisition of community services in 2011: As part of the *Transforming Community Services* programme led by the Department of Health between 2008 and 2012, CMFT became responsible for providing the largest collection of community services in Manchester. The total services transferred by Manchester Community Health to CMFT represented income of approximately £43 million.
- (b) CMFT's acquisition of Trafford Healthcare NHS trust in 2012: Following the acquisition, Trafford General Hospital was established as a division of CMFT, and CMFT engaged in a major programme of service change, which included:
 - (i) the transformation of the A&E department into an Urgent Care Centre;
 - (ii) the transformation of the Intensive Care Unit into a High Dependency Unit;
 - (iii) the transfer of elective orthopaedic activity from Manchester Royal Infirmary to Trafford General, with these services integrated within the Trafford General division; and
 - (iv) the integration and rationalisation of numerous clinical and non-clinical support services (such as pathology, radiology, tissue viability, infection control, translation services, portering, catering and cleaning) and back office functions.
- (c) CMFT's establishment of its hepato-pancreato biliary²⁵⁸ service in 2014: Following a decision by Greater Manchester commissioners, services at Pennine Acute were transferred to Manchester Royal Infirmary. The service represented income of approximately £3.2 million and a capital cost of £0.9 million.

15.63 The parties also have experience of significant service changes that have had a significant impact on the workforces involved. This includes bringing together children's hospital services from Pendlebury and Booth Hall with existing children's services at CMFT's main site in 2009; the acquisition of community services providers by both CMFT and UHSM in 2011; and CMFT's acquisition of Trafford Healthcare NHS trust in 2012.

15.64 The parties told us that the consolidation of children's services at CMFT and CMFT's acquisition of Trafford Healthcare NHS trust demonstrated the

²⁵⁸ Hepato-pancreato biliary services provide care for patients with benign (non-cancerous) and malignant (cancerous) diseases of the liver, biliary system and pancreas.

importance of understanding the appropriate clinical model for different services, having clarity over leadership arrangements; and engaging with consultants, other clinical staff and support staff.

- 15.65 NHS Improvement found that the management teams at both trusts were committed to achieving improvements for patients in Manchester.
- 15.66 Our review of the parties' internal documents demonstrates their commitment to improving health outcomes in Manchester and assuming a central role in the implementation of the wider health transformation of Greater Manchester. For example:
- (a) CMFT's vision is 'to be recognised internationally as leading healthcare; excelling in quality, safety, patient experience, research, innovation and teaching; dedicated to improving health and wellbeing for our diverse population,' and one of its key priorities (in its current operational plan) is to 'play our part in transforming the health and social care system through supporting Greater Manchester devolution, and the delivery of Locality Plans (particularly in Manchester and Trafford)'.²⁵⁹
 - (b) UHSM's strategic goals (in its latest strategic plan) include 'to be the hospital of choice for the residents of South Manchester, Trafford and East Cheshire', and to be at the heart of the regeneration of Manchester.²⁶⁰
 - (c) One of UHSM's strategic objectives (in its latest operational plan) is to 'create a SHS for Manchester and Trafford which provides consistent, high-quality care throughout the City and the Borough'.

Planning work undertaken to date

- 15.67 In setting out the further work required of the parties to support the implementation of their proposals, NHS Improvement acknowledged that the parties had already undertaken substantial planning work.
- 15.68 Following the decision to merge, the parties undertook a strategic review process, which involved extensive engagement with clinicians and key stakeholders and the assessment of a variety of models for the organisation and governance of hospital services.

²⁵⁹ [CMFT forward plan](#).

²⁶⁰ [UHSM 2014 to 2019 five-year strategic plan summary](#).

- 15.69 A Single Hospital Service Programme Management Office has been in place since August 2016 and it has day-to-day responsibility for managing the planned transaction, including liaising with regulatory authorities and managing the inputs of external advisers.²⁶¹
- 15.70 The parties have provided a draft integration plan, which covers the wider merger transaction and includes work streams relating to corporate integration, workforce, and communication and engagement with staff and other stakeholders (eg Health Watch, Manchester's local voluntary and community support organisation, Health and Wellbeing Boards in Manchester and Trafford, the Health Scrutiny Committees at Manchester and Trafford local authorities, and local councillors and MPs). The draft plan indicates that all of the required service changes required to deliver the proposed RCBs will be in place within two years of the merger.
- 15.71 For each of the proposed RCBs outlined in the benefits submission, the parties have also provided us and NHS Improvement with project initiation documents and plans. These documents set out the proposed operational model, integration planning, resource allocation, project milestones and key delivery dates.
- 15.72 The parties told us that the particular service relocations submitted as proposed RCBs had been chosen on the basis that they did not raise major clinical interdependency issues, as each of the services where relocation was planned involved a consolidation on to a site where these services were already delivered. The parties also told us that none of the relocations would result in the withdrawal of services from a site that was critical to the delivery of other clinical services.
- 15.73 We have given due consideration to NHS Improvement's view that interdependency (i) remains a complex issue, and (ii) will require some further detailed consideration by the parties. In this regard, we note that the parties have undertaken initial strategic planning to identify different roles for the main hospital sites from which the merged trust will operate:
- (a) Acute hospitals: Manchester Royal Infirmary and Wythenshawe Hospital.

²⁶¹ The Single Hospital Service Programme Management Office reports through a Programme Board to a Joint Sub-Committee of the three boards at CMFT, UHSM and Pennine Acute. Membership of the Programme Board includes representatives of commissioners (Manchester CCG, Trafford CCG and NHS England) along with the Greater Manchester Health and Social Care Partnership and NHS Improvement.

(b) Community hospitals: Trafford General Hospital, Altrincham Hospital and Withington Community Hospital.

(c) Specialist Hospitals: Royal Manchester Children's Hospital, St Mary's Hospitals (Women's and Children's), University Dental Hospital and Manchester Royal Eye Hospital.

15.74 The parties are developing information management and technology plans to ensure that business processes are enabled immediately following the merger. CMFT has developed a significant technical knowledge base in relation to the migration, integration and development of technical systems following its acquisition of Trafford General Hospital in 2012.

Clinical engagement

15.75 The parties have explained in their benefits submission that the formulation of their benefits case has been underpinned by a strong process of clinical engagement. This includes:

(a) prior to the decision to merge, the establishment of a Clinical Advisory Group²⁶² and Clinical Working Groups to review service delivery models and advise on potential benefits, and discussions between clinicians from across Manchester to determine how patient outcomes could be improved through working collaboratively; and

(b) following the merger decision, groups of clinicians charged with identifying and developing the service delivery models that the merged trust will adopt to improve services for patients.

15.76 We have been struck by the enthusiasm and support for the merger of clinicians from both trusts. Those clinicians who we have met have cited the benefits of the merger to patients as their reason for supporting the merger. NHS Improvement told us that the level of clinical engagement that had taken place to date had been very encouraging.

15.77 The high levels of clinical engagement indicate that the proposed RCBs included in the parties' benefits submission will have sufficient clinical buy-in to support their delivery. This is particularly important given the past difficulties of the parties in working together to improve patient outcomes in Manchester.

²⁶² The Clinical Advisory Group includes senior clinicians from both trusts, including the trusts' Medical Directors and Chief Nurses.

Wide support for merger

- 15.78 In addition to management commitment to deliver improvements for patients and the high level of clinical engagement, the merger is supported by stakeholders across the wider local health economy, including the GMHSCP, CCGs, NHS England and other providers.

GMHSCP and NHS Improvement oversight

- 15.79 There are governance and funding structures in place to hold the parties to account in delivering post-merger improvements to patients.
- 15.80 NHS Improvement is currently undertaking its merger assurance process, and as part of this process, it intends to review the parties' final integration plan²⁶³ and perform a detailed assessment of the financial impact of the merger during July and August 2017.²⁶⁴ NHS Improvement told us that its approval of the transaction would be contingent on the parties demonstrating that they can implement the merger successfully in accordance with NHS Improvement's guidance.
- 15.81 NHS Improvement told us that the local autonomy and responsibility resulting from Greater Manchester devolution meant that local bodies were well placed to oversee the changes taking place and ensure that the merged trust delivered improvements for patients.
- 15.82 NHS Improvement, together with the GMHSCP, plans to hold the parties to account for delivery of the transaction and implementation of changes for patients going forward.
- 15.83 We understand that NHS Improvement and the GMHSCP are working together to develop a model for the regulatory oversight and assurance of the merged trust.
- 15.84 NHS Improvement told us that it envisaged a multi-tiered approach to its relationship with the merged trust, which incorporated involvement with partners across the health system (see paragraph 14.9). NHS Improvement told us that as part of its multi-tiered approach, it planned to monitor the merged trust's progress against the parties' implementation plans and the

²⁶³ NHS Improvement's transaction execution work involves analysing the parties' integration plan, in order to determine whether the parties have considered all risks to the transaction appropriately and have developed a plan to execute the transaction successfully.

²⁶⁴ NHS Improvement's assessment of the financial impact of the merger will involve a due diligence exercise to understand and challenge the assumptions within the merged trust's long-term financial model.

delivery of the benefits set out in the full business case and submission to the CMA.²⁶⁵

Parties' incentives to realise benefits

- 15.85 The GMHSCP told us that the investment agreements for its £43 million transformation funding package for the Manchester Single Hospital Service (see paragraph 4.25) would include a series of deliverables (such as specific milestones, financial savings and performance targets), and that these deliverables would be monitored on a quarterly basis. The GMHSCP told us that if performance, financial or activity targets were missed, a recovery plan would be put in place, and if the merged trust seriously underperformed, the GMHSCP could stop the funding for the merger.²⁶⁶
- 15.86 We also understand that NHS Improvement's STF payment of £30 million per year for the merged trust (see paragraph 4.24) is directly linked to delivery trajectories of financial and performance objectives (specific to each party). We understand that the GMHSCP and NHS Improvement will work together to assure delivery and release of funding.

Merger specificity

- 15.87 There are also a number of general considerations that are particularly relevant for our assessment of merger specificity of the various potential benefits claimed by the parties.
- 15.88 The single hospital service review (SHS review), commissioned by the Manchester Health and Wellbeing Board and led by Sir Jonathan Michael, found that closer collaborative working between the parties (and 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 and the establishment of a single NHS acute trust for Manchester.
- 15.89 The SHS review found that only a merged organisation could deliver the supporting systems and structures (eg accountability for care, clarity of leadership, joint IT systems and common HR processes) necessary to deliver the single service models across multiple service areas, and manage the complex interdependencies between clinical and non-clinical services

²⁶⁵ NHS Improvement would do this through a regular integration agenda item on system oversight meetings, and at quarterly review or monthly progress meetings between the merged trust and NHS Improvement.

²⁶⁶ Joint hearing with the GMHSCP and NHSI.

that would be affected by the pursuit of large scale change across multiple service areas.

- 15.90 NHS Improvement told us that it could be possible for the parties to achieve some of the improvements set out in the benefits submission without a merger, and that other organisations had previously done so through recruitment, shared rotas and other arrangements. However, NHS Improvement found that in this particular case, a merger appeared to be the most effective way to achieve the improvements at scale across Manchester, and that the parties were more likely to work together to ensure delivery of these improvements if the merger took place.
- 15.91 In our assessment of each proposed RCB, we have assessed whether each benefit is unlikely to accrue without the merger (or the creation of a similar lessening of competition).
- 15.92 However, we can also identify several reasons why, in general, the proposed RCBs are more likely to be realised through the merger than by other means, which are set out below.

Scale and complexity of change

- 15.93 The implementation of the proposed RCBs may be prohibitive if the merger did not take place, given the scale of the changes proposed and the complexity of putting in place multiple cooperative agreements or similar arrangements in the absence of the merger.
- 15.94 The proposed RCBs are examples of the wider opportunities created by the proposed merger. We understand that the parties are in the process of developing plans for achieving improvements for patients across 75 distinct clinical services areas, including those proposals included in the benefits submission. Therefore, the scale and complexity of change intended by the merger is likely to be greater than that outlined in the parties' benefits submission.

Misalignment of incentives

- 15.95 In the absence of the merger, the parties, as separate organisations with separate fiduciary duties, governance structures and workforces, will not always have the financial or clinical incentives to commit to the type of changes that the parties have submitted as the proposed RCBs, or indeed the other various potential benefits claimed to arise from the merger.

- 15.96 The parties have previously been reluctant to agree to service changes that would result in the loss of a service and related revenue, which would have an adverse financial impact on either trust. This had particularly been the case at UHSM, which has experienced operational and financial pressures in recent years.
- 15.97 The diffuse distribution of specialised services between acute trusts across Greater Manchester, and the importance of these services to the parties (both in terms of revenue and prestige), has resulted in a reluctance from the parties to agree to service changes that would diminish their importance as a provider of specialised services.
- 15.98 The parties have also been reluctant to concede the loss of services (as part of previous service improvement initiatives) due to the impact this would have had on their ability to recruit high-quality clinical staff interested in and capable of continuing the parties' medical research and teaching efforts, and provide other related specialised services once some services were lost.
- 15.99 The parties believe that the merger will remove these barriers to delivering improvements by establishing a single accountable board which can drive through the necessary changes.

Barriers to working together

- 15.100 The parties have explained to us that one of the key drivers of the merger is to overcome the clinical, cultural and organisational barriers that have led to past failed attempts at working together to effect service changes.
- 15.101 The parties highlighted 13 such initiatives, which had ended in delay, compromise or abandonment:
- (a) Nine initiatives ended without achieving any significant change in service provision.
 - (b) Two initiatives delivered service improvements but with significant delays in implementation.
 - (c) Two delivered new models of service provision, but with significant compromises that resulted in lost opportunities to improve patient outcomes.
- 15.102 Appendix D provides a summary of these initiatives and the reasons why they were delayed, compromised or abandoned.

Assessment of RCBs

15.103 In this section, we outline the proposed RCBs put forward by the parties as arising from the merger, and NHS Improvement's views on those proposed RCBs. We then consider whether the proposed RCBs are RCBs within the meaning of the Act, drawing in particular on the factors noted in paragraphs 15.51 and following, above, concerning the risks of delivery and implementation of benefits and merger specificity.

RCBs proposed by the parties

15.104 The parties identified proposed RCBs in the following clinical services:

- (a) Cardiology (the parties have identified proposed RCBs in acute coronary syndrome, heart rhythm abnormalities and acute aortic surgery).
- (b) Women's health (urgent gynaecological surgery and community midwifery).
- (c) Orthopaedics (elective orthopaedics and fractured neck of femur).
- (d) General surgery.
- (e) Head and neck cancer surgery.
- (f) Vascular surgery.
- (g) Stroke.
- (h) Urology (patient access to core urology services, urology cancer services, kidney stone removal and urology seven-day services).

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

15.106 The parties explained that they identified the proposed RCBs based on the statutory framework and their interpretation of the CMA's policy for considering RCBs, as well as several other criteria, including:

- (a) the overall impact of the proposed RCB (eg on the number of patients and/or the impact on each patient);
- (b) the level of clinician enthusiasm and support for the proposed RCB (given the need for ongoing clinical support in its development);

- (c) the financial requirements for implementation (with particular reference to capital requirements); and
 - (d) the ability to deliver the proposed RCB within a reasonable time frame post-merger.
- 15.107 The parties told us that the selection of the proposed RCBs sought to maximise the total impact of the patient benefit case submitted to the CMA, but that it also had to be developed within the practical constraint of time and resources, which meant that the total number of proposed RCBs that the parties could develop was not unlimited.
- 15.108 The parties have explained that the formulation of their proposed RCBs case has been underpinned by a strong process of clinical engagement, including the establishment of a 'Clinical Advisory Group' and 'Clinical Working Groups' to review service delivery models and advise on potential benefits.
- 15.109 The proposed service changes required to realise the proposed RCBs are driven by a number of clinical developments, including greater clinical specialisation, workforce shortages, developments in medical treatment and a greater understanding of the relationship between patient volumes and outcomes.
- 15.110 The parties claim that the merger is key to realising these proposed RCBs, as neither party can individually deliver the proposed service changes required to realise the proposed RCBs due to the concentration of patient flows and scarce clinical expertise needed to effect such change.
- 15.111 The parties do not believe that any form of collaboration that falls short of a merger will be sufficient to realise the proposed RCBs, as the scale of change necessary to deliver them would have a financial impact and bring risk to clinical service delivery that neither party, as separate, independent entities, would accept. The parties claim that this is evidenced by past failed attempts to work together to achieve service improvements as separate trusts (summarised in Appendix D).
- 15.112 Further, the parties claim that only the merger (and not any other form of partnership) will enable them to make changes across multiple areas simultaneously, and provide a single, unified management structure to make the required changes. Both make it far more likely for the proposed RCBs to be sustained over time.
- 15.113 The parties are confident of implementing the changes required to realise the proposed RCBs due to their past experience of effecting large-scale

service changes involving significant impact on workforces, and their major project delivery experience.

NHS Improvement's view on the proposed RCBs

15.114 NHS Improvement's view was that 11 of the 15 proposed RCBs are likely to represent improvements for patients that are sufficiently far advanced to assess them as RCBs:

- (a) acute aortic surgery;
- (b) acute coronary syndrome;
- (c) elective orthopaedics;
- (d) general surgery;
- (e) head and neck cancer surgery;
- (f) heart rhythm abnormalities;
- (g) kidney stone removal;
- (h) stroke;
- (i) urgent gynaecology surgery;
- (j) urology cancer surgery; and
- (k) vascular surgery.²⁶⁷

15.115 NHS Improvement noted that the number of patients likely to benefit from the proposed service changes was likely to be a subset of the total number of patients expected to receive a particular service.

15.116 NHS Improvement acknowledged that the parties had undertaken planning work already, but considered that the parties had further work to do to demonstrate that certain improvements for patients were likely to be delivered within a reasonable time frame. NHS Improvement intended to

²⁶⁷ NHS Improvement did not consider that the proposed RCBs relating to community midwifery and urology patient access were likely to represent improvements for patients within the framework for assessing RCBs. NHS Improvement did not consider that the proposed RCBs relating to urology seven-day services and fractured neck of femur were sufficiently advanced to assess them under the framework for assessing RCBs.

assess the deliverability of the parties' plans through its merger assurance process.

15.117 NHS Improvement informed us that (for 10 of the 11 proposed RCBs that it considered were likely to represent improvements for patients that are sufficiently far advanced to assess them as RCBs) the merger was the most effective way of enabling the parties to work together to ensure the implementation of the proposed RCBs.²⁶⁸ NHS Improvement accepted that it could be possible to achieve some of the service changes without a merger (eg joint recruitment and shared rotas). However, it thought that a merger was the most effective method of implementing improvements at scale across Manchester.

Assessment of the proposed RCBs

15.118 Our assessment for each of the proposed RCBs has been summarised in Table 7.

²⁶⁸ NHS Improvement considered that the proposed RCBs relating to urology cancer to be driven by commissioners and that the proposed service reconfiguration was likely to take place irrespective of whether the merger proceeded.

Table 7: Summary of assessment of proposed RCBs

<i>Service</i>	<i>Proposed service change</i>	<i>Claimed benefits*</i>	<i>Is the proposed service change likely to improve patient outcomes?</i>	<i>Can the proposed service change be expected to accrue within a reasonable period from the merger?</i>	<i>Is the proposed service change unlikely to accrue without the merger?</i>	<i>Is the proposed RCB an RCB?</i>
Acute aortic surgery	Seven-day rota and centralisation of clinicians and patient flows	<ul style="list-style-type: none"> Improved mortality rates 	Yes	Yes	Yes	Yes
Acute coronary syndrome	Seven-day rota and centralisation of clinicians and patient flows in a dedicated unit	<ul style="list-style-type: none"> Reduced time to treatment Reduced length of stay Improved mortality rates Reduced waiting times for other patients 	Yes	Yes	Yes	Yes
Community midwifery	Improved information sharing and standardisation of training and governance	<ul style="list-style-type: none"> Reduced risk of adverse patient outcomes 	No	N/A†	N/A†	No
Elective orthopaedics	Centralisation of clinicians and patient flows at Trafford General Hospital	<ul style="list-style-type: none"> Reduced cancellations Reduced time to treatment Reduced length of stay 	Yes	Yes	Yes	Yes
Fractured neck of femur	Seven-day rota and centralisation of clinicians and patient flows in a dedicated unit	<ul style="list-style-type: none"> Reduced time to treatment Reduced length of stay Improved mortality rates Reduced risk of complications 	Yes	Yes	Yes	Yes
General surgery	Centralisation of clinicians and patient flows at Manchester Royal Infirmary	<ul style="list-style-type: none"> Reduced time to treatment Reduced length of stay Improved mortality rates Less costly implementation 	Yes	Yes	Yes	Yes
Head and neck cancer surgery	Seven-day rota and centralisation of clinicians and patient flows	<ul style="list-style-type: none"> Reduced length of stay Improved patient experience Improved mortality rates 	Yes	Yes	Yes	Yes
Heart rhythm abnormalities	Seven-day rota and centralisation of clinicians and patient flows	<ul style="list-style-type: none"> Reduced time to treatment Reduced length of stay Reduced risk of complications 	Yes	Yes	Yes	Yes
Kidney stone removal	Centralisation of clinicians and patient flows at Wythenshawe Hospital	<ul style="list-style-type: none"> Reduced time to treatment 	Yes	Yes	Yes	Yes

<i>Service</i>	<i>Proposed service change</i>	<i>Claimed benefits*</i>	<i>Is the proposed service change likely to improve patient outcomes?</i>	<i>Can the proposed service change be expected to accrue within a reasonable period from the merger?</i>	<i>Is the proposed service change unlikely to accrue without the merger?</i>	<i>Is the proposed RCB an RCB?</i>
Stroke	Seven-day rota	<ul style="list-style-type: none"> • Reduced length of larger stroke • Improved morbidity and mortality rates 	Yes	Yes	Yes	Yes
Urgent gynaecology surgery	Increase in dedicated surgery lists	<ul style="list-style-type: none"> • Reduced waiting time for surgery • Reduced length of stay • Reduced risk of escalation to emergency treatment 	Yes	Yes	Yes	Yes
Urology cancer surgery	Centralisation of clinicians and patient flows	<ul style="list-style-type: none"> • Improved health outcomes 	Yes	Yes	No‡	No
Urology patient access	Pooled patient lists	<ul style="list-style-type: none"> • Choice of site for treatment 	No	N/A†	N/A†	No
Urology seven-day services	Seven-day rota	<ul style="list-style-type: none"> • Reduced time to treatment • Reduced length of stay 	No	N/A†	N/A†	No
Vascular surgery	Centralisation of clinicians and patient flows at Manchester Royal Infirmary	<ul style="list-style-type: none"> • Improved morbidity rates 	Yes	Yes	Yes	Yes

Source: CMA analysis, parties' submissions.

* For a more comprehensive and detailed summary of the proposed patient benefits, see the parties' summary of patient benefits on our [case page](#).

† We found that the proposed benefits arising from the proposed service changes in community midwifery, urology patient access and urology seven-day services did not represent RCBs within the meaning of section 30(1)(a) of the Act. As a result, we did not deem it necessary to consider whether they were likely to accrue within a reasonable period from the merger or whether they were unlikely to accrue without the merger.

‡ We found that the proposed benefits arising from the reconfiguration of urology cancer surgery did not represent an RCB within the meaning of section 30(1)(a) of the Act, as the decision on the service reconfiguration had been announced by the GMHSCP prior to the merger taking place.

15.119 The remainder of this section is structured as follows. For each of the proposed RCBs, we first summarise the nature and scale of the service change. We then consider whether the service change is likely to improve outcomes for patients, whether it may be expected to accrue within a reasonable period from the merger and whether it is unlikely to accrue without the merger (or a similar lessening of competition), taking into account the views of NHS Improvement. Finally, we conclude whether each proposed RCB is an RCB within the meaning of section 30 of the Act.

Acute aortic surgery

Proposed service change

- 15.120 There are currently no agreed guidelines for referring patients requiring acute aortic surgery across Greater Manchester to a specialist centre. The process of identifying a cardiac surgical centre able to accept a patient and then transferring the patient to that centre can cause dangerous delays, as the mortality rate for these patients worsens with every hour of delay before definitive treatment. Further, the specialist scanning equipment required to diagnose a Type A aortic dissection²⁶⁹ is not available at all times in all A&E departments in Greater Manchester and, therefore, some patients may not be correctly diagnosed and may not receive the surgery they need.
- 15.121 The merger will enable the parties to centralise services for patients requiring acute aortic surgery and establish a dedicated rota that will provide seven-day services for both elective and emergency services. This will benefit not only patients treated in Greater Manchester, where delays to surgery can impact patient mortality, but also those patients who are currently transferred to other centres for treatment, and those patients who may not be receiving any treatment under current service arrangements.
- 15.122 The number of patients that will benefit from these new arrangements will depend on the extent to which the merged trust can work with other acute trusts in Greater Manchester to improve diagnoses and referral rates for treatment. However, the proposed service reconfiguration is likely to improve mortality rates for 50 to 100 patients each year.

²⁶⁹ A Type A aortic dissection is a tear in the inner lining of the ascending aorta. It is a critical, life-threatening condition, which requires emergency aortic surgery.

Is the proposed service change likely to improve patient outcomes?

15.123 NHS Improvement identified from the parties' benefits submission four main proposed service improvements for patients with Type A aortic dissection:

- (a) improved access to aortic surgeons and cardiac surgeons with an interest in aortic surgery to reduce time to emergency surgery for patients currently transferred to other centres;
- (b) improved access to aortic surgeons and cardiac surgeons with an interest in aortic surgery, thereby avoiding the need for non-specialists to perform the surgery;
- (c) increased patient volumes on a single site; and
- (d) development of pathways and protocols to ensure patients with Type A aortic dissection that present to other local hospitals in Greater Manchester are correctly diagnosed and promptly transferred to the merged trust.

15.124 NHS Improvement found that:

- (a) the reduced time to treatment for patients currently transferred to other centres may contribute to improved outcomes for patients, although factors other than time to surgery were also highly relevant, such as institutional and surgeon volume and surgical techniques;²⁷⁰
- (b) avoiding the use of non-specialist surgeons would contribute to improved patient outcomes;²⁷¹
- (c) the merged trust would perform a higher number of Type A aortic dissections operations than the individual trusts currently perform, which would contribute to improved outcomes for the approximately 27 patients currently treated by the trusts per year;²⁷² and
- (d) the parties' proposals to reduce the number of patients not being correctly diagnosed at other hospitals by developing protocols and a pathway for the management of patients with suspected aortic dissection would likely result in improvements for patients presenting to other

²⁷⁰ The parties did not submit current mortality rates and, therefore, NHS Improvement was unable to assess whether or how much patient mortality might improve as a result of the reduced times to treatment.

²⁷¹ NHS Improvement based its view on the assumption that, as a result of the proposals, patients were operated by a specialist surgeon when, under the current arrangements, they would have been operated on by a non-specialist surgeon.

²⁷² NHS Improvement noted that it was unclear how much of an improvement was likely to result from the higher institutional volumes or how much surgeon volumes might improve under the proposed arrangements.

hospitals in Greater Manchester that are not currently being correctly diagnosed with Type A aortic dissection or not accessing treatment sufficiently quickly. NHS Improvement noted that although it was unclear how many patients would experience this improvement, improved diagnosis had the potential to be lifesaving, as this condition was highly likely to be fatal if left untreated.

15.125 Our view is that the proposed service change would be likely to result in improvements for the approximately 27 patients per year with Type A aortic dissection currently being treated by CMFT or UHSM, and for the 14 patients per year 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.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

15.126 The proposed reconfiguration of acute aortic surgery comprises three main elements:

- (a) creation of a subspecialty rota;
- (b) setting up standardised pathways and protocols for patients referred to the merged trusts from other local hospitals; and
- (c) consolidation of the service onto a single site.

15.127 NHS Improvement found that:

- (a) the parties' proposals to provide greater patient access by implementing sub-specialist rotas and introducing seven-day or out-of-hours working in cardiology appeared to be deliverable in the first year of the merger;
- (b) improving pathways from local hospitals to the merged trust appeared to be achievable within the first year of the merger; and
- (c) the consolidation of acute aortic surgery onto one site appeared to require more work to show that it was likely to be delivered in a reasonable time frame. In particular, NHS Improvement noted that the parties had not yet identified an appropriate site for the service, determined how they would create additional capacity at the site if needed, and identified any clinical interdependencies arising from the reconfiguration of the service.

15.128 In determining whether the centralisation of acute aortic surgery is likely to be implemented within a reasonable period from the merger, we have taken into account the following considerations:

- (a) The parties are currently reviewing the proposed new model and are calculating the impact on theatre scheduling and bed capacity, which will feed into the decision on site selection.
- (b) The parties claim that the additional costs associated with the treatment of patients who are not currently referred to either CMFT or UHSM (due to the lack of standardised pathways and protocols between the trusts and other local hospitals) is likely to be covered by the additional tariff income from treating these patients, and that any additional income may offset other costs that may emerge in the implementation of the proposed service reconfigurations in cardiology, vascular surgery or stroke.²⁷³
- (c) The centralisation of acute aortic surgery may require public consultation. The parties told us that in their integration planning, they had allowed for a period of eight to 12 weeks for public consultation, and that it was for the local Health and Scrutiny Committee to determine whether such consultation was necessary and the nature of that consultation. For example, the consultation could be in the form of a formal consultation process or some form of public engagement process. Further, the parties told us that the CMFT management team had significant experience of achieving service change that required public consultation following its acquisition of Trafford Healthcare NHS Trust.
- (d) The parties have begun the planning work required to establish a rota for acute aortic surgery and have provided us and NHS Improvement with indicative rotas.
- (e) The proposals for acute aortic surgery have been developed by cardiology consultants from CMFT and UHSM and, therefore, there is clinical engagement and support for the proposed service reconfiguration.

15.129 We acknowledge that the parties are yet to undertake important elements of the planning work, in particular the selection of a site and the identification of any clinical interdependencies arising from the reconfiguration of the service.

²⁷³ NHS Improvement is currently undertaking a detailed assessment of the financial impact of the merger.

We consider that this reflects the greater scale and complexity of this element of the proposed service reconfiguration.

15.130 However, we think the parties are well placed and suitably incentivised to undertake the required planning work and implement the necessary changes to centralise the service within a reasonable period following the merger, as there are a number of factors that support the parties' plans for post-merger integration and realisation of benefits. We outline these factors in paragraphs 15.51 to 15.86.

15.131 Our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

15.132 The parties claim that their proposals for acute aortic surgery could not be achieved without the merger, because neither trust would have access to sufficient patient volumes to justify the cost of recruiting the consultants necessary to develop their own seven-day service.

15.133 The parties also argue that any form of collaboration other than a merger, such as a partnership, is unlikely to succeed, given the past difficulties of the trusts to work together. The parties told us that they had twice sought, unsuccessfully, to establish cardiology joint ventures in 2012 and 2013.²⁷⁴

15.134 We do not think that it is likely that either CMFT or UHSM would develop their own seven-day service for acute aortic surgery, and we do not expect that the parties would be able to implement the reconfiguration in any other form of arrangement other than a merger, given their past difficulties to establish such arrangements in cardiology.

15.135 There are also a number of considerations that are relevant to the merger transaction and our assessment of the proposed RCBs, which suggest that, absent the merger, effective implementation of the proposed service changes outlined in the parties' benefit submission is unlikely. We outline these considerations in paragraphs 15.87 to 15.102.

15.136 Our view is that the proposed service change is unlikely to accrue through any form of collaboration between the parties other than the merger.

²⁷⁴ Please refer to Appendix D for a summary of these initiatives and the reasons for their delay, compromise or abandonment.

Is the proposed RCB an RCB?

15.137 Our view is that the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

Acute coronary syndrome

Proposed service change

15.138 Approximately 4,000 lower-risk heart attack patients (ie those experiencing non-ST elevation myocardial infarction (NSTEMI))²⁷⁵ referred to CMFT or UHSM each year experience delays to referral and treatment due to a lack of an available consultant opinion (particularly out of hours and during weekends); a mismatch between demand and capacity; and delays in multi-disciplinary team decision-making for patients where the optimal treatment is not clear. These delays result in significantly higher patient mortality risk, increased length of stay, and resulting delays to the treatment of other patients.

15.139 The parties claim that the merger will enable the parties to implement:

- (a) a seven-day rota for cardiology consultants specialised in treating heart attack patients; and
- (b) a dedicated unit for these patients to reduce the referral time to treatment by concentrating patients and expertise in a single location.

15.140 The parties expect the proposed service reconfiguration to improve patient mortality outcomes (with possibly 50 to 100 fewer deaths each year) and save around 17,000 bed days each year due to reduced length of stay.

Is the proposed service change likely to improve patient outcomes?

15.141 NHS Improvement identified from the parties' benefits submission four main proposed service improvements for patients experiencing NSTEMI:

- (a) Seven-day access to acute coronary syndrome specialist consultants and diagnostics.

²⁷⁵ NSTEMI is commonly known as a heart attack. Heart attacks can be classified by a measurement from an electrocardiogram known as the ST segment. It corresponds to the area of damage inflicted on the heart.

- (b) Improved access to multi-disciplinary team (MDT) decision-making.
- (c) Consolidation of the acute coronary syndrome service onto a single site.
- (d) Establishing standardised pathways and protocols for patients referred to the merged trusts from other local hospitals.

15.142 NHS Improvement found that:

- (a) the increased availability of acute coronary syndrome consultants and diagnostic services would likely result in a reduction in the time that some NSTEMI patients wait for diagnosis and treatment, and a significant proportion of the 4,039 NSTEMI patients treated at CMFT or UHSM would experience these reduced waiting times;²⁷⁶
- (b) the reduction in time to diagnosis would result in more patients receiving treatment in line with national and European guidance (aimed at improving patient outcomes) and reduced anxiety for patients and their families while waiting for diagnosis;
- (c) the parties' proposal to increase the frequency of cardiothoracic MDT meetings from once weekly at each site to daily for the combined acute coronary syndrome service would likely benefit some patients through reducing waiting times for an appropriately convened MDT to make decisions about care;²⁷⁷
- (d) consolidating the acute coronary syndrome service onto a single site would allow the parties to more easily flex their capacity to meet and balance their demand in a way that the parties could not easily manage as separate entities or as a single service run across multiple sites; and
- (e) the standardisation of pathways and protocols across Greater Manchester would likely result in improvements for some patients being transferred to the merged trust from other local hospitals in the form of reduced waiting times from admission at local hospitals to referral to the merged trust.

15.143 Our view is that the proposed service change would likely result in improvements for some NSTEMI patients through reduced time to diagnosis and treatment, resulting in more patients receiving treatment in line with national

²⁷⁶ NHS Improvement expects that the 1,700 patients admitted to the merged trust on a Thursday, Friday or Saturday would experience the greatest improvement.

²⁷⁷ This would affect patients for whom the optimal treatment is unclear and who experience delays under the current arrangements, as they are waiting for the MDT team to convene.

and European guidance, and reduced anxiety for patients and their families while waiting for diagnosis.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

15.144 The proposed reconfiguration of the acute coronary syndrome service comprises three main elements:

- (a) Creation of a sub-specialty rota.
- (b) Setting up standardised pathways and protocols for patients referred to the merged trusts from other local hospitals.
- (c) Consolidation of the service onto a single site.

15.145 NHS Improvement found that:

- (a) the parties' proposals to provide greater patient access by implementing sub-specialist rotas and introducing seven-day or out-of-hours working in cardiology appeared to be deliverable within the first year of the merger;
- (b) improving pathways from local hospitals to the merged trust appeared to be achievable within the first year of the merger; and
- (c) the consolidation of the acute coronary syndrome service onto one site required more work to show that it was likely to be delivered in a reasonable time frame. In particular, NHS Improvement noted that the parties had not yet identified an appropriate site for the service, determined how they would create additional capacity at the site if needed, and identified any clinical interdependencies arising from the reconfiguration of the service.

15.146 In determining whether the consolidation of the acute coronary syndrome service is likely to be implemented within a reasonable period from the merger, we have taken into account the following considerations:

- (a) The new service model will initially involve the redirection of out-of-hours and weekend NSTEMI patients to either Manchester Royal Infirmary or Wythenshawe Hospital (on alternating nights and weekends), as well as the operation of weekend lists for urgent surgery. This would allow seven-day services to be delivered across the two sites in line with the planned care model. The centralisation of services onto a single site will take place in the first or second year following the merger.

- (b) The parties are currently reviewing the proposed new model and are calculating the impact on theatre scheduling and bed capacity, which will feed into the decision on site selection. The parties claim that the reduced length of stay (caused by the proposed changes to the acute coronary syndrome service) will create the bed capacity required to deliver the new model, although the parties acknowledge that the ability of the merged trust to flex capacity in times of higher demand is crucial to the maintenance of an effective emergency service.
- (c) The parties claim that the reduction in length of stay offers the potential to reduce bed capacity across the merged trust's sites,²⁷⁸ and that, in combination with the reduced length of stay expected from the consolidation of cardiac rhythm management services (see paragraphs 15.233 and following), this would give the potential to take a ward out of use. The parties estimate that this might achieve a net saving of approximately £1 million.²⁷⁹ Alternatively, the parties suggest that the additional capacity could be reutilised to provide care for another group of patients (either within cardiac services or in another specialty).
- (d) The centralisation of cardiac services may require public consultation. We discuss the implications of public consultation on the implementation of the parties' proposed service changes in paragraph 15.128(c).
- (e) The parties have begun the planning work required to establish a rota for the acute coronary syndrome service and have provided us and NHS Improvement with indicative rotas.
- (f) The proposals for the acute coronary syndrome service have been developed by cardiology consultants from CMFT and UHSM and, therefore, there is clinical engagement and support for the proposed service reconfiguration.

15.147 We acknowledge that the parties are yet to undertake important elements of the planning work, in particular the selection of a site and the identification of any clinical interdependencies arising from the reconfiguration of the service. We consider that this reflects the greater scale and complexity of this element of the proposed service configuration.

15.148 However, we think the parties are well placed and suitably incentivised to undertake the required planning work and implement the necessary changes to centralise the service within a reasonable period following the merger, as

²⁷⁸ The effect for acute coronary syndrome patients would be equivalent to about 23 beds.

²⁷⁹ NHS Improvement is currently undertaking a detailed assessment of the financial impact of the merger.

there are a number of factors that support the parties' plans for post-merger integration and realisation of benefits. We outline these factors in paragraphs 15.51 to 15.86.

15.149 Our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

15.150 The parties claim that their proposals for NSTEMI patients could not be achieved without the merger, because neither trust would have access to sufficient patient volumes to justify recruitment costs if they were each required to take on the consultants necessary to develop their own seven-day service. Moreover, the parties also suggested that any such recruitment would be hindered by the national shortage of cardiac physiologists.

15.151 The parties also argue that any form of collaboration other than a merger, such as a partnership, is unlikely to succeed, given the past difficulties of the trusts to work together. The parties told us that the establishment of cooperative arrangements for the treatment of STEMI patients in 2006 involved protracted negotiations between CMFT and UHSM before it could be brought to a successful conclusion, and since then they have twice sought, unsuccessfully, to establish cardiology joint ventures in 2012 and 2013.

15.152 We do not think that it is feasible for either CMFT or UHSM to develop their own seven-day acute coronary syndrome service, and we do not expect that the parties would be able to implement the reconfiguration in any other form of arrangement other than a merger, given their past difficulties to establish such arrangements in cardiology.

15.153 There are also a number of considerations that are relevant to the merger transaction and our assessment of the proposed RCBs, which suggest that, absent the merger, effective implementation of the proposed service changes outlined in the parties' benefit submission is unlikely. We outline these considerations in paragraphs 15.87 to 15.102.

15.154 Our view is that the proposed service change is unlikely to accrue through any form of collaboration between the parties absent the merger.

Is the proposed RCB an RCB?

15.155 Our view is that the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients,

may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

Community midwifery

- 15.156 The parties claim that the existence of community midwifery zones²⁸⁰ across Greater Manchester creates organisational barriers and safety issues for those patients who choose to or, as a result of an emergency, are required to give birth outside of their community midwife zone.
- 15.157 Although the parties have in place safe information-sharing arrangements to ensure that important patient information is available for these patients, they argue that the merger will enable the easier and more efficient sharing of information. Further, they claim that the merger will enable the standardisation of maternity governance and training so that midwives can escalate emergencies to common standards across a large part of the Greater Manchester conurbation. This will improve the standard of care for the 1,500 patients each year who give birth outside of their community midwife zone.
- 15.158 NHS Improvement found that the parties' proposals relating to community midwifery did not represent an improvement for patients within the framework for assessing RCBs.
- 15.159 To demonstrate how the proposals represented an improvement for patients, NHS Improvement suggested that the parties could do more to explain how the merger would enable the parties to make measurable improvements in quality, choice or innovation in maternity services.
- 15.160 NHS Improvement considered that:
- (a) NHS trusts were expected to make arrangements to ensure that patients could move between maternity services as smoothly as possible;
 - (b) paper records were maintained so that patients could carry important information with them;
 - (c) some other providers have addressed similar issues by giving their community midwives access to handheld electronic devices that allowed them to record and share information electronically: these electronic records could be used to send information to hospital delivery units; and

²⁸⁰ Antenatal care is provided to pregnant women by different community midwifery services in Greater Manchester according to the geographic zone area (ie the community midwifery zone) in which their GP surgery, or the clinic they first attended in relation to their pregnancy, is located.

- (d) information governance requirements did not prevent sharing information with patients' consent and (where necessary) for a patients' care needs.

15.161 We agree with NHS Improvement's view. Our view is that the benefits arising from the proposal to share information and standardise governance across community midwifery zones in Greater Manchester are not an RCB on the basis that the proposal does not represent a benefit to patients within the meaning of section 30(1)(a) of the Act.

Elective orthopaedics

Proposed service change

15.162 Both trusts currently provide non-complex elective orthopaedic services:

- (a) CMFT primarily delivers its routine non-complex elective orthopaedic services from Trafford Hospital. Complex elective orthopaedic patients, namely those who may need access to other services during their inpatient stay (such as intensive care), are treated at Manchester Royal Infirmary.²⁸¹ The separation of non-elective and elective orthopaedic patients (commonly referred to as ring fencing) means that the trust's ability to provide timely surgery for its elective orthopaedic patients is not impacted by non-elective activity.²⁸²
- (b) UHSM delivers both elective and non-elective orthopaedic services from Wythenshawe Hospital, and the lack of surgical theatre and bed capacity at Wythenshawe Hospital, along with the co-location of elective and non-elective orthopaedics services, results in higher-than-average cancelled operations, failure to rearrange cancelled operations in a timely manner and an overall failure to meet the referral to treatment target for planned surgical procedures.

15.163 The merger will enable the consolidation of elective orthopaedic activity at Trafford General Hospital, including the transfer of approximately 2,500 patients receiving elective surgery at Wythenshawe Hospital.²⁸³ These patients will benefit from reduced cancellations and reduced length of stay and reduced time to treatment. Further, all 5,000 elective orthopaedic patients treated at the merged trust each year will benefit from greater

²⁸¹ Non-elective orthopaedic services are also delivered from Manchester Royal Infirmary.

²⁸² Ring fencing is considered best practice.

²⁸³ Related outpatient, diagnostic and follow-up services for patients currently treated at UHSM will continue to be delivered locally at Wythenshawe Hospital. Patients with more complex care needs will continue to receive surgery at Manchester Royal Infirmary or Wythenshawe Hospital.

workforce resilience brought about from having a larger number of consultants in each sub-specialty treatment area.

Is the proposed service change likely to improve patient outcomes?

15.164 NHS Improvement identified from the parties' benefits submission two main improvements for elective orthopaedic patients:

- (a) Ring fencing elective care services by transferring existing elective orthopaedic surgical activity from UHSM to Trafford General Hospital.
- (b) Improved access to complex procedures and innovative treatments.

15.165 NHS Improvement found that the ring fencing of elective care services at Trafford General Hospital would likely lead to improved patient experience for some patients currently treated at Wythenshawe Hospital in the form of reduced cancellations and reduced time to treatment,²⁸⁴ which are also likely to lead to a reduced period of pain and inactivity and improved health-related quality of life for some patients.²⁸⁵

15.166 NHS Improvement noted that ring fencing would also enable UHSM to end the suboptimal strategies it currently employed to manage its elective capacity (such as placing non-elective patients on elective orthopaedic theatre lists and/or in elective care beds, resulting in cancellations of elective operations), thus reducing length of stay and improving patient experience for some patients.

15.167 NHS Improvement did not accept the parties' proposal that the parties would have an enhanced ability to perform highly complex elective orthopaedic surgery and that this would represent an improvement for patients, on the basis that concentration of complex elective orthopaedic activity onto fewer sites is required to gain 'critical mass' and enhance quality of care. NHS Improvement noted that patients in Manchester were currently able to access complex orthopaedic surgery at Wrightington Hospital,²⁸⁶ and that it

²⁸⁴ Following CMFT's acquisition of Trafford Hospital in 2012 and the subsequent introduction of ring-fenced elective orthopaedic surgery on that site, CMFT has improved its theatre utilisation from 70% in the financial year ended 31 March 2016 to 87% in the financial year ended 31 March 2017, and reduced its orthopaedic surgery cancellation rate from 9.7% to 5.7% during the same period.

²⁸⁵ NHS Improvement noted that it was unclear exactly how many patients would experience reduced time to treatment or the extent to which waiting times might be reduced.

²⁸⁶ Wrightington Hospital is 27 miles from Trafford Hospital and is a Centre of Excellence for orthopaedic surgery. It is part of Wrightington, Wigan and Leigh NHS foundation trust, which is a medium-sized acute trust providing district hospital services for a population of around 320,000 people in and around Wigan and Leigh and specialist orthopaedics services to a wider regional, national and international population.

was not clear that the patient population could sustain two complex surgery centres.

- 15.168 Our view is that the proposed service change would likely deliver improvements for some elective orthopaedic patients in the form of improved patient access, outcomes and experience, and that UHSM patients would experience the greatest improvement. We note that, should proposals relating to complex elective orthopaedic surgery be implemented, the proposal could reduce the quality of service provision for complex patients receiving surgery at Wrightington Hospital.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

- 15.169 NHS Improvement found that the centralisation of elective orthopaedic services required more work to demonstrate that it was likely to be delivered in a reasonable time frame.

- 15.170 In determining whether the consolidation of elective orthopaedic activity at Trafford General Hospital is likely to be implemented within a reasonable period from the merger, we have taken into account the following considerations:

(a) Trafford General Hospital currently has vacant ward accommodation that would be recommissioned to accommodate the elective work transferring from Wythenshawe Hospital.

(b) The parties expect:

- (i) that theatre capacity at Trafford General Hospital would be secured by introducing extended theatre sessions and six-day working and possibly transferring some of the day-case work in other specialties away from the site;
- (ii) that nursing and clinical support resource required to support this work would be delivered by utilising the existing orthopaedic workforce that existed across the two trusts; and
- (iii) to generate additional revenue from improved productivity and reduced length of stay, although there may be some additional costs arising from the extended theatre sessions and six-day working at Trafford General Hospital. We note that NHS Improvement is currently undertaking a detailed assessment of the financial impact of the merger.

(c) The parties do not anticipate that additional workforce will be required to implement the proposal. However, existing staff from the merged trust may be required to work in different ways to support the delivery of elective services at Trafford General Hospital, and this will require a process of staff engagement and some formal HR procedures. The parties expect to maintain existing arrangements for orthopaedic on-call rotas, and medical and anaesthetic out-of-hours provision at Trafford General Hospital are already in place to support the delivery of an elective orthopaedic service.

(d) The proposal has been endorsed by orthopaedic consultants at both CMFT and UHSM and, therefore, there is clinical engagement and support for the proposed service reconfiguration.

15.171 We acknowledge that the parties are yet to undertake important elements of the planning work, in particular, calculating the impact on theatre scheduling and bed capacity at Trafford General Hospital, as well as identifying any clinical interdependencies arising from the reconfiguration of the service. We consider that this reflects the scale and complexity of the proposed service configuration.

15.172 However, we think the parties are well placed and suitably incentivised to undertake the required planning work and implement the necessary changes to centralise the service within a reasonable period following the merger. The parties have undertaken a significant amount of planning work to date in respect of their proposal, including the selection of the site for the service, and the ring fencing of elective orthopaedic activity is in line with best practice.

15.173 Further, there are a number of factors that support the parties' plans for post-merger integration and realisation of benefits. We outline these factors in paragraphs 15.51 to 15.86.

15.174 Our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

15.175 The parties claim that the implementation of the proposal is dependent on the merger, as without the merger, it could not be expected that UHSM would transfer its elective orthopaedic activity to CMFT and lose this income.

15.176 The parties explained that the possibility of a Manchester Elective Orthopaedic Centre was explored in 2010, and although Trafford Healthcare NHS trust, UHSM and CMFT reached agreement on the clinical model, they

could not agree financial and governance arrangements, and UHSM subsequently withdrew from the discussions.

- 15.177 We think that under current arrangements or other forms of collaboration other than a merger, UHSM is not likely to transfer its elective orthopaedic activity (and corresponding income) to CMFT, as demonstrated by the failure to centralise elective orthopaedic activity in 2010.
- 15.178 There are also a number of considerations that are relevant to the merger transaction and our assessment of the proposed RCBs, which suggest that, absent the merger, effective implementation of the proposed service changes outlined in the parties' benefit submission is unlikely. We outline these considerations in paragraphs 15.87 to 15.102.
- 15.179 Our view is that the proposed service change is unlikely to accrue through any form of collaboration between the parties other than the merger.

Is the proposed RCB an RCB?

- 15.180 Our view is that the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

Fractured neck of femur

Proposed service change

- 15.181 Both trusts provide services to patients suffering from fractured neck of femur, commonly known as hip fractures. UHSM is more successful than CMFT in terms of meeting best practice tariff criteria for fractured neck of femur patients, ensuring that surgery takes place within 36 hours, and has a shorter average length of stay for these patients. CMFT, however, has better patient mortality outcomes. Both trusts lack a seven-day orthogeriatric service (orthopaedic care for frail and/or elderly patients) and the level of pre-operative input from orthogeriatricians is variable depending on the time and day of the week.
- 15.182 The parties claim that the merger will enable them to establish a dedicated hip fracture unit at either Manchester Royal Infirmary or Wythenshawe Hospital, offering seven-day services to 550 patients each year. These patients will benefit from reduced time to treatment and reduced length of stay, reduced risk of complications and improved mortality rates.

Is the proposed service change likely to improve patient outcomes?

- 15.183 NHS Improvement found that the parties' proposals relating to fractured neck of femur were insufficiently advanced to assess them under the framework for assessing RCBs.
- 15.184 NHS Improvement's view was that the parties' proposals represented complex service redesign and while the parties had set out their high-level vision for the service, they could do more work to develop each element of the proposal.
- 15.185 NHS Improvement advised that the parties could:
- (a) explain how and why consolidating patients and staff onto a single site would lead to increased access to an orthogeriatrician or facilitate delivery of a seven-day service;
 - (b) demonstrate how orthogeriatric, therapy and trauma coordinator staff would work differently following the merger and why consolidation of the two services enabled this;
 - (c) provide a workforce plan that set out in detail the new model of care and how this would be delivered;
 - (d) when describing proposed outpatient clinics, explain how these arrangements would represent an improvement over existing arrangements at UHSM and what changes CMFT patients may experience following the merger that would require access to outpatient clinics; and
 - (e) explain the barriers that were currently limiting the parties from delivering the proposed daily multidisciplinary ward round and enhanced recovery model of care, and how consolidation onto a single site would remove these barriers.
- 15.186 In response, the parties told us that:
- (a) by concentrating specialist staff and patients in the same place, staff resource could be scheduled to cover a larger number of patients at critical points in their care pathways;
 - (b) through the consolidation of the orthopaedic surgery lists from both trusts and the greater availability of orthogeriatrician support, it would be possible for specialist arthroplasty surgeons (who repair rather than

replace hips) to identify and work on those patients suitable for repair procedures and those requiring replacement;²⁸⁷

- (c) outpatient care was a key component of the rehabilitation package of fractured neck of femur patients and was in line with NHS England and Monitor guidance to encourage and reward expert and timely specialist care in the rehabilitation of patients, as it improved patient care; and
- (d) the merger would enable staff to be better coordinated to expand existing 'virtual fracture clinics',²⁸⁸ which would result in patients only receiving face-to-face appointments with consultants when necessary, thus minimising disruption for the patient.

15.187 The parties also told us that the merged trust would focus on:

- (a) reducing the time from attendance at Emergency Departments to ward admission, which would improve the patient experience;
- (b) establishing a reliable early orthopaedic senior review for all patients;
- (c) reducing the time from admission to theatre;²⁸⁹ and
- (d) timely and early mobilisation and rehabilitation, which would reduce patient mortality (some patients develop hospital-acquired pneumonia) and improve morbidity outcomes (reduced levels of pressure damage, deep vein thrombosis and pulmonary embolism).

15.188 Our view is that the proposed service change would likely result in 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.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

15.189 NHS Improvement found that those proposed service changes which involved the centralisation of services onto a single site required more work to demonstrate that they were likely to be delivered in a reasonable time frame.

²⁸⁷ The parties claim that primary total hip replacement provides a better outcome for mentally competent elderly patients with a displaced femoral neck fracture, as the complication and re-operation rates are significantly lower, and hip function and health related quality of life are found to be at least as good four years after the surgery.

²⁸⁸ A virtual fracture clinic refers to the review of images by a consultant-led multidisciplinary team.

²⁸⁹ The parties aim to provide surgery to those patients fit for surgery within 36 hours of admission.

15.190 In determining whether establishing a dedicated hip fracture unit is likely to be implemented within a reasonable period from the merger, we have taken into account the following considerations:

- (a) The parties claim that the benefits associated with the planned changes to elective orthopaedic services includes a reduction of 2,475 bed days in respect of optimising length of stay for patients with a fractured neck of femur, and that, working across the merged trust, it expected that it would be possible to restructure this capacity to undertake additional elective work. The parties expect that the associated income would cover the additional costs and provide a contribution to overheads.
- (b) The parties told us that the location of the single site would be subject to an options appraisal, and that the service would be located at either Manchester Royal Infirmary or Wythenshawe Hospital, as it required Accident and Emergency and full critical care services on site.
- (c) The parties do not anticipate that additional workforce will be required to implement the proposal. However, existing staff from the merged trust may be required to work in different ways to support the delivery of services, and this will require a process of staff engagement and some formal HR procedures.²⁹⁰
- (d) The proposals for fractured neck of femur services have been endorsed by orthopaedic consultants at both CMFT and UHSM and, therefore, there is clinical engagement and support for the proposed service reconfiguration.

15.191 We acknowledge that the parties are yet to undertake important elements of the planning work, in particular the selection of a site and the identification of any clinical interdependencies arising from the reconfiguration of the service. We consider that this reflects the greater scale and complexity of this element of the proposed service configuration.

15.192 However, we think the parties are well placed and suitably incentivised to undertake the required planning work and implement the necessary changes to centralise the service within a reasonable period following the merger.

15.193 The parties told us that they had identified a number of workforce areas that would be resolved within the first year following the merger (as part of the post integration transaction plan), including:

²⁹⁰ The parties told us that it may be necessary for an existing orthogeriatric vacancy at CMFT to be filled in order to maintain the standard of service over the longer term.

- (a) specialist consultant job planning to optimise efficiencies of staff deployment;
- (b) introduction of specialist consultant 'hot weeks', whereby arthroplasty surgeons would be timetabled to undertake the theatre lists, thus reducing time to surgery and reducing length of stay for fractured neck of femur patients;
- (c) reorganisation of junior and middle grade medics to provide cross-cover support between the orthopaedic speciality and orthogeriatrician sub-speciality;
- (d) increasing the common standards and close working amongst Allied Health Professionals and Advanced Practice Nurses; and
- (e) planning staff resources for a dedicated rehabilitation centre (intended to be based at Trafford General Hospital).

15.194 Further, there are a number of factors that support the parties' plans for post-merger integration and realisation of benefits. We outline these factors in paragraphs 15.51 to 15.86.

15.195 Our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

15.196 The parties claim that the dedicated hip fracture unit is dependent upon the merger to enable sufficient patient volume onto a single site and to combine the medical staff of both CMFT and UHSM, as staff from both trusts are required to support the deliverability of the seven-day service. The parties do not believe it would be feasible to implement joint working arrangements due to the relevant clinical staff being managed under different contractual terms and separate governance structures.

15.197 We think that neither CMFT nor UHSM have sufficient patient numbers to establish separate dedicated hip fracture units, and contractual and governance arrangements constrain the parties from consolidating the service in the absence of the merger.

15.198 There are also a number of considerations that are relevant to the merger transaction and our assessment of the proposed RCBs, which suggest that, absent the merger, effective implementation of the proposed service changes outlined in the parties' benefit submission is unlikely. We outline these considerations in paragraphs 15.87 to 15.102.

15.199 Our view is that the proposed service change is unlikely to accrue through any form of collaboration between the parties other than the merger.

Is the proposed RCB an RCB?

15.200 Our view is that the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

General surgery

Proposed service change

15.201 Both parties currently provide general surgery for patients requiring non-elective surgery who have presented as an emergency.

15.202 Under the commissioner-led *Healthier Together* programme,²⁹¹ which aims to reduce the variation in the quality of care and outcomes for emergency general surgery patients across Greater Manchester, Manchester Royal Infirmary has been designated as one of four hub hospitals to provide emergency general surgery and high-risk general surgery services in four sectors covering General Manchester.²⁹²

15.203 The merger will enable the consolidation of emergency and high-risk general surgery services at Manchester Royal Infirmary to provide seven-day comprehensive sub-specialty consultant cover for approximately 4,700 patients each year. The reforms brought about by the *Healthier Together* programme could save between 151 and 289 lives each year, and the parties account for approximately 25% of general surgery admissions in Greater Manchester.²⁹³ The reconfiguration is expected to be fully implemented by August 2018.

15.204 The merger could also avoid the need for around £10 million of capital investment at Manchester Royal Infirmary to accommodate the additional general surgery activity transferred from UHSM as a result of the

²⁹¹ The *Healthier Together* programme is a wide programme for health and social care reform across Greater Manchester. The *Healthier Together* programme is now part of the wider transformation programme being led by the GMHSCP.

²⁹² UHSM did not receive this designation, as CMFT and UHSM are in the same sector covering Manchester and Trafford.

²⁹³ CMFT and UHSM already have among the lowest mortality rates in Greater Manchester so a pro-rata allocation to the merged trust of the anticipated mortality benefits for the region as a whole may not be accurate.

reconfiguration, as other activity will be transferred to Wythenshawe Hospital.

Is the proposed service change likely to improve patient outcomes?

15.205 The *Healthier Together* programme is expected to improve patient outcomes and improve patient access to sub-specialist care. For example:

- (a) patients with more serious or life-threatening emergency care needs will receive treatment in centres with the right facilities and expertise, in order to maximise chances of survival and a good recovery;
- (b) hospitals and surgeons who undertake a critical mass of specialist emergency surgery cases are able to demonstrate better clinical outcomes; and
- (c) the consolidation of specialist resources will enable the delivery of a seven-day service.

15.206 The parties also claim that the proposed service reconfiguration will also generate financial savings of around £10 million, as the merger means Manchester Royal Infirmary will have existing capacity to accommodate the additional general surgery activity transferred from UHSM (as non-emergency services will be transferred to Wythenshawe Hospital). We note that NHS Improvement is currently undertaking a detailed assessment of the financial impact of the merger.

15.207 Our view is that the proposed service change is likely to improve patient access to sub-specialist care, resulting in improved patient outcomes. The reconfiguration may also generate financial savings.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

15.208 The *Healthier Together* programme is already in the process of being implemented and is expected to be fully implemented by August 2018.

15.209 The parties have established a Healthier Together Operational Board to lead implementation. To date, the parties have agreed clinical models and activity and they have also modelled theatre and bed capacity, as well as considering consultant workforce requirements.

15.210 Given the progress made to date towards implementation, our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

15.211 The parties claim that although the *Healthier Together* programme exists independently of the merger, the delivery of the proposed service reconfiguration is dependent on the merger:

(a) The designation of Manchester Royal Infirmary (and not Wythenshawe Hospital) as one of four hub hospitals to provide emergency general surgery and high-risk general surgery services was subject to a judicial review by clinicians at UHSM.²⁹⁴ However, following the decision to merge, UHSM has actively cooperated with the implementation of the *Healthier Together* programme. The parties argue that the implementation of the *Healthier Together* programme would have been delayed absent the merger.

(b) The merger enables the transfer of some elective surgery (ie activity that is not general surgery) from Manchester Royal Infirmary to Wythenshawe Hospital, providing Manchester Royal Infirmary with the additional capacity to absorb the emergency and high-risk general surgery activity transferring from Wythenshawe Hospital.

15.212 NHS Improvement found that the benefits of the *Healthier Together* programme would be delivered in the absence of the merger, given that commissioners had announced the reconfiguration. However, as regards the parties' claim that better utilisation of the merged trust's estate, NHS Improvement advised that while the parties have further planning to do in order to find the additional capacity required to implement the proposed service change, and the implementation costs are not final, the parties were likely to be able to deliver the improvements more quickly and for less cost due to the opportunities created by the merger.

15.213 We have had particular regard to NHS Improvement's advice, when assessing whether, despite our finding that the general surgery reconfiguration is part of the counterfactual for the merger (see paragraphs 8.36 and onwards), the claimed benefits are also an RCB. We note, in this regard, that a number of the other RCBs we have found involve site consolidations, which we would expect to facilitate an overall better utilisation of the merged party's estate, consistent with the parties' position and NHS Improvement's views regarding the proposed RCB for general surgery.

15.214 We therefore think that the merger facilitates the transfer of emergency and high-risk general surgery activity from Wythenshawe Hospital to Manchester

²⁹⁴ [2016] EWHC 17 (Admin). The judicial review was ultimately unsuccessful.

Royal Infirmary. Consequently, the merger enables the parties to implement the service reconfiguration more quickly and for less cost than any other arrangement, where the parties' competing incentives remain in place.

15.215 Our view is that the merger will enable the proposed service change to be implemented more quickly and at a lower cost than through any form of collaboration between the parties other than the merger.

Is the proposed RCB an RCB?

15.216 Our view is that the more timely and less costly implementation of the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

Head and neck cancer surgery

Proposed service change

15.217 Both CMFT and UHSM currently provide specialist head and neck cancer surgery within Greater Manchester and face a number of challenges:

- (a) Although both trusts meet the NICE guidance on improving outcomes on head and neck cancers, UHSM does not meet the more recently published recommendations in relation to the minimum volume of patients to be treated.
- (b) Specialist head and neck cancer surgeons are not always available out of hours and at weekends to treat emergencies, which means that patients sometimes receive emergency treatment or surgery from a non-specialist surgeon.
- (c) Microvascular surgery out-of-hours and weekend rotas do not meet NICE guidelines.
- (d) Patients do not have access to the full range of specialist treatments available (as some treatments are only provided by one trust) and patients must travel to Liverpool to access an osseo-integration (prosthetics) service.

15.218 The merger will enable the centralisation of head and neck cancer surgery at a single site and the implementation of a seven-day rota. Approximately 400 head and neck cancer surgery patients each year will benefit from improved coordinated patient management, resulting in an improved patient

experience, reduced length of stay and improved health outcomes, including improved mortality rates.

Is the proposed service change likely to improve patient outcomes?

15.219 NHS Improvement identified from the parties' benefits submission four main improvements for head and neck cancer surgery patients:

- (a) Increased patient volumes from consolidating head and neck cancer surgery services onto a single site.
- (b) A more robust microvascular surgery rota.
- (c) Improved access to specialist head and neck cancer surgeons.
- (d) Reduced travel time for patients requiring prosthetics services.

15.220 NHS Improvement found that:

- (a) the increased patient volumes treated at the consolidated single site was likely to improve patient outcomes (in line with evidence supporting the relationship between higher patient volumes and improved outcomes);²⁹⁵
- (b) patients currently treated at UHSM would benefit from improved outcomes, including mortality rates, through being treated in line with recent recommendations regarding minimum volumes for head and neck cancer MDTs;²⁹⁶
- (c) the parties' proposal to combine their microvascular surgeons (and recruit into a vacant post at CMFT) was likely to benefit patients through the introduction of a more formal out-of-hours and weekend consultant rota for microvascular surgeons;²⁹⁷
- (d) increased access to specialist head and neck cancer surgeons would be likely to deliver improvements to some patients in the form of reduced

²⁹⁵ NHS Improvement noted that it expected all patients treated at the merged trust to experience improved outcomes, but that it was unclear how much outcomes would improve as a result of the merger.

²⁹⁶ NHS Improvement noted that although both trusts met the minimum volumes set out in current NICE guidance on improving outcomes in head and neck cancers, only CMFT currently adhered to a more recently published guideline.

²⁹⁷ NHS Improvement noted that it was unclear how many patients would benefit from this improvement or the impact it would have on those affected.

risk of being operated on by a surgeon working outside of their expertise out of hours or at the weekends;²⁹⁸

- (e) increased access to specialist head and neck cancer surgeons would also enable the merged trust to provide twice daily consultant ward rounds and weekday cover between 8am and 8pm, which would lead to more timely decisions and treatments; and
- (f) the development of a new prosthetics service in Manchester would reduce travel time for those patients who currently travel out of the area to access this service.²⁹⁹

15.221 Our view is that the proposed service change would be likely to benefit patients in the form of improved patient outcomes, access and experience.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

15.222 NHS Improvement found that the parties' proposals to provide greater patient access by implementing seven-day working appeared to be deliverable in the first year of the merger, but that the centralisation of services required more work to demonstrate that it was likely to be delivered in a reasonable time frame.

15.223 In determining whether the consolidation of head and neck cancer surgery on to a single site is likely to be implemented within a reasonable period from the merger, we have taken into account the following considerations:

- (a) The parties do not expect the proposal to impact upon the number of patients treated and therefore there will be no material change in income for the parties.
- (b) The parties expect the cost of restructuring the service to be broadly neutral, as additional costs in some areas will be covered by savings elsewhere. We note that NHS Improvement is currently undertaking a detailed assessment of the financial impact of the merger.

²⁹⁸ NHS Improvement noted that this was likely to affect a subset of the approximately 12 patients per year currently operated on out of hours by a non-specialist surgeon, as under the proposed arrangements, it was not certain that a specialist surgeon would always be available on-call, as the 12 specialist surgeons would be part of the general ENT and oral Maxillo-Facial out-of-hours on-call rota.

²⁹⁹ NHS Improvement noted that it would expect this to impact the approximately ten patients per year in the Greater Manchester area who currently travel to Liverpool to access this service, although some patients might continue to choose to access this service at Liverpool after the Manchester service is developed.

- (c) The selection of the location of the single site will be decided on by the merged trust as part of its wider implementation work.
- (d) Commissioners have indicated to the parties that, given the relatively small patient population, they do not expect the proposal to require public consultation.
- (e) The parties are in the process of comparing existing clinical rotas and coordinating staff to support the rota for the consolidated service.³⁰⁰
- (f) The proposal has been endorsed by head and neck consultants at both CMFT and UHSM and, therefore, there has been clinical engagement and support for the proposed service reconfiguration.

15.224 We acknowledge that the parties are yet to undertake important elements of the planning work, in particular the selection of a site and the identification of any clinical interdependencies arising from the reconfiguration of the service. We consider that this reflects the greater scale and complexity of this element of the proposed service configuration.

15.225 However, we think the parties are well placed and suitably incentivised to undertake the required planning work and implement the necessary changes to centralise the service within a reasonable period following the merger, as there are a number of factors that support the parties' plans for post-merger integration and realisation of benefits. We outline these factors in paragraphs 15.51 to 15.86.

15.226 Our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

15.227 The parties claim that the proposal could not be implemented in the absence of the merger, given the past difficulties of the trusts to work together to improve outcomes for patients and the lack of a process in Greater Manchester to push for the consolidation of head and neck cancer surgery.

15.228 The parties also argue that it would not be possible for either CMFT or UHSM to develop their own individual prosthetics service, as neither trust had sufficient patient volumes to deem the service financially viable. The parties claim that Oasis Cancer Trust has agreed to fund the purchase of the

³⁰⁰ The existing joint oral maxillo-facial rota will remain unchanged, but a new ENT rota to cover the sites at CMFT, UHSM, Tameside and Glossop Integrated Care NHS foundation trust and Stockport NHS foundation trust.

equipment required for the service if CMFT can assure it of the ongoing viability of the service. However, CMFT cannot provide this assurance under the current service reconfiguration due to lack of patient numbers.

15.229 We think that the consolidation of head and neck cancer surgery onto a single site is unlikely to take place in the absence of the merger, given the past difficulties that the parties have experienced in working together to improve outcomes for patients. Further, we accept that it is not viable for either CMFT to UHSM to develop their own prosthetics service.

15.230 There are also a number of considerations that are relevant to the merger transaction and our assessment of the proposed RCBs, which suggest that, absent the merger, effective implementation of the proposed service changes outlined in the parties' benefit submission is unlikely. We outline these considerations in paragraphs 15.87 to 15.102.

15.231 Our view is that the proposed service change is unlikely to accrue through any form of collaboration between the parties other than the merger.

Is the proposed RCB an RCB?

15.232 Our view is that the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

Heart rhythm abnormalities

Proposed service change

15.233 Both CMFT and UHSM provide specialist services in the implantation and maintenance of cardiac pacemakers for patients with heart arrhythmias³⁰¹ across Greater Manchester. Patients experience delays in treatment due to insufficient clinical expertise meaning neither CMFT nor UHSM can offer a seven-day cardiac rhythm management (CRM) service. This includes patients admitted to other hospitals in Greater Manchester where local clinicians have been unable to immediately access expert opinion from a relevant specialist at CMFT or UHSM.

15.234 The merger will enable the parties to implement a seven-day service on a single site, resulting in approximately 430 patients each year experiencing reduced time to treatment, reduced length of stay, reduced risks arising from

³⁰¹ An arrhythmia is a problem with the rate or rhythm of the heart.

stabilisation measures that may be used in local hospitals prior to treatment and reduced risk of complications.

Is the proposed service change likely to improve patient outcomes?

15.235 NHS Improvement identified from the parties' benefits submission three main proposed service improvements for CRM patients:

- (a) Improved access to specialist cardiology CRM consultants for non-elective pacemaker implantation.
- (b) Improved access to specialist cardiology CRM consultants and cardiac physiologists for non-elective implantable cardioverter defibrillator (ICD)³⁰² analysis.
- (c) Standardised pathways and protocols in conjunction with other local hospitals and local ambulance services.

15.236 NHS Improvement found that:

- (a) the increased availability of CRM specialist consultants would likely reduce the time that some patients would wait for non-elective implantation of a pacemaker, particularly patients presenting out of hours or at weekends,³⁰³ resulting in reduced patient anxiety experienced while awaiting the procedure and reduced risk of complications due to prolonged immobilisation;³⁰⁴
- (b) the increased availability of CRM specialists (consultants and cardiac physiologists) would likely reduce the time that some patients presenting out of hours or at weekends would wait for urgent or emergency analysis of their existing ICD device; and
- (c) the standardisation of pathways and protocols would reduce the time to transfer or treatment, likely resulting in:
 - (i) reduced patient anxiety experienced while awaiting the procedure;
 - (ii) reduced risk of complications due to prolonged immobilisation;

³⁰² An ICD is a device similar to a pacemaker that monitors a person's heart rhythm and shocks their heart back into a normal rhythm whenever this is needed.

³⁰³ NHS Improvement expects that this would benefit a significant proportion of the approximately 133 patients requiring non-elective pacemaker implantation out of hours or at the weekend.

³⁰⁴ NHS Improvement found that for those patients who require implantation of a pacemaker within 24 hours, the likely reduced time to treatment may lead to additional clinical improvements associated with receiving care delivered in line with best practice guidance published by the British Heart Rhythm Society.

- (iii) reduced risks of patients deteriorating while they await transfer and treatment; and
- (iv) the use of temporary pacing wires being avoided or, for those patients who continue to require a temporary wire, an increase in the likelihood of the wire being inserted at the merged trust and therefore a reduced risk of the wire being inserted by someone other than a cardiology consultant.

15.237 Our view is that the proposed service change is likely to result in improvements for patients requiring non-elective implantation of pacemakers or non-elective ICD analysis in the form of reduced time to treatment or reduced time to ICD analysis, which will likely lead to reduced anxiety and reduced risk of complications due to prolonged immobilisation.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

15.238 The proposed reconfiguration of the CRM service comprises three main elements:

- (a) Creation of a subspecialty rota.
- (b) Setting up standardised pathways and protocols for patients referred to the merged trusts from other local hospitals.
- (c) Consolidation of the service onto a single site.

15.239 NHS Improvement found that:

- (a) the parties' proposals to provide greater patient access by implementing sub-specialist rotas and introducing seven-day or out-of-hours working in cardiology appeared to be deliverable in the first year of the merger;
- (b) improving pathways from local hospitals to the merged trust appeared to be achievable within the first year of the merger; and
- (c) the consolidation of the CRM service onto one site appeared to require more work to show that it was likely to be delivered in a reasonable time frame. In particular, NHS Improvement noted that the parties had not yet identified an appropriate site for the service, determined how they would create additional capacity at the site if needed, and identified any clinical interdependencies arising from the reconfiguration of the service.

15.240 In determining whether the consolidation of the CRM service is likely to be implemented within a reasonable period from the merger, we have taken into account the following considerations:

- (a) The parties are currently reviewing the proposed new model and are calculating the impact on theatre scheduling and bed capacity, which will feed into the decision on site selection. The parties claim that the reduced length of stay (caused by the proposed changes to the CRM service) is not sufficient to facilitate a material reduction in bed capacity, but that it would contribute to the potential closure of a cardiology ward in conjunction with the reduced length of stay caused by the proposed changes to the acute coronary syndrome services (see paragraph 15.138).
- (b) The centralisation of cardiac services may require public consultation. We discuss the implications of public consultation on the implementation of the parties' proposed service changes in paragraph 15.128(c).
- (c) The parties have begun the planning work required to establish a rota for the CRM service and have provided us and NHS Improvement with indicative rotas.
- (d) The proposals for the CRM service have been developed by cardiology consultants from CMFT and UHSM and, therefore, there is clinical engagement and support for the proposed service reconfiguration.

15.241 We acknowledge that the parties are yet to undertake important elements of the planning work, in particular the selection of a site and the identification of any clinical interdependencies arising from the reconfiguration of the service. We consider that this reflects the greater scale and complexity of this element of the proposed service configuration.

15.242 However, we think the parties are well placed and suitably incentivised to undertake the required planning work and implement the necessary changes to centralise the service within a reasonable period following the merger, as there are a number of factors that support the parties' plans for post-merger integration and realisation of benefits. We outline these factors in paragraphs 15.51 to 15.86.

15.243 Our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

- 15.244 The parties claim that their proposals for CRM patients could not be achieved without the merger, because neither trust would have access to sufficient patient volumes to justify the cost of recruiting the consultants necessary to develop their own seven-day service.
- 15.245 The parties also argue that any form of collaboration other than a merger, such as a partnership, is unlikely to succeed, given the past difficulties of the trusts to work together. The parties told us that they had twice sought, unsuccessfully, to establish cardiology joint ventures in 2012 and 2013.³⁰⁵
- 15.246 We do not think that it is likely that either CMFT or UHSM would develop their own seven-day service CRM service, and we do not expect that the parties would be able to implement the reconfiguration in any other form of arrangement other than a merger, given their past difficulties to establish such arrangements in cardiology.
- 15.247 There are also a number of considerations that are relevant to the merger transaction and our assessment of the proposed RCBs, which suggest that, absent the merger, effective implementation of the proposed service changes outlined in the parties' benefit submission is unlikely. We outline these considerations in paragraphs 15.87 to 15.102.
- 15.248 Our view is that the proposed service change is unlikely to accrue through any form of collaboration between the parties other than the merger.

Is the proposed RCB an RCB?

- 15.249 Our view is that the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

³⁰⁵ Please refer to Appendix D for a summary of these initiatives and the reasons for their delay, compromise or abandonment.

Kidney stone removal

Proposed service change

15.250 Both trusts currently provide lithotripsy services.³⁰⁶ UHSM provides lithotripsy services 3.5 days a week at its dedicated lithotripsy unit at Wythenshawe Hospital. CMFT provides lithotripsy services fortnightly at a mobile unit located at Manchester Royal Infirmary.

15.251 The merger will enable the consolidation of lithotripsy services at Wythenshawe Hospital, where a permanent lithotripsy facility is located. This will significantly reduce waiting times for the approximately 60 patients each year who are treated at a mobile facility at Manchester Royal Infirmary.

Is the proposed service change likely to improve patient outcomes?

15.252 NHS Improvement identified from the parties' benefits submission three main improvements for kidney stone patients:

- (a) Improved access to lithotripsy services (which would be centralised at Wythenshawe Hospital).
- (b) Increased choice of day and time of treatment.
- (c) Increased choice of treatment.

15.253 NHS Improvement found that:

- (a) centralised lithotripsy services would likely result in reduced time to treatment for a subset of CMFT patients, and although the reduction would be modest, it would result in reduced pain, which could have otherwise resulted in absence from work and difficulties in carrying out everyday tasks;³⁰⁷
- (b) centralised lithotripsy services would also mean that the unit may not have to close when staff took leave, representing an improvement for those UHSM patients who would have had to wait for the unit to reopen to receive their treatment under the current arrangements;

³⁰⁶ Lithotripsy (or extracorporeal shock wave lithotripsy) involves locating the kidney stone using x-ray imaging or ultrasound scanning and then sending targeted shock waves to the kidney stone to break it up into small pieces, allowing the kidney stone to pass naturally from the body. Lithotripsy is usually performed by a technician or other individual with specialised training and is usually a day-case procedure, without the need for general anaesthetic.

³⁰⁷ NHS Improvement noted that although it was unclear as to how many patients would benefit or the extent to which wait times would improve, it would be unlikely that waiting times for these CMFT patients would improve beyond the three- to four-week waiting time that UHSM patients currently experienced.

- (c) the proposed operating hours of the lithotripsy unit (ie five days a week from 8am to 5pm) would represent an increase in the day and time of treatment offered for both CMFT and UHSM patients, although the improvement was likely to be most significant for CMFT patients; and
- (d) under the proposed arrangements, CMFT patients who require urgent treatment, and would otherwise have had to have alternative treatments due to lack of timely access to lithotripsy services, would now have the option of lithotripsy services if that was deemed the most clinically appropriate option.³⁰⁸

15.254 Our view is that that the proposed service change would be likely to lead to 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.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

15.255 NHS Improvement found that the parties' proposal to share capacity and resources to increase access to lithotripsy services for kidney stones patients appeared to be deliverable in the first year of the merger.

15.256 The parties submit that the consolidation of lithotripsy services at Wythenshawe Hospital will require the coordination of specialist kidney stone nurses at UHSM and CMFT (through an expanded rota), in order to manage the lithotripsy machine. The parties intend to (as part of their implementation planning) assess patient requirements, in order to determine the optimum operating hours of the service, and this will include consideration of seven-day working.

15.257 Our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

15.258 We do not think that, in the absence of the merger, CMFT is incentivised to transfer its lithotripsy patients (and the associated income) to UHSM.

³⁰⁸ NHS Improvement noted that it was unclear as to how many of the approximately 140 kidney stone patients treated at CMFT per year received alternative treatments when lithotripsy services would have been preferable, and how much of an impact this would have on patients, as there were positive and negative factors associated with the different treatments for kidney stones.

15.259 There are also a number of considerations that are relevant to the merger transaction and our assessment of the proposed RCBs, which suggest that, absent the merger, effective implementation of the proposed service changes outlined in the parties' benefit submission is unlikely. We outline these considerations in paragraphs 15.87 to 15.102.

15.260 Our view is that the proposed service change is unlikely to accrue through any form of collaboration between the parties other than the merger.

Is the proposed RCB an RCB?

15.261 Our view is that the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

Stroke

Proposed service change

15.262 Neither CMFT nor UHSM currently offers seven-day stroke services in line with new guidelines on services for patients suspected of having had a transient ischaemic attack (ie a mini-stroke)³⁰⁹ due to a lack of sufficient consultants.

15.263 The merger will enable the parties to combine resources, as well as recruiting a small number of additional consultants, to offer seven-day services and meet the new guidelines. Approximately 900 patients each year, who currently wait longer than 24 hours for an assessment, will benefit from a reduction in the morbidity and mortality risks associated with subsequent larger strokes.

Is the proposed service change likely to improve patient outcomes?

15.264 NHS Improvement found that combining the parties' services would result in the ability to develop new work plans for existing staff that would likely result in additional capacity to assess transient ischaemic attack (TIA) patients, particularly at the weekend. NHS Improvement found that this would be likely to reduce the time that patients waited to be assessed. In terms of the significance of the improvements for those patients affected, NHS

³⁰⁹ The Royal College of Physicians' guidelines require that all patients suspected of having had a mini-stroke should be assessed urgently within 24 hours by a specialist physician in a neurovascular clinic or acute stroke unit.

Improvement acknowledged that the Royal College of Physicians' guidance in relation to TIA patients was aimed at reducing the risk of subsequent larger stroke and associated reduced mortality and improved morbidity outcomes.

15.265 NHS Improvement found that it was unclear exactly how many TIA patients would benefit from reduced waiting times or the extent to which their waiting times would reduce, but it expected that patients admitted late on a Friday or over the weekend could experience the greatest improvement, and that the reductions in waiting times would likely result in more TIA patients being treated within 24 hours.

15.266 Our view is that the proposed service change would likely lead to a reduction in time that some TIA patients waited for assessment and that the reduced time to assessment would likely result in reduced risk of a subsequent larger stroke.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

15.267 NHS Improvement found that the proposal to introduce seven-day working for the stroke service appeared to be deliverable in the first year of the merger.

15.268 In determining whether the proposal is likely to be implemented within a reasonable period from the merger, we have taken into account the following considerations:

(a) The parties expect the cost of restructuring the service to be broadly neutral, as additional costs in some areas will be covered by savings elsewhere. We note that NHS Improvement is currently undertaking a detailed assessment of the financial impact of the merger.

(b) The proposed change will not require commissioner approval.

(c) The parties expect to have to recruit additional physicians to ensure a sustainable rota for weekend clinics, and although both CMFT and UHSM have previously encountered recruitment challenges, the parties claim that the merged trust will be a significantly more attractive proposition, which is consistent with the experience of other merged trusts in recent years.

(d) The proposal for the stroke service has been endorsed by stroke physicians at both CMFT and UHSM and therefore there is clinical engagement and support for the proposed change.

- (e) Clinicians and other members of the workforce appear to be committed to the merger and the proposed service change.
- (f) The merger is supported by key stakeholders across Manchester, including the commissioners responsible for the services subject to the change.

15.269 Our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

15.270 The parties claim that their proposals for TIA patients could not be achieved without the merger, because neither trust would be able to recruit sufficient stroke physicians to operate a seven-day service, and, even if this was possible, the cost of recruitment would prove prohibitive.

15.271 The parties also argue that, in the absence of the merger, the introduction of a weekend clinic for TIA patients through, for example, the creation of shared rotas would require shared IT systems (to enable consultants across both trusts to review patient notes), and patients' follow-up appointments would be fixed to one site (rather than across multiple sites in the merged trust).

15.272 We do not think that it is likely that either CMFT or UHSM would develop their own seven-day stroke service.

15.273 There are also a number of considerations that are relevant to the merger transaction and our assessment of the proposed RCBs, which suggest that, absent the merger, effective implementation of the proposed service changes outlined in the parties' benefit submission is unlikely. We outline these considerations in paragraphs 15.87 to 15.102.

15.274 Our view is that the proposed service change is unlikely to accrue through any form of collaboration between the parties other than the merger.

Is the proposed RCB an RCB?

15.275 Our view is that the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

Urgent gynaecological surgery

Proposed service change

15.276 CMFT currently operates two surgical lists for patients requiring urgent gynaecological surgery. UHSM does not have any dedicated lists for these patients and instead adds these patients to existing elective and emergency surgery lists. The current arrangements at both trusts result in delays and cancellations for patients who may be in significant pain and emotional distress. It can also result in the escalation of a patient's condition such that emergency treatment becomes necessary.

15.277 The parties intend to improve access for approximately 400 patients each year requiring urgent gynaecology surgery by creating an additional dedicated urgent gynaecology surgery list and pooling their patient lists so that patients can access three scheduled lists each week, allowing for timely treatment and reducing the risk of urgent cases requiring emergency treatment.

Is the proposed service change likely to improve patient outcomes?

15.278 NHS Improvement identified from the parties' benefits submission three groups of urgent gynaecology patients that could potentially experience reduced time to surgery through the proposals:

- (a) Patients requiring urgent surgical management of miscarriage;
- (b) Patients requiring urgent marsupialisation of Bartholin's abscess;³¹⁰ and
- (c) Patients requiring urgent laparoscopic salpingectomy surgery.³¹¹

15.279 NHS Improvement found that the increased access to planned urgent gynaecology surgery theatre time would be likely to lead to:

- (a) modest reductions in the time that some patients waited for urgent surgical management of miscarriage, although any reduction in waiting

³¹⁰ Marsupialisation is a surgical procedure used to drain the abscess to relieve symptoms.

³¹¹ Laparoscopic salpingectomy surgery, for women diagnosed with an ectopic pregnancy, is keyhole surgery during which the entire fallopian tube containing the pregnancy is removed.

time for urgent surgery would be likely to lead to a reduction in psychological distress;³¹²

- (b) modest reductions in the time that some patients waited for urgent marsupialisation of Bartholin's abscess, although any reduction in waiting time for urgent surgery would be likely to lead to clinical and patient experience benefits, including reduced physical pain, reduced distress and reduced risk of recurrence;³¹³ and
- (c) reductions in the time that some patients waited for urgent laparoscopic salpingectomy surgery, resulting in a reduced risk of their condition deteriorating prior to their surgery, reduced psychological distress associated with waiting for treatment and increased certainty of when their surgery would take place.³¹⁴

15.280 Our view is that the proposed service change would be likely to lead to modest reductions in the time that some patients waited for urgent gynaecological surgery and that the reduced waiting time for urgent surgery would likely lead to reduced psychological distress, pain, risk of recurrence and risk of a patient's condition deteriorating to an emergency status.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

15.281 NHS Improvement found that the parties' proposal to share capacity and resources to create dedicated surgery lists for urgent gynaecology patients appeared to be deliverable in the first year of the merger.

15.282 In determining whether the proposal is likely to be implemented within a reasonable period from the merger, we have taken into account the following considerations:

- (a) The parties expect the cost of restructuring the service to be broadly neutral, as additional costs in some areas will be covered by savings

³¹² Based on the information provided by the parties, NHS Improvement estimated that as many as half of CMFT patients and most UHSM patients could experience this reduced time to surgery, although it was unclear by how much waiting times were likely to reduce.

³¹³ Based on the information provided by the parties, NHS Improvement estimated that as many as one-third of CMFT patients and most UHSM patients could experience this reduced time to surgery, although it was unclear by how much waiting times were likely to reduce.

³¹⁴ Based on the information provided by the parties, NHS Improvement noted that it was unclear how many of the approximately 30 women receiving laparoscopic salpingectomy per year at the trusts may experience this improvement, although NHS Improvement noted that both CMFT and UHSM currently aimed to perform this surgery within 24 hours and that both estimated that half of patients did not currently receive surgery within this time frame.

elsewhere. We note that NHS Improvement is currently undertaking a detailed assessment of the financial impact of the merger.

- (b) The proposal will not require commissioner approval.
- (c) The parties do not expect a significant impact on the staff that are already treating these patients, and the impact of creating the additional urgent theatre session is dependent upon whether there is an opportunity to create the session from existing staff or whether additional recruitment will be necessary.³¹⁵
- (d) The proposal has been developed by women's health consultants from both CMFT and UHSM and, therefore, there has been clinical engagement and support for the proposed service reconfiguration.

15.283 Our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

15.284 The parties claim that CMFT has tried on several occasions to create exclusive theatre time each day to treat urgent gynaecology patients, but these attempts have failed due to insufficient patient volumes. The parties argue that UHSM would face similar issues, as it has fewer patients than CMFT requiring urgent gynaecology surgery. The parties claim that the combined patient volumes of the merged trusts would enable clinicians to make a stronger case for an additional theatre list.

15.285 The parties do not believe that the proposal could be delivered in an organisational form other than a merger due to governance and indemnity arrangements, as the transfer of patients between the trusts would result in clinicians at one trust treating a patient based on the decisions made by clinicians at the other trust, and both trusts are likely to have different policies and procedures.

15.286 We think that neither CMFT nor UHSM have sufficient patient numbers to create dedicated surgery lists for urgent gynaecology patients. Further, a merger is necessary to overcome the governance and indemnity issues attached to any other form of collaboration.

15.287 There are also a number of considerations that are relevant to the merger transaction and our assessment of the proposed RCBs, which suggest that,

³¹⁵ The considerations determining the creation of an additional urgent theatre session are included in the business case for the merger submitted to NHS Improvement as part of its merger assurance process.

absent the merger, effective implementation of the proposed service changes outlined in the parties' benefit submission is unlikely. We outline these considerations in paragraphs 15.87 to 15.102.

15.288 Our view is that the proposed service change is unlikely to accrue through any form of collaboration between the parties other than the merger.

Is the proposed RCB an RCB?

15.289 Our view is that the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

Urology cancer surgery

15.290 Manchester Royal Infirmary and Wythenshawe Hospital are two of four specialist urology cancer surgery centres serving the population of Greater Manchester, Cheshire and High Peak.³¹⁶

15.291 The parties claim that the merger will enable the consolidation of urology cancer surgery services at either Manchester Royal Infirmary or Wythenshawe Hospital. This can be expected to lead to significant improvements in patient outcomes for 400 to 500 patients each year (in line with the evidence supporting the relationship between increased patient volumes and improved patient outcomes).

15.292 The proposed service change is part of a wider commissioner-led service reconfiguration of urology cancer surgery services across Greater Manchester, which will consolidate specialised urology cancer surgery services at two high volume specialised urology cancer surgical centres in Greater Manchester (one centre will provide kidney and bladder resection surgery and the other centre will provide prostate robotic surgery).

15.293 Commissioners commenced the reconfiguration process in 2016 and expect the planned reconfiguration to result in lower mortality rates, reduced post-operative complications, reduced length of stay and improved long term patient outcomes.

15.294 NHS Improvement found that as commissioners' procurement exercise was already underway prior to the merger, the redesign of the services would

³¹⁶ The other trusts designated as specialist cancer centres for urology cancer services are Salford Royal NHS foundation trust and Stockport NHS foundation trust.

likely be implemented and deliver the expected improvements to patients even in the absence of a merger.

15.295 The GMHSCP subsequently told us that that it had designated UHSM (kidney and bladder resection surgery) and The Christie (prostate robotic surgery) as the two high-volume specialised urology cancer surgical centres in Greater Manchester.

15.296 Our view is that the benefits arising from the reconfiguration of urology cancer services are not an RCB on the basis that the service reconfiguration will take place absent the merger.

Urology patient access

15.297 Both CMFT and UHSM provide day-case urology services. Patients referred to either CMFT or UHSM for their first outpatient appointment will generally continue with any subsequent treatment at that trust. This may include travelling to a different site for treatment if the provision of first outpatient appointment and subsequent treatment occurs at different locations.

15.298 The parties claim that the merger will enable the pooling of patient lists across the merged trust, thus allowing approximately 6,000 patients each year requiring day-case urology services to choose the hospital site that is most convenient for them.

15.299 NHS Improvement found that the parties' proposals relating to urology patient access did not represent an improvement for patients within the framework for assessing RCBs. NHS Improvement noted that patients were already able to access urology day-case surgery at Wythenshawe Hospital and Withington Hospital (if they chose UHSM as their provider) or Trafford Hospital (if they chose CMFT as their provider).

15.300 To demonstrate how the proposals represented an improvement for patients, NHS Improvement suggested that the parties could talk to patients to understand their reasons for choosing a provider and whether travel time was an important factor in determining their choice.

15.301 NHS Improvement acknowledged that, for some patients, proximity of site and corresponding travelling time may be an important factor in determining their choice of provider. However, NHS Improvement considered that patients (together with their GP) may also choose their provider by taking into account a number of other considerations, such as hospital quality, reputation or waiting times, and some patients may be willing to travel further for outpatient appointments or day-case surgery for these reasons.

- 15.302 In response, the parties told us that by pooling patient lists, patients would be able to choose the location of both their first outpatient appointment and their subsequent day-case surgery (irrespective of whether they chose CMFT or UHSM for their first outpatient appointment), and that it seemed reasonable to expect that patients would value the ability to choose the location of their day-case surgery independently of their choice of location for their first outpatient appointment.
- 15.303 Patients requiring urology day-case surgery services can already choose their provider and the corresponding site for their first outpatient appointment. Further, site location and corresponding travel time represents one of a number of factors that patients (and their GPs) are likely to consider when choosing their provider.
- 15.304 While we acknowledge that this proposed benefit might be a minor convenience to patients, we consider its potential magnitude to be very small. As our assessment of whether the benefits outweighed the SLC did not turn on an RCB of this size, we did not find it necessary to conclude whether it represented a benefit to patients within the meaning of section 30(1)(a) of the Act.

Urology seven-day services

- 15.305 Neither CMFT nor UHSM currently comply with urology seven-day service standards.³¹⁷ The parties claim that the merger will enable the implementation of a combined seven-day urology rota in line with these standards.
- 15.306 NHS Improvement found that the parties' proposals relating to urology seven-day services were insufficiently advanced to assess them under the framework for assessing RCBs.
- 15.307 NHS Improvement advised that the parties could provide information on:
- (a) why neither CMFT nor UHSM were currently able to make the necessary changes to enable the delivery of a second ward round at weekends (or why for UHSM this would require an additional ten Programmed Activities);

³¹⁷ The seven-day service standards require that every patient admitted to hospital must be seen by a senior decision-making doctor of consultant level skill and experience within 14 hours of admission and until they are no longer acutely unwell.

- (b) whether the lack of a second ward round was the only way in which the services currently fell short of seven-day service standards (and how many urology patients were likely to be affected);
- (c) how and to what extent their ability to comply with the standards was compromised by their consultants' elective duties; and
- (d) the changes they intended to implement following the merger (eg establishing new rotas).

15.308 Our view is that the claimed benefits arising from the implementation of a combined seven-day urology rota are not an RCB on the basis that the proposal does not represent a benefit to patients within the meaning of section 30(1)(a) of the Act.

Vascular surgery

Proposed service change

15.309 Both trusts currently provide vascular services. Manchester Royal Infirmary provides elective and non-elective arterial surgery and complex interventional procedures to patients referred from Trafford Hospital, Salford Royal and Bolton NHS Foundation Trust. Wythenshawe Hospital provides the same services to patients referred from Tameside and Glossop Integrated Care NHS foundation trust, Stockport NHS foundation trust, Macclesfield District General Hospital and The Christie.

15.310 The merger will enable the centralisation of arterial surgical services at Manchester Royal Infirmary, which will provide arterial surgery and complex interventional procedures for patients across Greater Manchester. This is in line with commissioners' intention to consolidate vascular services in Greater Manchester onto a single hub with all other spoke hospitals networked to the single hub. Wythenshawe Hospital will continue to provide non-arterial day-case surgery and day-case vascular interventional radiology.

15.311 The increase in patient volumes at the single site can be expected to improve outcomes for more than 3,300 patients who are admitted for treatment each year at CMFT and UHSM. These patients will benefit from improved morbidity rates, reduced length of stay, reduced complication rates, and reduced tissue loss and amputation (for patients with diabetic foot complications).

Is the proposed service change likely to improve patient outcomes?

- 15.312 NHS Improvement found that the increased number of patients served at Manchester Royal Infirmary would likely result in reduced mortality rates, as there was good evidence to support the link between higher volumes of vascular surgery and improved patient outcomes.³¹⁸
- 15.313 NHS Improvement did not accept that the proposed service reconfiguration would result in a reduced length of stay and reduced complication rates for vascular surgery patients and reduced tissue loss and amputation for patients with diabetic foot complications. This was because NHS Improvement considered that the evidence to support these improvements was undeveloped and because, while acknowledging that frequency of senior medical review can influence length of stay or complication rates, NHS Improvement concluded that it was not clear how the parties' proposal increased the frequency of senior medical review.
- 15.314 Our view is that the proposed service change would likely result in reduced mortality because of the increased patient volumes treated at the centralised vascular hub at Manchester Royal Infirmary, but that the proposals would not result in a reduced length of stay and reduced complication rates for vascular surgery patients and reduced tissue loss and amputation for patients with diabetic foot complications.

Can the proposed service change be expected to accrue within a reasonable period from the merger?

- 15.315 NHS Improvement told us that the centralisation of vascular surgery services required more work to demonstrate that it was likely to be delivered in a reasonable time frame.
- 15.316 In determining whether the centralisation of vascular surgery at Manchester Royal Infirmary is likely to be implemented within a reasonable period from the merger, we have taken into account the following considerations:
- (a) Prior to the centralisation of services at Manchester Royal Infirmary, in the short term, the parties intend for all non-elective work to be performed at Manchester Royal Infirmary and for all elective work to remain at Wythenshawe Hospital, and elective arterial surgery will only transfer to Manchester Royal Infirmary when sufficient angiography suite, theatre and bed capacity is available. The parties claim that the

³¹⁸ NHS Improvement noted that data submitted by the parties demonstrated that they already achieved low mortality rates relative to other surgical centres.

merged trust will have sufficient flexibility to allocate services to sites in a way that will allow all vascular surgery to be accommodated at Manchester Royal Infirmary.

- (b) The parties expect the cost of restructuring the service to be broadly neutral, as additional costs in some areas will be covered by savings elsewhere. We note that NHS Improvement is currently undertaking a detailed assessment of the financial impact of the merger.
- (c) The establishment of a single arterial surgical site for vascular services at Manchester Royal Infirmary is consistent with commissioning plans for Greater Manchester.³¹⁹
- (d) The proposals for vascular surgery have been endorsed by the vascular surgeons at both CMFT and UHSM and, therefore, there is clinical engagement and support for the proposed service reconfiguration.

15.317 We think that the centralisation of vascular services at Manchester Royal Infirmary is a complex process. We acknowledge that the parties are yet to undertake important elements of the planning work, in particular calculating the impact on theatre scheduling and bed capacity at Manchester Royal Infirmary, as well as identifying any clinical interdependencies arising from the reconfiguration of the service. We consider that this reflects the scale and complexity of the proposed service configuration.

15.318 However, we think the parties are well placed and suitably incentivised to undertake the required planning work and implement the necessary changes to centralise the service within a reasonable period following the merger.

15.319 The parties have undertaken a significant amount of planning work to date in respect of their proposal, including the selection of the site for the service and the formulation of a project initiation document. The centralisation of vascular services at Manchester Royal Infirmary is in anticipation of a wider, commissioner-led service reconfiguration of vascular services across Greater Manchester.

15.320 Further, there are a number of factors that support the parties' plans for post-merger integration and realisation of benefits. We outline these factors in paragraphs 15.51 to 15.86.

³¹⁹ NHS Improvement told us that, although commissioners' plans to reconfigure the service appear to be at an early stage, they have confirmed that they will build on existing arrangements, in particular sub-specialised services that are provided only at Manchester Royal Infirmary, and that the proposed single hospital for Manchester should permit the unification of the vascular surgical workforce of CMFT and UHSM in the future.

15.321 Our view is that the proposed service change may be expected to accrue within a reasonable period from the merger.

Is the proposed service change unlikely to accrue without the merger?

15.322 The parties claim that the dependence of this service reconfiguration on the merger is demonstrated by the previous difficulties to consolidate vascular services across CMFT and UHSM (and Pennine Acute).³²⁰

15.323 We note that a proposed reconfiguration of vascular surgery services is planned (which we consider insufficiently certain to be taken into account as part of the counterfactual for the merger). Nonetheless, we think that the past difficulties to consolidate vascular services across CMFT and UHSM demonstrates the difficulties in effecting large-scale change in the absence of the merger, and consider that these difficulties may not be overcome by the parties absent the merger, despite the planned reconfiguration.

15.324 There are also a number of considerations that are relevant to the merger transaction and our assessment of the proposed RCBs, which suggest that, absent the merger, effective implementation of the proposed service changes outlined in the parties' benefit submission is unlikely. We outline these considerations in paragraphs 15.87 to 15.102.

15.325 Our view is that the proposed service change is unlikely to accrue through any form of collaboration between the parties other than the merger.

Is the proposed RCB an RCB?

15.326 Our view is that the claimed benefits arising from the proposed service change are an RCB, as they are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the merger and are unlikely to accrue without the merger.

Conclusion on RCBs

15.327 Our view is that the merger will give rise to RCBs in the following services:

- (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

³²⁰ Please refer to Appendix D for a summary of this initiative.

would likely lead to improved clinical outcomes, including reduced mortality.

- (b) Acute coronary syndrome: improvements for some NSTEMI 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 ICD analysis in the form of reduced time to treatment or reduced time to ICD 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 TIA 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.

Proportionality of prohibition

- 15.328 In this section, we assess the magnitude of the 11 RCBs that we have found according to the type of patient benefit, and balance them against the nature of the SLC and the magnitude of its adverse effects (see Section 14), which prohibition would remedy.
- 15.329 In assessing the magnitude of the RCBs, we have had regard to the nature of the evidence base that informed our assessment of the magnitude of the adverse effects of the SLC we have found, which were a number of qualitative factors from which we found that the overall adverse effect resulting from such SLC is likely to be significantly constrained (see paragraphs 14.4 to 14.20).
- 15.330 Our assessment of the magnitude of the RCBs has been predominantly qualitative, although in some areas (discussed in paragraphs 15.332 and following below), the parties have been able to submit to us some quantitative indicators of the magnitude of individual RCBs. On the basis of those qualitative and quantitative indicators, we have been able to conclude that, in the particular circumstances of this case, the adverse effect likely to result from the SLC that we have found is substantially lower than the beneficial impact of the RCBs that would be lost as a result of a prohibition remedy.
- 15.331 We have been mindful of the broad time frame within which each of the patient benefits comprising the RCBs can be expected to be implemented (within a reasonable time frame of the merger), noting that some benefits are likely to be implemented more quickly than others (for example, in general, we would expect patient benefits involving site consolidation to be slower to implement than patient benefits involving consultant rota reconfigurations).³²¹

³²¹ CMA29, footnote 94.

Magnitude of the RCBs

Reduced patient mortality

- 15.332 We believe that it is likely that there will be a decrease in patient mortality across some clinical areas as a result of various changes that the parties will be able to make as a direct result of the merger. One of these changes, applicable to many of the RCBs, involves treating some patients faster, and it is this improvement in time to treatment that is the difference between surviving or not for a subset of those patients. The relevant clinical areas in which we expect to see this improvement realised are acute aortic surgery (paragraph 15.125), acute coronary syndrome (paragraph 15.143) and stroke (paragraph 15.266).
- 15.333 Closely related to this is that after the merger the parties will be able to treat some patients at times of the week which they are currently unable to do. This is another form of improvement in time to treatment and some of these patients are more likely to survive their treatment as a result. Relevant clinical areas in this regard are acute aortic surgery (paragraph 15.125), acute coronary syndrome (paragraph 15.143), fractured neck of femur (paragraph 15.188), general surgery (paragraph 15.205), head and neck cancer surgery (paragraph 15.221), heart rhythm abnormalities (paragraph 15.237).
- 15.334 Finally, the merger will help the parties deliver better patient care whilst the patients are in hospital. Of particular relevance here are reductions in the average length of stay by patients, which, by reducing infection rates and falls, will help improve patient mortality rates.
- 15.335 The parties were unable to identify precisely the number of patients likely to experience improvements in mortality, and the extent to which mortality would be improved (for example, they did not estimate how many lives would be saved by the introduction of weekend stroke services). However, aggregating those estimates which they did provide amounts to an estimate of between around 150 to around 200 lives saved per year.³²²
- 15.336 NHS Improvement was not able to quantify the extent of all of these improvements, but for some aspects of the RCBs which reduce mortality, NHS Improvement was able to indicate how many patients would be affected. For example, for acute coronary syndrome, NHS Improvement said that a significant proportion of the 4,039 NSTEMI patients treated by the

³²² Parties' summary of patient benefits.

parties could experience reduced waiting times, in line with national and European guidance designed to improve clinical outcomes, and that the 1,700 patients admitted on Thursdays, Fridays and Saturdays would experience the greatest improvement.

15.337 We have placed significant weight on NHS Improvement's view that many of the RCBs would reduce mortality, and consider that RCBs of this nature, which could save a significant number of lives per year, constitute an extremely significant benefit.

Reduced complications and morbidity

15.338 We believe that it is likely that there will be a decrease in the number of complications and the rate of morbidity as a direct result of the merger. Reducing the time to treatment in stroke (paragraph 15.266), kidney stone removal (paragraph 15.254) and general surgery (paragraph 15.207) will reduce the incidence of clinical complications for some patients in these specialties. Likewise, allowing for seven-day rotas providing increased access to specialists and increasing treatment volumes in general surgery (paragraph 15.207), fractured neck of femur (paragraph 15.188), and head and neck cancer surgery (paragraph 15.221) will contribute to reducing complications for some patients receiving treatments in these specialties faster than they would absent the merger. Moreover, improving treatment pathways for patients with heart rhythm abnormalities (paragraph 15.237) is likely to reduce complications. The reduction in infection rates and falls, from reducing lengths of stay of patients, is also relevant here.

15.339 The parties did not provide quantitative estimates for every RCB of the number of complications which would be avoided, and the extent to which morbidity would be reduced. However, as a broad indication, the parties estimated that approximately 430 patients would benefit from improved heart rhythm abnormality pathways, as they would not need temporary pacing wires (or they would receive clinically appropriate pacing wires which would otherwise be unavailable), which they submitted have complication rates as high as 25%. The parties also estimated that weekend vascular services patients would have a 50% reduction in complication rates, leading to around 60 patients per year avoiding complications. The parties estimated that, as a result of faster treatment of weekend TIA patients, 40 to 60 patients would avoid a full stroke per year. Finally, the parties estimated that the dedicated fractured neck of femur unit would (by improving patients' rehabilitation) allow 50 to 60 patients per year to avoid being discharged to a nursing home, and that it would ensure that around 80 fewer patients would experience infections.

- 15.340 NHS Improvement said that many of the RCBs would improve outcomes for patients, but was not able to quantify the extent of all of these improvements. NHS Improvement said it would expect the increased availability of specialists treating heart rhythm abnormalities to benefit a significant proportion of the approximately 133 patients requiring non-elective implantation of a pacemaker at the parties each year, particularly patients presenting out of hours or at weekends.³²³
- 15.341 We have placed significant weight on NHS Improvement's view that many of the RCBs would improve clinical outcomes for patients, including by reducing complications and morbidity, and consider that RCBs of this nature, which could reduce complications and morbidity for a significant number of patients, also constitute extremely significant benefits.

Improved patient experience

- 15.342 We believe that it is likely that there will be an improved patient experience as a direct result of the merger, in addition to saving patients' lives and reducing complications and morbidity, by treating patients more effectively and thereby providing a higher-quality service.
- 15.343 The merger will allow the parties to improve patients' experiences by reducing pain for kidney stone removal patients (paragraph 15.254), and reducing anxiety for patients in acute coronary syndrome (paragraph 15.143), heart rhythm abnormalities (paragraph 15.237), elective orthopaedics (paragraph 15.168) and fractured neck of femur (paragraph 15.188), through faster treatment. A shortened length of stay for patients receiving treatment in acute coronary surgery, heart rhythm abnormalities, elective orthopaedics, fractured neck of femur and head and neck cancer (paragraph 15.221) will also improve the patient experience. We have found that improved use of available capacity will also improve the patient experience, especially in elective orthopaedics and head and neck cancer surgery, for example by reducing the frequency with which patients are moved between wards. Introducing greater certainty as to when a surgical procedure will take place and thereby reducing cancellations for patients receiving treatments in elective orthopaedics and fractured neck of femur will also improve patients' experience.
- 15.344 The parties submitted that the RCBs would reduce the average length of stay from 4.9 days to 2 days for the approximately 4,000 acute coronary syndrome patients treated at UHSM and CMFT each year (in addition to

³²³ [Appendix to NHS Improvement's advice to the CMA.](#)

reducing the period between admission to referral from local hospitals from 2.5 days to one day for approximately 3,300 patients per year). The parties submitted that there would be a modest reduction in length of stay for 430 heart rhythm abnormality patients. The parties submitted that the RCBs would reduce the length of stay for approximately 2,500 elective orthopaedics patients per year by an average of two bed days. The parties submitted that the average length of stay for CMFT's 208 fractured neck of femur patients would be reduced by 12 days. The parties submitted that the average length of stay for UHSM's 150 head and neck cancer patients would be reduced by 3.3 days.

15.345 NHS Improvement said that length of stay could be reduced in elective orthopaedics, and that treatment could be more timely in acute coronary syndrome and head and neck cancer surgery, but NHS Improvement did not think it likely that the parties' proposed reconfiguration of vascular surgery would reduce patients' average length of stay.³²⁴

15.346 Patients may experience anxiety and pain while waiting for treatment, and hospital stays prevent patients from going about their everyday lives. This is in addition to the considerable clinical problems caused by extended hospital delays (primarily from infections and falls), which we have taken into account in our assessment of the RCBs' effects on mortality, complications and morbidity. What is already a frightening experience for many patients can be aggravated by poor coordination and the unexpected cancellation of treatment. We consider that the merger is likely to have a beneficial impact on a significant number of patients' hospital experiences and, therefore, that RCBs of this nature constitute significant benefits.

Improved patient access

15.347 We believe that the RCBs will improve patient access in certain specialties by giving patients greater choice of which day they will access lithotripsy services (paragraph 15.254), and by allowing a new local prosthetics service to be introduced for head and neck patients (paragraph 15.219).

15.348 The parties submitted that their 200 lithotripsy patients would have greater choice of which day to access lithotripsy services. The parties also estimated that 10 to 15 head and neck patients per year would benefit from the introduction of a local prosthetics service, which would allow patients to

³²⁴ [Appendix to NHS Improvement's advice to the CMA.](#)

attend maintenance and development sessions in Manchester (rather than the nearest alternative, Liverpool).

15.349 NHS Improvement agreed that the greater availability of lithotripsy services would benefit the patients of both parties, but that it would be of more significance to CMFT's patients (of which there were 61 in 2015/16) than UHSM's (of which there were 145 in 2015/16).³²⁵ NHS Improvement also agreed that approximately ten patients per year would benefit from the option of a Manchester prosthetics service, although it noted that some might choose to continue to travel to Liverpool.³²⁶

15.350 Patients will benefit from greater choice of treatment time for lithotripsy services, and from the availability of a local prosthetics service. Given the existing options for these services, and the number of patients benefiting from greater access, we found that this benefit was genuine but limited.

Conclusion on balancing RCBs and adverse effects

15.351 We have found that the merger may be expected to result in an SLC in NHS elective and maternity services and NHS specialised services. This finding was based on the merger's effects on competition between the parties in 18 NHS elective and maternity services and five NHS specialised services.³²⁷ Our consideration of the magnitude of the adverse effects which are likely to arise from our SLC finding is discussed in paragraphs 14.4 to 14.20.

15.352 As described in Section 14, we believe that, whilst the merger may be expected to give rise to an SLC in NHS elective and maternity services and NHS specialised services, any adverse effect resulting from such SLC is likely to be significantly constrained.

15.353 We have found substantial beneficial effects on clinical outcomes and patient care from the RCBs associated with the merger. In particular, we have given material weight to the reduction in mortality, and complications and morbidity for a significant number of patients which are likely to result from the merger, which we consider to be extremely significant benefits, in addition to the merger's likely beneficial impact on patient access and on the hospital experiences for a significant number of patients. These, in our view, are likely collectively to amount to a substantial improvement in patient care in Manchester.

³²⁵ [Appendix to NHS Improvement's advice to the CMA.](#)

³²⁶ [Appendix to NHS Improvement's advice to the CMA.](#)

³²⁷ See Table 6 and paragraph 14.2.

15.354 Taking all of these factors in the round, we consider that the adverse effect likely to result from the SLC that we have found in NHS elective and maternity services and NHS specialised services is substantially lower than the beneficial impact of the RCBs that would be lost as a result of a prohibition remedy. In our judgement this is not a finely balanced conclusion.

15.355 Accordingly, we have decided that it would be disproportionate to prohibit the merger. Therefore, we are clearing the merger.