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

## Appendices and glossary

# Appendix A: Terms of reference and conduct of the inquiry

## Terms of reference

1. On 27 February 2017, the CMA referred the anticipated merger between Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust for an in-depth phase 2 investigation:

    1. In exercise of its duty under section 33(1) of the Enterprise Act 2002 (the Act) the Competition and Markets Authority (CMA) believes that it is or may be the case that:

        *(a)* arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation, in that:

            (i) enterprises carried on by Central Manchester University Hospitals NHS Foundation Trust will cease to be distinct from enterprises carried on by University Hospital of South Manchester NHS Foundation Trust; and

            (ii) the condition specified in section 23(1)(b) of the Act is satisfied; and

        *(b)* the creation of that situation may be expected to result in a substantial lessening of competition within a market or markets in the United Kingdom for goods or services, including the supply of several acute elective specialties and maternity services.

    2. Therefore, in exercise of its duty under section 33(1) of the Act, the CMA hereby makes a reference to its chair for the constitution of a group under Schedule 4 to the Enterprise and Regulatory Reform Act 2013 in order that the group may investigate and report, within a period ending on 13 August 2017, on the following questions in accordance with section 36(1) of the Act:

        *(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.

**Sheldon Mills**
**Senior Director, Mergers**
**Competition and Markets Authority**
**27 February 2017**

## Conduct of the inquiry

2. We published biographies on the members of the inquiry group conducting the inquiry on 27 February 2017 and the administrative timetable for the inquiry was published on our webpages on 2 March 2017.

3. We invited a wide range of interested third parties to comment on the merger. We sent detailed questionnaires to a number of NHS acute hospitals, NHS community hospitals, private hospitals, NHS commissioners, NHS England and NHS Improvement and we gathered oral evidence through six hearings with selected third parties. Evidence was also obtained through further written requests. We also used evidence from the CMA's phase 1 inquiry into the merger.

4. We received written evidence from the Parties and a non-confidential version of their main submission is on the case page. We also held hearings with the parties on 10 May 2017 and on 4 July 2017.

5. On 9 March 2017, we published an issues statement on our webpages, setting out the areas of concern on which the inquiry would focus.

6. On 21 March 2017, members of the inquiry group, accompanied by staff, visited the premises of CMFT and UHSM.

7. In the course of our inquiry, we sent to the Parties and other parties some working papers and extracts from those papers for comment.

8. In the course of our inquiry, we held a number of hearings with third parties. Summaries of those hearings have been published on the case page.

9. On 15 June 2017, we announced our provisional findings. Copies of our provisional findings, notice of our provisional findings and notice of possible remedies have been published on the case page.

10. A non-confidential version of the final report will be available on the case page.

11. We would like to thank those who assisted us in our inquiry.

# Appendix B: Industry background and regulation in the NHS

## Introduction

1. This appendix provides an overview of the provision of NHS services in England and the regulatory framework under which those services are provided. It also provides an overview of the provision of NHS services in Greater Manchester, in order to present information relevant to the proposed merger of CMFT and UHSM.

2. The appendix covers the following:

   *(a)* Structure of the NHS.

   *(b)* Description of the healthcare services provided by the NHS and those NHS services provided in hospitals.

   *(c)* Commissioning of NHS services.

   *(d)* Pricing of acute healthcare services.

   *(e)* Funding of NHS services.

   *(f)* Regulation of the NHS.

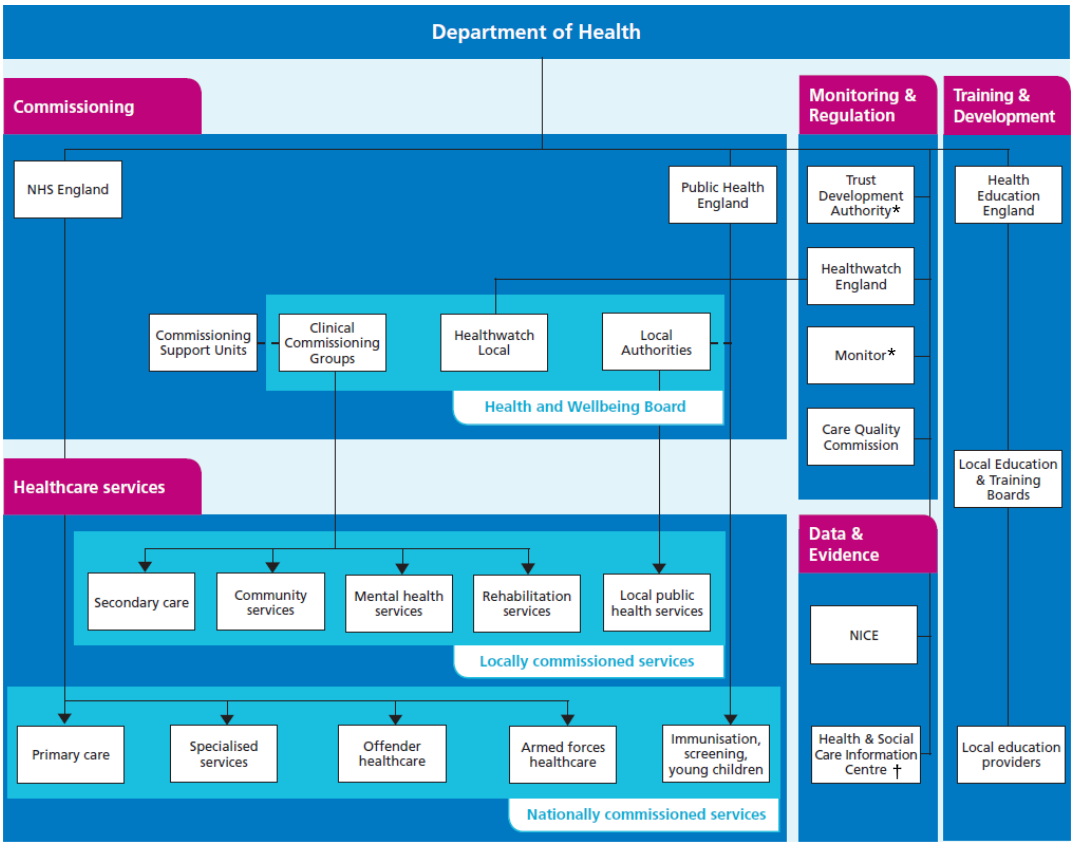
   *(g)* Health policy developments and the role of competition and patient choice in the NHS.

   *(h)* Recent developments in the NHS.

## Structure of the NHS

3. Figure 1 below summarises the current structure of the NHS in England.

**Figure 1: Structure of the NHS following the Health and Social Care Act 2012**




Source: Understanding the new NHS (2014).
* The Trust Development Authority and Monitor now operate under NHS Improvement, which carries out the statutory functions of both organisations. Created on 1 April 2016, NHS Improvement is an umbrella organisation that, as well as Monitor and the NHS Trust Development Authority includes Patient Safety, the National Reporting and Learning System, the Advancing Change Team, and the Intensive Support Teams. NHS Improvement oversees NHS foundation trusts, NHS trusts and independent providers of NHS-funded care.
† The Health and Social Care Information Centre has operated under the name NHS Digital since 2016. The Health and Social Care Information Centre remains its statutory title.

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. Its responsibilities include:

*(a)* providing leadership, including health promotion, health protection against infectious diseases, the safety of medicines and ethical issues;

*(b)* developing policy and legislation;

*(c)* supporting the delivery of improvement in the health and social care system via, for example, performance monitoring and evaluation;

*(d)* leading the integration of health and wellbeing into wider government policy;

*(e)* allocating the funding received from HM Treasury;

*(f)* setting healthcare standards, targets and outcome measures, and agreeing an annual mandate with NHS England based on these outcome frameworks. The government's mandate to NHS England for the financial year ending 31 March 2017 was published in January 2016; and

*(g)* ensuring that the NHS works within its allocated resources and achieves the required efficiency savings.

5. The Department of Health is also responsible for the NHS Constitution, which sets out the principles and values of the NHS in England.

6. Prior to the enactment of the HSCA 2012, the Department of Health was responsible for the planning and delivery of NHS services. This role is now performed by NHS England, although the Secretary of State for Health is ultimately responsible to Parliament for the provision of the health service in England.

7. NHS England (formally the NHS Commissioning Board) is an independent body at arm's length to the government and is responsible for setting the priorities and direction of the NHS and improving health and care outcomes for people in England. NHS England has a statutory duty to exercise its functions with a view to securing continuous improvement in the quality of services.[1] This statutory duty is required to be exercised in conjunction with statutory duties to promote autonomy, choice, reduction of inequality, effectiveness, efficiency, and various other duties.

8. NHS England is also the commissioner of primary care services and specialised healthcare services.

9. Clinical Commissioning Groups (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.[2] CCGs commission most secondary care services.

10. Both NHS England and CCGs have a duty to involve patients, carers and the public in decisions about the services that they commission.

[1] Continuous improvement in quality refers to either the prevention, diagnosis or treatment of illness or the protection or improvement of public health.
[2] As at March 2017.

## NHS services

11. The healthcare services provided by the NHS can broadly be divided into the following categories, although these services are not legally defined nor mutually exclusive:

*(a)* Primary care refers to medical services provided by GPs, dentists, community pharmacies and high street optometrists.[3]

*(b)* Secondary care is clinical care provided by specialists (eg consultants) in a particular field of medicine, whether in a hospital or community setting. Patients are referred to these specialists by a GP or an allied health care professional.

*(c)* Tertiary (specialised) care refers to services provided in more specialised medical centres in respect of rare, costly or complex conditions, as specified in NHS England's Manual of Prescribed Specialised Services. Examples include specialist centres in neurosurgery, paediatric cardiac surgery and cancer care. Patients may be referred to tertiary care by their GP or by a secondary care consultant. Tertiary services may require significant investment due to the need for specialised medical equipment and clinical staff to provide these services.

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 the context of this merger, 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.

Highly specialised services are provided to a smaller number of patients compared to specialised services, usually no more than 500 patients per year. These services are typically delivered nationally through a very small number of centres of excellence. Examples of highly specialised services include liver transplant services, enzyme replacement therapy, and proton beam therapy for specific cancer treatments.

[3] NHS walk-in centres and NHS 111, a telephone service for non-emergency enquiries, also form part of primary care.

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

***NHS services provided by hospitals***

12. Hospitals are typically categorised by the types of services that they provide, although the provision of such services are not mutually exclusive. For example, a district general hospital is typically the major secondary care provider in the local area and offers a wide range of services. Other types of hospitals include specialised hospitals (hospitals that deal with specific medical conditions, for instance the Christie NHS Foundation Trust); community hospitals (hospitals providing a diverse range of services to a smaller population than a district general hospital and closer to the home of local residents); and teaching hospitals (hospitals that teach medical students and nurses and are often linked to a medical school, nursing school or university).

13. Hospitals providing NHS services typically provide secondary care to patients. Secondary care provided in a hospital setting is referred to as acute care.

14. Acute care services can broadly be divided into the following categories, although these services are not legally defined nor mutually exclusive:

    *(a)* Elective care: care that is typically planned or scheduled in advance and typically requires a referral from a primary care provider (eg a GP, dentist, optician or an allied healthcare professional[4] (eg a scheduled operation). Generally, the decision to admit the patient to hospital is separated in time from the patient's actual admission.

    *(b)* Non-elective care: care that is typically unplanned or not scheduled in advance (eg services provided by an accident and emergency (A&E) department). Non-elective care can be provided on an urgent or emergency basis:

        (i) Urgent care refers to the treatment of patients requiring immediate attention, although their condition is not considered life threatening.

[4] An allied healthcare professional refers to any healthcare professional other than a doctor or a nurse. Examples include dieticians, physiotherapists and radiographers.

(ii) Emergency care refers to the treatment of patients with life threatening or major conditions.

Some services can be provided on an elective or non-elective basis. For example, an elective Caesarean section[5] is a planned procedure, when the need for the procedure is agreed in advance and the operation takes place before the natural onset of labour. An emergency (non-elective) Caesarean section is carried out when the need for the procedure is urgent. This may happen if an elective Caesarean was planned but labour started earlier than expected; if there are complications with the pregnancy or labour; or if labour has stopped or is very slow.

*(c)* Inpatient care: care provided to patients who have been admitted to hospital, either as a day case[6] or for a longer period of time. These services are also linked to elective or non-elective care pathways.

*(d)* Outpatient care: care provided on an appointment basis without the need for the patient to be admitted into hospital. An outpatient appointment may be used to assess the need for further treatment or to follow up on a patient after they have had a period of treatment or an operation, as well as for treatment itself. Procedures that would have previously been carried out as inpatient cases, such as a colposcopy[7] or a cystoscopy,[8] are increasingly being undertaken in an outpatient setting. Outpatient services cover a wide range of specialties. These services can be linked to either elective or non-elective care pathway.

15. CMFT 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 central Manchester;

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[5] A Caesarean section is a surgical procedure used to deliver one or more babies. It is often performed when a vaginal delivery could put the baby or mother at risk.
[6] A day case refers to the elective admission of a patient, who receives care during the course of a day and does not require the use of a hospital bed overnight. If the patient is required to stay in hospital overnight, this is classified as an inpatient admission.
[7] A colposcopy is a diagnostic procedure used to examine the cervix, in order to assess the risk of cervical cancer.
[8] A cystoscopy is a diagnostic procedure used to examine the urinary bladder using an instrument called a cystoscope.

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

*(e)* a small amount of private patient services.

16. As a teaching hospital, CMFT carries out a significant amount of medical research and is a member of the Manchester Academic Health Science Centre.[9]

17. UHSM 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.

18. UHSM, like CMFT, is a teaching hospital and is a member of the Manchester Academic Health Science Centre.

### *NHS trusts and NHS foundation trusts*

19. Hospitals providing NHS services are typically managed by either NHS trusts or NHS foundation trusts, although independent providers can also provide NHS funded care.

*NHS trusts*

20. NHS trusts are bodies established by order of the Secretary of State for Health to provide goods and services for the purposes of the health service. NHS trusts are legally directed by and financially accountable to NHS Improvement on behalf of the Secretary of State for Health.[10]

21. The board of an NHS trust is responsible for ensuring that the hospitals under their management provide high-quality, efficient care for the patients that they serve. The board also decides how a hospital will develop so that services improve. For example, some hospitals are regional or national centres for

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[9] 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.

[10] The NHS Trust Development Authority, operating within NHS Improvement, remains the formal statutory body for such purposes.

more specialised care, while others are attached to universities and help to train health professionals (these hospitals are referred to as teaching hospitals).

*NHS foundation trusts*

22. Under section 33 of the National Health Service Act 2006 (the 2006 Act), NHS trusts (and other entities incorporated as public benefit corporations) are able to apply to NHS Improvement[11] to become NHS foundation trusts, if the application is supported by the Secretary of State for Health.[12]

23. NHS foundation trusts are public benefit corporations[13] that are authorised to provide goods and services for the purposes of the health service in England.

24. NHS foundation trusts typically have greater operational autonomy than NHS trusts, although the degree of autonomy is largely dependent on the trust's performance. For example, they can:

    *(a)* acquire and dispose of property (and accept gifts of property);

    *(b)* generate, retain and reinvest surpluses;

    *(c)* borrow to invest in new and improved services; and

    *(d)* engage in private patient work.[14]

25. Both CMFT and UHSM are NHS foundation trusts.

26. Please refer to Annex 1 for further information on the funding and governance of NHS foundation trusts.

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[11] Monitor, operating within NHS Improvement, remains the formal statutory body for such purposes.
[12] NHS Improvement authorises applications by NHS trusts to become NHS foundation trusts if it is satisfied in relation to a range of matters, including the applicant's constitution; the establishment of a board of governors and board of directors; and the ability of the applicant to provide goods and services for the purposes of the NHS. NHS Improvement must be satisfied that the application is well led so it can deliver high-quality services to patients on a sustainable basis.
[13] A public benefit corporation is a bespoke legal entity originally created by the Health and Social Care (Community Health and Standards) Act 2003 (the HSC Act 2003) and now governed by the 2006 Act, as amended by the HSCA 2012.
[14] Pursuant to section 43(2A) of the 2006 Act (as amended by section 164(5) of the HSCA 2012), NHS foundation trusts must ensure that the income they receive from providing goods and services for the NHS is greater than the income they receive from other sources. The 2006 Act (as amended by the HSCA 2012) also obliges NHS foundation trusts to publish information on all their non-NHS work and to explain its impact on the delivery of goods and services for the NHS (sections 43(3A and 3B), inserted by section 164(3) of the HSCA 2012. In addition, any NHS foundation trust that wishes to increase the share of its income from non-NHS sources, including private work, by more than five percentage points in any one year must obtain prior approval from its governors (section 43(D), inserted by section 164(3) of the HSCA 2012).

## Commissioning of NHS services

27. The main commissioners of NHS services are NHS England and CCGs. In addition, local authorities commission public health services and social care.[15]

### *NHS England*

28. NHS England is responsible for commissioning:

*(a)* primary care services, including out-of-hours services and other services provided by GPs;[16]

*(b)* specialised healthcare services where a national strategic approach is required;[17]

*(c)* health services for serving personnel and families in the armed forces;

*(d)* health services for people who are in prison or other secure accommodation, and for the victims of sexual assault (adults and children); and

*(e)* various public health services, such as immunisation and national screening programmes.

29. NHS England directly commissions specialised services to be provided in a hospital setting and community services that are specified in Schedule 4 to the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012. In commissioning specialised services, NHS England is guided by Clinical Reference Groups (CRGs). These are service-specific teams of professionals and patients who produce national specifications and policies for various different clinical areas, including, for example, guidance on the minimum number of procedures that have to be provided by a hospital to safeguard quality.

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[15] In the financial year ending 31 March 2017, there will be a mandatory minimum of £3.9 billion of pooled NHS funding to be spent by local authorities as part of the Better Care Fund's integration programme (see An alternative guide to the new NHS in England'). The Better Care Fund is a programme spanning both the NHS and local government. It has been created to provide vulnerable people with 'wraparound' fully integrated health and social care, resulting in an improved experience and better quality of life.

[16] The Five Year Forward View, published in October 2014 and setting out a new vision for the future of the NHS based around new models of care, introduced primary care co-commissioning, whereby CCGs were given an opportunity to take on greater responsibility for the commissioning of GP services.

[17] Specialised healthcare services are provided in relatively few hospitals and accessed by comparatively small numbers of patients – they account for circa 10% of the total NHS budget (See Understanding the new NHS (2014)). There is ongoing work to change the way in which specialised services are commissioned, including more collaborative commissioning between CCGs and NHS England.

30. NHS England is also responsible for overseeing the operation of CCGs. It is responsible for ensuring that every provider of primary care is a member of a CCG and that the constitutions of CCGs cover the whole of England, but do not overlap.

31. CCGs' statutory obligations with regard to NHS England include:

*(a)* improving the quality of services;

*(b)* complying with certain financial obligations (broadly that expenditure does not exceed allotted funds);

*(c)* maintaining proper audited accounts (and ensuring that they are submitted to NHS England);

*(d)* supplying financial information to NHS England as directed by NHS England or the Secretary of State; and

*(e)* exercising their functions in a way that provides good value for money.

32. NHS England works in conjunction with CCGs to develop standards, such as the NHS Outcomes Framework,[18] which identify service standards to which CCGs can be held to account.

33. NHS England's responsibilities are discharged through four regional teams (NHS North of England; NHS Midlands and East; NHS South of England; and NHS London).

***CCGs***

34. CCGs are responsible for commissioning (in their local area):

*(a)* elective acute care;

*(b)* urgent and emergency care;

*(c)* community health services;

*(d)* rehabilitative care;

*(e)* maternity and newborn services;

[18] The NHS Outcomes Framework sets out the outcomes and corresponding indicators that are used to hold NHS England to account for improvements in health outcomes.

*(f)* mental health services;

*(g)* learning disability services; and

*(h)* infertility services.[19]

35. In addition, some CCGs co-commission primary care services with NHS England. Primary care co-commissioning can take the form of:

*(a)* greater involvement: CCGs work more closely with their local NHS England teams in decisions about primary care services;

*(b)* joint commissioning: one or more CCGs jointly commission GP services with NHS England through a joint committee; or

*(c)* delegated commissioning: CCGs take on full responsibility for the commissioning of GP services.[20]

36. In 2017, 115 CCGs will have assumed full responsibility for the commissioning of primary medical care services under delegated commissioning arrangements. A further third will hold the responsibilities jointly with NHS England. Nearly all CCGs are expected to have taken on delegated arrangements by 2018.[21]

37. CCGs are designed to be clinically led and responsive to the health needs of their local populations.[22] They are membership bodies made up of GP practices in the area they cover. The members set out in their constitution the way in which they will run their CCG. Constitutions are agreed with NHS England and published. The law requires that members appoint a governing body, which oversees the governance of the CCG and which must have at least six members, including the CCG's Accountable Officer; Chief Finance Officer; a registered nurse; a secondary care specialist; and two lay members.

38. CCGs are supported by Commissioning Supporting Units (CSUs), strategic clinical networks and clinical senates.

*(a)* Six CSUs provide practical support to CCGs in a number of areas, including transactional commissioning (eg market management, contract

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[19] CCGs can commission services from a range of providers, including from the voluntary and private sectors.
[20] In the financial year ending 31 March 2017, 114 CCGs will have assumed full responsibility for the commissioning of primary medical services under delegated commissioning arrangements.
[21] See TheKingFund (2016), Social care for older people.
[22] Each CCG serves a median population size of around 250,000 people (ranging from 61,000 people to 860,000 people) (see NHS England (2014), Understanding the new NHS).

negotiations, and information and data analysis) and transformational commissioning (eg service redesign).

*(b)* Strategic clinical networks focus on priority service areas to improve equity and quality of care and health outcomes for their population. They bring together those who use, provide and commission services to support more effective delivery of services.

*(c)* Clinical senates are multi-professional advisory groups of experts from across health and social care, including patients and volunteers. There are 12 clinical senates across England. Their purpose is to represent a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them in making the best decisions about healthcare for the populations that they represent.

***Commissioning in Greater Manchester***

39. Commissioning of health and care services in Greater Manchester is currently carried out by 10 CCGs, NHS England and 10 local authorities (for public health services and social care).

40. In the financial year ended 31 March 2016, CMFT's main commissioners of NHS services were:

*(a)* NHS England, through its North West Commissioning Hub (it commissioned services to the value of £339 million);[23]

*(b)* Central Manchester CCG (£123 million);[24] and

*(c)* Trafford CCG (£79 million).[25]

41. In the financial year ended 31 March 2016, UHSM's main commissioners of NHS services were:

*(a)* NHS England, through its North West Commissioning Hub (£140 million);

[23] CMFT is the largest provider of specialised services in Greater Manchester.
[24] The three Manchester CCGs (Central Manchester CCG, North Manchester CCG and South Manchester CCG) collectively commissioned services to the value of £201 million at CMFT in the year ended 31 March 2016. The three Manchester CCGs merged in April 2017 to form a single citywide CCG, Manchester CCG.
[25] In the year ended 31 March 2016, CMFT received £784 million from NHS England and CCGs (see CMFT accounts for the year ended 31 March 2016).

*(b)* South Manchester CCG (£83 million);[26] and

*(c)* Trafford CCG (£64 million).[27]

42. Following the devolution of health and social care to Greater Manchester in 2015,[28] the Greater Manchester Health and Social Care Partnership (GMHSCP)[29] assumed control over the region's health and social care budget, which amounts to circa £6 billion per annum.

43. The GMHSCP operates through a single governance arrangement, which includes the following bodies:

*(a)* The Strategic Partnership Board provides leadership and is responsible for agreeing strategic priorities and ensuring ongoing organisational commitment to the devolution agenda across the Greater Manchester health economy

*(b)* The Strategic Partnership Board Executive is responsible for monitoring the delivery of locality plans, providing a forum for issues relating to locality plans that cannot be addressed at a locality level, and proposing allocations from and monitoring the Transformation Fund (see paragraph 159).

*(c)* The Joint Commissioning Board was established in recognition of the fact that achieving Greater Manchester's health and social care reform objectives required a radical extension of the approach to joint commissioning. It is responsible for delivery of the Greater Manchester commissioning strategy, commissioning of health and social care services on Greater Manchester footprint and delivery of the GMHSCP's strategic plan via its commissioning decisions.

*(d)* The Greater Manchester Provider Federation Board brings together all Greater Manchester NHS Trust and NHS Foundation Trusts together. It

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[26] The three Manchester CCGs collectively commissioned services to the value of £99 million at UHSM in the year ended 31 March 2016. The three Manchester CCGs merged in April 2017 to form a single citywide CCG, Manchester CCG.
[27] In the year ended 31 March 2016, UHSM received £368 million from NHS England and CCGs (see UHSM annual report and accounts for the year ended 31 March 2016).
[28] The Devolution Agreement, signed on 3 November 2014 by the government and the GMCA, devolved powers to the GMCA in local transport, policing, housing and planning. A further agreement, signed on 25 February 2015, devolved control over health and social care expenditure in Greater Manchester.
[29] 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. It operates through a single governance arrangement headed by a Strategic Partnership Board, which oversees the delivery of a single, shared strategic plan.

was established in recognition of the requirement to take collective decisions across the Greater Manchester NHS providers.

44. Greater Manchester remains part of the NHS and social care system and will continue to meet its statutory requirements and duties, including those set out in the NHS Constitution and the NHS Mandate and those that underpin the delivery of social care and public health services.

45. NHS England, the CCGs and local authorities have retained their statutory functions and existing accountability for current funding flows. However, NHS England has delegated the internal responsibility for the operational management of the delivery of the NHS 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 other than GP services and secondary dental care services.

*(c)* Public health related services.

46. 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.

***NHS Standard Contract***

47. The NHS Standard Contract is published by NHS England and must be used by commissioners for all contracts for NHS funded healthcare services other than those for primary care services.[30]

48. Each locally agreed contract describes the services that a provider is required to offer under its commissioning arrangement with the relevant commissioner.

49. The contract references arrangements under which the provision of services can be protected where the continued availability of those services is regarded as essential. Services can potentially be designated as 'commissioner requested services' where there is no alternative provider

[30] The NHS Standard Contract is updated annually to accommodate updated legislation and/or clinical guidance affecting the provision of relevant services.

close enough, where removing them would increase health inequalities, or where removing them would make other related services unviable.[31]

50. Where the contract contains precise service specifications, the commissioner can in principle refuse to pay for a new service or treatment introduced by the provider that is beyond the scope of what is described in the specifications. Where the service specifications in the contract are less precise, the provider will have a stronger argument that it is reasonable for its services to evolve gradually in line with good clinical practice.

51. If commissioners are materially concerned about the quality or outcomes of services being provided, or that the provider may not be meeting legal requirements or about patient safety more generally, they can suspend services until the provider is able to demonstrate that it can and will provide services to the required standard.

52. The provider or commissioner can terminate the contract or certain services specified in the contract under the following circumstances:

*(a)* Commissioner default: the provider may terminate the contract or service in the event of significant late payment or persistent material breach on the part of a commissioner.

*(b)* Provider default: the commissioner may terminate the contract or service for a number of reasons, including if the provider ceases to carry on its business; is in persistent or repetitive breach of quality requirements; or is in material breach of any regulatory compliance standards.

*(c)* No fault termination: the parties can terminate the contract at any time by mutual consent, or either party can terminate the contract on notice.[32]

***Referral to treatment targets***

53. Under the NHS Constitution, patients are entitled to access certain services commissioned by NHS bodies within maximum waiting times. For example, the maximum waiting time for non-emergency consultant-led cases is 18 weeks from GP referral to first definitive treatment.[33] The NHS e-Referral

[31] The commissioner requested services regime is operated by NHS Improvement separately to the NHS Standard Contract.
[32] The notice period us set out in the contract.
[33] For urgent referrals in relation to suspected cancer, a range of different waiting time standards apply, including a maximum of two weeks from GP referral to a first appointment with a cancer specialist, and a maximum wait of 62 days from GP referral to first treatment.

service enables patients to compare waiting times for different hospitals and clinics and to choose the hospital that best meets their needs.

54. The NHS Standard Contract includes specific performance requirements based on these NHS Constitution standards. In each case, a percentage threshold is applied, so, for instance, each provider is required to ensure that 92% of patients still waiting to start consultant-led treatment have been waiting no more than 18 weeks.

55. Under the NHS Choice Framework, which sets out patients' rights to choice in healthcare, both NHS England and CCGs are obliged to take all reasonable steps to ensure that any patients for whom the maximum waiting time to see a specialist is not met are offered a quicker appointment to start treatment at a range of suitable alternative providers (if the patient requests this).

56. The NHS Standard Contract requires providers to submit information on referrals and waiting times to national systems, which NHS England and CCGs can review, in order to assess provider's performance in respect of meeting the referral to treatment targets.[34] Commissioners can also require providers, through the NHS Standard Contract, to provide regular summary reports and evidence of validation and management of waiting lists.

57. The NHS Standard Contract includes provisions that enable commissioners to apply financial sanctions to those providers who do not meet the maximum waiting times targets. However, under the arrangements for the operation of the Sustainability and Transformation Fund, application of these sanctions has, in practice, been suspended for most providers since April 2016.

### *Commissioning for Quality and Innovation (CQUIN)*

58. Any provider of healthcare services commissioned under an NHS Standard Contract is eligible for payment under the CQUIN scheme.[35]

59. The CQUIN payment scheme was introduced in 2009 to secure improvements in the quality of services and better outcomes for patients. The scheme enables commissioners to make a proportion of a provider's income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. CQUIN schemes vary depending on the provider and usually comprise a combination of national and local CQUIN goals.

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[34] This is also incorporated and reviewed as part of the Operational Performance pillar of NHS Improvement's Single Oversight Framework.
[35] This includes independent providers of NHS services.

60. The CQUIN scheme for 2017 to 2019 offers 2.5% of contract value:

*(a)* 1.5% is available for delivery of mandated CQUIN indicators. There are thirteen indicators focusing on clinical and transformation initiatives, and the number of indicators applicable for each provider will depend on the type of provider.

*(b)* 1% is available to support local areas on their Sustainability and Transformation Plans (STPs).

## Pricing of acute healthcare services

61. Prior to the introduction of Payment by Results (PbR) in 2003, it was common practice for commissioners to have block contracts with hospitals, where payment was fixed irrespective of the number of patients treated by each hospital.

62. PbR, an activity-based system that reimburses providers for the work that they carry out at an agreed national price, was introduced to:

*(a)* support patient choice by allowing money to 'follow the patient' to different types of provider;

*(b)* reward efficiency and quality by allowing NHS foundation trusts to retain any surplus if they were able to provide the required standard of care at a lower cost than the national price;

*(c)* reduce waiting times by paying providers for the volume of work done;

*(d)* re-focus discussions between commissioner and provider away from price and towards quality and innovation.[36]

63. Since the entry into force of the applicable provisions of the HSCA 2012, responsibility for the pricing of acute healthcare services has transferred from the Department of Health to NHS England and NHS Improvement, and the PbR regime has evolved to a greater emphasis on local pricing under the National Tariff regime, although both block contracts and PbR arrangements remain in use.

### *National Tariff*

64. The National Tariff applies to the majority of acute healthcare services. It retains the substantive principles of PbR, most notably that payment is based

[36] See Department of Health (November 2012), A simple guide to Payment by Results.

on the activity and services provided, but it provides greater flexibility in enabling commissioners to reflect local conditions in the commissioning of contracted NHS services.

65. The National Tariff is set each year by NHS England and NHS Improvement: NHS England specifies those healthcare services for which a national price is applicable, and NHS Improvement is required to set that price.

66. Commissioners pay a price stipulated in the National Tariff (if available) or a price determined in accordance with the rules of the National Tariff payment regime.

67. The two main features of the National Tariff are currencies and tariffs:

*(a)* Currencies are the units of healthcare for which payments are made. They can take a number of forms and cover different time periods.

*(b)* Tariffs are the prices paid for each currency.

68. The tariff for each service or unit of activity is intended to cover the cost incurred by an averagely efficient provider of that service. It is based on national average costs reported by NHS providers and a market forces factor (MFF), which takes account of unavoidable local differences in costs, such as the cost of land and labour.

69. NHS England and NHS Improvement have published the National Tariff for 2017 to 2019, which came into force on 1 April 2017.[37]

### *Variations to the National Tariff*

*National variations*

70. It may be appropriate to apply nationally determined variations to national prices to reflect, for example, certain features of costs that the formulation of national prices has not taken into account.

71. A national variation is intended to achieve one of the following:

*(a)* Improve the extent to which actual prices paid reflect location-specific costs.

[37] This is the first time that the National Tariff has been set for a period of two years.

*(b)* Improve the extent to which actual prices paid reflect the complexity of patient needs.

*(c)* Provide incentives for sharing the responsibility for preventing avoidable unplanned hospital stays.

*(d)* Share financial risk appropriately following or during a move to new payment approaches.

*Local prices*

72. Local prices apply to services that do not have national prices. Commissioners and providers are required to apply the following principles when determining a local payment approach:

*(a)* The approach must be in the best interest of patients.

*(b)* The approach must be transparent, in order to improve accountability and encourage the sharing of best practice.

*(c)* The commissioner and provider must engage constructively with each other when seeking to agree an approach.

*Local variations*

73. Local variations are adjustments to a national price or currency for a nationally priced service. The variation must be agreed by the commissioner and provider of that service. The purpose of local variations is to allow commissioners and providers an opportunity to innovate in the design and provision of services for patients. The three principles under local prices apply to local variations.

*Local modifications*

74. Local modifications are adjustments to national prices for specific services and in respect of specific providers. Local modifications are intended to ensure that healthcare services can delivered where they are required by commissioners for patients even if the nationally determined price for those services would otherwise be uneconomic. The three principles under local prices apply to local modifications.

75. There are two types of local modification:

*(a)* A provider and commissioner agree a proposed increase to a nationally determined price for a specific service.

*(b)* A provider is unable to agree an increase to a nationally determined price with a commissioner and therefore, the provider applies to NHS Improvement for approval of the modification.

## Funding of NHS services

76. NHS services are publicly funded. Circa 99% of the funds are raised through general taxation and National Insurance contributions. The remainder comes from patient charges for services, such as optical care, prescriptions and dental care.[38]

77. HM Treasury is responsible for determining the budget for all major public services, including healthcare. HM Treasury allocates funds to the Department of Health, which is responsible for determining how this is allocated in England.[39] Most of the total NHS settlement (over 80%) is allocated to NHS England. The Department of Health retains a proportion of the budget to meet:

*(a)* its own running costs;

*(b)* the costs of various central health and miscellaneous services (CHMS), including some centrally administered services and projects managed centrally for the NHS (eg clinical negligence);

*(c)* the costs of a range of centrally funded statutory and other arm's length bodies (eg the NHS Business Services Authority and Health Education England); and

*(d)* the costs of public health spending, which is passed onto and managed by local authorities and Public Health England.

78. NHS England retains a proportion of the budget received from the Department of Health (around 20%) to fund its running costs and the services it commissions directly. The remainder is passed on to CCGs to enable them to commission services for their local populations.[40]

79. For the financial year ending 31 March 2017, the overall NHS budget allocated to the Department of Health was £120 billion. The Department of

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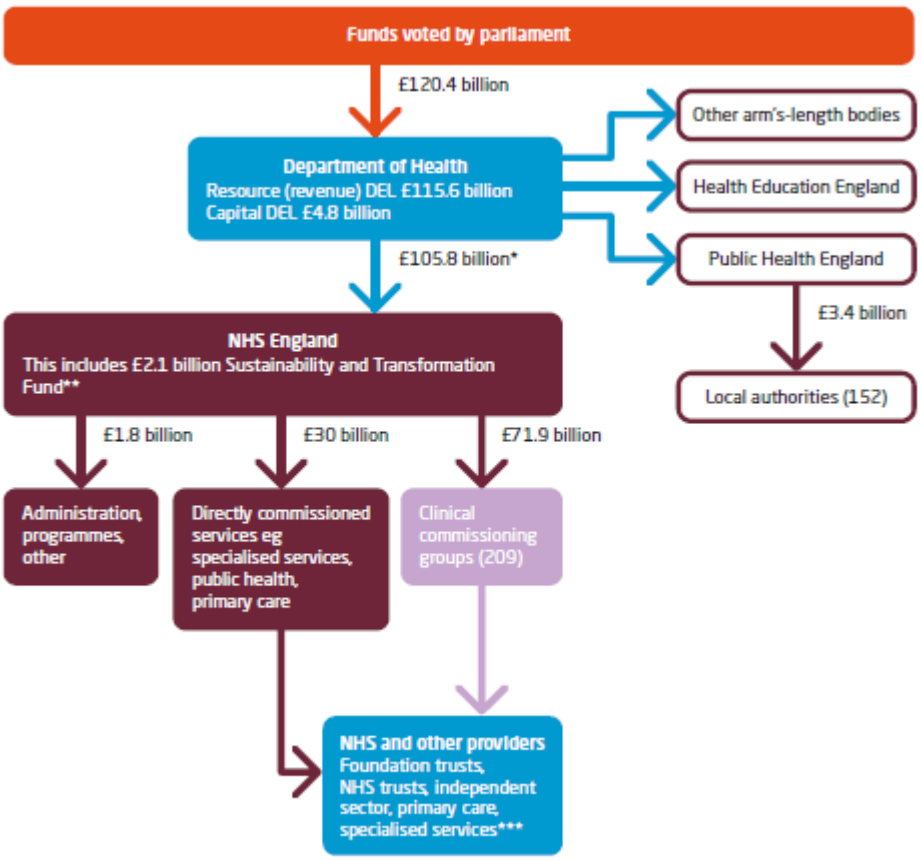
[38] See The King's Fund: How the NHS is funded.
[39] Health and social care services in Northern Ireland, Scotland and Wales are the responsibility of the devolved administrations.
[40] CCG budgets are allocated on a 'weighted capitation' basis. This means that budgets are set based on the size of the local population, and adjusted for other factors, including the age profile, health and location of the population.

Health provided NHS England with £106 billion, and NHS England provided CCGs with £72 billion (see Figure 2).

80. The increase in spending announced in the 2015 Spending Review will see the NHS budget increase to £133.1 billion by 2021.[41]

**Figure 2: Healthcare funding flows for the year ending 31 March 2017**




Source: The King's Fund (July 2016), Deficits in the NHS 2016.

81. Almost half of the NHS budget is spent on acute and emergency care. General practice, community care, mental health and prescribing each account for around 10% of total spend.[42]

## Regulation of the NHS

82. In this section, we consider the mechanisms in place to safeguard and support the improvement of the quality, performance, finance and leadership of NHS services.[43] This includes the:

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[41] See The King's Fund: The NHS budget and how it has changed.
[42] See NHS England (2014), Understanding the new NHS.
[43] Quality (in relation to the provision of NHS services) is defined as excellence in patient safety, clinical effectiveness and patient experience.

*(a)* regulatory framework governing the provision of NHS services;

*(b)* bodies empowered with monitoring and regulating the commissioning and provision of NHS services; and

*(c)* other institutions tasked with supporting high-quality and sustainable service provision and protecting patients by providing guidance, advisory services, training and other related functions.

***Regulatory framework***

*HSCA 2012*

83. The HSCA 2012 introduced significant changes to the provision of NHS services in England. The legislative changes came into force on 1 April 2013 and included:

*(a)* the replacement of primary care trusts (PCTs) by CCGs to ensure that the planning and commissioning of healthcare services in local areas was led by clinicians. CCGs now control the majority of the NHS budget;

*(b)* allowing fair competition for NHS funding to independent, charity and third sector[44] healthcare providers, in order to provide greater choice to patients in choosing their care;

*(c)* the establishment of Monitor (now exercising its functions as part of NHS Improvement) as the sector regulator;

*(d)* the introduction of regulatory powers in relation to the pricing of certain NHS services;

*(e)* the creation of the Healthwatch network, comprising independent organisations in every local authority area (the Healthwatch network) and a national body (Healthwatch England), to represent the interests of patients and the wider public;

*(f)* the creation of Public Health England, an executive agency of the Department of Health, to protect and improve health and wellbeing, and reduce health inequalities; and

[44] Third sector is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations, such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

*(g)* conferring additional responsibility on the National Institute for Health and Care Excellence (NICE) to develop guidance and set quality standards for social care, as well as healthcare.

*National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*

84. The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (Procurement, Patient Choice and Competition Regulations 2013) include a number of regulations that are designed to:

*(a)* ensure that commissioners secure high-quality, efficient NHS healthcare services that meet the needs of people who use those services;

*(b)* protect the rights of patients to choose who provides their healthcare in certain circumstances; and

*(c)* prevent anti-competitive behaviour by commissioners unless this is in the interests of patients.

85. Please refer to Annex 2 for further information on the Procurement, Patient Choice and Competition Regulations 2013.

***Regulatory bodies***

*NHS England*

86. NHS England is responsible for setting the priorities and direction of the NHS and improving health and care outcomes for people in England. In addition, it commissions primary and specialised healthcare services, and oversees the operation of CCGs.

*NHS Improvement*

87. NHS Improvement brings together Monitor and the NHS Trust Development Authority, and is a combination of the continuing statutory functions and legal powers vested in those two bodies under a single leadership and operating model.

88. NHS Improvement's aim is to support NHS foundation trusts and NHS trusts in providing patients with consistently safe, high-quality, compassionate care within local health systems that are financially sustainable.

89. NHS Improvement's main duty when exercising its functions is to protect and promote patient interests by promoting economic, efficient and effective

healthcare services while maintaining or improving quality. NHS Improvement must carry out that duty having regard to likely future demand for NHS services, and enabling NHS services to be provided in an integrated way (if this would improve quality or efficiency or reduce inequality of access or outcomes).

90. The NHS Trust Development Authority is a Special Health Authority established in 2012 by secondary legislation[45] made under the 2006 Act. The NHS Trust Development Authority's role is to oversee NHS trusts in England, make certain appointments to NHS bodies and exercise certain patient safety functions. It has a general power to take such steps as it considers necessary and appropriate to assist and support persons providing NHS services to ensure continuous improvement in the quality of the provision and the financial sustainability of NHS services.

91. Monitor was established as the independent regulator of NHS foundation trusts in 2004.[46] Following the enactment of the HSCA 2012, Monitor became the sector regulator for the provision of healthcare services in England and was given additional statutory duties.

92. Monitor's role is to:

*(a)* authorise and regulate NHS foundation trusts;

*(b)* regulate certain other independent sector providers when providing NHS funded care;

*(c)* set prices for NHS services;

*(d)* enable integrated care;

*(e)* prevent anti-competitive behaviour that is against the interests of patients; and

*(f)* support commissioners to maintain service continuity.

93. Monitor does this by:

*(a)* licensing providers;

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[45] The National Health Service Trust Development Authority (Establishment and Constitution) Order 2012.
[46] Monitor was established as the independent regulator of NHS Foundation Trusts by the Health and Social Care (Community Health and Standards) Act 2003 (the 2003 Act). The 2003 Act provided for the authorisation and regulation of NHS foundation trusts by Monitor. These provisions were subsequently consolidated in the 2006 Act, under which Monitor continued to perform its functions.

*(b)* publishing the national tariff;

*(c)* authorising NHS trusts as NHS foundation trusts;

*(d)* requiring information from certain persons, including CCGs and NHS England, for the purposes of its regulatory functions; and

*(e)* enforcing rules relating to procurement, patient choice and competition.

94. From 1 April 2013, Monitor has concurrent powers with the CMA to apply the Chapter I and Chapter II prohibitions in the Competition Act 1998.

95. Both the NHS Trust Development Authority and Monitor have a role relating to patient safety. The NHS Trust Development Authority exercises certain patient safety functions of NHS England. In exercising those functions, the NHS Trust Development Authority must act with a view to securing and improving the safety of services provided by the NHS, including the safety of patients.[47] Monitor must have regard to the need to maintain patient safety when exercising its functions (but cannot take action in the interest of patient safety that is not connected to its functions).

*Monitoring NHS trusts and NHS foundation trusts*

96. Up until September 2016, the NHS Trust Development Authority used the Accountability Framework to oversee NHS trusts, and Monitor used its Risk Assessment Framework to monitor the governance and financial performance of NHS foundation trusts.[48]

97. In September 2016, these frameworks were replaced by the Single Oversight Framework, which applies to both NHS trusts and NHS foundation trusts.[49]

98. The Single Oversight Framework does not give a performance assessment in its own right. Rather, the purpose of the framework is to focus on five themes (quality of care; finance and use of resources; operational performance; strategic change; and leadership and improvement capability) to identify where providers may benefit from or require improvement support to

[47] The NHS Trust Development Authority is also responsible for the Healthcare Safety Investigation Branch, which has operational independence and is responsible for investigation of incidents or accidents relating to patient safety. The Healthcare Safety Investigation Branch also makes recommendations for improving patient safety.
[48] The Risk Assessment Framework still applies to independent providers.
[49] The Single Oversight Framework works within the continuing statutory duties and powers of Monitor with respect to NHS foundation trusts and of the NHS Trust Development Authority with respect to NHS trusts.

ultimately help providers attain, and maintain, CQC ratings of Good or Outstanding.

99. NHS Improvement segments the provider sector according to the scale of issues faced by individual providers and therefore the level of support required.[50] The four segments in the Single Oversight Framework are:

*(a)* Segment 1: providers with maximum autonomy;

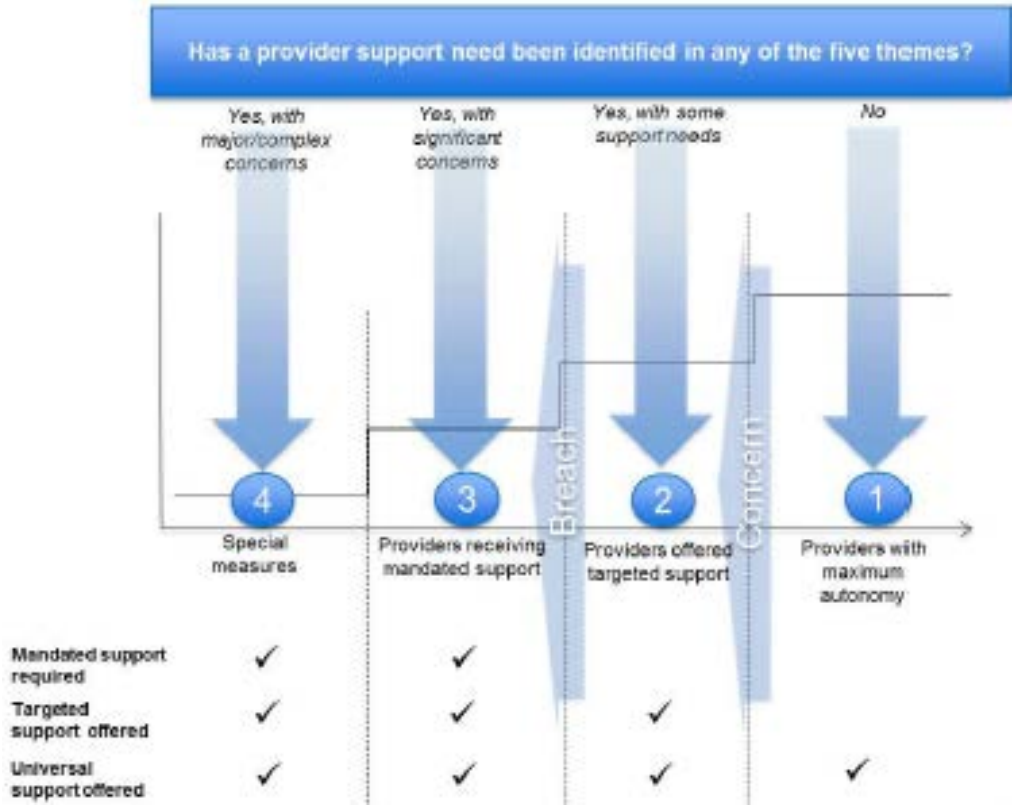
*(b)* Segment 2: providers offered targeted support;

*(c)* Segment 3: providers receiving mandated support for significant concerns; and

*(d)* Segment 4: providers in special measures.

100. The Single Oversight Framework is summarised in Figure 3 below.

**Figure 3: Summary of NHS Improvement Single Oversight Framework**




Source: NHS Improvement Single Oversight Framework.

101. NHS Improvement can place NHS trusts and NHS foundation trusts into special measures. Special measures apply to providers which have

[50] Segmentation is informed by data monitoring and judgement (based on an understanding of providers' circumstances).

experienced serious failures in quality of care or financial performance and where there are concerns that existing management cannot make the necessary improvements without support.

*Prevention of anti-competitive behaviour in the provision of NHS services*

102. NHS Improvement must exercise the functions conferred upon Monitor with a view to preventing anti-competitive behaviour in the provision of NHS services, which is against the interests of people who use such services.

103. The HSCA 2012 confirmed that the UK merger control regime applies to NHS foundation trusts and assigned to NHS Improvement (exercising Monitor's functions) a role advising the CMA on relevant customer (patient) benefits.

104. The HSCA 2012 expressly gives the CMA exclusive jurisdiction over mergers between NHS foundation trusts. The role of the CMA in this context is to examine the impact that a merger between two such trusts could have on competition, and the consequences this may have for the quality of healthcare services provided.

105. Please refer to Annex 3 for a summary of the functions of NHS Improvement and the CMA in respect of mergers involving NHS foundation trusts.

*Enforcing compliance with the Procurement, Patient Choice and Competition (No 2) Regulations 2013 (PPC Regulations)*

106. NHS Improvement cannot undertake investigations on its own initiative in relation to the compliance of commissioners with their obligations under the PPC Regulations. It can, however, investigate complaints, require explanations and information from commissioners, and give directions or accept undertakings from commissioners (eg to prevent failures to comply, to put in place measures to mitigate the effect of such failures, and to vary or withdraw arrangements and tender procedures).[51]

*Licensing of NHS providers*

107. NHS Improvement (exercising Monitor's statutory functions) is responsible for the NHS provider licence. NHS providers, including independent providers,

[51] NHS Improvement is not permitted to direct a commissioner to hold a competitive tender.

must apply for and hold a licence (unless they are legally exempt from doing so).[52]

108. The NHS provider licence sets out the conditions that healthcare providers must meet to help ensure that the health sector works for the benefit of patients. These conditions enable NHS Improvement to:

*(a)* set prices for NHS-funded care (in partnership with NHS England);

*(b)* facilitate integrated care;

*(c)* safeguard patient choice and prevent anti-competitive behaviour;

*(d)* support commissioners to protect essential health services for patients if a provider gets into financial difficulties; and

*(e)* oversee the manner in which NHS foundation trusts are governed.

109. In providing healthcare services for the purposes of the NHS, licensees must comply with the conditions of their licence. NHS Improvement monitors and enforces compliances with these conditions.

110. NHS Improvement may carry out a formal or informal investigation of potential breaches of licence conditions. Following an investigation, where NHS Improvement has found there to be a breach or suspected breach of the licence, it may, in accordance with its Enforcement Guidance, decide to take enforcement action which may include imposing requirements on the licensee (discretionary requirements) or accepting undertakings from them (enforcement undertakings), in order to make sure they return to compliance.

111. The discretionary requirements that NHS Improvement may impose are:

*(a)* compliance requirements, which require a provider to take such steps as specified by NHS Improvement to ensure that the breach in question does not continue or recur;

*(b)* restoration requirements, which require a provider to take such actions as specified by NHS Improvement to restore the situation to what it would have been, absent the breach; and

*(c)* variable monetary penalties.

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[52] NHS foundation trusts are automatically licenced. NHS trusts are exempt from needing to apply for a licence. However, NHS Improvement has deemed it appropriate for NHS trusts to comply with equivalent conditions to those under the NHS provider licence, and the NHS Trust Development Authority ensures that NHS trusts comply with these equivalent conditions.

112. A provider may offer enforcement undertakings during the course of a formal investigation. NHS Improvement may accept the undertaking if it has reasonable grounds to suspect that the provider, is (or was) in breach of a licence condition; the requirement to hold a licence; or a requirement to supply NHS Improvement with information. Enforcement undertakings are usually used as an alternative to further investigation with the attendant possibility of imposing discretionary requirements.

113. An enforcement undertaking may include one or more of the following commitments:

*(a)* Action to ensure that the breach does not continue or recur.

*(b)* Action to ensure that the position is, so far as possible, restored to what it would have been, absent the breach.

*(c)* Action, including the payment of a sum of money, to benefit any other licensee and/or provider or commissioner of NHS healthcare services affected by the breach.

114. NHS Improvement has additional specific powers to take action where the governance of an NHS foundation trust is such that it is failing, or will fail, to comply with one or more of the conditions of its licence:

*(a)* Where NHS Improvement is satisfied that an NHS foundation trust's directors and/or governors are failing to secure compliance with conditions in the trust's licence or take steps to reduce the risk of a breach of a condition in the trust's licence under section 111 of the HSCA 2012, NHS Improvement may include in the licence such conditions relating to governance as Monitor considers appropriate.

*(b)* Where NHS Improvement is satisfied that an NHS foundation trust has breached or is breaching an additional licence condition that was included under section 111 of the HSCA 2012, NHS Improvement may use its powers to require the trust to remove, suspend or disqualify one or more of its directors and/or governors or, if the trust does not do so, NHS Improvement may make such changes.

115. NHS Improvement may also revoke a provider's licence if it is satisfied that the provider has failed to comply with a licence condition.

*CQC*

116. CQC is the independent regulator of health and adult social care services in England. All providers of such services are required to register with CQC.

CQC monitors, inspects and regulates health and adult social care services to make sure that they meet fundamental standards of quality and safety.

117. Providers of regulated activity must meet the regulations under Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009. The regulations relate to

*(a)* the suitability of the provider (ie their competence, skills and experience);

*(b)* the competence of clinical staff and safety of medical activities;

*(c)* the quality of premises and equipment; and

*(d)* good governance.

118. CQC asks five key questions of all services:

*(a)* Are they safe? (ie patients are protected from abuse and avoidable harm);

*(b)* Are they effective? (ie patient care, treatment and support achieves good outcomes, promotes a good quality of life and are based on the best available evidence);

*(c)* Are they caring? (ie staff involve and treat patients with compassion, kindness, dignity and respect);

*(d)* Are they responsive? (ie services are organised so that they meet patient needs); and

*(e)* Are they well-led? (ie the leadership, management and governance of the organisation assures the delivery of high-quality patient-centred care; supports learning and innovation; and promotes an open, fair culture.

119. Most providers of regulated activity receive ratings following an inspection. CQC gives ratings on a four point scale: the ratings are Outstanding, Good, Requires Improvement and Inadequate.

120. If CQC finds that the provision of care is not safe or of sufficient quality, its powers to take action against those responsible include:

*(a)* Using requirement notices or warning notices to set out what improvements the care provider must make and by when.

*(b)* Making changes to a care provider's registration to limit what they may do (eg by imposing conditions for a given time).

*(c)* Placing a provider in special measures, where CQC closely supervises the quality of care while working with other organisations to help the provider improve within set timescales.

*(d)* Hold the care provider to account for their failings by issuing simple cautions or fines or by prosecuting cases where people are harmed or placed in danger of harm.

*General Medical Council*

121. Pursuant to the Medical Act 1858, the General Medical Council (GMC) has statutory authority to oversee the practice of medicine in the UK. It is the independent regulator of doctors in the UK.

122. The GMC:

*(a)* Provides guidance to doctors. Much of its published guidance concerns professional ethics, such as the protection of patient confidentiality, the treatment of patients with respect, and the proper handling of children.

*(b)* Maintains a register of qualified doctors across the UK and issues these doctors with a licence to practice medicine. The GMC can remove doctors from its register of practitioners if they are found to be unfit to practice medicine.

*(c)* Requires doctors to demonstrate that they are fit to practice medicine (a process known as revalidation).

*(d)* Regulates medical education and training in the UK.

123. There are similar bodies in place for other healthcare professionals (eg the Nursing and Midwifery Council; the General Dental Council; the General Pharmaceutical Council; the General Optical Council; and the Health and Care Professions Council).

***Other supporting institutions***

*NICE*

124. NICE was established as a special health authority in 1999 and became a non-departmental public body under the HSCA 2012. It is responsible for standards of care in health and care services across England and Wales.

125. NICE's primary role is the promotion of clinical excellence in the health and care service. It fulfils this obligation by issuing guidance and quality standards

to health professionals, NHS organisations and the public. Healthcare professionals within the NHS in England are expected to consider NICE clinical guidance when determining the appropriate course of treatment for a patient.

*Royal Medical Colleges*

126. The Royal Medical Colleges are professional medical bodies incorporated by royal charter. There are a number of colleges and each one ministers to the practitioners of a particular medical specialty, such as surgery, anaesthetics and paediatrics.

127. Colleges promote research within the field, administer examinations, and offer continuing professional development and other training. They also publish medical practice guidelines[53] and make representations to the Department of Health and other professional bodies when such bodies seek to develop their own standards and regulations.

*Public Health England*

128. Public Health England is an operationally autonomous executive agency of the Department of Health. It was established in April 2013 in place of the Health Protection Agency.

129. Public Health England is responsible for:

*(a)* making the public healthier by encouraging discussions, advising government and supporting action by local government, the NHS and other people and organisations;

*(b)* supporting the public so they can protect and improve their own health;

*(c)* protecting the nation's health through the national health protection service, and preparing for public health emergencies;

*(d)* sharing its information and expertise with local authorities, industry and the NHS, to help them make improvements in the public's health;

*(e)* researching, collecting and analysing data to improve its understanding of health and come up with answers to public health problems;

[53] These guidelines do not represent legal or formal requirements and instead, for many providers, they reflect best practice to consider when developing policy.

*(f)* reporting on improvements in the public's health so everyone can understand the challenge and the next steps; and

*(g)* helping local authorities and the NHS to develop the public health system and its specialist workforce.

*Healthwatch England*

130. 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.

*Health and Wellbeing Boards*

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

132. 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 the Manchester CCGs, CMFT, UHSM and the Pennine Acute Hospitals NHS Trust (PAHT), and other commissioners and providers of health and social care services in Manchester.

133. The MHWB is responsible for overseeing the delivery of the Manchester Locality Plan, which sets out the vision to improve health and social care in Manchester. The plan has three pillars:

*(a)* Single commissioning system that combines the health and care commissioning responsibilities held by the three Manchester CCGs and Manchester City Council.

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

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

*Health Education England*

134. Health Education England is an independent organisation at arm's length of the Department of Health. Its key functions include:

*(a)* providing national leadership for planning and developing the whole healthcare and public health workforce;

*(b)* appointing and supporting development of Local Education and Training Boards (LETBs) and holding them to account;

*(c)* promoting high-quality education and training, which is responsive to the changing needs of patients and communities and delivered to standards set by regulators;

*(d)* allocating and accounting for NHS education and training resources, ensuring transparency, fairness and efficiency in investments made across England;

*(e)* ensuring security of supply of the professionally qualified clinical workforce; and

*(f)* assisting the spread of innovation across the NHS, in order to improve quality of care.

*Local Safeguarding Boards*

135. Local Safeguarding Boards support children and vulnerable adults with care and support needs. They do this by assuring themselves that local safeguarding arrangements are in place and that safeguarding practice is continuously improving and enhancing the quality of life of children and vulnerable adults under their remit.

*Parliamentary and Health Service Ombudsman*

136. The Parliamentary and Health Service Ombudsman adjudicates on complaints from patients that have not been resolved by the NHS, government departments and other public organisations. The service is impartial and free for patients.

*NHS Digital*

137. NHS Digital (formally the Health and Social Care Information Centre) is an executive non-departmental public body and is the national provider of information, data and IT systems for commissioners, analysts and clinicians in

health and social care. Its purpose is to improve health and social care in England by making better use of technology, data and information.

## Health policy developments and the role of competition and patient choice in the NHS

138. In this section, we outline the development of health policy in recent years and the role of competition and patient choice in the provision of NHS services.

139. Competition in the NHS is one of a number of important drivers of the quality of services for patients, supplementing the role played by regulation.[54] This does not mean that providers cannot and do not collaborate to improve service quality.

### *Health policy developments impacting competition and patient choice*

140. Government has introduced a number of policies impacting upon the nature and scope of competition and patient choice in the provision of NHS services, such as:

*(a)* separating the responsibility for providing and commissioning healthcare in 1991 (referred to as the purchaser/provider split);

*(b)* establishing NHS foundation trusts in 2003;

*(c)* replacing block contracts with PbR in 2003, thus remunerating acute healthcare providers for the number of patients treated and the services actually provided and therefore, incentivising providers to maintain or improve the quality of care provided, in order to attract a higher volume of patients;

*(d)* allowing some NHS care to be provided by the independent sector from 2004;

*(e)* introducing the principle of patient choice in 2006, which was enshrined in the NHS Constitution in 2009, thus incentivising NHS providers to improve the quality of their services, in order to attract patients and corresponding income;

*(f)* establishing the Any Qualified Provider (AQP) principle in 2012, under which qualified providers have contracts with commissioners giving them the right to provide certain NHS services; and

[54] Competition among NHS providers of elective services is almost always in relation to quality, rather than price.

*(g)* establishing the PPC Regulations in 2013.

### *Types of competition in the NHS*

141. There are two different models of competition in the provision of NHS services: competition in the market and competition for the market.

142. Competition in the market (ie competition for patient referrals) occurs where patients have a choice among providers of the same services, which is primarily in respect of routine elective services. Hospitals are incentivised to maintain and improve services, in order to attract patient referrals and corresponding income.

143. Competition for the market (ie competition for contracts) occurs where the commissioning entity enters into contracts with providers under which the providers have the right to provide services to patients. Competition for the market may occur in relation to community services and some non-elective services, but it is less likely to occur in relation to elective services that are subject to a National Tariff. Competition for the market may also occur in relation to specialised services when they are competitively tendered by NHS England at a regional or national level.

144. When entering into contracts with providers, commissioners are bound by the terms of the Procurement, Patient Choice and Competition Regulations 2013, which ensure that commissioners secure high-quality, efficient NHS healthcare services that meet the needs of patients, and protect the rights of patients to choose who provides their healthcare in certain circumstances.

145. There are some services (eg certain specialised and community services) where both competition for the market (when commissioners hold competitive tenders) and competition in the market (when patients exercise choice of provider either informally or pursuant to government mandated patient choice), are present.

### *Patient choice*

146. The principle of patient choice is intended to empower patients to select the provider that best meets their needs, and to incentivise providers to maintain or improve services, in order to attract patients and corresponding income.

147. In the context of secondary care, patient choice refers to a patient's first consultant-led outpatient appointment for routine elective care. The patient is 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.[55]

148. 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 is underpinned by supporting infrastructure, including the NHS e-Referral Service, a secure and free NHS appointment booking service, which allows patients to book their first outpatient appointment at a hospital or clinic of their choice,[56] and NHS Choices, which provides performance information on providers to assist patients in selecting an appropriate provider. Information available to patients 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 (from the trusts' 'friends and family' surveys and from users of NHS Choices);

*(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.[57]

[55] For a physical health condition, the patient will be seen by the consultant or by a clinician who works in the consultant's team. For a mental health condition, the patient will be seen by the consultant or named healthcare professional who leads the mental health team or by another healthcare professional in the team.
[56] The NHS e-Referral service can be accessed in the following ways: (a) a patient's GP can book an appointment on the patient's behalf; (b) the patient can book an appointment using the appointment request letter provided to the patient by their GP; or (c) a patient can phone the NHS e-Referral Service line.
[57] NHS Choices.

## Recent developments in the NHS

149. The increasing demand for NHS services has placed greater operational, clinical and financial pressure on the NHS.

### *Five Year Forward View*

150. The Five Year Forward View developed by NHS England, CQC, Public Health England and NHS Improvement, and published in October 2014 proposed a number of initiatives to transform the delivery of health and social care and respond to these pressures. The Five Year Forward View estimated that growing demand (if met by no further annual efficiencies and flat real terms funding) would produce a mismatch between resources and patient needs of nearly £30 billion a year by the financial year ending 31 March 2021.

151. The Five Year Forward View called for a greater focus on the prevention and improvement of public health and greater integration of health and social care, in order to meet the changing needs of patients and to improve the sustainability of services.

152. One of the proposals was the development of new models of care,[58] in order to remove the traditional divide between primary care, community services and hospitals, and health and social care, which acts as a barrier to coordinated healthcare services:

*(a)* Multispecialty Community Providers (MCPs): larger GP practices to provide a far wider range of care, effectively moving specialist care out of hospitals and into the community.

*(b)* Primary and Acute Care Systems (PACS): vertical integration to enable single organisations to provide GP, hospital, community and mental healthcare services.

*(c)* Urgent and emergency care networks: to improve the coordination of services and reduce pressure on A&E departments.

*(d)* Viable smaller hospitals: support and sustain local hospital services, in order to enable large hospitals to focus on providing complex acute

[58] The new models of care are based on organisational forms proposed by the Dalton Review, a review undertaken by Sir David Dalton, Chief Executive of Salford Royal NHS Foundation Trust, to examine new options and opportunities for NHS providers.

services where there is evidence supporting a relationship between the treatment of a high volumes of patients and improved patient outcomes.

*(e)* Specialised care: greater concentration of specialised care, where there is a strong relationship between patient volumes and quality of care.[59]

*(f)* Modern maternity services: move towards provision of maternity services outside of a hospital setting.

*(g)* Enhanced health in care homes: new shared models of in-reach support, including medical reviews, medication reviews, and rehabilitation services, to reduce levels of permanent admission from hospitals to care homes.

153. Between January and September 2015, 50 vanguards were selected to lead the development of these new care models and act as the blueprints for the NHS moving forward.[60]

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

### *Financial sustainability*

155. In response to the financial pressures facing the NHS, NHS Improvement and NHS England have developed a number of initiatives to improve the financial sustainability of the NHS and to support providers in deficit (ie those providers whose costs are greater than their income).

#### *Sustainability and Transformation Plans*

156. Sustainability and Transformation Plans were introduced by NHS England and NHS Improvement (through joint planning guidance for the financial year ended 31 March 2017) to help ensure that health and social care services were built around the needs of local populations. This was achieved by

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[59] Although the general consensus is that higher volumes of hospital treatment leads to superior patient outcomes, the evidence suggests that the relationship between volumes and outcomes in unclear. For example, see the Competition and Cooperation Panel and York Health Economics Consortium study on the impact of hospital treatment volumes on patient outcomes (April 2010).
[60] See NHS England: Vanguards.

requiring 44 regions or geographical footprints[61] across England to produce a multi-year plan, demonstrating how each region would develop high-quality, sustainable health and social care services over the next five years. The final plans were published in December 2016.

157. Sustainability and Transformation Plans are now Sustainability and Transformation Partnerships as they move into implementation. They are a key mechanism for delivering the Five Year Forward View.

158. 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 Local Care Organisations;

*(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.

159. NHS England has created a Sustainability and Transformation Fund to support local areas in delivering their plans. The fund stands at £2.1 billion for the financial year ending 31 March 2017.[62] From April 2017, STPs will become the single application and approval process for accessing NHS transformation funding. Greater Manchester has secured £450 million to transform health and social care in Greater Manchester.

*Accountable care systems*

160. 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

[61] Each 'footprint' has an average population size of 1.2 million people (the smallest covers a population of 300,000 and the largest 2.8 million).
[62] The fund consists of a £1.8 billion sustainability strand for providers (mainly of acute emergency care) and £0.3 billion for transformation.

responsibility for resources and public health in return for greater control over the operations of the local health system, including the ability to:

*(a)* agree an accountable performance contract with NHS England and NHS Improvement;

*(b)* manage funding for their defined population;[63]

*(c)* create an effective collective decision making and governance structure; and

*(d)* operate through horizontal integration (eg clinical networks) or vertical integration (the providers within the ACS partner with GPs to form clinical hubs).

161. Candidates for ACS status are likely to include successful vanguards, devolution areas, and STPs that have been working towards the ACS goal. This includes Greater Manchester.

*Financial control totals*

162. 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.[64]

163. 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. Providers that agree and meet their financial control totals are able to access the Sustainability and Transformation Fund.

164. CMFT's operational plan for the year ended 31 March 2017 forecasts a surplus of £4.9 million (excluding non-operating income), which is consistent with the control total agreed with NHS Improvement, and includes receipt of £20.2 million from the Sustainability and Transformation Fund.

165. UHSM is forecasting achievement of its surplus of £0.4 million for the year ended 31 March 2017, which is consistent with the control total agreed with NHS Improvement, and includes receipt of £8.3 million from the Sustainability and Transformation Fund.

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[63] This will include committing to a financial system control total across commissioners and providers.
[64] See NHS England news release (21 July 2016): NHS action to strengthen trusts' and CCGs' financial and operational performance for 2016/17.

# Annex 1: NHS foundation trusts

1. This annex summarises the governance and funding arrangements of NHS foundation trusts.

## Governance

2. NHS foundation trusts are public benefit corporations that are authorised to provide goods and services for the purposes of the health service in England.

3. Public benefit corporations are bespoke legal entities originally created by the HSC Act 2003 and now governed by the 2006 Act, as amended by the HSCA 2012.

4. Public benefit corporations are required to have a constitution, which includes the provisions required by statute and may include further provisions which are consistent with statute.

5. Public benefit corporations have members, who are:

   *(a)* individuals living in the area that is specified as a constituency in the corporation's constitution (referred to as a public constituency); or

   *(b)* employees (staff constituency); or

   *(c)* patients of the hospital and carers of those patients (patient constituency).

6. The minimum number of members of each constituency must be stated in the constitution. Individuals may apply, or be invited by the corporation, to become members.

7. Public benefit corporations have a council of governors, who are either appointed or elected by members of the corporation. The 2006 Act (as amended) imposes various requirements relating to the council of governors, including its composition, the election or appointment of governors, payment of expenses and provisions that must be contained in its constitution.

8. Public benefit corporations also have a board of directors, which is capable of exercising all the powers of the corporation on its behalf. In addition, the constitution may provide that duties may be delegated to a committee of directors or an executive director. The board consists of executive directors, including the Chief Executive and the Finance Director, and non-executive directors, including the Chairperson.

9. Public benefit corporations must keep a register of members, governors and directors, and a register of directors' interests, which must be made available

for public inspection. The constitution must make provision for dealing with conflicts of interests, and also set out the procedures for meetings; eligibility for posts; terms of office; remuneration; disqualification and removal; and how to deal with vacancies.

10. A public benefit corporation must produce an annual report and a set of audited accounts. The latest versions of these documents, as well as the current constitution and authorisation and the latest information as to forward planning, must be available for inspection by members of the public free of charge.

## Borrowing

11. NHS foundation trusts may borrow money for the purpose of or in connection with their functions.

12. The Secretary of State may give financial assistance to NHS foundation trusts. The Secretary of State has issued guidance that clarifies the principles on which a loan will be granted and the consequences of failing to comply with the terms to which the loan is subject.[65]

### *Public dividend capital (PDC)*

13. PDC represents the Department of Health's equity interest in defined public assets across the NHS. It constitutes an asset of the Consolidated Fund[66] and is provided by the Department of Health in exceptional circumstances where additional capital is required.

14. The Department of Health is required to make a return on its net assets. A charge, reflecting the cost of the capital provided to an NHS foundation trust, is payable as public dividend capital dividend and is calculated based on net assets on the balance sheet.[67]

15. We understand that NHS foundation trusts are required to make the annual dividend payment regardless of whether or not they have surplus cash or are making operating deficits. A dividend is not payable if the NHS foundation trust has net liabilities on its balance sheet. The PDC of an NHS trust that

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[65] See section 42A of the NHSA 2006, as inserted by section 163(6) of the HSCA 2012.
[66] The Consolidated Fund represents the account held by Chancellor of the Exchequer of the Government at the Bank of England into which public monies are paid and from which major payments are made, other than those dependent on periodic parliamentary approval.
[67] The charge is calculated at the rate set by HM Treasury on the average relevant net assets of an NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (a) donated assets (including lottery funded assets); (b) net cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility; and (c) any PDC dividend balance receivable or payable.

then subsequently receives NHS foundation trust status continues as PDC for the NHS foundation trust under the same conditions.

***Private finance initiative***

16. Private finance initiative (PFI) schemes traditionally involved the creation of partnerships between the public and private sectors, enabling the NHS to raise funds for capital projects from commercial organisations without recourse to public funds. Private companies were contracted to design and construct assets, which were then leased back to the public sector, usually over a period of around 30 years.

17. Following a review of public private partnerships by HM Treasury in 2012, there has developed a new approach to private sector involvement in public sector infrastructure projects and this has replaced traditional PFI schemes. Under this approach, the government acts as a minority equity co-investor with investments managed by a commercially focused central unit located within HM Treasury.

## Protection of property

18. The provider licence issued by NHS Improvement (exercising Monitor's statutory functions) to NHS foundation trusts includes a condition which provides that the licensee will not dispose of certain assets without the consent in writing of NHS Improvement, in circumstances where NHS Improvement has concerns about the licensee's ongoing viability.

# Annex 2: Procurement, Patient Choice and Competition Regulations 2013

1. This annex provides a summary of the Procurement, Patient Choice and Competition Regulations 2013.

## Purpose of the regulations

2. The regulations impose requirements on NHS England and CCGs, in order to:

   *(a)* ensure good practice in relation to the procurement of healthcare services for the purposes of the NHS;

   *(b)* ensure the protection of patients' rights to make choices regarding their NHS treatment; and

   *(c)* prevent anti-competitive behaviour by commissioners with regard to such services.

## Key requirements

3. Part 2 of the regulations imposes requirements on NHS England and CCGs (together referred to as relevant bodies) in relation to procurement, patient choice and anti-competitive behaviour:

   *(a)* Regulation 2 lays down a general objective for relevant bodies when procuring healthcare services for the purposes of the NHS that they secure the needs of patients who use the services and improve the quality and efficiency of the services, including through the services being provided in an integrated way.

   *(b)* Regulation 3 lays down general requirements that apply to the procurement of healthcare services for the purposes of the NHS. This includes requirements for procurement to be carried out in a transparent and proportionate manner and for providers to be treated equally and in a non-discriminatory way.

   *(c)* Regulations 4 and 5 provide for requirements relating to transparency in the award of contracts for the provision of healthcare services for the purposes of the NHS. Where a relevant body is advertising an intention to seek offers from providers to provide services, it must publish a contract notice on a website maintained by the Board (regulation 4(1) and (2)). A relevant body need not advertise an intention to seek such offers where it

is satisfied that the services are only capable of being provided by a particular provider (regulation 5).

*(d)* Regulation 6 prohibits the award of a contract by a relevant body for the provision of NHS healthcare services where conflicts between the interests in commissioning the services and the interests in providing them affect, or appear to affect, the integrity of the award of the contract.

*(e)* Regulation 7 requires a relevant body to establish and apply transparent, proportionate and non-discriminatory criteria for the purposes of taking certain decisions in relation to the provision of healthcare services for the purposes of the NHS.

*(f)* Regulation 9 requires relevant bodies to maintain and publish a record of all contracts entered into by them for the provision of healthcare services for the purposes of the NHS.

*(g)* Regulation 10 lays down a general prohibition on anti-competitive behaviour by relevant bodies, except where it is in the interests of people who use NHS healthcare services.

*(h)* Regulation 11 requires the NHS Commissioning Board (NHS England) not to restrict the ability of a person to apply for inclusion in the list of patients of a practice providing primary medical services, or to express a preference to receive such services from a particular medical practitioner or class of medical practitioner.

*(i)* Regulation 12 places a requirement on relevant bodies to offer a choice of alternative provider in accordance with regulation 48(4) of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (the 2012 Regulations), in the circumstances laid down in regulation 47 of the 2012 Regulations.

4. Part 3 of the regulations provides Monitor with powers to investigate and take enforcement action in relation to breaches of the requirements imposed on relevant bodies by these regulations and regulations 39, 42 and 43 (choice of health service provider) of the 2012 Regulations. These include powers for Monitor to declare arrangements for the provision of healthcare services for the purposes of the NHS to be ineffective (regulation 14), to give directions to a relevant body (regulation 15), and to accept undertakings from a relevant body (regulation 16).

*(a)* Regulation 17 provides that a person who has brought an action for loss or damages under the Public Contracts Regulations 2006 may not bring

an action for the same loss or damage resulting from a breach of these regulations or of regulation 39, 42 or 43 of the 2012 Regulations.

*(b)* Regulation 18 revokes the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 (S.I. 2013/257), which are replaced by these Regulations.

# Annex 3: Review of NHS mergers by NHS Improvement and the CMA

1. This annex outlines the functions of the CMA and NHS Improvement in respect of mergers involving NHS foundation trusts.[68]

2. The merger of NHS foundation trusts may be subject to two types of assessment:

   *(a)* An assessment of competitive effects by the CMA under the merger provisions of the Enterprise Act 2002 (the Enterprise Act) to determine if the merger may be expected to lead to a substantial lessening of competition (SLC) in any market(s) in the United Kingdom.

   *(b) A* transactional assessment by NHS Improvement.

## Assessment of competitive effects

3. Under the merger provisions of the Enterprise Act, the CMA is required to review mergers where it believes that it is or may be the case that:

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

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

4. A merger must meet all three of the following criteria to constitute a relevant merger situation for the purposes of the Enterprise Act:

   *(a)* Either two or more enterprises (broadly speaking, business activities of any kind) must cease to be distinct, or there must be arrangements in progress or in contemplation which, if carried into effect, will lead to enterprises ceasing to be distinct.

   *(b)* The UK turnover associated with the enterprise which is being acquired exceeds £70 million (known as the turnover test), or the enterprises which cease to be distinct supply or acquire goods or services of any description and, after the merger, together supply or acquire at least 25% of all those

[68] Mergers between NHS trusts are subject to review by NHS Improvement. As far as possible, NHS Improvement adopts an approach that is consistent with the approach taken by the CMA for NHS foundation trusts and other enterprises.

particular goods or services of that kind supplied in the UK or in a substantial part of it (known as the share of supply test).

*(c)* The merger must not yet have taken place, or it must have taken place not more than four months before the day the reference is made.[69]

5. In the context of a merger between two NHS foundation trusts, there is no need to examine whether the trusts are enterprises, because the HSCA 2012 expressly provides that the merger provisions of the Enterprise Act apply in this situation. It provides at section 79 that such a merger is to be treated as being a case in which two or more enterprises cease to be distinct.

6. The government's explanatory notes for section 79 make explicit the intention of the HSCA 2012 to give the CMA exclusive jurisdiction over mergers between NHS foundation trusts.

7. This clause applies Part 3 of the Enterprise Act, which sets out the general merger control regime for enterprises in the UK, to NHS foundation trusts where it would otherwise be uncertain as to whether those provisions would apply to them. This clause is intended to avoid legal uncertainty as to when the merger control regime in Part 3 of the Enterprise Act would apply to mergers involving NHS foundation trusts. This provision allows for a single regime for merger control, which avoids duplication of the roles of NHS Improvement and the CMA.

8. Therefore, the merger of two NHS foundation trusts is to be treated as though it were a merger under Part 3 of the Enterprise Act, provided the turnover or share of supply test is met, such that a merger therefore falls within the jurisdiction of the CMA.[70]

9. Under the HSCA 2012, NHS Improvement is required to provide advice to the CMA on relevant customer benefits.[71]

## Transactional assessment

10. NHS Improvement's transactional assessment process is designed to ensure that the prospective merged entity will be legally constituted, well-governed, financially viable, and guided by a robust post-integration plan. The process

[69] If the merger takes place without being made public and without the CMA being informed of it, the four-month period starts from the earlier of the time the merger was made public or the time the CMA was told about it.
[70] The legislation does not clarify jurisdiction over mergers that fall below the turnover/share of supply thresholds in the Enterprise Act, or mergers of other types of NHS organisations.
[71] See section 79(5) of the HSCA 2012.

allows the merging parties to work with NHS Improvement to identify potential risks and to ensure that those risks are properly considered and assessed.

11. NHS Improvement requires merging parties to make a number of submissions regarding the proposed transaction, including:

    *(a)* a business case setting out the reasons for the merger and noting any proposed reconfiguration of services;

    *(b)* a long-term financial model exhibiting financial forecasts for the combined entity for a period of five years;

    *(c)* due diligence to ensure that the merging entities are aware of the risks to which they are subject as a result of the transaction;

    *(d)* the business draft form transfer agreement; and

    *(e)* submissions pertaining to the governance of the integrated entity, detailing what arrangements have been put in place to ensure high-quality governance.

12. In addition, NHS Improvement normally requires the opinions of independent accountants on various matters pertaining to the financial health of the merged entity, including its working capital, financial reporting procedures and post-transaction integration plan.

13. NHS Improvement also conducts meetings with key leaders in both organisations and meets with the proposed Board of the new organisation to address major issues.

14. At the end of this process, NHS Improvement issues risk ratings for the merged entity.

15. NHS foundation trusts that do not address risks which NHS Improvement has identified will be subject to NHS Improvement's regulatory intervention powers.

16. If an application to NHS Improvement to permit a merger is successful, NHS Improvement must specify the property and liabilities to be transferred to the new NHS foundation trust and make an order dissolving the two merging trusts and transferring their property and liabilities to the new organisation. Such an order is conclusive evidence of incorporation and that the corporation is an NHS foundation trust. The Secretary of State for Health's consent is not required in these circumstances.

# Appendix C: Analytical method and detailed analysis of NHS elective and maternity specialties

1. This appendix sets out the analytical method that we used for our quantitative analysis of GP referral data in our assessment of NHS elective and maternity services. It then details the results of our analysis.

## Overlaps between the parties' services

2. As a starting point for the identification of treatments and specialties in which the parties overlap, we used an extract of Hospital Episode Statistics (HES) data covering the two financial years from April 2014 to March 2016.[1,2] We have limited our analysis to the two most recent years of data as older data may not be reflective of the parties' current services, coding approaches, and referral patterns that they are likely to face in the future. We used an extract that includes episodes for patients who are registered with a GP practice in England.[3]

### *Minimum volume thresholds*

3. In its fast-tracked phase 1 investigation of this case, the CMA used a threshold of ten episodes over a four-year period to identify overlaps.[4] However, the parties submitted that ten first outpatient appointments in a year would be the equivalent of around one outpatient clinic per year in that specialty. In the parties' view, a more appropriate threshold for deciding whether providers deliver services in a specialty would be the equivalent of one outpatient clinic per fortnight, which would be around 150 to 200 first outpatient appointments per year, given the need to accommodate both first and follow up appointments.[5] A lower threshold is likely to filter in many

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[1] The HES dataset contains individual records for every NHS admitted acute, community or psychiatric hospital admission, outpatient appointment and A&E attendance in England. We used an extract for outpatients and admitted patients covering the period 1 April 2014 to 31 March 2016. HES data are patient-level, and include information about each patient's registered GP practice, information about their referrer, where they received treatment (provider and site), and what treatment they received (specialty and subspecialties).
[2] For our analysis of elective specialties and maternity, we defined specialties per Treatment Function Codes (TFCs) in the National Specialty List. References to TFCs in this appendix are capitalised and, where appropriate, also include the reference to the numerical code in parenthesis (eg 'General Surgery (100)').
[3] Initially we used an extract of the HES dataset that only included episodes for patients who are registered with a GP practice located in a CCG area of any CCG included in either of the parties' NHS Standard Contract. The parties submitted that this approach excluded around 2% of their routine elective activity. We therefore widened the extract to include all patients registered with a GP practice in England.
[4] CMFT/UHSM phase 1 decision, paragraph 52.
[5] CMFT/UHSM phase 1 submission, paragraph 221 and footnote 92.

specialties which are not genuine overlaps, and which may be due to activity being coded to an incorrect specialty (coding errors).

4. In recognition of the merit of the parties' submission, we adopted a higher threshold than the approach taken in the phase 1 decision, and consider the parties to overlap in all outpatient product markets in which both parties recorded at least 100 episodes in either 2014/15 or 2015/16, and in all inpatient and day-case product markets in which both parties recorded at least 50 episodes in either 2014/15 or 2015/16.[6] We used a lower threshold for day-case and inpatient settings, as there are fewer admitted patients than outpatients in any given specialty. These thresholds were selected 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.

***First attendances and regular patients***

5. For outpatients, we limited our analysis to first outpatient attendances, as patients and/or their GPs are unlikely to have any opportunity to exercise choice of provider for follow-up outpatient attendances. Analogous to this, we also removed spells[7] for regular inpatients or day-case patients that were admitted within 30 days of another admission involving the same patient, provider, and Healthcare Resource Group (HRG) root,[8,9] as regular patients are unlikely to be exercising a fresh choice of provider for each of their regular attendances.

6. The parties submitted that the services most affected by regular inpatients and day-cases included Nephrology (361), for haemodialysis patients, and

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[6] As part of the current NHS mergers regime, NHS Improvement economists often conduct referral analysis as part of NHS Improvement's initial assessments of potential NHS mergers. NHS Improvement economists regularly exclude services with low volumes, which they have defined as HRG subchapters (in the case of admitted patients) and specialties (in the case of outpatients) with volumes below around 100, usually over a two-year period.

[7] A spell is the total continuous stay of a patient using a hospital bed, and spells are a natural way of counting the volume of inpatient and day-case activity. Spells are to be distinguished from episodes. A (consultant) episode is the time that a patient spends in the continuous care of a responsible consultant. A spell can be made up of a single or multiple episodes, and this should be taken into account when analysing data from HES, which records episodes.

[8] HRGs are clinically meaningful groups of patient activity derived primarily from procedure (OPCS-4) and diagnosis (ICD-10) codes within patient records. HRGs are used to support commissioning and reimbursement for healthcare services. HRGs are identified by five character codes. The first two alphabetical characters define the HRG chapter and subchapter, and the next two numeric characters represent the HRG Number within the subchapter. The HRG root refers to the first four character codes, and can be regarded as referring to very granular 'type' of healthcare. See NHS Digital's Casemix Companion for more detail.

[9] The parties raised a potential risk that, because regular patients made many attendances, there was a higher risk that any coding mistakes by providers in the HRG root would result in us counting the new patient-HRG root combination as a new 'choice event' where none existed. In response, we repeated our grouping of spells into sequences of regular attendances but removed the condition requiring spells to have the same HRG root to be considered within the same sequence of regular admissions. We found that this did not have any material impact on its analysis: removing the HRG root condition only led to a 0.2% absolute difference in the number of spells identified as excess/subsequent, and the most affected specialty (Anticoagulant Service 324) only had a 1 percentage point difference in the proportion of spells identified as excess spells.

Clinical Haematology (303), for procedures and treatments such as transfusions, chemotherapy and apheresis.

7. Consistent with the parties' submission, of the specialties identified as potential overlaps in phase 1, we found that the specialties which were particularly affected by the presence of regular patients in which more than 10% of admissions were 'excess' spells (ie spells which fall within a sequence of regular admissions, but which were subsequent to another spell within that sequence) were Nephrology (361), Clinical Oncology (800), Medical Oncology (370), Anticoagulant Service (324), and Clinical Haematology (303).

8. The parties did not agree with our approach of treating regular attenders as day-cases. Instead, the parties submitted that regular attenders should be regarded as a separate treatment setting. However, as we removed all 'excess' regular spells (ie spells that fall within a sequence of regular admissions, but that were subsequent to another spell within that sequence), the impact of regular attenders on our analysis is limited and did not warrant creating a separate treatment setting.[10]

**Table 1: Total number of admitted patient spells in England and proportion of spells identified as excess, phase 1 overlap specialties with over 10% proportion of spells excess, 2014/15 to 2015/16**

| *Specialty (Treatment Function Code)* | *Total spells* | *Excess spells %* |
|---|---|---|
| Nephrology (361) | 1,751,612 | 93 |
| Clinical Oncology (Radiotherapy) (800) | 892,216 | 29 |
| Medical Oncology (370) | 879,677 | 23 |
| Anticoagulant Service (324) | 256 | 15 |
| Clinical Haematology (303) | 1,320,327 | 12 |

Source: CMA analysis of HES data, 2014/15 to 2015/16.

## *Overlap findings*

9. 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 proposed merger in the provision of services to private patients and in relation to seven overlapping NHS elective specialties.[11] We did not investigate these further.[12]

10. On that basis, we found that the parties overlap in at least one treatment setting (ie inpatient, day-case, or outpatient) for 33 remaining specialties shown in Table 2 below.

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[10] We found that, of the specialties identified as potential overlaps in phase 1, first regular spells accounted for 2.1% of the parties' admitted activity which was used in our referral analysis.
[11] The specialties are anaesthetics, palliative medicine, anticoagulant services, medical oncology, clinical oncology, gynaecological oncology and interventional radiology.
[12] See the issues statement.

11. Compared with the CMA's phase 1 analysis, the combination of using the two most recent years of data, moving to the higher threshold, and removing excess spells for regular patients means several specialties and product markets are no longer considered overlaps.[13,14,15]

12. We accepted the parties' submission that activity in Obstetrics (501) and Midwifery Services (560) should be combined and analysed as a single specialty (which we have called Maternity), for the purposes of the referral analysis.

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[13] Compared with the CMA's phase 1 analysis, the combination of using the two most recent years of data, moving to the higher threshold, and removing excess spells for regular patients means that the following 12 specialties are no longer considered overlaps in any treatment setting: Transplantation Surgery (102); Cardiothoracic Surgery (170); Paediatric Plastic Surgery (219); Paediatric Diabetic Medicine (263); Palliative Medicine (315); Nephrology (361); Medical Oncology (370); Paediatric Neurology (421); Podiatry (653); Clinical Oncology (800); and Interventional Radiology (811).
In addition, as shown in Table 2, in a number of product markets the parties do not overlap and, as a result, we no longer consider the following markets: inpatient Pain Management (191); inpatient Paediatric Urology (211); inpatient and day-case General Medicine (300); inpatient Endocrinology (302); inpatient Respiratory Medicine (340); inpatient Rheumatology (410); and inpatient and day-case Geriatric Medicine (430). We reviewed these specialties and product markets and were satisfied that these are unlikely to be genuine and material overlaps.
[14] With respect to Transplantation Surgery (102), the parties submitted that transplantation surgery at UHSM related to heart and lung transplants, while transplantation surgery at CMFT concerned kidney and pancreas transplants. As a result, there was no overlap between the two trusts in relation to these services.
[15] Separate to these changes, the parties also informed us that UHSM did not consider that it offered Paediatric Surgery (171) services, and identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology, and discounted Paediatric Surgery as an overlap.

**Table 2: Number of first appointments and non-excess admissions in product markets where the parties overlap and have more than 100 first outpatient episodes and 50 non-excess admitted spells each year. Referrals from all sources are included and cover the period from 2014/15 to 2015/16. Specialties cleared in phase 1 are excluded.**

| *Specialty (Treatment Function Code)* | *Inpatient* | | *Day-case* | | *Outpatient* | |
|---|---|---|---|---|---|---|
| | *CMFT* | *UHSM* | *CMFT* | *UHSM* | *CMFT* | *UHSM* |
| General Surgery (100) | [3,000-4,000] | [2,000-3,000] | [5,000-6,000] | [6,000-7,000] | [15,000-16,000] | [7,000-8,000] |
| Urology (101) | [2,000-3,000] | [2,000-3,000] | [6,000-7,000] | [6,000-7,000] | [9,000-10,000] | [9,000-10,000] |
| Vascular Surgery (107) | [500-1,000] | [1,000-2,000] | [1,000-2,000] | [500-1,000] | [10,000-11,000] | [4,000-5,000] |
| Trauma & Orthopaedics (110) | [2,000-3,000] | [2,000-3,000] | [5,000-6,000] | [4,000-5,000] | [37,000-38,000] | [17,000-18,000] |
| ENT (120) | [500-1,000] | [1,000-2,000] | [2,000-3,000] | [1,000-2,000] | [28,000-29,000] | [15,000-16,000] |
| Oral Surgery (140) | [1,000-2,000] | [500-1,000] | [4,000-5,000] | [2,000-3,000] | [15,000-16,000] | [1,000-2,000] |
| Orthodontics (143) | | | | | [2,000-3,000] | [1,000-2,000] |
| Plastic Surgery (160) | | | | | [0-500] | [12,000-13,000] |
| Cardiac Surgery (172) | [1,000-2,000] | [1,000-2,000] | | | [1,000-2,000] | [500-1,000] |
| Pain Management (191) | | | [2,000-3,000] | [5,000-6,000] | [1,000-2,000] | [2,000-3,000] |
| Paediatric Urology (211) ‡ | | | [2,000-3,000] | [0-500] ‡ | [3,000-4,000] | [1,000-2,000] ‡ |
| General Medicine (300) | | | | | [5,000-6,000] | [500-1,000] |
| Gastroenterology (301) | [2,000-3,000] | [500-1,000] | [28,000-29,000] | [10,000-11,000] | [10,000,11,000] | [8,000-9,000] |
| Endocrinology (302) | | | [0-500] | [0-500] | [2,000-3,000] | [1,000-2,000] |
| Clinical Haematology (303) | | | | | [6,000-7,000] | [1,000-2,000] |
| Diabetic Medicine (307) | | | | | [4,000-5,000] | [1,000-2,000] |
| Cardiology (320) | [2,000-3,000] | [2,000-3,000] | [2,000-3,000] | [4,000-5,000] | [35,000-36,000] | [32,000-33,000] |
| Paediatric Cardiology (321) | | | | | [4,000-5,000] | [0-500] |
| Dermatology (330) | | | | | [11,000-12,000] | [7,000-8,000] |
| Respiratory Medicine (340) | | | [500-1,000] | [2,000-3,000] | [6,000-7,000] | [14,000-15,000] |
| Infectious Diseases (350) | | | | | [2,000-3,000] | [1,000-2,000] |
| Rheumatology (410) | | | [1,000-2,000] | [1,000-2,000] | [4,000-5,000] | [4,000-5,000] |
| Paediatrics (420) | [0-500] | [0-500]† | [1,000-2,000] | [0-500] | [12,000-13,000] | [4,000-5,000] |
| Neonatology (422) | [1,000-2,000] | n/a† | | | [1,000-2,000] | n/a† |
| Geriatric Medicine (430) | | | | | [1,000-2,000] | [1,000-2,000] |
| Maternity (501 and 560) | [38,000-39,000] | [10,000-11,000] | | | [25,000-26,000] | [20,000-21,000] |
| Gynaecology (502) | [2,000-3,000] | [1,000-2,000] | [9,000-10,000] | [5,000-6,000] | [37,000-38,000] | [8,000-9,000] |
| Physiotherapy (650) | | | | | [14,000-15,000] | [32,000-33,000] |
| Occupational Therapy (651) | | | | | [1,000-2,000] | [500-1,000] |
| Speech and Language Therapy (652) | | | | | [0-500] | [500-1,000] |
| Dietetics (654) | | | | | [4,000-5,000] | [500-1,000] |
| Chemical Pathology (822) | | | | | [0-500] | [0-500] |
| Audiology (840) | | | | | [6,000-7,000] | [5,000-6,000] |

Source: CMA analysis of HES data, 2014/15 to 2015/16.

† The parties informed us that UHSM had been incorrectly coding activity for Well Babies (424) and Neonatology (422) as inpatient Paediatrics (420). We corrected for this by removing those spells in UHSM's Paediatrics (420) activity that had a method of admission (ADMIMETH) as either '82 = The birth of a baby in this Health Care Provider' or '83 = Baby born outside the Health Care Provider except when born at home as intended'. However, it was not clear which of these spells of the removed activity should be reallocated as UHSM's inpatient Neonatology (422). On a cautious basis, we included Neonatology (422) as a potential overlap, and report CMFT's activity for this specialty in this table.

‡ The parties informed us that UHSM did not consider that it offered Paediatric Surgery (171) services, and identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

## Baseline referral analysis

13. Referral analysis provides a starting point for the assessment of the 'closeness' of competition between acute trusts, by using the share of referrals that each provider gains from each referrer (eg GP practices) as a proxy for the strength of patients' and referrers' preferences for different providers.

14. For outpatient product markets, the results of the referral analysis have a similar interpretation to diversion ratios. The analysis infers a relative ranking of alternate hospitals for patients of any given hospital (the 'anchor' hospital) from the choices of other patients at that referrer. For each referrer, the analysis reallocates all the referrals made to the anchor hospital (ie in the event of the anchor hospital being closed) to all other hospitals that the referrer sent patients to, using the same proportions as each hospital's share of that referrer's referrals.[1] This is repeated for every referrer in our extract and aggregated to form a single ranking of alternative providers for each product market.

15. We have also conducted a referral analysis for inpatients and day-cases. For inpatients and day-cases, based on past evidence, we expect patients will be evenly split as to whether they expect at the time of their initial referral that they would subsequently need to be admitted for treatment or planned surgery.[2,3] Where patients do expect follow-on treatment, patients and their GPs may consider 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 will, 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, but would not be able to separate out those

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[1] 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 5 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.
[2] In ASP/RSC, the CMA's patient survey found that 44% of surveyed patients thought it was very likely or quite likely that they would subsequently need to be admitted for treatment or planned 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, whilst the quality of day-case and inpatient services is more important for other patients. (ASP/RSC final report, paragraphs 6.36 to 6.40.)
[3] In their response to our provisional findings, the parties submitted that the survey does not provide any information on whether the respondents' expectations about admittance to hospital in ASP/RSC are accurate. However, since patients' choice of provider are based on their ex ante expectations, the question of whether these expectations were accurate ex post is peripheral.

patients who choose solely on the basis of considerations related to the quality of outpatient services.

16. The parties argued that *(a)* neither patients nor their referring GPs know what type of treatment they are going to receive at the point of referral, and that therefore all patients will consider the quality of inpatient and day-case services together, and *(b)* to the extent that providers competed for patient referrals within a specialty, they do so without differentiating their offer by care setting. Therefore, in the parties' view, referral analysis should be applied to first outpatient appointments only. The parties submit that an analysis of referrals involving inpatient and day-case admissions are meaningless, and that the CMA should not find an SLC in any specialty in day-case or inpatient services if there do not appear to be competition concerns in the outpatient services of that specialty.[4]

17. Contrary to the parties' assertion that neither patients nor their referring GPs know what type of treatment they are going to receive at the point of referral, and that therefore all patients will consider the quality of inpatient and day-case services together, our view, based on survey evidence, is that different patients (and their GPs) will have varying degrees of confidence about the likelihood of needing admission and may alter their choice accordingly. Whilst some patients expect follow-on treatment and therefore take into account or place more weight on the quality of inpatient services when making their initial choice of provider, there will also be a proportion of patients (and GPs) that anticipate that they will not require any inpatient or day-case treatment, and will choose a provider that focuses on, or only provides, outpatient services in the relevant specialty (or whose outpatient facilities suit their preferences better) over the outpatient services of integrated providers.

18. Similarly, we believe that it is possible for providers to differentiate their offer within a specialty by care setting, for example, by making investments in equipment, facilities and treatments which are specific to particular care settings.

19. Therefore, we believe it is appropriate to examine inpatient and day-case referral patterns and shares of admissions in the local area because, from a supply-side perspective, the conditions of competition may differ across these segments, due to the fact that, generally, there are asymmetric constraints among different providers of inpatient, day-case and outpatient care for each

[4] Parties' response to provisional findings, paragraph 29.

specialty.[5] Relying solely on an analysis of outpatient referrals will risk overestimating the competitive constraint posed by providers that focus mainly or only on outpatient treatment (or are otherwise more effective competitors in terms of their outpatient offer than their inpatient/day-case offer), particularly for those patients (and their GPs) that anticipate that they will need some follow-on inpatient or day-case treatment.

20. The fact that the conditions of competition may differ across outpatient, day-case, and inpatient segments in this case is evidenced by the fact that Care UK provided outpatient services,[6] but not day-case or elective inpatient services, and is highlighted by the referral analysis as a material competitor to the parties in several outpatient specialties, including ENT (Ear, Nose and Throat), General Surgery, Urology, Trauma and Orthopaedics, General Medicine, and Gynaecology.

21. Care UK's operations in Greater Manchester stemmed from its Clinical Assessment and Treatment Service (CATS) contract.[7] Care UK provided a mobile, community-based NHS service,[8] and tried to attract patients from other outpatient services.[9] This illustrates the possibility that an outpatient-only provider can attract patients and compete with the outpatient services at a rival integrated provider, without providing any competitive constraint on rivals' inpatient and day-case services.

22. Therefore, we believe that there is value in examining the referral patterns for inpatients and day-cases where the patient's initial choice of provider may be preserved (this would involve removing those observations in which the source of admission is unlikely to involve patient choice, such as transfers from another NHS institution). However, we accept that as a result of *(a)* uncertainty about the extent to which patients and their GPs anticipate the need for admitted care and take quality of inpatient and day-case care into account, and *(b)* our reliance on the assumption that each patient's registered GP practice was also the referring organisation (see paragraph 40 below), the referral analysis for inpatients and day-cases is more uncertain than for

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[5] Whilst 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. (ASP/RSC final report, paragraphs 5.19 and 5.20.)
[6] This business was sold to InHealth in January 2017. See Press Release: InHealth Invests in Community Based Services in the North West.
[7] www.greater-manchester-cats.nhs.uk.
[8] The parties submitted that if patients that were referred to Care UK's CATS service turned out to require an admission, they were referred on to a specific provider (such as BMI Healthcare or Pennine Acute) for this admission as part of a 'prescribed pathway'.
[9] For example, under 'Why choose NWCATS?' on its website, Care UK states that its service offers short waiting times, mobile units that mean that patients can be seen at a location close to home, evening and weekend appointments, free parking and WiFi, and consistently good clinical outcomes and standards.

outpatients. Therefore, we have also supplemented the results of the inpatient and day-case referral analyses by examining the parties' and third-parties' volume of admissions and shares of inpatient and day-case activity over an 80% catchment based on patients' addresses,[10] as a sensitivity test which does not rely on assumptions about the referring organisation.[11]

23. The parties submitted several alternative explanations for the variation in providers' shares of reallocated referrals between different treatment settings within a specialty, other than differences in the competitive strength across providers in different treatment settings.[12] For instance:

*(a)* There may be differences between providers in the care setting in which certain treatments are provided to patients. Generally, innovation in medical treatments lead to some treatments being provided in day-case and outpatient settings instead of inpatient settings. However, the adoption of innovations may be uneven so, for some specialties, similar patients may receive similar treatments in different care settings, depending on which provider they attend. In particular, the parties submitted that UHSM is in the process of transferring joint injections in Rheumatology from a day-case to an outpatient setting.

*(b)* Variations could be random, due to differences in the underlying health characteristics of each providers' local population, or caused by differences in the set of referrals used for our analysis of inpatient and day-case admissions compared with the set of GP-only referrals used for outpatient appointments (explained further in paragraphs 51 to 56 below).

24. We noted the parties' submissions on this point, but nevertheless considered that differences in providers' shares of reallocated referrals could not be entirely explained by these other factors. Where the parties provided specific examples of differences in clinical practices which may lead to systematic biases in our referral analysis (such as Rheumatology), we take these into account in our competitive assessment.

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[10] We derived 80% catchment areas for each specialty centred on each of CMFT and UHSM by using the Lower Super Output Area (LSOA) of patients' home address. We took into account the parties' submission on catchment area construction and ordered LSOAs by the straight-line distance from the population-weighted centroid of each LSOA to MRI (in the case of CMFT's catchment area) and Wythenshawe (in the case of UHSM's catchment area), and added LSOAs that are closest to each of the parties' main sites to the catchment area until the set of LSOAs in the catchment area made up 80% of CMFT or UHSM's patients.

[11] The parties argued that shares of inpatient and day-case activity would not overcome the problems that they identified with the referral analysis if, for the reasons outlined in paragraph 16, there is no link between patients' expectations about the care setting in which treatment will be provided and patients' choice of provider due to preferences about the quality of services in different treatment settings. However, as we do not accept that there is no link, for the reasons set out in paragraphs 17 to 21 above, we consider that there is value in examining shares of inpatient and day-case activity.

[12] Parties' response to provisional findings, paragraph 27.

***Trust-level and site-level referral analysis***

25. Generally, in cases where the CMA considers that a provider's sites have a degree of operational and strategic independence, and/or where the competition conditions facing a provider's sites may be expected to be materially different (eg if two sites providing the same services are in different local markets, very far apart and facing different local competitors), it may be appropriate to conduct referral analysis at a site-level.

26. In this case while CMFT operates across three sites (CMFT's main Oxford Road site, Trafford General Hospital, and Altrincham Hospital) and UHSM two sites (Wythenshawe Hospital, and Withington Community Hospital), in both instances not only are the parties' sites controlled financially, operationally, and strategically by a single management team, but furthermore, the parties' sites are closely located within the same conurbation. For this reason, we believe that it is appropriate to treat all of each party's sites as single entities. In addition, as the relevant data field for determining the site of treatment is not used for determining payment to providers, the quality of site code data is often quite poor quality. For example, in this case, the parties informed us that UHSM's activity at Withington before 2015/16 was not coded correctly.

***Coding differences among trusts and grouped specialties***

27. The parties suggested that certain specialties should be grouped for analytical purposes, where providers may have different coding practices and record patients with similar conditions under different specialties. In phase 1, the CMA accepted that grouping Obstetrics (501) and Midwifery Services (560) is appropriate.

28. The parties further suggested that the following specialties should be grouped:

    *(a)* General Surgery (100) and Colorectal Surgery (104) – CMFT records activity in Colorectal Surgery, but UHSM records this activity under General Surgery.

    *(b)* Oral Surgery (140) and Maxillo-Facial Surgery (144) – CMFT does not record any activity in Maxillo-Facial Surgery, and records all relevant activity in Oral Surgery. In contrast, UHSM records activity in both Oral Surgery and Maxillo-Facial Surgery.

    *(c)* ENT (120) and Audiology (840) – CMFT believes that some audiology referrals may have been recorded in ENT.

*(d)* Stroke Medicine (328), Transient Ischemic Attack (329), General Medicine (300), and Geriatric Medicine (430) – UHSM records activity under the Transient Ischemic Attack (TIA) specialty, but not in the Stroke Medicine specialty. In contrast, CMFT records activity in the Stroke Medicine specialty, but not in the TIA specialty. In addition, both parties believe that some stroke-related activity is likely to be recorded in the General Medicine specialty. Furthermore, the Geriatric Medicine specialty is likely to include stroke-related care, particularly at UHSM where one of its geriatricians is also a stroke consultant. Finally, care for older people at CMFT is likely to be recorded within General Medicine rather than in Geriatric Medicine.

29. As a robustness check, we repeated our referral analysis for these groupings of specialties and product markets, and found that the results for combined specialties were broadly similar to the results for their constituents.

30. In addition, the parties highlighted a coding issue within two specialties, Urology (101) and Pain Management (191), in which some patients referred to CMFT, UHSM and other providers may be undergoing treatment at their first appointment with a consultant. The parties submitted that these treatments may be being coded as day-case activity (as a result of the patient receiving an anaesthetic and possibly consistent with higher tariffs being payable for day-case activity). To account for this possibility, we grouped the day-case activity with other first outpatient appointments within each of these two specialties for our GP referral analysis.

***Referral analysis results and initial filtering***

31. The results of the baseline referral analysis and the parties' shares of activity are presented in the tables below. There are 33 overlapping specialties.

**Table 3: Baseline referral analysis, all sources of referrals, 2014/15 to 2015/16**

| | *CMFT anchor* | | | | | | *UHSM anchor* | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Inpatient* | | *Day-case* | | *Outpatient* | | *Inpatient* | | *Day-case* | | *Outpatient* | | |
| *Specialty (Treatment Function Code)* | *UHSM rank* | *UHSM share (%)* | *UHSM rank* | *UHSM share (%)* | *UHSM rank* | *UHSM share (%)* | *CMFT rank* | *CMFT share (%)* | *CMFT rank* | *CMFT share (%)* | *CMFT rank* | *CMFT share (%)* | *Further review?* |
| General Surgery (100) | 1 | 21.6 | 1 | 52.3 | 2 | 12.7 | 1 | 38.9 | 1 | 42.2 | 1 | 28.6 | Yes – DC |
| Urology (101) | 1 | 33.1 | 1 | 57.7 | 1 | 34.6 | 1 | 47.9 | 1 | 58.4 | 1 | 37.1 | Yes – IP, DC |
| Vascular Surgery (107) | 1 | 55.0 | 1 | 46.9 | 1 | 45.7 | 1 | 60.5 | 1 | 75.7 | 1 | 77.9 | Yes – IP, DC, OP |
| Trauma & Orthopaedics (110) | 1 | 22.5 | 1 | 24.4 | 2 | 19.7 | 2 | 25.7 | 1 | 31.0 | 1 | 35.3 | No |
| ENT (120) | 1 | 21.9 | 1 | 40.8 | 2 | 25.4 | 1 | 28.5 | 1 | 56.6 | 1 | 43.2 | Yes – DC, OP |
| Oral Surgery (140) | 2 | 28.1 | 1 | 35.9 | 3 | 14.4 | 1 | 63.0 | 1 | 55.3 | 1 | 54.3 | Yes – IP, DC, OP |
| Orthodontics (143) | | | | | 1 | 24.0 | | | | | 1 | 43.0 | Yes – OP |
| Plastic Surgery (160) | | | | | 1 | 64.4 | | | | | 2 | 9.8 | Yes – OP |
| Cardiac Surgery (172) | 1 | 78.9 | | | 1 | 73.7 | 1 | 87.6 | | | 1 | 88.0 | Yes – IP, OP |
| Pain Management (191) | | | 1 | 50.6 | 2 | 37.3 | | | 2 | 24.8 | 1 | 30.6 | Yes – DC |
| Paediatric Urology (211) ‡ | | | 1 | 62.2 | 1 | 78.3 | | | 1 | 92.6 | 1 | 92.3 | Yes – DC, OP |
| General Medicine (300) | | | | | 1 | 25.1 | | | | | 1 | 59 | Yes – OP |
| Gastroenterology (301) | 1 | 35.6 | 1 | 44.6 | 1 | 48.6 | 1 | 64.0 | 1 | 74.4 | 1 | 66.8 | Yes – IP, DC, OP |
| Endocrinology (302) | | | 3 | 4.0 | 2 | 22.2 | | | 3 | 12.5 | 3 | 27.9 | No |
| Clinical Haematology (303) | | | | | 1 | 33.7 | | | | | 1 | 64 | Yes – OP |
| Diabetic Medicine (307) | | | | | 1 | 46.5 | | | | | 1 | 84.4 | Yes – OP |
| Cardiology (320) | 1 | 51.3 | 1 | 44.0 | 1 | 52.2 | 1 | 45.0 | 1 | 31.0 | 1 | 63.7 | Yes – IP, DC, OP |
| Paediatric Cardiology (321) | | | | | 1 | 39.6 | | | | | 1 | 92.2 | Yes – OP |
| Dermatology (330) | | | | | 2 | 40.0 | | | | | 1 | 45.6 | Yes – OP |
| Respiratory Medicine (340) | | | 1 | 44.8 | 1 | 69.9 | | | 2 | 24.6 | 1 | 44.5 | Yes – DC, OP |
| Infectious Diseases (350) | | | | | 2 | 23.4 | | | | | 2 | 35.0 | No |
| Rheumatology (410) | | | 1 | 34.3 | 1 | 46.5 | | | 1 | 39.1 | 1 | 55.4 | Yes – OP |
| Paediatrics (420) † | 4 | 5.1 | 1 | 37.6 | 1 | 46.1 | 3 | 15.0 | 1 | 74.5 | 1 | 55.0 | Yes – DC, OP |
| Geriatric Medicine (430) | | | | | 1 | 64.5 | | | | | 1 | 57.0 | Yes – OP |
| Maternity (501 and 560) | 1 | 28.9 | | | 1 | 30.0 | 1 | 74.9 | | | 1 | 71.7 | Yes – IP, OP |
| Gynaecology (502) | 1 | 27.8 | 1 | 28.1 | 1 | 21.8 | 1 | 46.5 | 1 | 75.7 | 1 | 63.4 | Yes – IP, DC, OP |

| | *CMFT anchor* | | | | | | *UHSM anchor* | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Inpatient* | | *Day-case* | | *Outpatient* | | *Inpatient* | | *Day-case* | | *Outpatient* | | |
| *Specialty (Treatment Function Code)* | *UHSM rank* | *UHSM share (%)* | *UHSM rank* | *UHSM share (%)* | *UHSM rank* | *UHSM share (%)* | *CMFT rank* | *CMFT share (%)* | *CMFT rank* | *CMFT share (%)* | *CMFT rank* | *CMFT share (%)* | *Further review?* |
| Physiotherapy (650) | | | | | 1 | 51.0 | | | | | 1 | 53.9 | Yes – OP |
| Occupational Therapy (651) | | | | | 1 | 33.6 | | | | | 1 | 46.6 | Yes – OP |
| Speech and Language Therapy (652) | | | | | 1 | 42.5 | | | | | 1 | 35.8 | Yes – OP |
| Dietetics (654) | | | | | 2 | 28.1 | | | | | 1 | 78.2 | Yes – OP |
| Chemical Pathology (822) | | | | | 1 | 92.5 | | | | | 1 | 80.3 | Yes – OP |
| Audiology (840) | | | | | 2 | 42.8 | | | | | 2 | 21.2 | Yes – OP |
| Combined Colorectal and General Surgery (104 and 100) | 1 | 19.3 | 1 | 42.9 | 2 | 14.3 | 1 | 35.8 | 1 | 37.0 | 1 | 32.2 | Yes – DC |
| Combined ENT and Audiology (120 and 840) | 1 | 21.9 | 1 | 40.8 | 1 | 32.0 | 1 | 28.5 | 1 | 56.6 | 1 | 40.8 | Yes – DC, OP |
| Combined Oral Surgery and Maxillo-Facial Surgery (140 and 144) | 2 | 22.9 | 1 | 34.6 | 1 | 24.7 | 1 | 58.7 | 1 | 54.4 | 1 | 55.6 | Yes – IP, DC, OP |
| Combined Stroke and Old Age Related Specialties (300, 328, 329, and 430) | | | | | 1 | 41.1 | | | | | 1 | 59.1 | Yes – OP |
| Combined Outpatient and Day-Case Urology (101) | | | | | 1 | 40.3 | | | | | 1 | 42.7 | Yes – OP |
| Combined Outpatient and Day-Case Pain Management (191) | | | | | 1 | 45.2 | | | | | 2 | 27.0 | Yes - OP |

Source: CMA analysis of HES data, 2014/15 to 2015/16.
† The parties informed us that UHSM had been incorrectly coding activity for Well Babies (424) and Neonatology (422) as inpatient Paediatrics (420). We corrected for this by removing those spells in UHSM's Paediatrics (420) activity that had a method of admission (ADMIMETH) as either "82 = The birth of a baby in this Health Care Provider" or "83 = Baby born outside the Health Care Provider except when born at home as intended". However, it was not clear which of these spells of the removed activity should be reallocated as UHSM's inpatient Neonatology (422). On a cautious basis, we included Neonatology (422) as a potential overlap, but we did not report the results of our referral analysis for Neonatology in this table.
‡ The parties informed us that UHSM did not consider that it offered Paediatric Surgery (171) services, and identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

**Table 4: Parties' combined share and increment, all appointments and admissions, 2014/15 to 2015/16**

| | *CMFT centred 80% catchment* | | | | | | *UHSM centred 80% catchment* | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Inpatient* | | *Day-case* | | *Outpatient* | | *Inpatient* | | *Day-case* | | *Outpatient* | |
| *Specialty (Treatment Function Code)* | *Combined %* | *Increment %* | *Combined %* | *Increment %* | *Combined %* | *Increment %* | *Combined %* | *Increment %* | *Combined %* | *Increment %* | *Combined %* | *Increment %* |
| General Surgery (100) | [30-40] | [10-20] | [30-40] | [10-20] | [30-40] | [10-20] | [40-50] | [20-30] | [60-70] | [20-30] | [40-50] | [10-20] |
| Urology (101) | [30-40] | [10-20] | [60-70] | [20-30] | [30-40] | [10-20] | [80-90] | [20-30] | [80-90] | [30-40] | [70-80] | [20-30] |
| Vascular Surgery (107) | [60-70] | [20-30] | [70-80] | [20-30] | [60-70] | [30-40] | [60-70] | [20-30] | [70-80] | [20-30] | [80-90] | [40-50] |
| Trauma & Orthopaedics (110) | [20-30] | [10-20] | [20-30] | [10-20] | [30-40] | [10-20] | [50-60] | [20-30] | [60-70] | [20-30] | [60-70] | [30-40] |
| ENT (120) | [30-40] | [10-20] | [30-40] | [10-20] | [40-50] | [10-20] | [50-60] | [10-20] | [70-80] | [30-40] | [70-80] | [30-40] |
| Oral Surgery (140) | [40-50] | [10-20] | [30-40] | [10-20] | [30-40] | [0-5] | [70-80] | [30-40] | [80-90] | [30-40] | [50-60] | [5-10] |
| Orthodontics (143) | | | | | [40-50] | [10-20] | | | | | [60-70] | [20-30] |
| Plastic Surgery (160) | | | | | [70-80] | [0-5] | | | | | [60-70] | [0-5] |
| Cardiac Surgery (172) | [90-100] | [40-50] | | | [90-100] | [40-50] | [90-100] | [30-40] | | | [80-90] | [40-50] |
| Pain Management (191) | | | [30-40] | [10-20] | [30-40] | [10-20] | | | [70-80] | [20-30] | [80-90] | [20-30] |
| Paediatric Urology (211) ‡ | | | [70-80] | [10-20] | [90-100] | [30-40] | | | [90-100] | [20-30] | [90-100] | [40-50] |
| General Medicine (300) | | | | | [20-30] | [5-10] | | | | | [60-70] | [20-30] |
| Gastroenterology (301) | [40-50] | [10-20] | [50-60] | [10-20] | [50-60] | [20-30] | [80-90] | [30-40] | [90-100] | [30-40] | [50-60] | [20-30] |
| Endocrinology (302) | | | [20-30] | [0-5] | [20-30] | [10-20] | | | [20-30] | [5-10] | [40-50] | [10-20] |
| Clinical Haematology (303) | | | | | [20-30] | [5-10] | | | | | [80-90] | [30-40] |
| Diabetic Medicine (307) | | | | | [60-70] | [10-20] | | | | | [90-100] | [20-30] |
| Cardiology (320) | [70-80] | [30-40] | [30-40] | [10-20] | [50-60] | [20-30] | [60-70] | [30-40] | [30-40] | [10-20] | [50-60] | [20-30] |
| Paediatric Cardiology (321) | | | | | [80-90] | [0-5] | | | | | [80-90] | [10-20] |
| Dermatology (330) | | | | | [20-30] | [10-20] | | | | | [60-70] | [20-30] |
| Respiratory Medicine (340) | | | [40-50] | [10-20] | [70-80] | [30-40] | | | [30-40] | [10-20] | [40-50] | [10-20] |
| Infectious Diseases (350) | | | | | [50-60] | [5-10] | | | | | [20-30] | [10-20] |
| Rheumatology (410) | | | [20-30] | [10-20] | [40-50] | [10-20] | | | [70-80] | [20-30] | [80-90] | [40-50] |
| Paediatrics (420) † | [20-30] | [10-20] | [70-80] | [10-20] | [40-50] | [10-20] | [60-70] | [5-10] | [80-90] | [40-50] | [70-80] | [20-30] |
| Geriatric Medicine (430) | | | | | [30-40] | [10-20] | | | | | [80-90] | [10-20] |
| Maternity (501 And 560) | [60-70] | [10-20] | | | [80-90] | [10-20] | [80-90] | [30-40] | | | [90-100] | [30-40] |
| Gynaecology (502) | [20-30] | [5-10] | [50-60] | [20-30] | [40-50] | [5-10] | [70-80] | [20-30] | [90-100] | [10-20] | [80-90] | [30-40] |
| Physiotherapy (650) | | | | | [60-70] | [20-30] | | | | | [80-90] | [10-20] |

| | *CMFT centred 80% catchment* | | | | | | *UHSM centred 80% catchment* | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Inpatient* | | *Day-case* | | *Outpatient* | | *Inpatient* | | *Day-case* | | *Outpatient* | |
| *Specialty (Treatment Function Code)* | *Combined %* | *Increment %* | *Combined %* | *Increment %* | *Combined %* | *Increment %* | *Combined %* | *Increment %* | *Combined %* | *Increment %* | *Combined %* | *Increment %* |
| Occupational Therapy (651) | | | | | [50-60] | [20-30] | | | | | [50-60] | [20-30] |
| Speech and Language Therapy (652) | | | | | [70-80] | [20-30] | | | | | [50-60] | [10-20] |
| Dietetics (654) | | | | | [60-70] | [10-20] | | | | | [80-90] | [30-40] |
| Chemical Pathology (822) | | | | | [60-70] | [5-10] | | | | | [90-100] | [10-20] |
| Audiology (840) | | | | | [40-50] | [20-30] | | | | | [70-80] | [30-40] |
| Combined Colorectal and General Surgery (104 and 100) | [20-30] | [10-20] | [20-30] | [10-20] | [30-40] | [5-10] | [40-50] | [20-30] | [60-70] | [20-30] | [30-40] | [10-20] |
| Combined ENT and Audiology (120 and 840) | [30-40] | [10-20] | [30-40] | [10-20] | [40-50] | [10-20] | [50-60] | [10-20] | [70-80] | [30-40] | [70-80] | [30-40] |
| Combined Oral Surgery and Maxillo-Facial Surgery (140 and 144) | [40-50] | [10-20] | [30-40] | [10-20] | [30-40] | [10-20] | [60-70] | [30-40] | [80-90] | [30-40] | [60-70] | [20-30] |
| Combined Stroke and Old Age Related Specialties (300, 328, 329, and 430) | | | | | [20-30] | [10-20] | | | | | [70-80] | [20-30] |

Source: CMA analysis of HES data, 2014/15 to 2015/16.

† The parties informed us that UHSM had been incorrectly coding activity for Well Babies (424) and Neonatology (422) as inpatient Paediatrics (420). We corrected for this by removing those spells in UHSM's Paediatrics (420) activity that had a method of admission (ADMIMETH) as either '82 = The birth of a baby in this Health Care Provider' or '83 = Baby born outside the Health Care Provider except when born at home as intended'. However, it was not clear which of these spells of the removed activity should be reallocated as UHSM's inpatient Neonatology (422). On a cautious basis, we included Neonatology (422) as a potential overlap, but we did not report the parties' shares in Neonatology in this table.

‡ The parties informed us that UHSM did not consider that it offered Paediatric Surgery (171) services, and identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

32. In ASP/RSC, the CMA applied the following approach to the referral analysis in order to identify services which would be likely to warrant further review:

*(a)* one of the parties is the other's next most commonly chosen alternative; or

*(b)* one of the parties' share of referrals reallocated to the other party is 30% or greater.[28]

33. Applying the same approach to this case would rule one out of 33 overlapping specialties, Endocrinology (302), from further review.

34. In this case, we consider that product markets and specialties in which the parties' share of reallocated referrals are below 40% are unlikely to give rise to horizontal unilateral effects, unless there are other significant aggravating factors which suggest that competition between the parties plays a particularly important role in that product market or specialty. This takes into account the facts that:

*(a)* the CMA and predecessor bodies have not found horizontal unilateral effects to be likely in product markets or specialties in which the share of reallocated referrals was below 40%; and

*(b)* as discussed in Section 4 of the main report, we found that recent policy developments have encouraged greater levels of collaboration and collective responsibility in the provision of NHS acute services within local health economies, combined with increased financial and capacity constraints on the parties, leads to a reduced emphasis on the role of competition within the NHS.

35. Applying the higher threshold of 40% would, in addition to Endocrinology (302), rule out Trauma and Orthopaedics (110) and Infectious Diseases (350) from requiring further review.

***Proportion of referrals from GP practices that refer exclusively to CMFT or UHSM***

36. As explained above, referral analysis reallocates referrals made to an anchor hospital to all other hospitals in the same proportion as each hospital's share of the referrer's non-anchor referrals. If a GP practice refers exclusively to the

[28] In this case, both parts of the ASP/RSC filter are triggered for nearly all overlap specialties. Only one specialty (Infectious Diseases) was flagged for further review on the basis of a single part of the ASP/RSC filter (one of the parties' share of referrals reallocated to the other party is 30% or greater). The closest competitor condition (one of the parties is the other's next most commonly chosen alternative) did not lead to any specialties being flagged for further review that would not have been flagged by the 'greater than 30%' condition.

anchor hospital (ie it is an 'anchor-only' referrer), then there is no information for the referral analysis to use to reallocate referrals. Therefore, referrals from anchor-only referrers are excluded from the analysis.

37. However, it is useful to examine the proportion of referrals that are from anchor-only referrers, as this would provide some insight on the overall magnitude of the competitive constraint imposed by other providers, to complement the information about the relative ranking of alternate hospitals provided in the referral analysis.

**Table 5: Proportion of referrals derived from anchor-only GP practices, all admissions and first outpatient appointments, in product markets where the parties overlap and have more than 100 first outpatient episodes and 50 non-excess admitted spells each year, 2014/15 to 2015/16**

*%*

| *Specialty (Treatment Function Code)* | *Inpatient* | | *Day-case* | | *Outpatient* | | *Outpatient GP-only* | |
|---|---|---|---|---|---|---|---|---|
| | *CMFT* | *UHSM* | *CMFT* | *UHSM* | *CMFT* | *UHSM* | *CMFT* | *UHSM* |
| General Surgery (100) | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 |
| Urology (101) | 1.2 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 |
| Vascular Surgery (107) | 26.7 | 22.2 | 25.2 | 14.3 | 2.8 | 0.8 | 8.8 | 2.6 |
| Trauma & Orthopaedics (110) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ENT (120) | 1.3 | 6.7 | 0.9 | 0 | 0.0 | 0 | 0 | 0 |
| Oral Surgery (140) | 26.6 | 20.9 | 0.7 | 0.0 | 0.0 | 0 | 3.9 | 2.5 |
| Orthodontics (143) | | | | | 6.6 | 1.2 | | |
| Plastic Surgery (160) | | | | | 0 | 1.0 | 0.4 | 33.3 |
| Cardiac Surgery (172) | 21.5 | 24.6 | | | 26.3 | 16.7 | | |
| Pain Management (191) | | | 0 | 1.0 | 0 | 0.1 | 0.1 | 1.2 |
| Paediatric Urology (211) ‡ | | | 64.8 | 11.1‡ | 48.2 | 2.7‡ | 56.8 | 21.8 |
| General Medicine (300) | | | | | 0.9 | 0 | 5.1 | 0 |
| Gastroenterology (301) | 10.2 | 7.3 | 0.0 | 0 | 0.0 | 0 | 0 | 1.3 |
| Endocrinology (302) | | | 8.4 | 0.8 | 0.5 | 0.1 | 1.0 | 1.0 |
| Clinical Haematology (303) | | | | | 1.2 | 0 | 4.5 | 3.2 |
| Diabetic Medicine (307) | | | | | 8.7 | 1.8 | 19.3 | 22.6 |
| Cardiology (320) | 9.7 | 3.9 | 1.8 | 1.0 | 0 | 0 | 0.1 | 1.4 |
| Paediatric Cardiology (321) | | | | | 41.6 | 0.3 | 67.8 | 11.5 |
| Dermatology (330) | | | | | 0 | 0 | 0 | 0 |
| Respiratory Medicine (340) | | | 2.3 | 9.9 | 0 | 0.4 | 0.0 | 1.1 |
| Infectious Diseases (350) | | | | | 3.6 | 7.5 | | |
| Rheumatology (410) | | | 3.1 | 29.2 | 0 | 0 | 1.3 | 0.3 |
| Paediatrics (420)† | 7.5 | 13.9 | 41.8 | 11.1 | 0.0 | 0 | 0.8 | 0 |
| Geriatric Medicine (430) | | | | | 3.3 | 1.8 | 5.1 | 9.3 |
| Maternity (501 and 560) | 0.6 | 0 | | | 0.5 | 0 | 0.8 | 0.4 |
| Gynaecology (502) | 1.3 | 0 | 0.0 | 0 | 0.0 | 0 | 0 | 0 |
| Physiotherapy (650) | | | | | 0.0 | 0.0 | 2.9 | 11.6 |
| Occupational Therapy (651) | | | | | 4.6 | 0.5 | | |
| Speech and Language Therapy (652) | | | | | 20.1 | 18.8 | | |
| Dietetics (654) | | | | | 9.1 | 0 | | |
| Chemical Pathology (822) | | | | | 42.1 | 31.3 | | |
| Audiology (840) | | | | | 0.0 | 1.6 | 0.2 | 2.4 |

Source: CMA analysis of HES data, 2014/15 to 2015/16.
† The parties informed us that UHSM had been incorrectly coding activity for Well Babies (424) and Neonatology (422) as inpatient Paediatrics (420). We corrected for this by removing those spells in UHSM's Paediatrics (420) activity that had a method of admission (ADMIMETH) as either '82 = The birth of a baby in this Health Care Provider' or '83 = Baby born outside the Health Care Provider except when born at home as intended'. However, it was not clear which of these spells of the removed activity should be reallocated as UHSM's inpatient Neonatology (422). On a cautious basis, we included Neonatology (422) as a potential overlap, but we did not report the parties' activity in Neonatology in this table.
‡ The parties informed us that UHSM did not consider that it offered Paediatric Surgery (171) services, and identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

38. For most specialties and care settings, there are no or very few referrals from GP practices that refer exclusively to either CMFT or UHSM. The product markets where a significant proportion of referrals are from anchor-only referrers are:

*(a)* day-case and outpatient Paediatric Urology (211) referrals to CMFT;

*(b)* outpatient Paediatric Cardiology (321) referrals to CMFT;

*(c)* day-case Paediatrics (420) referrals to CMFT; and

*(d)* outpatient Chemical Pathology (822) referrals to CMFT.

39. For these product markets, CMFT may face relatively weak competitive constraints from both UHSM and third parties, given the significant proportions of referrals from sources that do not appear to consider other providers as close alternatives to CMFT. However, as CMFT may still exert a competitive constraint on UHSM in these product markets, we did not rule out these product markets from further review on this basis. We take the relatively high proportion of CMFT-only referrers in these product markets into account in our detailed review.

## Analysis of types of referral sources for outpatient appointments

40. In the baseline referral analysis above, and in referral analysis undertaken in previous cases, it has been assumed that each patient's registered GP practice was also the referring organisation. However, there are two potential issues with this assumption:

*(a)* Not all first outpatient appointments result from a referral by a GP. They can also be made by other community-based clinicians (eg dentists and opticians) and by consultants within the acute provider (eg 'tertiary' referrals). We believe that the former is likely to involve patient choice of provider, whilst the latter is unlikely to do so.

*(b)* Referrals after the first outpatient consultation (ie where the patient is already in the care of an acute provider), either to admit for inpatient care or for another outpatient appointment in a different specialty which is part of their treatment, do not involve any further patient choice of provider (although as discussed above, in some cases admitted patients may have taken this into account when they made their initial choice of provider).

41. We considered whether additional data fields in the HES dataset could be used to identify the actual referrer and the type of referrer for each episode. We found that it was not possible to reliably identify the actual referrer in

cases where the referrer was not a GP, as the relevant data fields are not used for determining payment to providers and so were extremely poor quality in this case.

42. However, it was possible to identify the type of referrer for outpatient episodes (but not inpatient or day-case). Using this information, we analysed the sources of referrals for each outpatient specialty to determine which specialties have a high proportion of referrals from sources other than GPs. For these specialties, either they are unlikely to involve patient choice of provider (ie where the proportion of referrals from sources that are likely to involve patient choice is low),[29] or they may involve patient choice (eg dentists and opticians) but the referral patterns are distorted because the analysis does not assign referrals to the actual referrer. We also repeated our referral analysis for outpatient episodes using only referrals from GPs. The results of our analysis of types of referrer for outpatient episodes are presented in Table 6a.

[29] We assumed that the following sources of referrals in the HES data involve patient choice of provider: referral from a General Medical Practitioner; referral from a General Dental Practitioner; self-referral; referral from a Community Dental Service; referral from an Optometrist; referral from a General Practitioner with a Special Interest or Dentist with a Special Interest; referral from an Allied Health Professional; referral from an Orthoptist; referral from a Prosthetist; other not initiated by the consultant responsible for the first outpatient appointment (included on a cautious basis); other; and unknown. (These last two sources were included on a cautious basis.)

We assumed that the following sources of referrals in the HES data did not involve patient choice of provider: referral from a Consultant, other than in an A&E Department; referral from an A&E Department; referral from a Specialist Nurse (Secondary Care); referral from a National Screening Programme; and all referrals initiated by the Consultant responsible for the first outpatient appointment, including following an emergency admission, following a domiciliary consultation, following an A&E attendance.

**Table 6a: Proportion of first outpatient referrals to parties in overlap specialties, by source of referral, 2014/15 to 2015/16**

| *Specialty (Treatment Function Code)* | *GPs %* | *Sources w. choice %* | *Largest non-GP source* | *%* |
|---|---|---|---|---|
| General Surgery (100) | 52 | 53 | Referral from a consultant, other than in A&E. | 33 |
| Urology (101) | 70 | 72 | Referral from a consultant, other than in A&E. | 22 |
| Vascular Surgery (107) | 47 | 48 | Referral from a consultant, other than in A&E. | 49 |
| Trauma & Orthopaedics (110) | 40 | 43 | Following an A&E Attendance | 29 |
| ENT (120) | 60 | 67 | Referral from a consultant, other than in A&E. | 24 |
| Oral Surgery (140) | 9 | 54 | General dental practitioner | 44 |
| Orthodontics (143) | 1 | 70 | General dental practitioner | 67 |
| Plastic Surgery (160) | 31 | 32 | Referral from a consultant, other than in A&E. | 37 |
| Cardiac Surgery (172) | 4 | 4 | Referral from a consultant, other than in A&E. | 74 |
| Pain Management (191) | 80 | 80 | Referral from a consultant, other than in A&E. | 19 |
| Paediatric Urology (211) ‡ | 57 | 57 | Referral from a consultant, other than in A&E. | 30 |
| General Medicine (300) | 36 | 48 | Referral from a consultant, other than in A&E. | 30 |
| Gastroenterology (301) | 60 | 63 | Referral from a consultant, other than in A&E. | 29 |
| Endocrinology (302) | 75 | 75 | Referral from a consultant, other than in A&E. | 23 |
| Clinical Haematology (303) | 41 | 45 | Referral from a consultant, other than in A&E. | 46 |
| Diabetic Medicine (307) | 32 | 41 | Referral from a consultant, other than in A&E. | 54 |
| Cardiology (320) | 24 | 25 | Referral from a consultant, other than in A&E. | 71 |
| Paediatric Cardiology (321) | 27 | 29 | Referral from a consultant, other than in A&E. | 65 |
| Dermatology (330) | 83 | 84 | Referral from a consultant, other than in A&E. | 13 |
| Respiratory Medicine (340) | 42 | 45 | Referral from a consultant, other than in A&E. | 49 |
| Infectious Diseases (350) | 9 | 10 | Other – not initiated by the consultant responsible for the consultant outpatient episode | 51 |
| Rheumatology (410) | 80 | 82 | Referral from a consultant, other than in A&E. | 17 |
| Paediatrics (420) † | 69 | 71 | Following an emergency admission | 11 |
| Neonatology (422) † | 0 | 0 | Referral from a consultant, other than in A&E. | 83 |
| Geriatric Medicine (430) | 58 | 60 | Referral from a consultant, other than in A&E. | 24 |
| Maternity (501 and 560) | 19 | 35 | Referral from a specialist nurse (secondary care) | 36 |
| Gynaecology (502) | 39 | 43 | Referral from a consultant, other than in A&E. | 36 |
| Physiotherapy (650) | 41 | 55 | Referral from a consultant, other than in A&E. | 38 |
| Occupational Therapy (651) | 2 | 2 | Referral from a consultant, other than in A&E. | 96 |
| Speech and Language Therapy (652) | 10 | 14 | Referral from a consultant, other than in A&E. | 74 |
| Dietetics (654) | 1 | 10 | Referral from a consultant, other than in A&E. | 89 |
| Chemical Pathology (822) | 77 | 78 | Referral from a consultant, other than in A&E. | 21 |
| Audiology (840) | 66 | 88 | Self Referral | 19 |

Source: CMA analysis of HES data, 2014/15 to 2015/16.
† The parties informed us that UHSM had been incorrectly coding activity for Well Babies (424) and Neonatology (422) as inpatient Paediatrics. Therefore, given that Neonatology (422) does not involve patient choice of provider, the proportion of the parties' Paediatrics (420) activity that is derived from GPs and other sources involving patient choice is underestimated.
‡ The parties informed us that UHSM did not consider that it offered Paediatric Surgery (171) services, and identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

43. We found that referrals in Oral Surgery (140) and Orthodontics (143) primarily consist of referrals from general dental practitioners. Therefore, for these

specialties, the analysis which uses only outpatient referrals from GPs is unlikely to be informative, and the results of the baseline analysis are also likely to be distorted.

44. We also found that for Cardiac Surgery (172), Infectious Diseases (350), Neonatology (422), Occupational Therapy (651), and Dietetics (654), 10% or less of first outpatient referrals are from sources that involve choice of provider. For these specialties, we believe that the risk of a loss of competition from the proposed merger is lower, as direct patient choice (including where that choice is exercised by GPs) is unlikely to play a significant role within these specialties.

45. Speech and Language Therapy (652) also had a low proportion of first outpatient referrals from sources that involve patient choice. 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 was no equivalent direct access at CMFT.

46. We agree with the parties' submissions that Occupational Therapy, Speech and Language Therapy, and Dietetics are 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. Our findings are also consistent with the parties' submissions that Neonatology patients are managed as an integrated network across Greater Manchester, and is not a specialty where patient choice operates.

47. On the basis of these considerations, we believe that the merger is unlikely to give rise to horizontal unilateral effects in markets for Cardiac Surgery (172); Infectious Diseases (350); Neonatology (422); Occupational Therapy (651); Dietetics (654); and Speech and Language Therapy (652).

48. We also examined the differences between the referral sources of CMFT's and UHSM's patients within each specialty. The results of our analysis are set out in table 6b. A higher proportion of non-GP referrals may be indicative of referrals being made from other providers where specialised care is needed for patients.

49. We did not rule out any specialties from further review on the basis of large differences in the proportion of first outpatient referrals from GPs between the parties. However, we believe that this analysis is a useful method for indicating those specialties where the parties may be providing different services within each specialty, particularly where it corroborates the parties' submissions about differences between their services, and our analysis of

common HRG codes between the parties (which is set out in paragraphs 57 to 62 below).

50. The observed differences in the composition of referral sources is broadly consistent with and supports the parties' submissions on their respective statuses as specialist centres in different specialties. For example:

*(a)* CMFT has a significantly higher proportion (greater than 20 percentage point differences) of non-GP referrals than UHSM for Vascular Surgery (107), ENT (120), Paediatric Urology (211), Gastroenterology (301), Clinical Haematology (303), Paediatric Cardiology (321), Paediatrics (420), and Gynaecology (502). UHSM has a significantly higher proportion of non-GP referrals than CMFT for Plastic Surgery (160), and Pain Management (191).[30]

*(b)* Smaller differences (around 10 percentage points or more) were observed for Oral Surgery (140),[31] Diabetic Medicine (307), Respiratory Medicine (340), and Geriatric Medicine (430).

[30] The analysis also highlighted some specialties which the parties did not raise as specialties in which there are significant differences between their services. CMFT also has a significantly higher proportion (greater than 20 percentage point differences) of non-GP referrals than UHSM for General Surgery (100), Urology (101), and Audiology (840).
[31] For Oral Surgery (140), the proportion of CMFT's referrals from sources not involving patient choice was 17 percentage points higher than for UHSM.

**Table 6b: Proportion of first outpatient referrals to CMFT and UHSM in overlap specialties, by source of referral, 2014/15 to 2015/16**

| | *CMFT* | | | *UHSM* | | |
|---|---|---|---|---|---|---|
| *Specialty (Treatment Function Code)* | *GPs %* | *Sources w. choice %* | *Non-A&E consultant %* | *GPs %* | *Sources w. choice %* | *Non-A&E consultant %* |
| General Surgery (100) | 42 | 44 | 36 | 74 | 74 | 25 |
| Urology (101) | 59 | 61 | 28 | 82 | 82 | 16 |
| Vascular Surgery (107) | 36 | 37 | 60 | 75 | 75 | 24 |
| Trauma & Orthopaedics (110) | 36 | 40 | 15 | 50 | 51 | 10 |
| ENT (120) | 49 | 60 | 32 | 81 | 82 | 8 |
| Oral Surgery (140) | 8 | 53 | 40 | 10 | 70 | 25 |
| Orthodontics (143) | 0 | 73 | 26 | 3 | 64 | 35 |
| Plastic Surgery (160) | 65 | 68 | 17 | 30 | 30 | 38 |
| Cardiac Surgery (172) | 2 | 3 | 67 | 8 | 8 | 89 |
| Pain Management (191) | 94 | 95 | 5 | 71 | 71 | 28 |
| Paediatric Urology (211) ‡ | 49 | 50 | 33 | 70 ‡ | 71 ‡ | 25 ‡ |
| General Medicine (300) | 36 | 47 | 31 | 34 | 53 | 21 |
| Gastroenterology (301) | 42 | 45 | 41 | 84 | 85 | 15 |
| Endocrinology (302) | 71 | 71 | 29 | 81 | 81 | 16 |
| Clinical Haematology (303) | 35 | 40 | 50 | 68 | 69 | 28 |
| Diabetic Medicine (307) | 29 | 39 | 56 | 44 | 47 | 50 |
| Cardiology (320) | 18 | 18 | 77 | 32 | 32 | 65 |
| Paediatric Cardiology (321) | 25 | 26 | 68 | 63 | 65 | 31 |
| Dermatology (330) | 81 | 83 | 13 | 86 | 86 | 13 |
| Respiratory Medicine (340) | 51 | 56 | 27 | 38 | 39 | 59 |
| Infectious Diseases (350) | 8 | 9 | 18 | 12 | 12 | 87 |
| Rheumatology (410) | 70 | 75 | 24 | 88 | 88 | 11 |
| Paediatrics (420) † | 63 | 65 | 6 | 84 | 85 | 10 |
| Neonatology (422) | 0 | 0 | 83 | 0 | 17 | 67 |
| Geriatric Medicine (430) | 63 | 66 | 12 | 54 | 56 | 34 |
| Maternity (501 and 560) | 16 | 17 | 19 | 22 | 58 | 25 |
| Gynaecology (502) | 29 | 34 | 41 | 87 | 87 | 11 |
| Physiotherapy (650) | 1 | 34 | 63 | 58 | 64 | 27 |
| Occupational Therapy (651) | 0 | 0 | 100 | 8 | 8 | 87 |
| Speech and Language Therapy (652) | 1 | 12 | 86 | 15 | 16 | 67 |
| Dietetics (654) | 0 | 10 | 90 | 65 | 65 | 34 |
| Chemical Pathology (822) | 82 | 84 | 16 | 89 | 92 | 1 |
| Audiology (840) | 47 | 84 | 1 | 74 | 74 | 25 |

Source: CMA analysis of HES data, 2014/15 to 2015/16.
† The parties informed us that UHSM had been incorrectly coding activity for Well Babies (424) and Neonatology (422) as inpatient Paediatrics. Therefore, given that Neonatology (422) does not involve patient choice of provider, the proportion of the UHSM's Paediatrics (420) activity that is derived from GPs and other sources involving patient choice is underestimated. On a cautious basis, we included Neonatology (422) as a potential overlap, but we did not report the results of the referral analysis for Neonatology in this table, particularly considering our finding in paragraph 44 above that Neonatology is not a specialty in which a significant proportion of patients come from sources with patient choice.
‡ The parties informed us that UHSM did not consider that it offered Paediatric Surgery (171) services, and identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

## Outpatient referral analysis using only GP referrals

51. In response to the parties' arguments over our assumption that each patient's registered GP practice was also the referring organisation, we repeated our referral analysis using only first outpatient appointments where the source of referral was a GP practice.[32]

52. Using this reduced set of episodes, and applying the same threshold of both parties recording at least 100 outpatient appointments per year during 2014/15 to 2015/16, we found that the parties overlap in 25 outpatient specialties shown in the Table 7 below, a reduction of eight outpatient specialties.

53. In particular, the following outpatient specialties are no longer considered overlaps in the reduced set of specialties: Orthodontics (143); Cardiac Surgery (172); Infectious Diseases (350); Neonatology (422); Occupational Therapy (651); Speech and Language Therapy (652); Dietetics (654); and Chemical Pathology (822).

54. In addition, we also excluded Oral Surgery (140) from the GP-only referral analysis, due to the low proportion of outpatient appointments that are due to direct referrals by GPs.

[32] We accepted the parties' submission that we should use NHS Digital's list of active GP practices in England (using its quarterly snapshot reports of the Number of Patients Registered at a GP Practice, combining lists across the two-year period 2014/15 to 2015/16), instead of NHS Digital's Organisation Data Service's list of General Medical Practices which is based on the NHS Prescription Service. The parties submitted that the latter included codes of organisations that did not offer patient choice, and also codes for prescribing cost centres rather than actual GP practices.

**Table 7: Outpatient referral analysis, referrals from GPs, 2014/15 to 2015/16**

| *Specialty (Treatment Function Code)* | *CMFT anchor - Outpatient* | | *UHSM anchor - Outpatient* | | | |
|---|---|---|---|---|---|---|
| | *UHSM rank* | *UHSM share (%)* | *CMFT rank* | *CMFT share (%)* | *Baseline - further review?* | *GP only - further review?* |
| General Surgery (100) | 2 | 15.1 | 2 | 24.1 | Yes | Yes |
| Urology (101) | 1 | 37.0 | 2 | 30.8 | Yes | Yes |
| Vascular Surgery (107) | 1 | 46.2 | 1 | 71.4 | Yes | Yes |
| Trauma & Orthopaedics (110) | 2 | 17.2 | 2 | 27.1 | No | No |
| ENT (120) | 2 | 29.1 | 2 | 34.2 | Yes | Yes |
| Oral Surgery (140) | | | | | Yes | N/A |
| Orthodontics (143) | | | | | Yes | N/A |
| Plastic Surgery (160) | 1 | 74.0 | 1 | 40.2 | Yes | Yes |
| Cardiac Surgery (172) | | | | | Yes | N/A |
| Pain Management (191) | 2 | 39.6 | 1 | 41.7 | Yes | Yes |
| Paediatric Urology (211) ‡ | 1 | 86.3 | 1 | 93.3 | Yes | Yes |
| General Medicine (300) | 3 | 15.1 | 1 | 48.6 | Yes | Yes |
| Gastroenterology (301) | 1 | 53.8 | 1 | 64.6 | Yes | Yes |
| Endocrinology (302) | 2 | 28.6 | 2 | 36.4 | No | No |
| Clinical Haematology (303) | 1 | 51.8 | 1 | 70.3 | Yes | Yes |
| Diabetic Medicine (307) | 1 | 52.8 | 1 | 78.2 | Yes | Yes |
| Cardiology (320) | 1 | 59.5 | 1 | 59.2 | Yes | Yes |
| Paediatric Cardiology (321) | 1 | 81.9 | 1 | 97.5 | Yes | Yes |
| Dermatology (330) | 1 | 52.9 | 1 | 52.8 | Yes | Yes |
| Respiratory Medicine (340) | 1 | 67.5 | 1 | 64.0 | Yes | Yes |
| Infectious Diseases (350) | | | | | No | N/A |
| Rheumatology (410) | 1 | 53.8 | 1 | 55.5 | Yes | Yes |
| Paediatrics (420) † | 1 | 65.6 | 1 | 69.2 | Yes | Yes |
| Geriatric Medicine (430) | 1 | 61.8 | 1 | 67.2 | Yes | Yes |
| Maternity (501 And 560) | 1 | 48.2 | 1 | 80.9 | Yes | Yes |
| Gynaecology (502) | 2 | 27.5 | 1 | 47.0 | Yes | Yes |
| Physiotherapy (650) | 1 | 34.4 | 2 | 8.9 | Yes | Yes |
| Occupational Therapy (651) | | | | | Yes | N/A |
| Speech and Language Therapy (652) | | | | | Yes | N/A |
| Dietetics (654) | | | | | Yes | N/A |
| Chemical Pathology (822) | | | | | Yes | N/A |
| Audiology (840) | 2 | 43.1 | 2 | 15.1 | Yes | No |
| Combined Colorectal and General Surgery (104 and 100) | 2 | 18.0 | 1 | 32.6 | Yes | Yes |
| Combined ENT and Audiology (120 And 840) | 2 | 34.1 | 1 | 30.5 | Yes | Yes |
| Combined Oral Surgery and Maxillo-Facial Surgery (140 and 144) | 1 | 28.5 | 1 | 52.7 | Yes | Yes |
| Combined Stroke and Old Age Related Specialties (300, 328, 329, and 430) | 1 | 40.3 | 1 | 57.8 | Yes | Yes |
| Combined Outpatient and Day-Case Urology (101) | 1 | 42.6 | 1 | 40.6 | Yes | Yes |
| Combined Outpatient and Day-Case Pain Management (191) | 1 | 46.7 | 2 | 30.4 | Yes | Yes |

Source: CMA analysis of HES data, 2014/15 to 2015/16.
† The parties informed us that UHSM had been incorrectly coding activity for Well Babies (424) and Neonatology (422) as inpatient Paediatrics. We were unable to correct for this coding error for outpatient activity, and therefore the results of the referral analysis may be affected by this.
‡ The parties informed us that UHSM did not consider that it offered Paediatric Surgery (171) services, and identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

55. Comparing the results of both referral analyses for first outpatient appointments, the results are generally similar for the specialties in which the parties overlapped in the reduced set of referrals that are only from GPs. In

particular, for those specialties, both analyses flag the same specialties for further review using the 40% share of reallocated referrals filter.

56. We placed greater reliance on the results of the GP-only referral analysis for outpatient specialties in our competitive assessment than on the equivalent results from the all-referral analysis, as this analysis is likely to better reflect the preferences of patients (and their GPs) when exercising their choice of provider.

## Overlaps at subspecialty level and common HRG codes

57. In many specialties, there is a significant degree of subspecialisation. The parties submitted that, for a number of specialties, they did not completely overlap in the treatments and services within each specialty:

*(a)* Vascular Surgery (107) – CMFT was the Greater Manchester provider of endovascular services, a subspecialism within Vascular Surgery, which was not provided at UHSM. In addition, a proportion of referrals for Vascular Surgery at CMFT would be related to CMFT's status as a specialist renal centre. These referrals were unlikely to be able to switch to UHSM.

*(b)* Oral Surgery (140) and Maxillo-Facial Surgery (144) – University Dental Hospital of Manchester in CMFT performed a large volume of specialist activity that could not be undertaken at UHSM.[33]

*(c)* Plastic Surgery (160) – UHSM was a regional specialist centre for plastic surgery, which was closely related to its specialist Burns and Breast Surgery services that were not offered by CMFT. In addition, the outpatient appointments for plastic surgery at CMFT were due to an outpatient clinic being run at CMFT by a UHSM plastic surgeon, and CMFT did not have independent access to a consultant workforce in this specialty. Finally, CMFT did not provide any inpatient plastic surgery services.

*(d)* Pain Management (191) – UHSM offered a chronic pain management service, and CMFT did not.

[33] 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.

*(e)* Clinical Haematology (303) – CMFT offered a number of specialist services relating to bone marrow transplantation, sickle cell disease and thalassaemia, which were not available at UHSM.

*(f)* Diabetic Medicine (307) – CMFT was a renal centre, and was likely to see diabetic patients with renal failure. Many patients referred to CMFT for treatment in this specialty may not be suitable for treatment at UHSM.

*(g)* Respiratory Medicine (340) – UHSM was a specialist centre for respiratory medicine, and included the North West Lung Centre, which provided services across the North West. Specialist services at UHSM in this area covered a range of conditions and treatment areas, including allergy, asthma, bronchiectasis, cystic fibrosis, lung transplantation and a sleep service. Patients that were referred to UHSM for specialised services could not be treated at CMFT.

*(h)* Paediatrics (420) and Paediatric Urology (211) – Royal Manchester Children's Hospital in CMFT was a regional specialist centre for children's services. UHSM delivered non-specialist services for its immediate catchment. In addition, children under two years old that required surgery must be treated at a specialist centre like CMFT, and were unable to be treated at UHSM.

*(i)* Geriatric Medicine (430) – UHSM's geriatric medicine services was more extensive than CMFT's, with more services offered in relation to falls and Parkinson's Disease.

*(j)* Gynaecology (502) – St Mary's Hospital in CMFT was a major specialist centre for gynaecology services, providing specialist services that were not available at UHSM, such as reproductive medicine services. UHSM only provided routine gynaecology services to its local catchment.[34]

58. For these specialties, any competition concerns arising from the merger would only affect patients that could be treated by both parties. To corroborate the parties' submissions and to obtain estimates of the number of patients within each specialty that could be treated by both parties, we identified the set of HRG roots and HRG codes within each specialty that are common to both parties in 2015/16, and calculated the proportion of admitted activity at CMFT

[34] The parties further submitted that the difference in services is 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 come from GPs, while this is the case for less than 40% of referrals for first outpatient appointments in gynaecology at CMFT.

and UHSM that has an HRG root and HRG code that is common to both parties.[35]

**Table 8: Proportion of CMFT and UHSM's relevant admitted spells in overlap specialties with HRG roots and HRG codes that are common to both parties, 2014/15 to 2015/16**

| | *HRG root* | | *HRG code* | |
|---|---|---|---|---|
| *Specialty (Treatment Function Code)* | *CMFT %* | *UHSM %* | *CMFT %* | *UHSM %* |
| General Surgery (100) | 91.1 | 98.7 | 90.2 | 97.8 |
| Urology (101) | 98.9 | 92.4 | 98.6 | 92.0 |
| Vascular Surgery (107) | 70.5 | 96.6 | 69.8 | 92.0 |
| Trauma & Orthopaedics (110) | 90.9 | 99.2 | 90.3 | 98.6 |
| Ent (120) | 91.4 | 98.4 | 89.3 | 95.9 |
| Oral Surgery (140) | 98.1 | 98.7 | 94.3 | 97.9 |
| Cardiac Surgery (172) | 86.9 | 97.0 | 85.6 | 96.7 |
| Pain Management (191) | 99.0 | 93.4 | 98.8 | 92.5 |
| Paediatric Urology (211)† | 64.0 | 97.5 | 62.1 | 97.5 |
| Gastroenterology (301) | 87.7 | 99.7 | 87.3 | 99.4 |
| Endocrinology (302) | 75.5 | 85.9 | 59.5 | 76.5 |
| Cardiology (320) | 98.8 | 99.1 | 98.6 | 99.1 |
| Respiratory Medicine (340) | 100.0 | 44.1 | 99.0 | 43.4 |
| Rheumatology (410) | 94.3 | 60.2 | 94.4 | 59.0 |
| Paediatrics (420) | 76.5 | 98.8 | 72.3 | 98.4 |
| Maternity (501 and 560) | 98.3 | 98.9 | 98.0 | 98.7 |
| Gynaecology (502) | 54.8 | 99.6 | 54.7 | 99.2 |

Source: CMA analysis of HES data, 2014/15 to 2015/16.
† The parties informed us that UHSM did not consider that it offered Paediatric Surgery (171) services, and identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

59. This analysis is broadly consistent with the parties' submissions. We found that the parties perform similar treatments in their overlapping inpatient and day-case specialties. For many specialties, each party provided 80% or more or what the other party provides. However, there appear to be some differences between the parties' inpatient and day-case activity at a sub-specialty level for Vascular Surgery (107), Respiratory Medicine (340), Rheumatology (410), Paediatrics (420), and Gynaecology (502).

60. In the case of Rheumatology (410), in particular, the parties submitted that one potential explanation for why CMFT appears to only be able to perform around 60% of UHSM's admitted activity is due to the fact that UHSM is in the process of transferring joint injections from wards, which are likely to be coded as day-case activity and included in our HRG code analysis, to specific joint injection clinics, which would be coded as outpatient follow-up appointments and thus excluded from our HRG code analysis.

[35] We accepted the parties' submission that whilst, in general, comparing HRG roots can help better understand the comparability of two providers' services, in particular specialties, using the HRG root and not the final character of the HRG code could be misleading. For example, in Paediatric activity, the last character (known as the split) is important to distinguish between patients that are under two years of age, between two and five, and between five and 16. The parties submitted that elective and day-case Paediatric activity on children two years and under was only carried out at CMFT and not UHSM. In response to this submission, we repeated our analysis using HRG codes instead of HRG roots.

61. We also note that, possibly contrary to the parties' submissions, the analysis of common HRG roots and codes did not detect any significant differences between the parties' activities within inpatient and day-case Oral Surgery (140), and within day-case Pain Management (191).

62. On the basis of this information, we believe that to the extent that any horizontal unilateral effects may arise in the specialties mentioned in paragraph 57 above, those effects would be limited to that proportion of patients observed in those specialties that require routine services or services which both parties can provide.

## Other factors for specialties not requiring further review

63. Finally, we have decided not to conduct a detailed review of outpatient services in the following specialities: Plastic Surgery (160), Paediatric Cardiology (321), Chemical Pathology (822), and Audiology (840). The reasons for that decision are set out below.

*(a)* Plastic Surgery (160) – in addition to the Parties' submission that UHSM is a regional specialist centre for plastic surgery, we observed that CMFT only recorded 408 episodes for outpatient plastic surgery, over the two years 2014/15 to 2015/16, compared with 12,155 episodes for UHSM. In other words, CMFT provided less than 3.4% of the parties' combined outpatient plastic surgery episodes. As a result, we believe that the proposed merger may only give rise to a small increment in outpatient plastic surgery and is therefore unlikely to give rise to horizontal unilateral effects. CMFT is unlikely to have imposed any material constraint on UHSM, and only a very small proportion of the total market is potentially affected at CMFT by the loss of competition from UHSM, so it is likely that the impact of the merger on this specialty will be limited.

*(b)* Paediatric Cardiology (321) – Paediatric Cardiology relates to the treatment of diseases and abnormalities of the heart in children. We observed that UHSM only recorded 310 paediatric cardiology outpatient episodes across the two years 2014/15 and 2015/16, compared with 4,856 for CMFT. In other words, UHSM provided less than 6.0% of the parties' combined outpatient paediatric cardiology episodes. As a result, we believe that the proposed merger may only give rise to a small increment[36] in outpatient Paediatric Cardiology and is therefore unlikely to give rise to horizontal unilateral effects. UHSM is unlikely to have imposed

[36] We considered that a 'small' increment was around 5%, ie where one party's total activity was around 5% of the parties' combined total activity in that specialty.

any material constraint on CMFT, and only a very small proportion of the total market is potentially affected at UHSM by the loss of competition from CMFT, so it is likely that the impact of the merger on this specialty will be limited.

*(c)* Chemical Pathology (822) – 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. As a result, the vast majority of activity within this specialty is not reported on the HES dataset. In our view, there is little competition for outpatient referrals in chemical pathology services, as the majority of pathology is done 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.

*(d)* Audiology (840) – we confirmed the parties' submission that many acute trusts in Greater Manchester appear to provide audiology services, but only CMFT, UHSM and St Helens and Knowsley Teaching Hospitals NHS Trust recorded 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 suggest that the parties will continue to face strong competitive constraints from Specsavers Hearcare Group, which is supported by internal documents.[37]

64. Therefore we concluded that the merger is unlikely to give rise to horizontal unilateral effects in: outpatient Plastic Surgery (160); outpatient Paediatric Cardiology (321); outpatient Chemical Pathology (822); and outpatient Audiology (840).[38]

[37] 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.
[38] We did not consider that the parties overlapped in other treatment settings for these specialties, for the reasons set out in paragraphs 3 to 12 above.

## Specialties requiring detailed review

65. On the basis of our assessment of the factors set out above,[39] we considered that the following 21 specialties required more detailed review to determine the likelihood of the proposed merger leading to an SLC in NHS elective and maternity services. These are listed in the table below:

**Table 9: Overlap specialties requiring detailed review**

| *Specialty (Treatment Function Code)* |
|---|
| General Surgery (100) |
| Urology (101) |
| Vascular Surgery (107) |
| ENT (120) |
| Oral Surgery (140) |
| Orthodontics (143) |
| Pain Management (191) |
| Paediatric Urology (211) |
| General Medicine (300) |
| Gastroenterology (301) |
| Clinical Haematology (303) |
| Diabetic Medicine (307) |
| Cardiology (320) |
| Dermatology (330) |
| Respiratory Medicine (340) |
| Rheumatology (410) |
| Paediatrics (420) |
| Geriatric Medicine (430) |
| Maternity (501 and 560) |
| Gynaecology (502) |
| Physiotherapy (650) |

### *General Surgery (100)*

66. General Surgery is a broad specialty, and comprises a range of surgical practice focused on abnormalities and diseases of the abdominal cavity and gastrointestinal tract. Elective practice in General Surgery is now increasingly unusual as most aspects of General Surgery have become more sub-specialised, for example, into Upper and Lower Gastrointestinal Surgery. For example, we have noted that according to one of CMFT's internal documents, CMFT includes hepatopancreatobiliary (HPB), colorectal and upper gastrointestinal (UGI) surgery in the General Surgery specialty.[40]

67. Acute, unscheduled care is more commonly considered as General Surgery because the initial presentation of patients and their early management is often dependent on surgical staff from a number of sub-specialty areas who share general surgical skills and contribute to shared on-call rotas.

[39] See, in particular, paragraphs 35, 47 and 64 above. We note that Infectious Diseases (350) is identified in both paragraphs 35 and 47.
[40] CMFT, Manchester Royal Infirmary, Division of Surgery, Business Plan 2014/15 – 2018/19. This document provides particularly clear evidence of the competitive constraints on CMFT's surgical services. Note that this plan covers more than just general surgery.

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

69. There are two planned reconfigurations, which are discussed in the counterfactual section, which have an impact on interpreting the referral analysis for General Surgery:

*(a)* Oesophageal and gastric (OG) cancer services are coded to General Surgery. 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.[41] As such, the parties are unlikely to compete for OG cancer patients in future.

*(b)* Similarly, the parties submitted that, under the *Healthier Together 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.[42]

*(c)* The parties further submitted that, under the *Healthier Together programme*, CMFT and UHSM's general surgery service would operate as a single service, with a single clinical team, across both their sites. The parties stated that this was a commissioner requirement, and that this would occur even without the merger. If the merger were not to occur, the parties submitted that they would have to create a single service through some form of joint venture or alliance contract in which revenues and costs were shared.

70. These reconfigurations may mean that the referral analysis overstates the closeness of competition between the parties in future. However, we did not rule out General Surgery from further review because the parties may continue to compete within other areas of General Surgery, and it was not

[41] Phase 1 merger submission dated 9 December 2016, paragraph 116.
[42] Phase 1 merger submission dated 9 December 2016, paragraph 116.

sufficiently certain that the parties would share revenue and costs in a way that completely eliminates any independent incentives to attract patients.[43]

71. Notwithstanding the reconfigurations in General Surgery, the results of the referral analysis suggest that the parties are close competitors (more than 40% share of reallocated referrals) for day-cases. 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).

**Table 10a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, General Surgery (100)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| UHSM | 21.6 | UHSM | 52.3 | Care UK | 49.8 |
| Salford Royal | 11.0 | Salford Royal | 7.2 | UHSM | 15.1 |
| Tameside | 11.0 | Tameside | 6.5 | Spire | 8.4 |
| Spire | 10.9 | Stockport | 5.6 | Stockport | 7.1 |
| Pennine Acute | 10.2 | BMI Healthcare | 5.5 | Salford Royal | 4.6 |

**Table 10b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, General Surgery (100)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| CMFT | 38.9 | CMFT | 42.2 | Care UK | 37.3 |
| BMI Healthcare | 18.8 | BMI Healthcare | 22.7 | CMFT | 24.1 |
| Stockport | 8.5 | Stockport | 13.6 | Stockport | 15.0 |
| Spire | 8.3 | East Cheshire | 5.8 | Spire | 9.2 |
| Salford Royal | 4.8 | Spire | 3.5 | East Cheshire | 5.8 |

72. As discussed in paragraphs 13 to 22 above, given the uncertainties around referral analysis for inpatients and day-cases, we have also examined the parties' shares of inpatient and day-case activity over an 80% catchment area based on patients' addresses. The parties' combined share and increment in the day-case catchment area around UHSM are high ([around 70%] and [around 25%] respectively).

**Table 11a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, General Surgery (100)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| CMFT | [10-20] | Stockport | [30-40] |
| Pennine Acute | [10-20] | Tameside | [20-30] |
| Stockport | [10-20] | UHSM | [10-20] |
| UHSM | [10-20] | CMFT | [10-20] |
| Salford Royal | [10-20] | Pennine Acute | [0-5] |

[43] Paragraph 6.52 of the CMA's NHS Mergers guidance states that in situations where merging providers had contracts for sharing clinical staff, there may still be an incentive for each provider to attract patients, and that clinical staff is one factor among many in patient choice or in quality.

**Table 11b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, General Surgery (100)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| UHSM | [20-30] | UHSM | [40-50] |
| CMFT | [20-30] | CMFT | [20-30] |
| Stockport | [20-30] | Stockport | [10-20] |
| Salford Royal | [5-10] | BMI Healthcare | [0-5] |
| BMI Healthcare | [5-10] | East Cheshire | [0-5] |

73. There is some evidence from the parties' internal documents that supports the view that the parties are close competitors, at least for some treatments and procedures within General Surgery.

*(a)* 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, and reports that 'our local competitors are also investing and trying to secure their services such as UHSM purchasing a Da Vinci robot'.

*(b)* For UGI surgery, CMFT noted that UHSM was its closest competitor.

74. At the same time, other references in the parties' internal documents suggest that the parties also face competitive constraints from third parties, in other parts of General Surgery.

*(a)* CMFT's relevant business plan places weight on competition from Salford Royal as another of its 'main competitors', identifying its 'strong marketing and PR programme developing a strong brand 'safe, clean, personal' and a staff group that voted their Trust the best acute Trust in the country. This is important around staff and patient inflow.' CMFT's plan also suggests that 'as the Trust concentrates on specialist services, smaller Trusts, private providers and community based services may seek to 'pick up' secondary and less specialist work'. This might be interpreted to be particularly relevant to general surgery.

*(b)* For general surgery, the business plan identifies a variety of competitors for most subspecialties. For example, for rectal cancer it notes that existing competitors include 'all local hospitals', and for 'core general and emergency surgery – MTC [major trauma centre] status' it notes that '[t]here are other providers that offer this service', including 'current MTC's and DGH's [district general hospitals]'.

75. On balance and considering all the evidence in the round we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in day-case General Surgery.

### *Urology (101)*

76. Urology is a surgical specialty dealing with diseases of the urinary tract, and is further subspecialised by the anatomical location and nature of the disease (benign or malignant). The organs covered by urology include the kidneys, urethra, ureters, urinary bladder, as well as those of the male reproductive system, such as the prostate and testes. These organs are connected in a complex system, so urologists will often manage both surgical and non-surgical problems, and work closely with Oncology and Gynaecology departments.

77. The results of the referral analysis suggest that the parties are close competitors (more than 40% share of reallocated referrals) for day-cases, and that CMFT places a strong constraint on UHSM for inpatients. Pennine Acute and Stockport are also significant competitors to CMFT and UHSM respectively for inpatients (around 20% share of reallocated referrals or more), and Care UK is a significant competitor for outpatients but not for inpatients or day-cases.

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

**Table 12a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Urology (101)**

| | *IP %* | | *DC %* | | *OP GP-only %* | | *DC and OP GP-only grouped %* |
|---|---|---|---|---|---|---|---|
| UHSM | 33.1 | UHSM | 57.7 | UHSM | 37.0 | UHSM | 42.6 |
| Pennine Acute | 24.5 | Pennine Acute | 11.0 | Care UK | 35.4 | Care UK | 24.8 |
| Stockport | 13.6 | Stockport | 10.2 | Pennine Acute | 7.6 | Pennine Acute | 9.0 |
| Salford Royal | 5.7 | Christie FT | 5.6 | Stockport | 4.0 | Stockport | 5.7 |
| Spire | 5.3 | Salford Royal | 4.5 | Tameside | 3.8 | Salford Royal | 3.9 |

**Table 12b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Urology (101)**

| | *IP %* | | *DC %* | | *OP GP-only %* | | *DC and OP GP-only grouped %* |
|---|---|---|---|---|---|---|---|
| CMFT | 47.9 | CMFT | 58.4 | Care UK | 39.8 | CMFT | 40.6 |
| Stockport | 19.5 | Stockport | 13.7 | CMFT | 30.8 | Care UK | 26.9 |
| Christie FT | 17.3 | Christie FT | 11.7 | Stockport | 15.3 | Stockport | 14.1 |
| Spire | 4.0 | Pennine Acute | 2.6 | East Cheshire | 5.4 | Christie FT | 3.8 |
| Salford Royal | 3.4 | Salford Royal | 2.1 | Spire | 2.0 | East Cheshire | 3.7 |

79. The parties' combined shares in the catchment area around UHSM is high in each Urology treatment setting (more than 75% combined) and, in the area around CMFT, it is high for Urology day-cases ([around 60%]).

**Table 13a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Urology (101)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| Pennine Acute | [20-30] | CMFT | [30-40] |
| Stockport | [20-30] | UHSM | [20-30] |
| UHSM | [10-20] | Pennine Acute | [10-20] |
| CMFT | [10-20] | Stockport | [10-20] |
| Salford Royal | [10-20] | Salford Royal | [0-5] |

**Table 13b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Urology (101)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| UHSM | [60-70] | UHSM | [50-60] |
| CMFT | [20-30] | CMFT | [30-40] |
| Stockport | [10-20] | Stockport | [5-10] |
| Christie FT | [0-5] | Christie FT | [0-5] |
| Spire | [0-5] | East Cheshire | [0-5] |

80. The parties' internal documents provide some support for the view that the parties are close competitors, at least for some treatments and procedures within Urology:

*(a)* The 2014 CMFT surgery business plan states that Core Urology, Female Urology and Simple Andrology can be provided by 'all local hospitals', but that some complex services are restricted to a smaller set of competitors, including UHSM.

*(b)* For Urology Oncology, UHSM (as a joint bidder with Stockport) is identified as the closest competitor. However, at the time of the plan, Salford Royal and the Christie were joint bidders with CMFT, and could be considered competitors in future tenders for related services.

81. We note that the urology cancer surgery reconfiguration (which we have accepted in our assessment of the counterfactual) is expected to eliminate this overlap between the parties, although there will continue to be scope for competition between the parties in relation to other Urology services.[44]

82. Accordingly, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in inpatient and day-case Urology.

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[44] As a robustness check, we repeated our analysis for inpatient and day-case Urology after removing spells which had a primary diagnosis code related to malignant neoplasms of male genital organs (ICD-10 codes C60-C63) or malignant neoplasms of urinary tract (C64-C68). The remaining 'benign urology' spells made up around 87% of the total Urology spells in our admitted patients HES dataset. Limiting our analysis to benign urology made no material difference to the parties' share of reallocated referrals for day-cases and led to moderate increases in their share of reallocated referrals for inpatients.

We have concluded that the proposed merger is unlikely to give rise to horizontal unilateral effects in outpatient Urology.

### *Vascular Surgery (107)*

83. Vascular Surgery is a surgical specialty that treats diseases of the vascular system (involving arteries, veins, and lymphatic vessels) through medical therapy, minimally-invasive procedures, and surgical reconstruction.

84. Historically, Vascular Surgery was a subspecialty of General Surgery, and was recognised as a separate specialty relatively recently. This means that, in general, there is a risk of some cross-coding in the HES data between General Surgery and Vascular Surgery, although the parties have not highlighted this as an issue in this case.

85. The parties submitted that, given the strong consensus among commissioners and providers that there should be a single vascular service for Greater Manchester, with a single clinical team, the parties argued that even without the merger, there would not be competition between the parties' services as they can be expected to operate as a single service.

86. We discuss the prospect of reconfiguration of vascular services in the counterfactual section of this report, and found it insufficiently certain to be included in the counterfactual, given the early stage of these reconfiguration discussions. Nevertheless, the prospect of reconfiguration of vascular services may mean that the referral analysis overstates the closeness of competition between the parties in the future.

87. The referral analysis indicates that the parties are close competitors with more than 40% share of reallocated referrals across all product markets.[45] CMFT appears to be a particularly strong constraint on UHSM.

**Table 14a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Vascular Surgery (107)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| UHSM | 55.0 | UHSM | 46.9 | UHSM | 46.2 |
| Pennine Acute | 26.1 | Pennine Acute | 21.8 | Pennine Acute | 20.0 |
| Spire | 7.9 | Tameside | 10.5 | Bolton FT | 13.8 |
| WWL FT | 4.9 | Spire | 5.8 | Tameside | 6.3 |
| Blackpool FT | 1.0 | Warrington & Halton FT | 5.3 | Spire | 4.2 |

[45] The HES data used for our referral analysis of Vascular Surgery may include episodes that relate to specialised vascular services which are commissioned by NHS England. Therefore, our findings on the impact of the merger on competition for vascular patients ('competition in the market') may relate to both routine and specialised elective Vascular Surgery services. Our findings on the impact of the merger as it relates to competition for the contract to provide specialised vascular services ('competition for the market') are set out in Section 11 of the final report.

**Table 14b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Vascular Surgery (107)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| CMFT | 60.5 | CMFT | 75.7 | CMFT | 71.4 |
| Spire | 12.1 | North Midlands FT | 7.5 | East Cheshire | 11.8 |
| North Midlands FT | 8.5 | Tameside | 5.7 | Tameside | 5.4 |
| Pennine Acute | 5.7 | Spire | 3.2 | Spire | 4.2 |
| Tameside | 5.1 | Pennine Acute | 2.8 | WWL FT | 1.3 |

88. CMFT has a significantly higher proportion (greater than 20 percentage point differences) of non-GP referrals than UHSM for Vascular Surgery, and a majority of referrals to Vascular Surgery at CMFT come from sources other than GPs. As discussed previously, CMFT is the Greater Manchester provider of endovascular services, a subspecialism within Vascular Surgery, which is not provided at UHSM. Similarly, patients needing artery stenting will need to be referred to UHSM because CMFT does not provide this service. Also, a proportion of referrals for Vascular Surgery at CMFT will be related to CMFT's status as a specialist renal centre. The parties submitted that vascular disease and renal disease were both common complications of diabetes, and that patients who required treatment for vascular disease in the presence of other diabetic complications like renal disease could only be managed at CMFT. These referrals were unlikely to be able to switch to UHSM.

89. Our HRG codes analysis suggested that nearly all of UHSM's inpatient and day-case Vascular Surgery activity involved treatments that were also performed at CMFT, but only around 71% of CMFT's inpatient and day-case Vascular Surgery activity involved treatments that were performed at UHSM.

90. Therefore, we repeated our referral analysis using only spells that had an HRG code that was common to both parties, as a robustness check, and found very similar results.

**Table 15a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, common HRG codes only, Vascular Surgery (107)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| UHSM | 63.2 | UHSM | 50.2 |
| Pennine Acute | 25.2 | Pennine Acute | 16.8 |
| WWL FT | 5.0 | Spire | 11.4 |
| Blackpool FT | 1.1 | Tameside | 11.2 |
| Lancashire FT | 0.9 | WWL FT | 3.2 |

**Table 15b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, common HRG codes only, Vascular Surgery (107)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| CMFT | 70.0 | CMFT | 70.5 |
| North Midlands | 9.5 | Tameside | 8.8 |
| Pennine Acute | 7.2 | North Midlands FT | 8.1 |
| Tameside | 5.7 | Spire | 5.9 |

| | | | |
|---|---|---|---|
| St George's FT | 1.7 | Pennine Acute | 2.8 |

91. The parties' combined share in each of their catchment areas is high for all product markets. They have particularly high shares in the area around UHSM.

**Table 16a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Vascular Surgery (107)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| Pennine Acute | [30-40] | CMFT | [40-50] |
| UHSM | [30-40] | UHSM | [20-30] |
| CMFT | [20-30] | Pennine Acute | [10-20] |
| Spire | [0-5] | Tameside | [10-20] |
| Tameside | [0-5] | Spire | [0-5] |

**Table 16b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Vascular Surgery (107)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| UHSM | [30-40] | CMFT | [50-60] |
| CMFT | [20-30] | UHSM | [20-30] |
| Pennine Acute | [20-30] | Pennine Acute | [5-10] |
| Countess of Chester FT | [0-5] | Tameside | [5-10] |
| Warrington & Halton FT | [0-5] | Warrington & Halton FT | [5-10] |

92. There is support for the results of the referral analysis in the parties' internal documents:

*(a)* For emergency vascular surgery, 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 varotid artery, aortic aneurysm and lower leg by-pass surgery. However, varicose veins is an area in which there are multiple providers on the market.

93. Accordingly, given the strong constraint both parties place on the other, notwithstanding the reconfiguration plan, we have concluded that the merger may be expected to give rise to horizontal unilateral effects in each treatment setting for Vascular Surgery.

### *ENT (120)*

94. Ear, Nose and Throat (also known as otorhinolaryngology) is a broad specialty dealing with congenital and acquired abnormalities and diseases of the head, neck, ears, nose, and throat. The specialty is made up of a number of subspecialised areas such as head and neck cancer, thyroid disease,

cochlear implants and hearing disorders (which raises a risk of cross-coding with Audiology), base of skull surgery, voice disorders and rhinology.

95. The parties submitted that surgeons at CMFT provided a number of subspecialist services within ENT, including large goitres (thyroid swelling), sinonasal cancers, revision rhinoplasty and nasal reconstruction, and complete otology. These subspecialist services attracted referrals from across the region, and a majority of CMFT's ENT referrals were from consultants and sources other than GPs.

96. 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 only. We have considered whether the relatively stronger constraint the parties face from third parties for inpatient ENT could alleviate the competition concerns with respect to day-case ENT. However, even if inpatient ENT providers were able to constrain the parties regarding some day-case ENT treatments, we do not believe such constraint would apply across all day-case ENT treatments such that all competition concerns would be alleviated.

**Table 17a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, ENT (120)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| UHSM | 21.9 | UHSM | 40.8 | Care UK | 45.0 |
| Pennine Acute | 14.6 | Salford Royal | 15.9 | UHSM | 29.1 |
| Spire | 11.7 | Pennine Acute | 8.3 | Pennine Acute | 6.4 |
| Tameside | 10.5 | Tameside | 7.5 | Salford Royal | 4.1 |
| Salford Royal | 9.1 | Stockport | 6.0 | Stockport | 4.1 |

**Table 17b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, ENT (120)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| CMFT | 28.5 | CMFT | 56.6 | Care UK | 35.4 |
| Stockport | 21.6 | Stockport | 18.0 | CMFT | 34.2 |
| Spire | 19.7 | Spire | 4.5 | Stockport | 17.6 |
| Salford Royal | 12.8 | East Cheshire | 4.0 | East Cheshire | 3.5 |
| Mid Cheshire FT | 2.8 | Salford Royal | 3.3 | Spire | 2.9 |

97. The parties' combined shares are above 55% for inpatients and day-cases in the area around UHSM.

**Table 18a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, ENT (120)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| Pennine Acute | [20-30] | CMFT | [20-30] |
| UHSM | [10-20] | Stockport | [10-20] |
| Stockport | [10-20] | UHSM | [10-20] |
| CMFT | [10-20] | Pennine Acute | [10-20] |
| Bolton FT | [5-10] | Tameside | [10-20] |

**Table 18b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, ENT (120)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| UHSM | [40-50] | UHSM | [30-40] |
| Stockport | [20-30] | CMFT | [30-40] |
| CMFT | [10-20] | Stockport | [10-20] |
| Salford Royal | [5-10] | Salford Royal | [0-5] |
| Spire | [5-10] | East Cheshire | [0-5] |

98. There is limited corroboration of these results in the parties' internal documents:

    *(a)* The 2014 CMFT surgery business plan anticipates centralisation in Head & Neck surgery in the coming years, and profiles its competitors as UHSM, AHT and Salford.

99. On balance, and considering the above evidence in the round, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in day-case ENT. We have concluded that the proposed merger is unlikely to give rise to horizontal unilateral effects in inpatient and outpatient ENT.

### *Oral Surgery (140) and Orthodontics (143)*

100. Oral Surgery is related to treating diseases, injuries, and defects in the mouth. It is closely related to Maxillo-facial Surgery, which covers the jaws and face. Orthodontics is a specialty of dentistry that is concerned with the treatment of crooked teeth and problems with the bite of the teeth.

101. As discussed in paragraph 57 above, University Dental Hospital of Manchester in CMFT performs a large volume of specialist activity that could not be undertaken at UHSM. CMFT estimated that approximately 30% of its Oral Surgery activity was consultant-to-consultant referrals for specialist services only provided by specialist dental hospitals.

102. A large proportion of the parties' referrals in these specialties are derived from general dental practitioners rather than GPs. This means that the results of the referral analysis are unreliable.

103. Therefore, we have relied on market shares of activity within 80% catchment areas for each party, to see whether the parties are likely to be constrained post-merger.

104. In Oral Surgery (140), the parties have a high combined share (greater than 55%) in the catchment area around UHSM, and a significant combined share for inpatients in the area around CMFT. As discussed in paragraph 28(b) above, CMFT does not record any activity in Maxillo-facial Surgery, and

records all relevant activity in Oral Surgery. In contrast, UHSM records activity in both Oral Surgery and Maxillo-facial Surgery. Therefore, we also examined the parties' share of combined Oral Surgery (140) and Maxillo-facial Surgery (144), and we found that the parties have a high combined share (greater than 65%) in the catchment area around UHSM.

**Table 19a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Oral Surgery (140)**

| *IP %* | | *DC %* | | *OP %* | |
|---|---|---|---|---|---|
| Pennine Acute | [40-50] | Pennine Acute | [30-40] | CMFT | [20-30] |
| CMFT | [20-30] | CMFT | [20-30] | Pennine Acute | [20-30] |
| UHSM | [10-20] | UHSM | [10-20] | Stockport | [10-20] |
| Aintree FT | [0-5] | Stockport | [10-20] | Tameside | [5-10] |
| Bolton FT | [0-5] | Tameside | [5-10] | Salford Royal | [5-10] |

**Table 19b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Oral Surgery (140)**

| *IP %* | | *DC %* | | *OP %* | |
|---|---|---|---|---|---|
| CMFT | [40-50] | UHSM | [40-50] | CMFT | [50-60] |
| UHSM | [30-40] | CMFT | [30-40] | Stockport | [20-30] |
| Pennine Acute | [20-30] | Stockport | [10-20] | Salford Royal | [5-10] |
| Aintree FT | [0-5] | East Cheshire | [0-5] | UHSM | [5-10] |
| Tameside | [0-5] | Pennine Acute | [0-5] | Christie FT | [0-5] |

**Table 19c: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, combined Oral Surgery (140) and Maxillo-facial Surgery (144)**

| *IP %* | | *DC %* | | *OP %* | |
|---|---|---|---|---|---|
| Pennine Acute | [30-40] | Pennine Acute | [30-40] | CMFT | [20-30] |
| CMFT | [20-30] | CMFT | [20-30] | Pennine Acute | [20-30] |
| UHSM | [10-20] | UHSM | [10-20] | Stockport | [10-20] |
| East Lancashire FT | [5-10] | Stockport | [10-20] | UHSM | [10-20] |
| Aintree FT | [0-5] | Tameside | [5-10] | Tameside | [5-10] |

**Table 19d: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, combined Oral Surgery (140) and Maxillo-facial Surgery (144)**

| *IP %* | | *DC %* | | *OP %* | |
|---|---|---|---|---|---|
| CMFT | [30-40] | UHSM | [40-50] | CMFT | [40-50] |
| UHSM | [30-40] | CMFT | [30-40] | UHSM | [20-30] |
| Pennine Acute | [20-30] | Stockport | [10-20] | Stockport FT | [10-20] |
| Aintree FT | [0-5] | East Cheshire | [0-5] | Salford Royal | [5-10] |
| Tameside | [0-5] | Pennine Acute | [0-5] | Christie FT | [0-5] |

105. In Orthodontics (143), the parties have a significant combined share for outpatients, particularly in the area around UHSM (67%).

**Table 20a: Shares of all appointments, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Orthodontics (143)**

| | *OP %* |
|---|---|
| CMFT | [30-40] |
| Salford Royal | [10-20] |
| Stockport | [10-20] |
| Tameside | [10-20] |
| UHSM | [10-20] |

**Table 20b: Shares of all appointments, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Orthodontics (143)**

| | *OP %* |
|---|---|
| CMFT | [40-50] |
| UHSM | [20-30] |
| Stockport | [10-20] |
| Salford Royal | [10-20] |
| East Cheshire | [0-5] |

106. The parties submitted that referral arrangements for Oral Surgery and Orthodontics were not consistent with those for other routine elective care services. In particular, referrals for treatment in these specialties were triaged by an NHS England commissioned triage centre, operated by FDS Consultants.[46]

*(a)* For Orthodontics, the parties submitted that referrals for adult treatment were not subject to the usual rules on patient choice. Funding requests for treatment in Orthodontics must be approved by local commissioners, who would specify the treatment provider where treatment was approved.

*(b)* For Oral Surgery, the parties submitted that referrals in Greater Manchester were also processed by the triage centre. Referrals were assessed by a clinician who would determine, from the information provided by the dentist, the appropriate setting for treatment. However, the parties acknowledged that where the triaging clinician determined that a hospital setting was appropriate, then patients would be offered a choice of provider.

107. The parties further submitted that Orthodontic services at UHSM were provided by a CMFT consultant. Under this arrangement, activity in Orthodontics was attributed to UHSM, which collected the associated revenue from commissioners, and CMFT was remunerated for the supply of its consultant. The parties argued that these arrangements meant that there was a limited degree of patient choice between CMFT and UHSM, as both services would have the same clinical approaches and leadership, and UHSM would only have a very limited ability to exercise independent strategic

[46] www.dental-referrals.org.

initiatives aimed at increasing its share of Orthodontics referrals. However, as set out in paragraph 6.52 of the CMA's NHS Merger Guidance, even where merging providers share clinical staff, there may still be an incentive for each provider to attract patients, and clinical staff is one factor among many in patient choice or in setting quality.

108. Accordingly, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in all treatment settings for Oral Surgery (or the combination of Oral Surgery and Maxillo-facial Surgery).

109. However, on the basis that there is no patient choice for Orthodontics referrals, we have concluded that the proposed merger is unlikely to give rise to horizontal unilateral effects in outpatient Orthodontics.

***Pain Management (191)***

110. Pain Management involves the treatment of patients in acute and chronic pain. Pain may relate to chronic conditions such as arthritis or diabetes nerve pain, or to malfunctions in the body's pain system.

111. UHSM offers a chronic pain management service, and CMFT does not. However, this is not reflected in our analysis of HRG codes as these codes do not appear to distinguish between chronic and acute pain. As a result, we have not been able to separate out acute and chronic pain management patients.

112. The parties noted that the Pain Management service at CMFT was primarily aimed at patients referred from other consultants within CMFT, and that Central Manchester CCG historically had not wished to commission such a service, although there had been and continued to be a service commissioned by Trafford CCG.

113. The referral analysis suggests 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.

114. The parties stated that there was a coding issue such that some Pain Management patients referred to CMFT, UHSM and other providers may be undergoing treatment at their first appointment with a consultant and coded as day-case activity instead of outpatient activity. To account for this possibility, we grouped the first day-case appointments with other first outpatient appointments, and repeated the referral analysis. The results suggest that Salford Royal places a similar competitive constraint on each party as the other merging party.

**Table 21a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Pain Management (191)**

| | *DC %* | | *OP GP-only %* | | *DC and OP GP-only grouped %* |
|---|---|---|---|---|---|
| UHSM | 50.6 | Salford Royal | 46.0 | UHSM | 46.6 |
| Salford Royal | 39.8 | UHSM | 39.6 | Salford Royal | 41.4 |
| Pennine Acute | 2.4 | Pennine Acute | 2.8 | Pennine Acute | 2.6 |
| BMI Healthcare | 1.9 | Stockport | 2.1 | Stockport | 1.8 |
| Stockport | 1.5 | Warrington & Halton FT | 2.0 | BMI Healthcare | 1.5 |

**Table 21b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Pain Management (191)**

| | *DC %* | | *OP GP-only %* | | *DC and OP GP-only grouped %* |
|---|---|---|---|---|---|
| Salford Royal | 29.6 | CMFT | 41.7 | Salford Royal | 30.0 |
| CMFT | 24.8 | Salford Royal | 30.5 | CMFT | 29.9 |
| Stockport | 16.2 | Stockport | 16.1 | Stockport | 16.4 |
| Pennine Acute | 6.0 | Pennine Acute | 2.5 | Pennine Acute | 4.9 |
| Christie | 5.9 | East Cheshire | 2.2 | BMI Healthcare | 3.2 |

115. The parties have a high combined share for day-cases (more than 75%) in the catchment area around UHSM.

**Table 22a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Pain Management (191)**

| | *DC %* |
|---|---|
| Pennine Acute | 27.3 |
| UHSM | 25.1 |
| Salford Royal | 17.4 |
| Tameside | 11.4 |
| CMFT | 10.2 |

**Table 22b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Pain Management (191)**

| | *DC %* |
|---|---|
| UHSM | 53.5 |
| CMFT | 23.2 |
| Salford Royal | 11.2 |
| Stockport | 9.2 |
| BMI Healthcare | 0.8 |

116. Notwithstanding the competitive constraint from Salford Royal, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient Pain Management.

### *Paediatric Urology (211)*

117. Paediatric Urology is the diagnosis and treatment of congenital and acquired conditions and diseases in children relating to the genitalia and urinary tract.

118. As discussed above, Royal Manchester Children's Hospital in CMFT is a regional specialist centre for children's services, whilst UHSM delivers non-specialist services for its immediate catchment. However, our HRG codes

analysis did not indicate that there was a substantial difference in the treatments provided by each party.

119. The parties informed us that UHSM had identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery (171). We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

120. The referral analysis 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 60% share of reallocated referrals).

**Table 23a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Paediatric Urology (211)**

| | *DC %* | | *OP GP-only %* |
|---|---|---|---|
| UHSM | 62.2 | UHSM | 86.3 |
| Alder Hey FT | 23.8 | WWL FT | 5.2 |
| GOSH FT | 5.7 | Alder Hey FT | 2.9 |
| Leeds | 4.1 | East Cheshire | 1.7 |
| Birmingham Children's FT | 3.3 | St George's FT | 0.8 |

**Table 23a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Paediatric Urology (211)**

| | *DC %* | | *OP GP-only %* |
|---|---|---|---|
| CMFT | 92.6 | CMFT | 93.3 |
| Alder Hey FT | 6.5 | East Cheshire | 3.9 |
| GOSH FT | 0.4 | WWL FT | 0.9 |
| Leeds | 0.3 | Alder Hey FT | 0.9 |
| Birmingham Children's FT | 0.1 | Leeds | 0.3 |

121. The parties have a high combined share (more than 70%) in each of their catchment areas for day-cases.

**Table 24a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Paediatric Urology (211)**

| | *DC %* |
|---|---|
| CMFT | [60-70] |
| Alder Hey FT | [20-30] |
| UHSM | [10-20] |
| Leeds | [0-5] |
| GOSH FT | [0-5] |

**Table 24b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Paediatric Urology (211)**

| | *DC %* |
|---|---|
| CMFT | [60-70] |
| UHSM | [20-30] |
| Alder Hey FT | [5-10] |
| GOSH FT | [0-5] |
| Leeds | [0-5] |

122. The parties submitted that, for Paediatric Urology, more than 50% of day-case and outpatient referrals to CMFT are from GP practices that refer exclusively to CMFT, and thus excluded from the reallocation stage of the referral analysis.[47,48]

123. In our view, the significant proportion of CMFT's referrals that derive from CMFT-only referrers suggest that it may face relatively weak competitive constraints in general, both from UHSM and third parties, in this specialty. However, the proportion of UHSM's referrals from UHSM-only referrers is much lower (11.1% for day-cases and 21.8% for GP-only outpatient referrals) which, when combined with CMFT's high share of UHSM's reallocated referrals, is consistent with CMFT imposing an asymmetric competitive constraint on UHSM in this specialty.

124. Accordingly, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient Paediatric Urology.

### *General Medicine (300)*

125. General Medicine is a very broad specialty, and will typically include medical activities that are not covered by other specialties.

126. Given the nature of this specialty, the results of the referral analysis may be unreliable, as we could not be confident that all providers include similar activities under this specialty. Notwithstanding this concern, the referral analysis suggests that CMFT provides a strong constraint on UHSM (more than a 40% share of reallocated referrals), whilst UHSM does not provide a strong constraint on CMFT. However, Stockport also provides a significant constraint on both parties.

[47] Parties' response to provisional findings, paragraph 35.
[48] We confirmed that, for 2014/15 to 2015/16, 56.8% of CMFT's outpatient Paediatric Urology referrals from GPs came from a GP practice that referred only to CMFT, and 64.8% of day-case Paediatric Urology referrals to CMFT (from all sources) are for patients who are registered at a GP practice at which no other registered patient has been referred for day-case Paediatric Urology treatment at a provider other than CMFT.

**Table 25a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, General Medicine (300)**

| | *OP GP-only %* |
|---|---|
| Stockport | 30.5 |
| Care UK | 17.1 |
| UHSM | 15.1 |
| Pennine Acute | 11.4 |
| Tameside | 7.7 |

**Table 25b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, General Medicine (300)**

| | *OP GP-only %* |
|---|---|
| CMFT | 48.6 |
| Stockport | 33.0 |
| East Cheshire | 10.7 |
| Care UK | 2.3 |
| WWL FT | 1.2 |

127. The parties submitted that the vast majority of activity in General Medicine at both trusts was non-elective in nature. Although we agree with the parties that the large number of non-elective admissions in this specialty implies that patient choice and competition may be expected to play a very limited role in influencing how the parties provide inpatient and day-case services in this specialty, it is not clear that this would also imply a similarly limited role for patient choice and competition with respect to their outpatient services.

128. Accordingly, based on the strength of the constraint that CMFT appears to impose on UHSM, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in outpatient General Medicine.

129. We note that CMFT attracts more patients than UHSM. In 2014/15 and 2015/16, there were [around 5,500] elective outpatient appointments at CMFT and [around 1000] at UHSM (ie UHSM provided around [15%] of the parties' combined activity).[49]

### *Gastroenterology (301)*

130. Gastroenterology relates to acute and long-term medical conditions affecting the gastrointestinal tract. Generally, this specialty has close links with General Surgery, Upper Gastrointestinal Surgery, and Colorectal Surgery.

131. The parties submitted that a significant proportion of activity in Gastroenterology could be related to referrals for endoscopies. However, not all endoscopies related to patients receiving treatment within the Gastroenterology speciality, which could result in endoscopies being

[49] See Table 2 above.

inconsistently coded to different specialties at different trusts. Similarly, most gastroenterologists were still general physicians with a special interest in gastroenterology, and still participated in general medical provision. Therefore, there may be a risk of different coding practices at CMFT, UHSM, and other acute trusts in Greater Manchester between Gastroenterology and General Surgery, and between Gastroenterology and General Medicine, so it was difficult to be confident that the GP referral analysis was providing a like-for-like comparison of activity across providers.

132. The parties further submitted that CMFT was a bowel cancer screening centre for Greater Manchester. This meant that a proportion of referrals that were made to CMFT, which were for screening purposes, could not be made to other trusts. This would 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. However, we note that for our GP-only outpatient referral analysis, we only retain referrals from GP practices and have therefore already excluded all episodes where the source of referral was from a national screening programme, which includes the NHS bowel cancer screening programme.[50]

133. The results of the referral analysis indicate 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 40% or more) for day-cases and outpatients.

**Table 26a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Gastroenterology (301)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| UHSM | 35.8 | UHSM | 44.6 | UHSM | 53.8 |
| Pennine Acute | 15.0 | Salford Royal | 20.9 | Salford Royal | 23.8 |
| Tameside | 12.5 | Pennine Acute | 10.7 | Pennine Acute | 6.9 |
| Salford Royal | 11.6 | Tameside | 10.2 | Tameside | 5.6 |
| Spire | 4.5 | East Cheshire | 2.0 | Bolton FT | 2.1 |

**Table 26b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Gastroenterology (301)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| CMFT | 64.0 | CMFT | 74.4 | CMFT | 64.6 |
| Salford Royal | 8.3 | Salford Royal | 8.2 | Salford Royal | 14.8 |
| Pennine Acute | 7.4 | East Cheshire | 5.1 | East Cheshire | 6.5 |
| East Cheshire | 5.6 | BMI Healthcare | 3.7 | Spire | 3.0 |
| Spire | 3.7 | Pennine Acute | 1.9 | Tameside | 1.8 |

[50] In the outpatient HES data, national screening programmes are coded as a separate source of referral.

134. The parties have significant or high combined shares for inpatients and day-cases.

**Table 27a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Gastroenterology (301)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| Pennine Acute | [30-40] | CMFT | [40-50] |
| CMFT | [20-30] | Salford Royal | [10-20] |
| UHSM | [10-20] | UHSM | [10-20] |
| Salford Royal | [10-20] | Pennine Acute | [10-20] |
| Tameside | [5-10] | Tameside | [5-10] |

**Table 27b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Gastroenterology (301)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| CMFT | [40-50] | CMFT | [50-60] |
| UHSM | [30-40] | UHSM | [30-40] |
| Salford Royal | [10-20] | Salford Royal | [0-5] |
| Pennine Acute | [0-5] | East Cheshire | [0-5] |
| Spire | [0-5] | BMI Healthcare | [0-5] |

135. Accordingly, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in each treatment setting for Gastroenterology.

### *Clinical Haematology (303)*

136. Clinical Haematology is the specialty that covers abnormalities of the blood system, such as clotting and bleeding disorders, haemoglobinopathies and haematological malignancies. Treatments in clinical haematology vary from community delivered chemotherapy regimens to bone marrow transplant treatments and the management of complications via inpatient and isolation facilities.

137. As discussed above, CMFT offers a number of specialist services relating to bone marrow transplantation, sickle cell disease and thalassaemia, which are not available at UHSM. However, as the parties overlap in outpatient clinical haematology, it was not possible for us to analyse differences in the HRG codes of the parties' clinical haematology patients.[51]

[51] Notwithstanding the fact that CMFT and UHSM do not overlap on inpatient or day-case Clinical Haematology, we used NHS Digital's Prescribed Specialised Services Identification Tool to analyse the number of CMFT's admitted episodes that involved either sickle cell disease or thalassaemia services. Since it is possible that some of CMFT's outpatients may anticipate needing these services and selected CMFT as a result, the proportion of CMFT's Clinical Haematology admitted episodes may be informative of the proportion of outpatient episodes affected. In the period 2014/15 to 2015/16, CMFT recorded 21,464 admitted episodes (not spells) in Clinical Haematology, of which 1,027 episodes (or 4.8%) involved sickle cell disease services and 1,179 episodes (or 5.5%) involved thalassaemia services.

138. The differences in the parties' Clinical Haematology services is also seen in the significant difference between the two trusts' proportion of referrals from GPs. Only 42% of CMFT's Clinical Haematology referrals come from GPs, whereas 84% of UHSM's referrals come from GPs.

139. The parties further submitted that in Clinical Haematology, when GPs were managing patients in primary care, they would routinely do a range of blood tests. The sample was taken in the GP clinic and was sent to the laboratory of local hospitals for analysis. The parties submitted that for patients with haematological conditions, there were some results that indicated a need for urgent referral to secondary care. In these circumstances, the laboratory notified the Clinical Haematology service in the hospital, and they then made direct contact with the GP practice to arrange to see the patient. In these circumstances, the patient would be seen at the hospital where the blood sample had been sent, and there would be no exercise of choice.

140. The referral analysis suggests that the parties provide strong constraints on each other (significantly above 40% of reallocated referrals), and that CMFT in particular provides a very strong constraint on UHSM.

**Table 28a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Clinical Haematology (303)**

| | *OP GP-only %* |
|---|---|
| UHSM | 51.8 |
| Salford Royal | 13.9 |
| Pennine Acute | 13.2 |
| Tameside | 4.4 |
| Stockport | 4.1 |

**Table 28b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Clinical Haematology (303)**

| | *OP GP-only %* |
|---|---|
| CMFT | 70.3 |
| Stockport | 12.4 |
| Pennine Acute | 5.0 |
| East Cheshire | 4.3 |
| Salford Royal | 2.4 |

141. Based on the referral analysis indicating CMFT's strong constraint on UHSM in this market, we concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in outpatient Clinical Haematology.

### *Diabetic Medicine (307)*

142. Diabetic Medicine deals with the treatment of diabetes.

143. As discussed above, CMFT is a renal centre, and is likely to see diabetic patients with renal failure. Salford Royal is the only other renal centre in Greater Manchester. The parties submitted that around 40% of people with diabetes will develop kidney disease which will, over time, generally lead to kidney failure. The CMFT diabetes centre holds a specialised renal diabetes clinic each week to cater for diabetic patients with kidney disease. When a patient's kidney function deteriorates sufficiently, they will be transferred to a multidisciplinary clinic that prepares patients for dialysis, kidney transplantation, or conservative/non-dialytic renal care, and this activity will be coded under Nephrology. (We note that we have not identified Nephrology as a materially overlapping specialty in our review.)

144. Many patients referred to CMFT for treatment in this specialty may not be suitable for treatment at UHSM. However, as the parties overlap in outpatient Diabetic Medicine, it was not possible for us to analyse differences in the HRG codes of the parties' diabetic patients. Nevertheless, the presence of the specialist renal centre and the renal diabetes clinics at CMFT means that CMFT's share of reallocated UHSM referrals will be overstated.

145. The referral analysis suggests that the parties are close competitors (more than a 40% share of reallocated referrals in each direction), and that CMFT provides a particularly strong constraint on UHSM (more than a 70% share 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.

**Table 29a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Diabetic Medicine (307)**

| | *OP GP-only %* |
|---|---|
| UHSM | 52.8 |
| Salford Royal | 15.0 |
| Pennine Acute | 13.9 |
| Mid Cheshire FT | 6.8 |
| Tameside | 4.8 |

**Table 29b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Diabetic Medicine (307)**

| | *OP GP-only %* |
|---|---|
| CMFT | 78.2 |
| Mid Cheshire FT | 8.7 |
| Salford Royal | 6.1 |
| Warrington & Halton FT | 3.6 |
| Wirral FT | 0.8 |

146. Accordingly, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in outpatient Diabetic Medicine.

### *Cardiology (320)*

147. Cardiology deals with diseases and abnormalities of the heart, including medical diagnosis and treatment of congenital heart defects, coronary artery disease, heart failure, valvular heart disease, and electrophysiology.

148. Both CMFT and UHSM offer specialised cardiology services.

149. The parties submitted that the vast majority of referrals for first outpatient appointment in Cardiology at CMFT (more than 80%) were derived from sources other than GPs. Based on this, the parties believed that the competitive incentives facing CMFT in Cardiology were quite weak given that the significant majority of referrals into this service were not from GPs (even if they are not so weak that the CMA considers it appropriate to conclude that direct patient choice plays an insignificant role). Given this, the parties argued that the adverse effects arising from any loss of competition in Cardiology were likely to be considerably less than in a specialty where GP referrals were a much larger proportion of total referrals.

150. 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 29% and CMFT's was 25%; the next largest trust had a share of around 9%).[52]

151. The referral analysis suggests that the parties are close competitors (more than 40%), across most treatment settings for Cardiology.

**Table 30a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Cardiology (320)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| UHSM | 51.3 | UHSM | 44.0 | UHSM | 59.5 |
| Pennine Acute | 10.9 | Pennine Acute | 15.4 | Pennine Acute | 11.0 |
| Stockport | 7.4 | Stockport | 11.3 | Tameside | 9.9 |
| Tameside | 6.0 | WWL FT | 8.7 | Salford Royal | 8.5 |
| Bolton FT | 4.9 | Salford Royal | 5.8 | Bolton FT | 2.2 |

[52] Shares were based on inpatient activity for April to December 2013.

**Table 30b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Cardiology (320)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| CMFT | 45.0 | CMFT | 31.0 | CMFT | 59.2 |
| Stockport | 9.4 | Stockport | 23.3 | East Cheshire | 14.7 |
| Pennine Acute | 6.8 | Pennine Acute | 10.9 | Tameside | 6.1 |
| North Midlands FT | 6.5 | WWL FT | 7.9 | Salford Royal | 4.8 |
| Blackpool FT | 5.7 | East Cheshire | 4.1 | Pennine Acute | 3.2 |

152. The parties have high combined shares (more than 55%) in each of their catchment areas for inpatients. The parties have a somewhat lower combined share (around or less than 40%) for day-cases, in both catchment areas.

**Table 31a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Cardiology (320)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| CMFT | [30-40] | Pennine Acute | [30-40] |
| UHSM | [30-40] | UHSM | [20-30] |
| Pennine Acute | [10-20] | CMFT | [10-20] |
| Stockport | [0-5] | Stockport | [10-20] |
| Tameside | [0-5] | WWL FT | [0-5] |

**Table 31b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Cardiology (320)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| UHSM | [30-40] | Pennine Acute | [20-30] |
| CMFT | [30-40] | UHSM | [10-20] |
| Pennine Acute | [5-10] | CMFT | [10-20] |
| Bolton FT | [0-5] | WWL FT | [10-20] |
| Stockport | [0-5] | Stockport | [5-10] |

153. Taking into account the parties' argument that the role of patient choice in CMFT's Cardiology service may be limited (due to the relatively low proportion of its referrals that are from GPs), but setting against that the high shares of reallocated referrals in the referral analysis (particularly for GP-only outpatient referrals) and UHSM's higher proportion of referrals from GPs (set out in Table 6b above), we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects across all treatment settings for Cardiology.

### *Dermatology (330)*

154. Dermatology is the specialty that relates to management of conditions of the skin, both benign and malignant. Within the specialty, there are subdivisions between medical (ie non-surgically managed conditions) and surgical dermatology (which deals with lesions of the skin which may require excision), and between cancer and non-cancer.

155. The parties submitted that in 2015, South and Central Manchester CCGs and Trafford CCG had 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.[53] Therefore, historical referral numbers and patterns, including those dating from 2015/16, were no longer relevant to an assessment of the effect of the merger on this specialty.

156. The results of the referral analysis, which may be an appropriate proxy for the closeness of competition for cancer-related dermatology, suggested that (at least historically) the parties were close competitors, but that Salford Royal acted as a significant constraint on both parties. We have confirmed that Salford Royal offers skin cancer clinics and cancer-related dermatology services.[54] 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.

**Table 32a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Dermatology (330)**

| | *OP GP-only %* |
|---|---|
| UHSM | 52.9 |
| Salford Royal | 31.0 |
| Tameside | 3.5 |
| East Cheshire | 3.3 |
| WWL FT | 1.8 |

**Table 32b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Dermatology (330)**

| | *OP GP-only %* |
|---|---|
| CMFT | 52.8 |
| Salford Royal | 25.2 |
| East Cheshire | 7.9 |
| Stockport | 6.8 |
| Tameside | 2.9 |

157. Furthermore, to the extent that benign dermatology referrals have been successfully redirected by commissioner to community providers, this suggests that community providers may provide a material out-of-market constraint to the parties and other acute providers with respect to benign dermatology referrals.

158. Accordingly, we have concluded that the proposed merger is unlikely to give rise to horizontal unilateral effects in outpatient Dermatology.

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[53] www.communityoutpatients.co.uk.
[54] NHS Choices: Salford Royal - Departments and services. Salford Royal (2014), *Skin cancer nurse specialist and multi-disciplinary team.*

### *Respiratory Medicine (340)*

159. Respiratory Medicine is the branch of medicine that deals with congenital and acquired abnormalities and disease of the respiratory tract, such as asthma, lung cancer, occupational lung disease, and cystic fibrosis.

160. As discussed in paragraph 57 above, 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.

161. The referral analysis indicated that the parties are close competitors (more than 40% reallocated referrals) for outpatients. For day-cases, UHSM places a strong constraint on CMFT, but the constraint appears asymmetric. Sheffield Teaching Hospitals NHS FT, despite being 40 miles away from Manchester, appears to place a constraint on UHSM which is equivalent to CMFT.

**Table 33a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Respiratory Medicine (340)**

| | *DC %* | | *OP GP-only %* |
|---|---|---|---|
| UHSM | 44.8 | UHSM | 67.5 |
| Sheffield FT | 23.3 | Pennine Acute | 14.1 |
| Tameside | 10.7 | Salford Royal | 9.5 |
| Pennine Acute | 6.6 | Tameside | 4.1 |
| Salford Royal | 3.7 | WWL FT | 1.3 |

**Table 33b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Respiratory Medicine (340)**

| | *DC %* | | *OP GP-only %* |
|---|---|---|---|
| Sheffield FT | 26.2 | CMFT | 64.0 |
| CMFT | 24.6 | Tameside | 7.6 |
| Lancashire FT | 7.7 | East Cheshire | 7.4 |
| Pennine Acute | 7.3 | Pennine Acute | 5.3 |
| East Cheshire | 5.8 | Salford Royal | 4.0 |

162. Our HRG codes analysis suggested that all of CMFT's admitted 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.

163. Therefore, we repeated our referral analysis using only spells that had an HRG code that was common to both parties, as a robustness check. We found that, when the analysis is limited to treatments in day-case respiratory

medicine that both CMFT and UHSM provide, Sheffield Teaching Hospitals NHS FT did not provide as strong a constraint on UHSM as the previous analysis suggested, for the parts of Respiratory Medicine which both CMFT and UHSM provide.[55]

**Table 34a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, common HRG codes only, Respiratory Medicine (340)**

| | *DC %* |
|---|---|
| UHSM | 57.6 |
| Tameside | 13.0 |
| Pennine Acute | 8.7 |
| Sheffield FT | 6.2 |
| Salford Royal | 4.3 |

**Table 34b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, common HRG codes only, Respiratory Medicine (340)**

| | *DC %* |
|---|---|
| CMFT | 31.9 |
| Sheffield FT | 10.5 |
| Pennine Acute | 9.6 |
| East Cheshire | 8.7 |
| Tameside | 4.6 |

164. The parties have a significant combined share (more than 40%) in CMFT's catchment for day-cases.

**Table 35a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Respiratory Medicine (340)**

| | *DC %* |
|---|---|
| UHSM | [20-30] |
| Pennine Acute | [20-30] |
| CMFT | [10-20] |
| Sheffield FT | [10-20] |
| Salford Royal | [5-10] |

**Table 35b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Respiratory Medicine (340)**

| | *DC %* |
|---|---|
| UHSM | [20-30] |
| Pennine Acute | [10-20] |
| Sheffield FT | [10-20] |
| CMFT | [10-20] |
| WWL FT | [5-10] |

165. There is some support in the parties' internal documents for the results of the referral analysis. The UHSM 2014/15 business plan notes that it is a market

[55] In their response to our provisional findings, the parties submitted that UHSM is unable to differentiate its specialised and non-specialised Respiratory Medicine services, and so it could not allow its non-specialised services to deteriorate as a result of the merger whilst maintaining high quality specialised services for which it is constrained by Sheffield Teaching Hospital. We acknowledge this point and have taken it into account in our assessment and the weight that we place on the common HRG code version of the referral analysis, which excludes the specialised services that CMFT does not provide.

leader across many Greater Manchester CCGs in Respiratory Medicine, holding '100% of the market for certain respiratory subspecialties, including adult Cystic Fibrosis and sleep services', and in this context comments that '[UHSM's] main competitor for most key specialties is CMFT.' Another UHSM strategic document says that UHSM's largest competitor is Pennine Acute but that CMFT is gaining market share, and it particularly highlights CMFT as a competitor for allergy services.

166. Accordingly, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient Respiratory Medicine.

### *Rheumatology (410)*

167. Rheumatology is a multidisciplinary branch of medicine that deals with the investigation, diagnosis, and management of patients with arthritis and other musculoskeletal conditions. The specialty generally has a significant amount of outpatient activity, with a small but material amount of day-case activity.

168. The referral analysis shows that the parties are close competitors (above 40% of reallocated referrals) in outpatient rheumatology. Stockport is a significant competitor for UHSM's day-case rheumatology activity.

**Table 36a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Rheumatology (410)**

| | *DC %* | | *OP GP-only %* |
|---|---|---|---|
| UHSM | 34.3 | UHSM | 53.8 |
| Stockport | 15.4 | Salford Royal | 16.4 |
| Pennine Acute | 12.5 | Pennine Acute | 7.9 |
| Salford Royal | 8.0 | Tameside | 5.3 |
| WWL FT | 7.6 | Stockport | 3.9 |

**Table 36b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Rheumatology (410)**

| | *DC %* | | *OP GP-only %* |
|---|---|---|---|
| CMFT | 39.1 | CMFT | 55.5 |
| Stockport | 37.4 | Stockport | 13.7 |
| Salford Royal | 10.0 | Salford Royal | 13.3 |
| Pennine Acute | 4.0 | East Cheshire | 4.3 |
| Leeds FT | 1.2 | Pennine Acute | 4.2 |

169. The parties have a very high combined share (around 70%) for day-cases around UHSM.

**Table 37a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Rheumatology (410)**

| | *DC %* |
|---|---|
| Pennine Acute | [30-40] |
| Stockport | [10-20] |
| UHSM | [10-20] |
| CMFT | [10-20] |
| Salford Royal | [10-20] |

**Table 37b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Rheumatology (410)**

| | *DC %* |
|---|---|
| UHSM | [50-60] |
| Stockport | [20-30] |
| CMFT | [20-30] |
| Salford Royal | [0-5] |
| Royal Free FT | [0-5] |

170. The parties submitted that UHSM is in the process of transferring joint injections in Rheumatology from a day-case to an outpatient setting, and that this would result in our referral analysis underestimating UHSM's competitive constraint on CMFT, relative to the constraint from other third parties, for day-case Rheumatology.[56,57]

171. Based on the parties' high shares of reallocated outpatient referrals, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in outpatient Rheumatology. Although CMFT's share of reallocated referrals from UHSM is just under 40%, given the parties' high share of day-case activity in the catchment area around UHSM and the fact that UHSM's competitive constraint on CMFT's day-case activity for joint injections is likely to be underestimated by the referral analysis, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in day-case Rheumatology.

[56] In our view, this would have the following impact on our analysis:
- In the referral analysis anchored on CMFT's day-case activity, UHSM would receive a lower share of reallocated referrals because UHSM's volume of day-case activity is lower than it would otherwise be if it performed joint injections in a day-case setting. Therefore, the referral analysis would underestimate UHSM's competitive constraint on CMFT relative to the constraint from other third parties.
- Similarly, UHSM's share of day-case Rheumatology activity would be lower than it would otherwise be if it performed joint injections in a day-case setting.
- In the referral analysis anchored on UHSM's day-case activity, the impact of the displaced joint injection activity would reduce the overall volume of UHSM's day-case activity to be reallocated, but it would not impact on the relative proportions of activity reallocated to CMFT and third parties.
- The referral analysis of first outpatient appointments is unaffected, as the parties submitted that joint injection treatments would take place in follow-up outpatient appointments, which are not included in the analysis.

[57] We have not attempted to calculate, and the parties have not provided any submissions or evidence on, the proportion of Rheumatology admissions and appointments that involve joint injections.

### *Paediatrics (420)*

172. Paediatrics is a medical specialty that manages medical conditions affecting babies, children and young people.

173. As discussed in paragraph 57 above, 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.

174. We noted that UHSM recorded a much higher number of Paediatrics inpatient spells than CMFT in the HES dataset, which the parties submitted was due to our classifying certain admitted episodes related to births as elective admissions when these should be non-elective admissions,[58] combined with UHSM incorrectly coding Well Babies and Neonatology activity to the Paediatrics specialty. We corrected for this by removing those episodes in UHSM's Paediatrics (420) activity that had a method of admission[59] relating to births.

175. The referral analysis suggests that the parties are close competitors for day-case and outpatient settings.

**Table 38a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Paediatrics (420)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| Pennine Acute | 46.5 | UHSM | 37.6 | UHSM | 65.6 |
| Stockport | 25.5 | Pennine Acute | 27.3 | Pennine Acute | 15.0 |
| Warrington and Halton FT | 5.9 | Stockport | 9.8 | Stockport | 5.9 |
| UHSM | 5.1 | Bolton FT | 7.9 | Tameside | 4.4 |
| WWL FT | 2.2 | Tameside | 4.0 | Bolton FT | 3.9 |

**Table 38b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Paediatrics (420)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| Stockport | 51.9 | CMFT | 74.5 | CMFT | 69.2 |
| Pennine Acute | 15.3 | Stockport | 10.7 | Stockport | 16.6 |
| CMFT | 15.0 | East Lancashire | 3.8 | East Cheshire | 6.4 |
| Warrington and Halton FT | 10.6 | East Cheshire | 3.8 | Pennine Acute | 3.1 |
| Alder Hey FT | 1.4 | Warrington and Halton FT | 3.4 | Tameside | 1.7 |

[58] Specifically, we classified ADMIMETH codes 82 (birth of baby in this healthcare provider) and 83 (baby born outside the healthcare provider except when born at home as intended) as elective episodes for the purposes of our referral analysis and competitive assessment. This is because we believe that, whilst births are non-elective in that they are not scheduled, many patients are nevertheless able to plan and exercise a meaningful choice of provider. On this basis, we included these episodes as part of our assessment of elective acute services.
[59] Specifically, we removed those UHSM Paediatrics (420) episodes which had a method of admission (ADMIMETH) as either '82 = The birth of a baby in this Health Care Provider" or "83 = Baby born outside the Health Care Provider except when born at home as intended". This led to a sizable decrease in the number of UHSM's inpatient Paediatrics admissions.

176. Our HRG code analysis suggested 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.[60]

177. Therefore, as a robustness check, we repeated our referral analysis using only spells that had an HRG code that was common to both parties. The results were very similar.

**Table 39a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, common HRG codes only, Paediatrics (420)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| Pennine Acute | 52.5 | UHSM | 35.9 |
| Stockport | 22.4 | Pennine Acute | 28.5 |
| Warrington & Halton FT | 7.8 | Stockport | 10.6 |
| WWL FT | 3.0 | Bolton FT | 9.1 |
| UHSM | 2.9 | Warrington & Halton FT | 2.6 |

**Table 39b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, common HRG codes only, Paediatrics (420)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| Stockport | 54.4 | CMFT | 74.1 |
| Pennine Acute | 15.8 | Stockport | 11.2 |
| Warrington & Halton FT | 13.9 | East Lancashire | 4.5 |
| CMFT | 9.1 | Warrington & Halton FT | 3.6 |
| Countess of Chester FT | 2.3 | East Cheshire | 2.3 |

178. The parties have very high combined shares for day-cases, and for inpatients in the catchment area around UHSM.

**Table 40a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Paediatrics (420)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| Stockport | [30-40] | CMFT | [50-60] |
| Pennine Acute | [20-30] | Stockport | [10-20] |
| CMFT | [10-20] | UHSM | [10-20] |
| UHSM | [10-20] | Pennine Acute | [5-10] |
| Tameside | [5-10] | Tameside | [0-5] |

**Table 40b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Paediatrics (420)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| UHSM | [50-60] | CMFT | [40-50] |
| Stockport | [20-30] | UHSM | [40-50] |
| CMFT | [5-10] | Stockport | [5-10] |
| East Cheshire | [0-5] | East Cheshire | [0-5] |
| Warrington & Halton FT | [0-5] | Taunton & Somerset FT | [0-5] |

[60] The parties submitted that we should examine the full HRG code, rather than the HRG root, as the final character of the HRG code (the 'split') could be used to distinguish paediatric activity by age and, in particular, to identify those patients under two years of age who could only be treated at CMFT. We accepted this submission and revised its analysis accordingly.

179. We noted that, for day-case Paediatrics, around 40% admissions to CMFT are from GP practices that referred exclusively to CMFT, and thus excluded from the reallocation stage of the referral analysis. In our view, the significant proportion of CMFT's referrals that derive from CMFT-only referrers suggest that it may face relatively weak competitive constraints, both from UHSM and third parties, for day-case Paediatrics. However, the proportion of UHSM's referrals from UHSM-only referrers is much lower (around 11%) which, when combined with CMFT's high share of UHSM's reallocated referrals, is consistent with CMFT imposing an asymmetric competitive constraint on UHSM for day-case Paediatrics.

180. Accordingly, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in day-case and outpatient Paediatrics. We have concluded that the proposed merger may not be expected to give rise to horizontal unilateral effects in inpatient Paediatrics.

***Geriatric Medicine (430)***

181. Geriatric Medicine covers a range of clinical, preventive, and remedial treatments for older people. An older person's care often requires multidisciplinary expertise to plan programmes of intervention and care, including across hospital and community settings (eg social care).

182. The parties submitted that UHSM had a much larger number of geriatricians and orthogeriatrician consultants employed, compared with CMFT.

183. The parties further submitted that the wide range of care to which geriatricians could contribute, and the large disparities in the number of geriatricians that may be employed by an acute trust, meant that assessing referral patterns into Geriatric Medicine was unlikely to give a useful picture of GP and patient preferences regarding the care that different acute trusts offered to elderly patients. Where an acute trust did not have a geriatrician, care would still be provided to an elderly person, but may be coded under different specialties. Therefore, the Geriatric Medicine specialty may not capture all of the care that each trust provided to the elderly, and there was likely to be a large degree of coding inconsistency between acute trusts. This was to a greater extent than was the case for other specialties. For these reasons, the parties submitted that there was insufficiently robust information that would allow us to form a view as to the likelihood of the proposed merger giving rise to horizontal unilateral effects in Geriatric Medicine.

184. We examined whether other NHS acute trusts in the local area around the parties recorded significantly lower amounts of activity in Geriatric Medicine. If so, this would be consistent with the view that our referral analysis may be

underestimating the extent to which the parties are constrained by third-party competitors, due to differences in coding practices. We found that Salford Royal, East Cheshire, and Tameside all recorded significantly less activity in Geriatric Medicine than CMFT (around 300 to 500 first outpatient appointments each in 2014/15 and 2015/16, compared with around 900 for CMFT). However, we also found that, although UHSM's Geriatric Medicine department employs a large number of geriatricians and is one of the largest in the North West,[61] both Pennine Acute and Stockport recorded more appointments than UHSM (around 1,900 and 2,000 appointments respectively compared with 1,000 appointments at UHSM). Similarly, except for Salford Royal, Geriatric Medicine accounted for a similar or greater proportion of each trust's total activity than for the parties.

**Table 41: Number of outpatient first appointments in Geriatric Medicine (430) and as a proportion of total outpatient first appointments for selected providers, 2014/15 and 2015/16**

| | *OPFA GP-only* | *OPFA GP-only %* |
|---|---|---|
| CMFT | [500-1000] | 0.50 |
| UHSM | [500-1000] | 0.64 |
| Stockport | [1000-2000] | 1.76 |
| Pennine Acute | [1000-2000] | 0.85 |
| Tameside | [500-1000] | 0.51 |
| Salford Royal | [500-1000] | 0.30 |
| East Cheshire | [0-500] | 0.51 |

185. Based on this information, we believe that our referral analysis is unlikely to be underestimating the constraint from local third parties. Therefore, and notwithstanding the parties' concerns about the increased uncertainty over potentially different coding practices, the referral analysis suggests that the parties are very close competitors (above 60% of reallocated referrals for each). Their shares of reallocated referrals are sufficiently high that we remain concerned, even after taking into account the increased uncertainty around the quality of the referral data for this specialty.

**Table 42a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Geriatric Medicine (430)**

| | *OP GP-only %* |
|---|---|
| UHSM | 61.8 |
| Salford Royal | 18.5 |
| Stockport | 7.9 |
| Pennine Acute | 7.5 |
| Tameside | 1.6 |

[61] According to UHSM's website: www.uhsm.nhs.uk/services/elderly-medicine.

**Table 42b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Geriatric Medicine (430)**

| | *OP GP-only %* |
|---|---|
| CMFT | 67.2 |
| Stockport | 25.1 |
| East Cheshire | 5.3 |
| Salford Royal | 0.9 |
| Aintree FT | 0.5 |

186. Therefore, we do not accept that there is insufficient evidence for us to make a conclusion in relation to outpatient Geriatric Medicine, and given the evidence that the parties are very close competitors we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in outpatient Geriatric Medicine.

### *Maternity (501 and 560)*

187. Obstetrics (501) and Midwifery Services (560) are specialties related to pregnancy, childbirth, and the postpartum period. We accepted the parties' submission that activity in Obstetrics (501) and Midwifery Services (560) should be combined and analysed as a single specialty (which we have called Maternity), for the purposes of the referral analysis.

188. St Mary's Hospital at CMFT is a specialist women's health hospital. Women with high-risk pregnancies will generally be treated at CMFT rather than UHSM. The parties submitted that around 13.5% of women admitted to St Mary's entered the intensive pathway that catered for women who required more complex care. In particular, 21.8% of women giving birth at CMFT that are from a postcode in a UHSM community midwife zone are booked on to an intensive pathway or transferred part way through their pregnancy. These women are likely to have been medically directed to St Mary's Hospital at CMFT, rather than exercising choice of provider. Therefore, the extent to which UHSM was a competitor to CMFT was likely to be overstated in the referral analysis, as there would be a significant proportion of women who could only be cared for at CMFT.

189. The parties submitted that relatively few women entered 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 came from a GP referral. In Manchester, most women were booked into hospital via their antenatal care provider, typically a community midwifery service.

190. However, in the absence of any evidence that GPs and midwives take different factors into consideration when advising women on choice of provider, or evidence that women who are referred to hospital via GPs are

systematically different from women who are referred via midwives, we consider that the ranking of alternatives provided in our referral analysis is likely to be broadly representative.

191. The parties further submitted that maternity was subject to capacity issues more than many other elective services. Pregnant women in south Manchester who were classed as low or normal risk would generally be encouraged by community midwives to book into Wythenshawe Hospital for their birth rather than St Mary's, so that scarce capacity at St Mary's could be kept available for women whose care needs were more complex.

192. However, in our view, there nevertheless appears to be scope for patients to choose between the parties. In Manchester, although women may be assigned to community midwifery teams before and after birth, women can give birth at a hospital of their choice (possibly with advice from their GP or midwife).[62]

193. Finally, the parties also submitted that an analysis of inpatient and outpatient services as separate product markets is particularly inappropriate within Maternity, for two reasons:

*(a)* For the vast majority of women, a pregnancy will conclude with a hospital admission to give birth. This contrasts with other specialties where it is not clear at the point of referral whether the patient will end up being treated as an outpatient, day-case patient or elective inpatient.

*(b)* Payment is different to other elective services. Providers are reimbursed separately in three stages (the antenatal phase, the delivery phase, and the postnatal phase) covering the entire pathway.

194. We accept that it is relatively unlikely for women to switch mid-term and choose different providers for their outpatient care (ie antenatal and/or postnatal care) and their inpatient care (ie delivery).[63] In many (but not all) such cases, mid-term transfers are due to risks or complications that developed during pregnancy and were not foreseen at the outset. Therefore, we placed more weight in our assessment on the referral analysis of the parties' outpatient appointments to draw conclusions about Maternity as a whole.

195. A UHSM strategy document identifies CMFT as UHSM's main competitor in Maternity and Obstetrics. The referral analysis suggests that UHSM is a

[62] Parties' submission on relevant customer benefits, paragraph 297.
[63] For instance, mid-term transfers are only 5% women admitted to St Mary's in 2016/17, according to antenatal data submitted by the parties.

material competitor for CMFT, but CMFT also faces a similar constraint from Pennine Acute. In contrast, CMFT appears to provide a very strong constraint on UHSM (more than 80% of reallocated outpatient referrals), and we believe that CMFT provides a strong constraint on UHSM even after taking into account the fact that CMFT's share of reallocated referrals may be inflated by a number of high-risk patients that could only be cared for at CMFT (around 13.5% of women at St Mary's on an intensive pathway).

**Table 43a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Maternity (501 and 560)**

| | *IP %* | | *OP GP-only %* |
|---|---|---|---|
| UHSM | 28.9 | UHSM | 48.2 |
| Pennine Acute | 23.8 | Bolton FT | 23.4 |
| Bolton FT | 13.7 | Stockport | 4.8 |
| Stockport | 12.7 | Tameside | 4.4 |
| Tameside | 5.9 | Pennine Acute | 2.9 |

**Table 43b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Maternity (501 and 560)**

| | *IP %* | | *OP GP-only %* |
|---|---|---|---|
| CMFT | 74.9 | CMFT | 80.9 |
| Stockport | 10.3 | Stockport | 3.9 |
| East Cheshire | 4.2 | Bolton FT | 2.4 |
| Warrington and Halton FT | 1.7 | Sheffield FT | 2.3 |
| Bolton FT | 1.4 | Warrington & Halton FT | 1.8 |

196. Accordingly, we have concluded that the proposed merger may be expected to give rise to horizontal unilateral effects in inpatient and outpatient Maternity services.

### *Gynaecology (502)*

197. Gynaecology is the branch of medicine that deals with the functions and diseases specific to the female reproductive systems.

198. As discussed in paragraph 57 above, 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.[64]

[64] 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.

199. The referral analysis suggests that UHSM is not a strong constraint on CMFT (30% or less of reallocated referrals), but CMFT places a strong constraint on UHSM for all care settings, and particularly for day-cases.

**Table 44a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Gynaecology (502)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| UHSM | 27.8 | UHSM | 28.1 | Care UK | 30.6 |
| Pennine Acute | 16.1 | Pennine Acute | 16.4 | UHSM | 27.5 |
| Salford Royal | 15.0 | Salford Royal | 8.3 | Pennine Acute | 10.1 |
| Tameside | 7.7 | Tameside | 7.5 | Salford Royal | 9.5 |
| Stockport | 6.4 | East Lancashire | 6.7 | Tameside | 5.0 |

**Table 44b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Gynaecology (502)**

| | *IP %* | | *DC %* | | *OP GP-only %* |
|---|---|---|---|---|---|
| CMFT | 46.5 | CMFT | 75.7 | CMFT | 47.0 |
| Stockport | 12.8 | Stockport | 6.3 | Care UK | 23.8 |
| Christie | 12.8 | BMI Healthcare | 5.1 | Stockport | 13.6 |
| Salford Royal | 8.7 | Liverpool Women's FT | 3.0 | East Cheshire | 5.0 |
| BMI Healthcare | 6.4 | East Cheshire | 2.1 | Salford Royal | 3.0 |

200. Our HRG codes analysis suggested that nearly all of UHSM's inpatient and day-case gynaecology activity involved treatments that were also performed at CMFT, but only around 55% of CMFT's inpatient and day-case gynaecology activity involved treatments that were performed at UHSM.

201. Therefore, as a robustness check, we repeated our referral analysis using only spells that had an HRG code that was common to both parties and found similar results for inpatients. The parties appear to be much more significant competitors to each other for day-cases if the analysis is limited to common HRG codes.[65]

**Table 45a: Referral analysis, top 5 competitors, CMFT anchor, common HRG codes only, Gynaecology (502)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| UHSM | 29.3 | UHSM | 46.0 |
| Pennine Acute | 16.5 | Pennine Acute | 11.1 |
| Salford Royal | 13.1 | Salford Royal | 10.7 |
| Tameside | 7.3 | BMI Healthcare | 7.2 |
| BMI Healthcare | 6.8 | Tameside | 6.4 |

[65] The parties submitted that the fact that around 45% of CMFT's admitted activity is not shared suggests that the parties are not close competitors at all and are actually providing quite different and/or complementary services as envisaged by commissioners when commissioning specialised services from CMFT. We acknowledge this point and have taken it into account in our assessment and the weight that we place on the common HRG code version of the referral analysis.

**Table 45b: Referral analysis, top 5 competitors, UHSM anchor, common HRG codes only, Gynaecology (502)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| CMFT | 47.1 | CMFT | 68.9 |
| Stockport | 13.8 | Stockport | 8.9 |
| Christie FT | 12.5 | BMI Healthcare | 7.4 |
| Salford Royal | 6.9 | East Cheshire | 3.1 |
| BMI Healthcare | 6.3 | Christie FT | 2.9 |

202. The parties have high combined shares (more than 75%) in the catchment area around UHSM for inpatients and day-cases, but somewhat lower combined shares in the catchment area around CMFT.

**Table 46a: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on CMFT, Gynaecology (502)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| Salford Royal | [30-40] | UHSM | [30-40] |
| CMFT | [10-20] | CMFT | [20-30] |
| Pennine Acute | [10-20] | Pennine Acute | [10-20] |
| UHSM | [5-10] | Stockport | [5-10] |
| Tameside | [5-10] | Salford Royal | [5-10] |

**Table 46b: Shares of all appointments and admissions, 2014/15 and 2015/16, top 5 competitors, 80% catchment area centred on UHSM, Gynaecology (502)**

| | *IP %* | | *DC %* |
|---|---|---|---|
| UHSM | [50-60] | UHSM | [70-80] |
| CMFT | [20-30] | CMFT | [10-20] |
| Stockport | [5-10] | Stockport | [0-5] |
| Christie FT | [0-5] | BMI Healthcare | [0-5] |
| Salford Royal | [0-5] | Christie FT | [0-5] |

203. Accordingly, we have concluded that the proposed merger may be expected to give rise to unilateral effects in each treatment setting for Gynaecology.

### *Physiotherapy (650)*

204. Physiotherapy helps to restore movement and function when a patient is affected by injury, illness, or disability, and also helps to reduce risk of injury or illness in the future.

205. The results of the GP-only referral analysis show that the shares of reallocated referrals from each party to the other in outpatient physiotherapy are below 40% in each case. The analysis suggests that the parties will continue to face strong competitive constraints particularly from Care UK.[66]

**Table 47a: Referral analysis, 2014/15 and 2015/16, top 5 competitors, CMFT anchor, Physiotherapy (650)**

[66] Physiotherapy was filtered in on the basis of the initial 'baseline' referral analysis which includes all referrals.

| | *OP GP-only %* |
|---|---|
| UHSM | 34.4 |
| Care UK | 30.9 |
| Pennine Acute | 8.6 |
| Stockport | 7.6 |
| Tameside | 6.0 |

**Table 47b: Referral analysis, 2014/15 and 2015/16, top 5 competitors, UHSM anchor, Physiotherapy (650)**

| | *OP GP-only %* |
|---|---|
| Care UK | 81.9 |
| CMFT | 8.9 |
| WWL FT | 1.8 |
| Aintree FT | 1.7 |
| Chelsea & Westminster FT | 1.7 |

206. Accordingly, we have concluded that the proposed merger is unlikely to give rise to horizontal unilateral effects in outpatient Physiotherapy.

## *Conclusion on specialties requiring further review*

207. In paragraph 10.141 of the final report we conclude that the proposed merger may be expected to give rise to horizontal unilateral effects in 35 product markets set out in Table 48 below.

**Table 48: Product markets in which the CMA has found horizontal unilateral effects**

| *Specialty (Treatment Function Code)* | *Inpatient* | *Day-case* | *Outpatient* |
|---|---|---|---|
| General Surgery (100) | | X | |
| Urology (101) | X | X | |
| Vascular Surgery (107) | X | X | X |
| ENT (120) | | X | |
| Oral Surgery (140) | X | X | X |
| Orthodontics (143) | | | |
| Pain Management (191) | | X | X |
| Paediatric Urology (211) | | X | X |
| General Medicine (300) | | | X |
| Gastroenterology (301) | X | X | X |
| Clinical Haematology (303) | | | X |
| Diabetic Medicine (307) | | | X |
| Cardiology (320) | X | X | X |
| Dermatology (330) | | | |
| Respiratory Medicine (340) | | X | X |
| Rheumatology (410) | | X | X |
| Paediatrics (420) | | X | X |
| Geriatric Medicine (430) | | | X |
| Maternity (501 And 560) | X | | X |
| Gynaecology (502) | X | X | X |
| Physiotherapy (650) | | | |

## Volume and revenue of activity affected in specialties where we expect horizontal unilateral effects

208. In Table 2 we have set out the number of appointments and admissions in each overlap product market, after removing follow-up outpatient appointments and admissions which are due to transfers (and therefore unlikely to be reflective of the initial patient choice) or which are subsequent attendances for regular patients.

209. However, as hospitals cannot easily discriminate in quality between first, follow-up, and transferred patients, the total volume of activity within each product market is relevant to a consideration of the impact of any SLC.

210. The table below reports the parties' total number of appointments and admissions in the 18 specialties made up of 35 product markets set out in paragraph 207 and Table 48. Averaged across two years, these 18 specialties account for around 45,000 inpatient admissions, 70,000 day-cases, and 689,000 outpatient appointments with CMFT and UHSM.

211. The 18 specialties account for: 59% of CFMT's and 76% of UHSM's inpatient admissions; 32% of CMFT's and 68% of UHSM's day-case admissions; and 41% of CMFT's and 52% of UHSM's outpatient appointments over this period.

**Table 49: Total number of appointments and admissions, selected specialties, 2014/15 to 2015/16**

| | *Inpatient* | | *Day-case* | | *Outpatient* | |
|---|---|---|---|---|---|---|
| *Specialty (Treatment Function Code)* | *CMFT* | *UHSM* | *CMFT* | *UHSM* | *CMFT* | *UHSM* |
| General Surgery (100) | [3,000-4,000] | [2,000-3,000] | [5,000-6,000] | [6,000-7,000] | [42,000-43,000] | [22,000-23,000] |
| Urology (101) | [2,000-3,000] | [2,000-3,000] | [6,000-7,000] | [6,000-7,000] | [29,000-30,000] | [37,000-38,000] |
| Vascular Surgery (107) | [500-1,000] | [1,000-2,000] | [1,000-2,000] | [500-1,000] | [18,000-19,000] | [17,000-18,000] |
| ENT (120) | [500-1,000] | [1,000-2,000] | [2,000-3,000] | [1,000-2,000] | [85,000-86,000] | [32,000-33,000] |
| Oral Surgery (140) | [1,000-2,000] | [500-1,000] | [4,000-5,000] | [2,000-3,000] | [32,000-33,000] | [2,000-3,000] |
| Pain Management (191) | [<50] | [0-500] | [2,000-3,000] | [5,000-6,000] | [8,000-9,000] | [17,000-18,000] |
| Paediatric Urology (211) ‡ | [500-1,000] | [<50] | [2,000-3,000] | [0-500] | [8,000-9,000] | [4,000-5,000] |
| General Medicine (300) | [0-500] | [<50] | [1,000-2,000] | [0-500] | [17,000-18,000] | [4,000-5,000] |
| Gastroenterology (301) | [2,000-3,000] | [500-1,000] | [28,000-29,000] | [10,000-11,000] | [34,000-35,000] | [30,000-31,000] |
| Clinical Haematology (303) | [500-1,000] | [<50] | [19,000-20,000] | [<50] | [45,000-46,000] | [13,000-14,000] |
| Diabetic Medicine (307) | 0 | [<50] | [<50] | [<50] | [51,000-52,000] | [10,000-11,000] |
| Cardiology (320) | [2,000-3,000] | [2,000-3,000] | [2,000-3,000] | [4,000-5,000] | [74,000-75,000] | [82,000-83,000] |
| Respiratory Medicine (340) | [0-500] | [2,000-3,000] | [500-1,000] | [2,000-3,000] | [30,000-31,000] | [87,000-88,000] |
| Rheumatology (410) | [0-500] | [0-500] | [1,000-2,000] | [1,000-2,000] | [36,000-37,000] | [21,000-22,000] |

| | | | | | | |
|---|---|---|---|---|---|---|
| Paediatrics (420) † | [0-500] | [7,000-8,000] | [1,000-2,000] | [0-500] | [24,000-25,000] | [15,000-16,000] |
| Geriatric Medicine (430) | [<50] | [<50] | [<50] | [<50] | [3,000-4,000] | [5,000-6,000] |
| Maternity (501 And 560) | [38,000-39,000] | [10,000-11,000] | [<50] | [<50] | [231,000-232,000] | [87,000-88,000] |
| Gynaecology (502) | [2,000-3,000] | [1,000-2,000] | [9,000-10,000] | [5,000-6,000] | [89,000-90,000] | [19,000-20,000] |
| Total (selected specialties) | [55,000-56,000] | [33,000-34,000] | [91,000-92,000] | [48,000-49,000] | [862,000-863,000] | [514,000-515,000] |
| Total (all specialties) | [93,000-94,000] | [44,000-45,000] | [289,000-290,000] | [71,000-72,000] | [2,128,000-2,129,000] | [986,000-987,000] |

Source: CMA analysis of HES data, 2014/15 to 2015/16.
* in this table means a figure between 1 and 5, which has been suppressed, and rows reporting totals have been rounded to the nearest 5.
† The parties informed us that UHSM had been incorrectly coding activity for Well Babies (424) and Neonatology (422) as inpatient Paediatrics. Therefore, UHSM's inpatient Paediatrics (420) activity is overestimated.
‡ The parties informed us that UHSM did not consider that it offered Paediatric Surgery (171) services, and identified a coding error whereby activity that should have been coded to Paediatric Urology (211) was erroneously allocated to Paediatric Surgery. We have therefore re-coded UHSM's Paediatric Surgery activity as Paediatric Urology.

212. The parties submitted that they did not have reliable service line reporting (SLR) data, and so could not provide any estimates of the revenues and costs for each specialty. We estimated the parties' revenue for treatments in those specialties, for 2015/16, by multiplying each episode's HRG code by the listed price in the National Tariff.

213. These revenue estimates are imprecise and need to be interpreted with caution as they are affected by the following limitations:

*(a)* National tariffs may not reflect the actual prices the hospital received. For example, it may be possible that the parties have agreed local prices, modifications or variations from the National Tariff. There are also a number of nationally determined variations to accommodate regional cost differences or to incentivise hospitals to follow established best practices (ie Best Practice Tariffs).

*(b)* The National Tariff does not cover all treatments. Some treatments within specialties have no national price, and some entire specialties are not covered. The table below reports the proportion of appointments and admissions in 2015/16 within each specialty for which we could not match against an item on the National Tariff.

214. In light of the above, these revenue estimates are imprecise and are likely to be underestimates, but to different degrees for each specialty. The underestimation appears likely to be severe in some specialties and product markets with large proportions of activity not remunerated via the National Tariff (eg the revenue from 66% of CMFT's admissions in day-case Urology was not included in our estimate).

**Table 50: Estimated total revenues and proportion of appointments and admissions unmatched to National Tariff, selected specialties, 2015/16**

| | *Inpatient* | | | | *Day-case* | | | | *Outpatient* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *CMFT* | | *UHSM* | | *CMFT* | | *UHSM* | | *CMFT* | | *UHSM* | |
| *Specialty (Treatment Function Code)* | *£'000* | *%* | *£'000* | *%* | *£'000* | *%* | *£'000* | *%* | *£'000* | *%* | *£'000* | *%* |
| General Surgery (100) | [3,300] | 40 | [1,100] | 33 | [1,900] | 20 | [1,600] | 15 | [2,200] | 0 | [1,200] | 1 |
| Urology (101) | [1,600] | 41 | [1,200] | 40 | [500] | 66 | [1,400] | 22 | [1,200] | 5 | [1,300] | 18 |
| Vascular Surgery (107) | [1,400] | 11 | [1,900] | 14 | [400] | 44 | [200] | 72 | [1,200] | 0 | [900] | 3 |
| ENT (120) | [800] | 14 | [1,100] | 3 | [1,500] | 12 | [1,000] | 9 | [3,700] | 1 | [1,400] | 7 |
| Oral Surgery (140) | [1,000] | 8 | [600] | 3 | [1,200] | 9 | [700] | 7 | [1,800] | 0 | [100] | 0 |
| Pain Management (191) | [0] | 50 | [0] | 8 | [500] | 8 | [1,600] | 9 | [400] | 0 | [800] | 13 |
| Paediatric Urology (211) | [400] | 54 | 0 | 0 | [300] | 64 | [0] | 94 | [500] | 0 | [100] | 0 |
| General Medicine (300) | [100] | 4 | [0] | 13 | [500] | 1 | [0] | 3 | [1,100] | 0 | [300] | 0 |
| Gastroenterology (301) | [900] | 27 | [400] | 26 | [5,700] | 10 | [2,000] | 16 | [2,200] | 0 | [2,000] | 0 |
| Clinical Haematology (303) | [500] | 28 | [0] | 0 | [4,300] | 22 | 0 | 0 | [3,000] | 0 | [800] | 9 |
| Diabetic Medicine (307) | 0 | 0 | 0 | 50 | 0 | 0 | [0] | 0 | [2,500] | 0 | [600] | 3 |
| Cardiology (320) | [2,200] | 23 | [3,000] | 18 | [2,300] | 11 | [3,900] | 24 | [4,900] | 0 | [5,700] | 0 |
| Respiratory Medicine (340) | [0] | 11 | [1,700] | 12 | [900] | 2 | [1,300] | 4 | [1,300] | 19 | [4,300] | 21 |
| Rheumatology (410) | [0] | 14 | [0] | 17 | [400] | 0 | [300] | 39 | [2,000] | 2 | [1,200] | 13 |
| Paediatrics (420) | [200] | 21 | [1,200] | 62 | [500] | 5 | [100] | 8 | [2,100] | 0 | [1,100] | 4 |
| Geriatric Medicine (430) | [0] | 0 | [100] | 0 | [0] | 0 | [0] | 0 | [300] | 0 | [600] | 0 |
| Maternity (501 and 560) | [17,000] | 43 | [7,200] | 19 | 0 | 0 | [0] | 0 | [7,400] | 9 | [2,400] | 32 |
| Gynaecology (502) | [1,800] | 20 | [1,000] | 16 | [1,400] | 59 | [1,500] | 8 | [5,500] | 2 | [100] | 0 |

Source: CMA analysis of HES data, 2015/16.

215. The parties submitted that in 2015/16, CMFT's total income for elective patients (including inpatients, day-cases, and outpatients) was £262.2 million and UHSM's total income for the same was £141.0 million. Therefore, as a lower bound, the 18 specialties accounted for at least 37.0% of CMFT's total elective income, and at least 43.4% of UHSM's total elective income in 2015/16.

**Table 51: Estimates of elective revenue for 18 specialties as a proportion of total income, 2015/16**

| | *£'000* | |
|---|---|---|
| | *CMFT* | *UHSM* |
| 18 specialties – National Tariff IP income | 43,390 | 24,971 |
| 18 specialties – National Tariff DC income | 22,204 | 15,740 |
| 18 specialties – National Tariff OP income | 31,396 | 20,544 |
| 18 specialties – total income | 96,990 | 61,255 |
| Total elective income | 262,233 | 141,008 |
| Total income from activities (elective; non-elective; and other patient and clinical income) | 820,048 | 377,821 |
| Total income | 967,394 | 436,934 |
| | | |
| 18 specialties as a % of total elective income | 37.0% | 43.4% |
| 18 specialties as a % of total income | 10.0% | 14.1% |

Source: CMA analysis of HES data, 2015/16.

# Appendix D: Past service improvement initiatives involving CMFT and UHSM

1. The table below summarises previous attempts by the parties to work together to improve healthcare services in Manchester.

**Table 1: Summary of past service improvement initiatives involving CMFT and UHSM**

| *Service (commissioner)* | *Timeframe* | *Existing service model* | *Planned service model* | *Outcome* |
|---|---|---|---|---|
| Thoracic surgery (Greater Manchester Primary Care Trusts (PCTs)) | 2006 to 2009 | Thoracic surgery services at CMFT and UHSM | Single thoracic surgery centre | **Service improvement with significant compromise**: neither CMFT nor UHSM was willing to lose this service, so a subset of services (lung cancer surgery only) was transferred to UHSM |
| Upper gastrointestinal cancer surgery (Manchester PCTs) | 2009 to 2012 | Three providers across Greater Manchester (CMFT, UHSM and Salford Royal NHS Foundation Trust (Salford Royal)). Service not compliant with National Institute for Health and Care Excellence (NICE)* guidelines | Services concentrated on one or two sites to deliver compliance with NICE guidelines | **No change to service provision**: CMFT initiated legal proceedings and reconfiguration process was abandoned following external arbitration |
| Trafford Accident and Emergency (A&E) services (Trafford CCG) | 2012 to 2013 | Trafford had a full A&E service | Downgrade of Trafford A&E service to an urgent care centre† | **Service improvement with significant delay**: UHSM raised objections with the Overview and Scrutiny Committee‡ and sought to make reconfiguration dependent on expanded A&E service at UHSM. New service model implemented partially in 2013 and fully in 2016 |
| Pathology (Greater Manchester CCGs) | 2011 | All trusts in Greater Manchester had full range of pathology services | Rationalisation into a hub and spoke model§ to drive efficiencies in service provision | **No change to service provision**: Trusts rejected rationalisation plan due to the strategic significance of these services |
| Major trauma (NHS England) | 2011 to 2015 | No major trauma centre: CMFT, UHSM and Salford Royal all provided elements of major trauma care | Single major trauma centre supported by major trauma units | **Service improvement with significant delay**: commissioners' decision to move to single centre based at Salford Royal challenged by UHSM |

| *Service (commissioner)* | *Timeframe* | *Existing service model* | *Planned service model* | *Outcome* |
|---|---|---|---|---|
| Trafford community services (Trafford PCT) | 2012 | Trafford community services contract put out to tender | CMFT and UHSM formed consortium to bid for contract | **No change to service provision**: CMFT and UHSM bid rejected due to lack of clarity over functioning of joint provision |
| Cardiac services (CCGs and NHS England) | 2012 to 2013 | Two cardiac centres in the Manchester city local authority area | Joint venture between CMFT and UHSM to deliver a single service spanning both sites | **No change to service provision**: UHSM withdrew from planned joint venture prior to public announcement in 2012 and from subsequent agreed memorandum of understanding in 2013 due to concerns about financial impact |
| Upper gastrointestinal, urology and gynaecology cancer surgery (NHS England) | 2012 to 2014 | Three upper gastrointestinal providers across Greater Manchester; five urology providers (CMFT, UHSM, Salford Royal, Stockport NHS Foundation Trust (Stockport) and The Christie NHS Foundation Trust (The Christie)); and four gynaecological cancer providers (CMFT, UHSM, Salford Royal, The Christie). Service not compliant with NICE guidelines | Services concentrated on three sites to deliver compliance with NICE guidelines | **No change to service provision**: CMFT, Salford Royal and The Christie developed joint bid, which was challenged by UHSM and Stockport, leading to abandonment of process |
| Gynaecological cancer (NHS England) | 2012 to 2015 | Four providers across Greater Manchester. Service not compliant with NICE guidelines | Single service hosted by CMFT and delivered by CMFT and The Christie to deliver compliance with NICE guidelines | **Service improvement with significant compromise**: UHSM continued to refer patients directly to The Christie instead of CMFT in line with the agreed service model |
| General surgery (Greater Manchester CCGs) | 2011 to 2015 | Full seven-day A&E service with surgical back up and high risk general surgery at multiple sites across Greater Manchester | Consolidation of services on to four sites (CMFT, Salford Royal, PAHT and Stockport) across Greater Manchester with less comprehensive services at other sites | **No change to service provision**: UHSM clinicians unsuccessfully challenged decision by way of judicial review. Implementation now under way |

| *Service (commissioner)* | *Timeframe* | *Existing service model* | *Planned service model* | *Outcome* |
|---|---|---|---|---|
| Urology cancer surgery (NHS England) | 2014 to 2015 | Five providers across Greater Manchester (CMFT, UHSM, Salford, Stockport and The Christie). Service not compliant with NICE guidelines | Services concentrated on one or two sites to deliver compliance with NICE guidelines | **No change to service provision**: all five providers submitted bids and CMFT challenged decision to award contract to UHSM and Salford Royal, resulting in abandonment of process |
| Vascular services (NHS England) | 2010 to 2014 | Three providers across Greater Manchester (CMFT, UHSM and PAHT). Service not compliant with national service specifications | Services concentrated on one or two sites to deliver compliance with national service specifications | **No change to service provision**: CMFT, UHSM and PAHT could not agree on new service model |
| High risk general surgery and vascular services (Manchester CCGs) | 2015 | Services currently provided at both CMFT and UHSM | Single shared service: vascular arterial surgery centralised at CMFT, and non-arterial vascular surgery and interventional radiology centralised at UHSM | **No change to service provision**: agreement reached on new model following external facilitation, but UHSM withdrew shortly after |

Source: Patient benefits submission, paragraph 79.
* NICE is responsible for standards of care in health and care services across England and Wales. NICE's primary role is the promotion of clinical excellence in the health and care service, and it fulfils this obligation by issuing guidance to health professionals, NHS organisations and the public.
† An urgent care centre is a type of healthcare centre, which treats minor injuries. These centres are managed by a nurse and patients do not require an appointment to attend the centre and receive treatment.
‡ The Overview and Scrutiny Committee is a local authority body responsible for reviewing changes to local healthcare services.
§ A hub and spoke model is designed to coordinate healthcare services across multiple sites, where one or more sites (the hub(s)) provides care for complex or high risk cases and another or other sites (the spoke(s)) provides care for lower risk cases.

# Glossary

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| **A&E** | Accident & Emergency. |
| **ACS** | Accountable care systems. |
| **Acute trust** | A **NHS trust** or **foundation trust** providing acute services. |
| **AQP** | Any Qualified Provider. Where AQP applies patients can select from any NHS or independent sector provider of acute elective care in England that is registered with the **CQC**, has a local **commissioner** or nationally led NHS Standard Contract, and is willing to provide services at the NHS tariff. |
| **ASP/RSC** | The CMA's Final Report on the anticipated merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust. |
| **Block contract** | A contract between a **commissioner** and a provider that pays a fixed sum to purchase specified healthcare services for a given period. |
| **Catchment area** | The geographical area from which a hospital draws most of its patients. |
| **CCG** | Clinical Commissioning Group. |
| **Choose and book** | Now called NHS e-Referral Service, a national service that combines electronic booking and a choice of place, date and time for first **outpatient** hospital or clinic appointments. |
| **CMA** | Competition and Markets Authority. |
| **CMFT** | Central Manchester University Hospitals NHS Foundation Trust. |
| **Commissioners** | The organisations that make arrangements for the provision of NHS healthcare services. These include **NHS England** (and its teams), **CCG**s (including where they act through commissioning support units), and local authorities exercising NHS commissioning functions under partnership arrangements. |
| **Community health services** | A range of services and treatments provided by care professionals in the community such as: health visiting, district nursing, health promotion drop-in sessions, |

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| | residential care home visits, school nursing activities and community dentistry. Services may be provided in various locations and settings in the community. Services are provided in accordance with the NHS Standard Contract for Community Services. |
| **CQC** | Care Quality Commission, an independent regulator of standards in health and adult care in England |
| **CQUIN** | Commissioning for Quality and Innovation. |
| **CRM** | cardiac rhythm management. |
| **Day-case patient** | A patient admitted electively during the course of a day with the intention of receiving care, who does not require the use of a hospital bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, the patient is regarded as an **inpatient** admission. |
| **Elective service/ care** | Planned specialist medical care or surgery, usually following referral from a primary or community health professional such as a **GP**. |
| **Emergency care** | Emergency care refers to the treatment of patients with life threatening or major conditions. |
| **Foundation trust** | A trust that has been authorised as an NHS foundation trust by **NHS Improvement**. Foundation trusts have more operational autonomy than NHS trusts. |
| **GMCA** | Greater Manchester Combined Authority. |
| **GMCO** | Greater Manchester Chief Officer. |
| **GMHSCP** | Greater Manchester Health and Social Care Partnership. |
| **GP** | General practitioner. |
| **HES** | Health Episode Statistics. |
| **HSCA 2012** | Health and Social Care Act 2012. |
| **HWB** | Health and Wellbeing Board. Statutory organisations established under the **HSCA 2012** which promote cooperation from leaders in the health and social care |

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| | system to improve the health and wellbeing of their local population and reduce health inequalities. |
| **ICD** | implantable cardioverter defibrillator. |
| **Inpatient** | A patient who has been admitted to hospital, other than as a day-case patient, and the services provided to such a patient. |
| **LCO** | Local care organisation. |
| **Monitor** | The sector regulator for the provision of healthcare services in England, now operating as part of **NHS Improvement**. |
| **MHWB** | Manchester Health and Wellbeing Board. |
| **MHCC** | Manchester Health and Care Commissioning. |
| **NAO** | National Audit Office. |
| **National Tariff** | The national tariff encompass a comprehensive payment system, including a set of specified currencies and associated prices and a suite of rules and variations that apply both nationally and locally. |
| **NHS** | National Health Service. |
| **NHS Act** | National Health Service Act 2006. |
| **NHS hospital services** | NHS services usually provided in a hospital setting which is paid for by the NHS. |
| **NHS Improvement** | An umbrella body which includes **Monitor** and the **NHS Trust Development Authority** and exercises a number of other functions. |
| **NHS England** | The operating name of the NHS Commissioning Board. It is responsible for setting the priorities and direction of the NHS and improving health and social care outcomes for people in England. |
| **NHS provider** | An NHS trust that provides NHS acute services. |
| **NHS services** | Any healthcare services that are paid for by the NHS. |
| **NHS trust** | Bodies established by order of the Secretary of State for Health to provide goods and services for the purposes of the |

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| | health service. NHS trusts are legally directed by and financially accountable to **NHS Improvement** on behalf of the Secretary of State for Health. |
| **NHS Trust Development Authority** | A special health authority responsible for overseeing the performance management and governance of NHS Trusts , now operating as part of **NHS Improvement**. |
| **Non-elective services/care** | Services that are not scheduled in advance; they arise when admission is unpredictable and at short notice because of clinical need. |
| **NSTEMI** | non-ST elevation myocardial infarction, this is commonly known as a heart attack. |
| **OG cancer** | Oesophageal and gastric cancer. |
| **Oxford Street site** | The location of CMFT's Manchester Royal Infirmary, Royal Manchester Children's Hospital, Saint Mary's Hospital and Manchester Royal Eye Hospital. This is approximately 1.5 miles south of Manchester city centre. |
| **Outpatient** | A patient attending an outpatient clinc, or the services provided to such a patient. |
| **Parties** | **CMFT** and **UHSM.** |
| **PbR** | Payment by Results. |
| **Pennine Acute** | Pennine Acute Hospitals NHS Trust. |
| **PFI** | Private finance initiative. |
| **PPC** | The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 |
| **Primary care** | Services provided by GPs, dentists, pharmacists, optometrists and ophthalmic medical practitioners, as well as district nurses and health visitors. |
| **RCB** | Relevant customer benefit. |
| **RTT** | Referral-to-treatment. The time period between a patient being referred and receiving treatment. |
| **Salford Royal** | Salford Royal NHS Foundation Trust. |

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| **Secondary care** | Medical and surgical care and treatment usually provided by consultants and other healthcare professionals in a hospital or community setting. |
| **SLC** | Substantial lessening of competition. |
| **STPs** | Sustainability and Transformation Plans. |
| **STF** | Sustainability and Transformation Fund. |
| **Stockport** | Stockport NHS Foundation Trust. |
| **Tameside** | Tameside and Glossop Integrated Care Foundation Trust. |
| **Tertiary care** | Third tier specialist services provided in more specialised, usually designated, centres, generally covering a large catchment population. Referrals to these services are usually from another consultant (consultant-to-consultant referral) or are part of an agreed specialist pathway of care, such as a cancer pathway. |
| **The Act** | Enterprise Act 2002. |
| **The Christie** | The Christie NHS Foundation Trust. |
| **The Inquiry Group** | The CMA panel members appointed by the Chair of the CMA to be responsible for conducting the Inquiry as identified on the CMA's case page. |
| **UHSM** | University Hospital of South Manchester NHS Foundation Trust. |
| **Urgent care** | Urgent care refers to the treatment of patients requiring immediate attention, although their condition is not considered life threatening. |