CO·OPERATION & COMPETITION PANEL
FOR NHS-FUNDED SERVICES

Cooperation and Competition Panel

Merger of Trafford Healthcare NHS Trust with Central Manchester University Hospitals NHS Foundation Trust

15 February 2012

Contents

EXECUTIVE SUMMARY

1. The Cooperation and Competition Panel (CCP) has reviewed the proposed merger of Trafford Healthcare NHS Trust (Trafford Trust) with Central Manchester University Hospitals NHS Foundation Trust (Central Manchester Hospitals). Our advice to the Department of Health and Monitor is that the proposed merger is consistent with Principle 10 of the Principles and Rules for Cooperation and Competition (Principles and Rules).[1]

2. In reaching our findings we considered the effect of the merger on patient choice and competition in routine elective, non-elective, outpatient, and community services in the Greater Manchester area.

3. For outpatient services and community services we concluded that it is likely that there will be sufficient choice and competition following the merger. We also concluded that adverse effects from the merger arising from the referral relationship between the merger parties and others are unlikely to arise.

4. For routine elective services we concluded that there is likely to be sufficient patient choice and competition following the merger in respect of services provided from the main hospital sites of Trafford Trust and Central Manchester Hospitals. We found that following the merger Central Manchester Hospitals would continue to face a range of competitors, which together are likely to pose a strong competitive constraint. We also found that although Central Manchester Hospitals exercises some competitive constraint on routine elective services provided from Trafford Trust, sufficient choice and competition would be likely to remain after the merger, in particular from Salford Royal NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust.

5. In relation to non-elective services provided by the merger parties, we concluded that there is likely to be sufficient choice and competition following the merger. We found that it is unlikely that the merger will change the existing incentives for the merger parties to invest in maintaining and improving the quality, range and efficiency of non-elective services that they provide.

6. Overall, we concluded that the merger of Trafford Trust and Central Manchester Hospitals is unlikely to give rise to a material cost for patients and taxpayers and is therefore consistent with the Principles and Rules.

PARTIES

7. Trafford Trust provides services for approximately 212,000 people living in and around Trafford, Greater Manchester. In 2010/11 Trafford Trust received income of approximately £95 million (approximately £75 million is from patient care services; approximately £10 million from education, research and other non-patient care services; and approximately £10 million was support from North West Strategic Health Authority (SHA) to assist Trafford PCT to break-even). Ninety per cent (£67.5 million) of Trafford Trust's patient care income is from contracts

[1] The Principles and Rules are available at: www.ccpanel.org.uk.

with Trafford PCT and seven per cent from Manchester and Salford PCTs. Trafford Trust's main site is Trafford General Hospital with satellite sites at Altrincham General Hospital (where a wide-range of outpatient services and minor injuries are treated) and Stretford Memorial Hospital (where some outpatient services are provided). Trafford Trust is registered without conditions by the Care Quality Commission (CQC). We contacted the CQC to learn if there were any other clinical issues that we should be aware of and we were told that it has no major concerns with Trafford Trust.

8. Central Manchester Hospitals provides services for approximately 166,000 people in central Manchester, as well as specialist services for patients across the north west of England. In 2011 it acquired part of Manchester PCT's community services provider arm.[2] In 2010/11 Central Manchester Hospitals received income of approximately £665 million with £552 million of that from patient care services.[3] Thirty four per cent of Central Manchester Hospitals' patient care income is from contracts with Manchester PCT, 29 per cent is from Western Cheshire PCT (for provision of specialist services), 12 per cent is from Trafford, Salford and Stockport PCTs.[4] Central Manchester Hospitals has five hospital sites: Manchester Royal Eye Hospital (providing specialist ophthalmic services); Manchester Royal Infirmary (providing a wide range of secondary and tertiary specialist services); Royal Manchester Children's Hospital (providing specialist services for children and young people); Saint Mary's Hospital (providing services for women, babies and children); and University Dental Hospital of Manchester (providing specialist dental services). Central Manchester Hospitals is registered without conditions by the CQC. We contacted the CQC to learn if there were any other clinical issues that we should be aware of and we were told that it has no major concerns with Central Manchester Hospitals.

9. A map of the PCT areas where the merger parties provide services is shown in Figure 1.

[2] Central Manchester Hospitals acquired adult services (e.g. district nursing) for central Manchester and for the greater Manchester area it acquired children's services, contraception, sexual health, community dentistry, and Leaning disabilities services.
[3] The remaining income comes from education and training (£43 million), non-patient care services to other organisations (£32 million), research and development (£22 million), and £16 million other income.
[4] The remaining 25 per cent is made up from specialist services provided to 134 PCTs across England.

FIGURE 1

Map of Greater Manchester PCT Areas

BACKGROUND TO THE TRANSACTION

10. The transaction under review by the CCP is the acquisition of Trafford Trust by Central Manchester Hospitals, which is planned to occur on 1 April 2012. We were told that this transaction is undertaken within the broader policy context that requires the majority of NHS trusts to become NHS foundation trusts by April 2014.[5] We were told by Trafford Trust that it decided in November 2010 that it was unlikely to achieve NHS foundation trust status on its own because it had a number of financial challenges arising from its relatively small size (i.e. in 2010/11, £10 million was provided by North West SHA to help Trafford Trust to break-even).

11. The National Audit Office has stated that a number of hospital trusts in England are not sustainable in their current form with concerns raised in respect of finance, quality, performance, and governance and leadership.[6] It is unlikely these organisations will be able to achieve NHS foundation trust status in their current form. The Government has explained that it is for individual NHS trusts to demonstrate how the quality and sustainability of services will be improved in order to achieve NHS foundation trust status. To bring about the necessary change it was suggested by the Government that a trust may take certain steps such as replacing the senior management teams; introducing turnaround teams to improve the efficiency and quality of existing service delivery; reviewing the scope of existing service

[5] The strong expectation is that the vast majority of NHS trusts will achieve NHS foundation trust status by 2014, on their own, as part of an existing NHS foundation trust or in another organisational form. A small minority of NHS trusts will continue beyond this date by exceptional agreement, with a specifically agreed later date to move to NHS foundation trust status.

[6] Of the 113 NHS trusts aspiring to obtain NHS foundation trusts Status; 80 per cent face financial issues; 65 per cent face quality and performance issues; 39 per cent face governance and leadership issues. See 'Achievement of foundation trust status by NHS hospital trusts', National Audit Office, 11 October 2011.

delivery; and working to ensure costs efficiently incurred in healthcare delivery are appropriately reimbursed (e.g. Public Finance Initiative (PFI) costs). Structural change in the market has also been proposed. For example, managerial/operational franchise arrangements with a more efficient provider or merging with another provider.[7]

12. The Government has also announced that under certain circumstances it will provide loans to trusts that need them and meet certain criteria. The merger parties told us that North of England SHA will provide financial support to Central Manchester Hospitals to assist with a range of costs the merger parties expect to arise from the merger (including support for transaction costs, redundancy and contract termination costs, projected operating deficit for Trafford Trust and potential future liabilities that might be incurred from building projects underway at Trafford Trust). It is expected by the merger parties that the majority of this financial support will end by 31 December 2012 with some limited financial support available after that date, in pre-defined circumstances only, pursuant to the satisfaction of various conditions.

JURISDICTION

13. The proposed merger of Trafford Trust and Central Manchester Hospitals is a transaction requiring review pursuant to Principle 10 of the Principles and Rules as it will result in two trusts, which were previously independent of each other, coming under common management and control.

14. We have not reviewed for consistency with the Principles and Rules the process by which Trafford Trust and Central Manchester Hospitals were selected as merger partners. Pursuant to the CCP's terms of reference, to the extent that this process gives rise to any procurement questions, the CCP will consider these questions only on appeal from the relevant dispute resolution process.[8] To the extent the process gives rise to conduct issue(s), a complaint must be made to the CCP before it can investigate.[9] Responsibility for monitoring the ongoing provision of high quality secondary care services from the merger parties remains with Greater Manchester PCT cluster (and its successor bodies), North of England SHA cluster and the CQC (responsible for continuously monitoring health care providers to make sure they are meeting essential standards).

CCP PROCESS

15. Following notification of the transaction to the CCP by the merger parties, we decided that it met our acceptance criteria for a merger case. Specifically:
    i. the proposed arrangement falls within the scope of Principle 10 of the Principles and Rules;
    ii. the CCP is the most appropriate body to consider this matter;

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[7] These trusts will only be able to access this support once they have met four key tests: (i) the problems they face must be exceptional and beyond those faced by other organisations; (ii) they must show that the problems are historic and that they have a clear plan to manage their resources in the future; (iii) they must show that they are delivering high levels of annual productivity savings; and (iv) they must deliver clinically viable, high quality services – including delivering low waiting times and other performance measures. Speech by Andrew Lansley, 26 October 2011, 'Rooting Out Poor Performance', Reform.
[8] See the CCP's Procurement Dispute Appeal Guidelines at www.ccpanel.org.uk.
[9] See the CCP's Conduct Complaint Guidelines.

iii. the merger parties made available sufficient relevant and applicable information on the case to the CCP; and
iv. the combined turnover of Trafford Trust and Central Manchester Hospitals exceeds the relevant threshold of £70 million.

16. As a result, we accepted the case on 16 December 2011, published a notice to that effect on our website on that date and invited submissions by interested individuals and organisations.[10] The deadline for completion of our Phase I assessment is 15 February 2012.

17. We contacted the local LINk representatives in Trafford and Manchester, as we do for all merger cases that we review, and received a response from each of these organisations. Manchester LINk and Trafford LINk told us that as the merger is intended to proceed without service redesign (options for service redesign are being selected for consultation following the merger) and so it is considered unlikely that the merger itself will reduce opportunities for local patients to access NHS services.

18. In the future clinical commissioning groups will be responsible for purchasing NHS funded services on behalf of patients and clinical commissioning groups are likely to have an important role in leading any reconfiguration of services that occurs in Trafford and Manchester. Central Manchester Clinical Commissioning Group told us that it supports the merger but was concerned that any reconfiguration following the merger might reduce the capacity at Manchester Royal Infirmary (if services were relocated away from Trafford Hospital) or reduce patient choice (if any services were relocated to Trafford Hospital).[11]

19. Our review of this merger, and our advice and recommendations in relation to it, fall within the broader regulatory framework for transactions within the NHS overseen by the Secretary of State for Health and Monitor, in relation to NHS foundation trusts. As this is a merger of an NHS trust and an NHS foundation trust, the Secretary of State for Health and Monitor will consider our advice and recommendations in relation to the proposed merger.

FRAMEWORK FOR MERGER ASSESSMENT

20. The framework that we use to assess mergers between healthcare providers is set out in the Principles and Rules and our *Merger Guidelines*.[12] The relevant provision of the Principles and Rules is Principle 10, which provides:

Principle 10: Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interests, for example because they will deliver significant improvements in the quality of care.

21. Our *Merger Guidelines* set out a cost-benefit framework for the assessment of mergers under this Principle.[13] Where a merger may give rise to costs to patients or taxpayers as a result of a

[10] The Notice of Acceptance for this case is available at www.ccpanel.org.uk.
[11] The merger parties told us that reconfiguration plans are at an early stage. The current timetable is to develop proposals for reconfiguration by April and to conduct public consultation between May and September 2012. The redesign will be led by local commissioners and overseen by a Strategic Programme Board.
[12] See the CCP's Merger Guidelines at www.ccpanel.org.uk.

loss of choice or competition, these will be weighed up against any benefits to patients and taxpayers that may arise from the merger. From this analysis the CCP will determine whether the proposed transaction is likely to result in a material net cost to patients and taxpayers.[14] The CCP may determine that the merger is inconsistent with Principle 10 of the Principles and Rules if costs to patients and taxpayers only arise with respect to part of the services included in the merger. For example, if costs to patients and taxpayers arise with respect to a single service, or a group of services, provided by just one of the merger parties.

22. Consistent with this framework, this report provides an assessment of the costs to patients and taxpayers that arise from the merger. At the outset of our analysis we noted the potential for the activities of the merger parties to overlap in respect of routine elective and non-elective care. Accordingly, in this report we focus on the effects of the merger in respect of these services (see paragraphs 39 to 71). We also analyse the effect of the proposed merger on outpatient services, community services and internal referrals of patients (see paragraphs 72 to 91). Prior to assessing the costs and benefits likely to arise from the merger we explain the background of patient choice and competition in the provision of hospital-based services (see paragraphs 23 to 28).

BACKGROUND TO PATIENT CHOICE AND COMPETITION

23. The merger takes place in a broader policy context of patient choice and competition that exists in the provision of healthcare. This context forms the background to our assessment of how patient choice and competition are likely to be affected by the merger. In the paragraphs below we explain the potential models of competition relevant to this market and national policy supporting patient choice and plurality of providers.

MODELS OF COMPETITION

24. In general there are two models of competition in healthcare services. First, there is competition for the market, where service providers compete for the right to provide services across a PCT area or other locality, generally on an exclusive basis. Prices are agreed between the commissioner and the provider (either on the basis of a competitive procurement exercise or by way of bi-lateral negotiation). Payment may be based on cost/volume contracts, where the provider pays for treatment on a per patient/per episode of care basis and does not pay for treatments not provided, or on block contracts, where the provider pays a lump sum for the provision of a particular category of treatments. Competition for the market occurs in community services, mental health services and tertiary services (which may be competitively tendered by specialist commissioning groups at the regional or national level).

25. Second, there is competition in the market, where patients (with advice from clinicians) can choose between competing providers of the same service. The 'Any Qualified Provider' (AQP)

[13] A merger might give rise to costs to patients and taxpayers if it diminishes patient and commissioner choice and competition. As set out in the *Framework for Managing Choice and Competition,* published by the Department of Health on 16 May 2008, patient choice and competition in the NHS can be expected to improve quality and safety in service provision, improve health and well-being, improve standards and reduce inequalities in access and outcomes, lead to better informed patients, generate greater confidence in the NHS, and provide better value for money.

[14] Where the CCP finds that there are no costs to patients or taxpayers arising from a merger, it will not necessarily critically evaluate patient or taxpayer benefits ascribed to the merger by the merger parties.

model is an example of where competition occurs in the market, where patients may choose between any NHS or independent sector provider in England is registered with the CQC, has a PCT or nationally let contract and is willing to provide care at the NHS tariff.[15] Within the NHS, remuneration under an AQP model is often based on national or local tariffs for the relevant services. Competition in the market and competition for the market are not necessarily mutually exclusive. For example, commissioners may hold a competitive process to select a range of providers with whom they wish to contract; patients may then be able to choose which of these providers they wish to use.

NATIONAL POLICY OF CHOICE AND COMPETITION

26. Since 2000 a series of reforms to the NHS have aimed to strengthen patient choice, particularly in relation to routine elective care, with the aim of creating stronger incentives for healthcare providers to improve access to services and the quality of care they provide. The policy of patient choice was first announced in the NHS Plan in 2000 with the aim of providing patients with the opportunity to book the date and time for every hospital appointment and elective admission .[16] Delivering the NHS Plan (2002) set out a series of further initiatives that emphasised patient choice. In particular, it committed to providing patients with information on alternative providers, and reinforcing their ability to choose providers so as to benefit from shorter waiting times. Consequently, a number of pilot programmes ran between 2002 and 2004 where patients could choose their provider of routine elective services.

27. Choice on referral to hospital was formally introduced on 1 January 2006. Patients requiring a routine elective service could expect to be offered a choice of at least four hospitals (or suitable alternative providers) and a choice of time and date for their booked appointment. This choice would be provided following referral from a GP or primary care professional using the Choose and Book system and NHS Choices (a website providing information on local services, conditions and treatment) to guide their decisions. From July 2007 patients could choose any provider on the ECN in respect of routine elective orthopaedic care. This ability to choose was expanded beyond routine elective orthopaedic care to all patients requiring an elective referral in April 2008. At this time ECN providers were supplemented through the development of the Free Choice Network (FCN) which included NHS trusts, newly appointed NHS foundation trusts, and further independent sector providers. A patient's right to choose was formally enshrined in the NHS Constitution, which was adopted in January 2009.

28. Under the AQP model patients can now select from any NHS or independent sector provider of routine elective services in England that is registered with the CQC, has a local commissioner or nationally-let contract, and is willing to provide services at the NHS tariff. Even when there is competition in the market (e.g. for routine elective care) commissioners have obligations and responsibilities in relation to the supply of services in their local area and have considerable influence over the pattern of local service provision.

[15] The 'Any Qualified Provider' model was previously known as the 'Any Willing Provider' model.
[16] The NHS Plan: A time for investment, a time for reform (July 2000).

ASSESSMENT OF MERGER COSTS

29. This section sets out our assessment of whether the proposed merger between Trafford Trust and Central Manchester Hospitals may have a material adverse effect on patients and taxpayers as a result of a loss of patient or commissioner choice and competition. In this section we:
    i. explain the counterfactual to the merger;
    ii. assess the relevant markets within which to assess the merger; and
    iii. assess the potential competitive effects of the merger in the relevant markets.[17]

30. We considered a range of information when carrying out our assessment. This included internal documents as well as submissions and other evidence provided by the merger parties and third parties (both providers and commissioners).[18] We also analysed travel times to alternative NHS-funded providers to the merger parties, and analysed GP referral patterns (see Appendices 1 and 2 for details of travel times and analysis of GP referrals).

COUNTERFACTUAL

31. To evaluate the effect of the proposed merger on patient choice and competition, it is necessary to have a benchmark against which to compare the effect of the merger. This is known as the counterfactual to the merger, and is the situation that would be expected to prevail if the proposed merger did not take place. The counterfactual enables us to compare the extent of patient choice and competition after the merger with the likely extent of patient choice and competition if the merger did not proceed. This allows us to form a judgement about whether the merger would be likely to reduce patient choice and competition.[19]

32. The merger parties told us that in the absence of the proposed merger Central Manchester Hospitals would continue to operate independently of Trafford Trust. However, we note that Trafford Trust is required by government policy to achieve NHS foundation trust status by April 2014 (see paragraph 10). Trafford Trust told us that its history of significant financial difficulties meant that it needed to be acquired by another organisation in order to achieve NHS foundation trust status. In this context we consider that the pre-merger situation was not sustainable. The merger parties told us that the transaction is on an 'as is' basis which means that the merger is intended to be completed without initiating any reconfiguration of services. The merger parties told us that although future reconfiguration of services is anticipated, no decisions have yet been made on what the potential service reconfiguration options might be.

33. We have been told by the merger parties and commissioners that they have no plans to cease to provide healthcare services from Trafford hospital. In this context, it is not a realistic

[17] This includes, where appropriate, an assessment of barriers to entry and the extent of any countervailing commissioner buying power. However, since we do not find costs to patients and taxpayers, we do not examine these issues in detail in this report.
[18] As part of our assessment we reviewed a wide range of documents and evidence provided by the merger parties. These included documents produced prior to the proposed merger (for example minutes from board meetings, strategy documents and market analysis reports), documents produced as part of the work stream to develop the merger proposals (for example option appraisal exercises, the Outline Business Case and submission to the CCP) as well as evidence provided as part of our merger inquiry.
[19] This approach is consistent with the Office of Fair Trading and Competition Commission approach. See paragraph 4.3.5 of the joint merger assessment guidelines available at www.competition-commission.org.uk/our_role/ms_and_fm/cc2_review.htm.

counterfactual to assume that services will cease to be provided from Trafford Hospital.[20] In circumstances where the pre-merger situation is not sustainable but the hospital is likely to continue providing healthcare services, the CCP considers that it is likely that alternatives to the merger could include any of the approaches for NHS trusts to achieve NHS foundation trust status that have been proposed by the Government (see paragraph 11);[21] or Trafford Trust could merge with a provider that does not raise concerns under the Principles and Rules (or any patient choice or competition concerns that were raised by the transaction could be successfully remedied).[22]

34. In summary, we consider that the appropriate counterfactual scenario for the assessment of this proposed merger is that Central Manchester Hospitals would continue to operating in its current form and Trafford Trust would either merge with another organisation in a transaction that would not give rise to a material adverse effect on patient choice and competition (or any competition concerns that were raised by the transaction would be successfully remedied) or another solution would be found. In other words, in the counterfactual scenario each of the merger parties would continue to operate independently of one other.

MARKET DEFINITION

35. The outcome of a market definition exercise is the identification of other services, and the locations from which they are provided, that are effective substitutes for the services provided by the merged organisation. This provides a framework for analysing the competitive effects of a merger through identifying providers of competing services who are capable of providing competitive pressure on the merged organisation.[23]

36. We identified the services provided by the merger parties and the extent to which the services provided by each trust overlap. The merger parties overlap in the supply of a wide range of routine hospital services (which include elective and non-elective services) and the supply of some community services.[24] Central Manchester Hospitals provides a range of specialist services but as Trafford Trust does not there are no overlaps in specialist or tertiary services and it is not necessary for us to consider the potential impact of the merger on these services.

37. We next identify which services might be effective substitutes for each of the services provided by the merger parties. Given the nature of the requirements of a patient needing to be treated for a given condition, we define separate product markets for each speciality (e.g.

[20] If clinical quality were to deteriorate we consider that commissioners would decide to provide additional funding to resolve the issues rather than closing down the services provided from Trafford Hospital.
[21] Trafford Trust considered various alternatives to the proposed merger, including merger with University Hospitals of South Manchester NHS Foundation Trust, Salford Royal NHS Foundation Trust, or a merger with a Trust from further afield, see www.messengernewspapers.co.uk/news/8721821.Health_service_shock_in_Trafford/
[22] See CCP Merger guidelines, paragraph 6.43. Possible alternative providers might include Salford Royal NHS Foundation Trust or University Hospital of South Manchester NHS Foundation Trust. We note that these other possible mergers might require a remedy to any costs that could arise from the transactions. These Trusts may each renew their interest in merging with Trafford Trust in the event that the proposed merger was prohibited.
[23] This approach is consistent with the Office of Fair Trading and Competition Commission approach. See section 5.2 of the joint merger assessment guidelines available at www.competition-commission.org.uk/our_role/ms_and_fm/cc2_review.htm.
[24] A complete list of the specialties that are provided by both Trusts are listed in Appendix 3.

ophthalmology, gastroenterology, cancer treatment).[25] However, consistent with previous hospital merger analysis, we clustered together specialties which face similar constraints and are provided by the same set of competitors.[26] We considered the following service clusters:[27]

i. Routine elective services for admitted patients. These services are provided by a wide range of providers in England, including NHS trusts, Independent Sector Treatment Centres and Independent Sector hospitals holding an NHS Standard Acute Contract. Potential routine elective service competitors include all providers of NHS-funded elective and non-elective services;
ii. Non-elective services (i.e. accident and emergency and maternity services). These services are mainly provided by NHS trusts. Potential non-elective services competitors include all providers of NHS-funded non-elective services;
iii. Community health services. These services are provided around England by NHS, independent and third sector providers with backgrounds in different areas of health and social care. Potential community service competitors include all providers of NHS-funded community, primary and hospital-based (including both elective, non-elective routine and specialist) services;
iv. Outpatient services. This cluster only includes outpatient services which are not linked to an admitted patient episode e.g. dermatology.[28] Potential outpatient service competitors include all providers of NHS-funded routine elective, non-elective and specialist healthcare services.

38. We have not found it necessary to define precisely the relevant geographic market as it is not material to our findings.[29] However, for the purposes of explaining our competitive assessment we refer to the area of Greater Manchester (see Figure 2) including a number of important providers: Pennine Acute Hospital NHS Trust to the north; University Hospital South Manchester NHS Foundation Trust to the south; Tameside Hospital NHS Foundation Trust to the west and Wrightington; Wigan and Leigh NHS Foundation Trust to the east.[30]

COMPETITION FOR ROUTINE ELECTIVE SERVICES IN GREATER MANCHESTER

39. In assessing the competitive effects of the merger, we analysed whether it would be likely to reduce competition for routine elective services in the Greater Manchester area. This would arise if, absent the merger, the merger parties impose a competitive constraint on each other

[25] That is because, on the demand side, a patient's diagnosis will determine the treatment that (s)he requires. For example the patient is unable to opt to have a replacement knee if (s)he is unsatisfied with the quality of the surgery that a hypothetical monopolist provider of ankle surgery is offering. However, it is our view that supply-side substitution possibilities might exist within each specialty, while remaining less likely to occur between specialties, as a provider of one specialty may not necessarily be able to provide another specialty.
[26] In some cases a provider of a range of specialities may not face similar constraints and the same set of competitors across all of its specialties. Some of its specialties may face greater or lesser constraints, for example as a result of the additional Independent Sector capacity funded by commissioners in certain specialities. In that case we may examine the speciality outside the clusters that we define.
[27] Where one service in a cluster might be facing a different set of competitors from other services in the cluster (for example ophthalmology) we analysed that service separately in more detail. The strength of the competitive constraints from providers of other services in each cluster may vary and will be taken into account, where relevant, in our competitive assessment.
[28] Outpatient services which are provided in conjunction with an admitted patient episode (i.e. pre-operative assessments and follow up appointments) are considered as part of the routine elective and non-elective service clusters and each individual specialist service.
[29] This is because we have within our competitive effects analysis considered the strength of the competitive constraints posed by all relevant potential rival hospitals. Given the nature of the identified product markets and the importance of convenience to patients we are able to identify potentially relevant rival hospitals based on the proximity of the facilities of those rivals. We have also considered the possibility of a competitive threat from more distant rivals moving into the area and we treat these as potential new market entrants.
[30] As location of hospital is important to patients/GPs when they choose a hospital, those hospitals providing the same services in different locations are not perfect substitutes for one another and hospitals that are near one another will tend to be more important competitors than those that are not. We also assess the relative strength of competitive constraints between providers in Greater Manchester.

and do not face strong competition from other providers. In the context of this transaction this means that the existence of the other merger party (Trafford Trust or Central Manchester Hospitals) leads management to take into account the threat to its revenue from patients/commissioners deciding to obtain services from the other provider. This in turn influences management when it is deciding how much to spend on maintaining and improving the quality of its service (meaning range, quality and efficiency of routine elective services). Next, when reaching a view on the costs that may arise from a merger, we review the strength of the competitive constraint that would remain from other providers.[31] This means that although a merger may reduce competition, whether this reduction is material depends on whether there are alternative providers that would be likely to provide sufficient competitive constraint following the merger. We undertook this assessment from the perspective of each of the two main sites for the two merger parties.

40. We assessed the competitive effects of the merger on the competitive constraints faced by the elective services provided at firstly Trafford Hospital (the main hospital site of Trafford Trust) and secondly Manchester Royal Infirmary (the main hospital site of Central Manchester Hospitals). We looked at these effects separately rather than on the merged organisation as a whole because the management of the merged organisation will be able to decide how to maintain or improve quality and/or efficiency at each separate hospital site (depending, in part, on the competitive constraint each hospital site faces). Where there is a material reduction in the competitive constraint that a hospital site faces, the management of the merged organisation may take decisions that impact on the quality of services offered to patients at that site, or the efficiency with which they are provided at that site, without the fear of the merged organisation losing patients (and revenue).[32]

41. Trafford Trust and Central Manchester Hospitals each provide a range of routine elective care services to patients from the Greater Manchester area. Trafford Trust provides these services from Trafford Hospital.[33] Central Manchester Hospitals provides these services from the Manchester Royal Infirmary (as well as elective paediatric, dental, ophthalmology and specialist/tertiary services). Figure 2 shows the location of hospitals that provide routine elective care in Greater Manchester and in the following paragraphs we assess how the merger might reduce the strength of the competitive constraint on routine elective services provided from Trafford Hospital and Manchester Royal Infirmary.

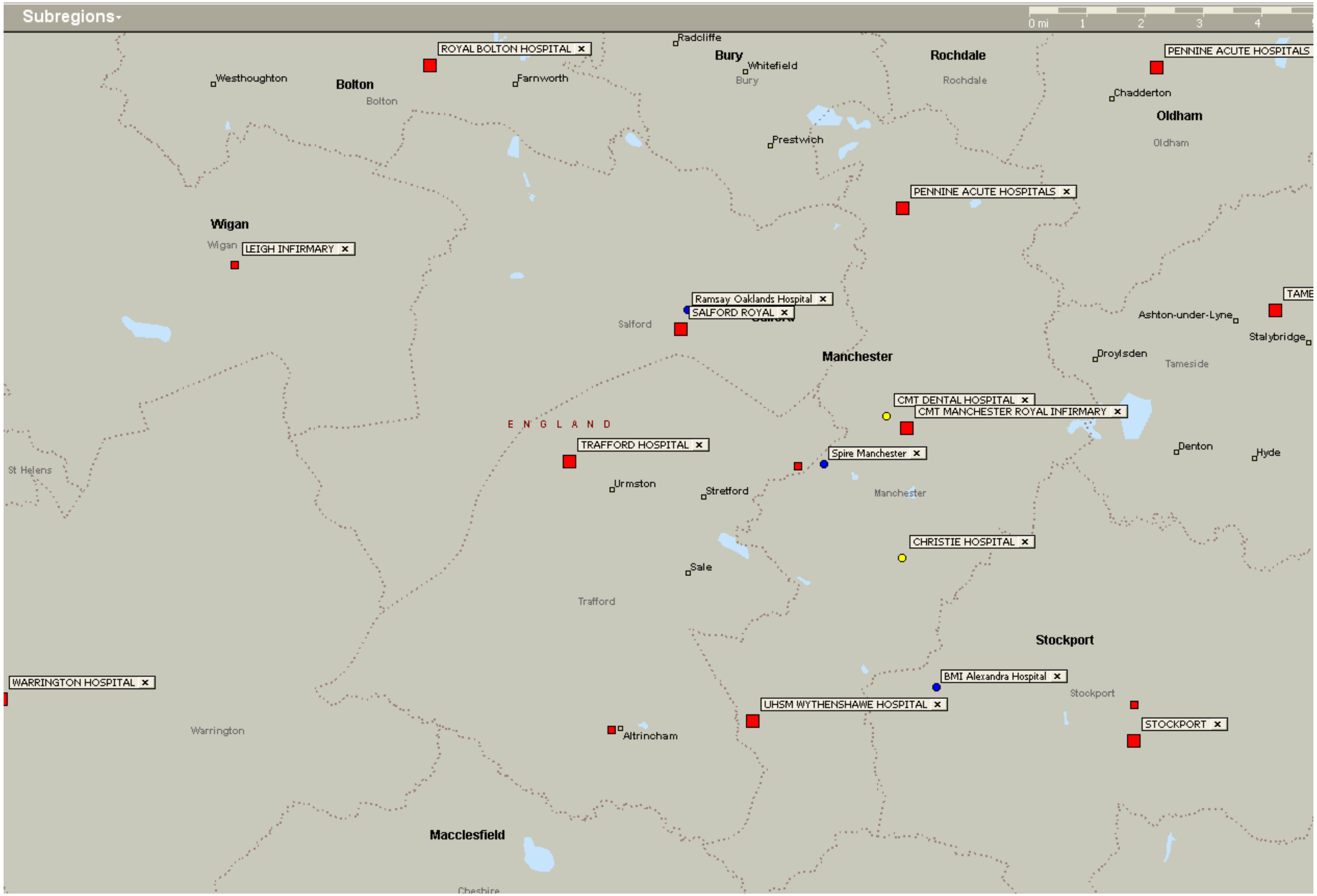
[31] We note that the competitive constraints faced from competitors located within the Greater Manchester area by each of the hospitals of the merger parties will not be equal and will depend on factors such as the preferences of GPs/patients and commissioners. It will also vary depending on whether the services provided are routine or more specialist.

[32] Services might be varied in a number of ways including: i) Reducing the range of procedures and treatments routinely offered on a site which would result in patients having to travel further for treatment at another site of the merged organisation than the patient would have travelled prior to the merger; ii) Amending existing staffing levels at a site, e.g. reducing the level of consultant-delivered services or out-of-hours cover and/or amending the skill mix requirements for designated staff groups (such as nurses and other health professionals); iii) Reducing or not extending the operating hours of elective services at a site (or the services that support their delivery such as diagnostics or anaesthetists) which would restrict the availability of appointment times and may lead to increases in waiting times; iv) Reducing or delaying the level of capital expenditure (such as equipment, accommodation or hospital buildings) and/or investing in new assets; v) Focusing less time and effort on ensuring high quality services are delivered at the lowest cost e.g. resulting in a longer length of stays for patients and over time the provision of inefficient services may require additional taxpayer funding for those services.

[33] Its services include a former Independent Sector Treatment Centre (ISTC) on the site of Trafford Hospital – the Greater Manchester Surgical Centre, which was operated by Netcare for five years between 2005 and 2010. Inpatient paediatric services were in 2010 relocated from Trafford Trust to University Hospitals of South Manchester NHS Foundation Trust (Trafford Trust continues to provide day-case and outpatient paediatric care). Inpatient obstetrics was also closed during this reconfiguration with Central Manchester Hospitals now providing antenatal clinics at Trafford Trust and subsequent deliveries being split roughly equally between University Hospitals of South Manchester NHS Foundation Trust and Central Manchester Hospitals.

FIGURE 2

Providers of Routine Elective Care in the Greater Manchester area



42. When assessing the competitive constraint on each of these hospital sites we evaluate a variety of information. We considered the range of potential providers of the same services within different travel times of each site. We then considered which of the potential providers and the hospital sites of the merger parties that patients choose to attend. We do so by identifying the catchment area for each hospital site from patient flow information (see Appendix 2 for our analysis of GP referral patterns).[34] We also considered the extent of any overlap in these catchment areas. All of this information helps us to understand whether patients would consider switching between one of the hospital sites (for example Trafford Hospital) and a potential competing hospital site (for example, the Hope Hospital of Salford Royal NHS Foundation Trust) in response to a change in relative quality at Trafford Hospital. Where we found that this switching does occur we also analyse the proportion of patients that might do this (i.e. the more patients that consider switching between these hospitals the greater the competitive constraint provided by the competitor).

43. In our analysis we also referred to internal documents from the merger parties and other providers (see paragraph 30) to understand the extent to which the hospital trusts perceive they would be likely to gain (or lose) referrals of patients between each other. We also try to identify if there has been any action taken by the competing hospital trust in the past to prevent referrals from being lost. Where the merger parties are found to be close competitors, we then assess whether there are other strong competitors that could offset the loss of competition from the merger.

Routine Elective Services provided from Trafford Hospital

44. The merger parties told us that the most significant concerns regarding the merger are likely to be that quality standards would drop for routine district general hospital services (particularly those provided at Trafford Hospital) as a result of the merger, or as a result of the new merged organisation holding such a strong market position that reduced quality would not adversely affect referral patterns or patient choice. However, the merger parties went on to explain that those concerns would not be realised because it is precisely for these services that there is the strongest competition with numerous local providers all providing good quality standards of care. The merger parties also told us that these local providers currently provide routine general hospital services and compete with Trafford Trust and Central Manchester Hospitals for market share. We consider the strength of these competitive constraints below.

45. We assessed the effect of the merger on the competitive constraints upon the routine elective care provided from Trafford Hospital by reviewing each of Trafford Trust's and Central Manchester Hospitals' shares of referrals within Greater Manchester. We then assessed the extent to which Trafford Trust and Central Manchester Hospitals compete with one another for routine elective referrals.

[34] A catchment area is defined here as the area served by GPs who refer at least one patient to the hospital site of interest. The GP referral analysis provides an insight into which provider patients together with their GPs are likely to choose to switch to in response to a deterioration of quality at each of the hospital sites that would be operated by the merged organisation, if they decide to switch at all.

46. Trafford Trust's services attract patients mainly from the Trafford area, with the remainder largely coming from Manchester PCT and Salford.[35] Trafford Trust told us that it communicates with GPs primarily through a bimonthly electronic newsletter (information on referral protocols and service developments, which we refer to as 'marketing material'). Trafford Trust's newsletter is e-mailed to GP practices throughout Trafford, and in some parts of Salford and south Manchester. Part of the motivation for these communications to GPs is to explain the quality of the services provided by Trafford Trust (the merger parties told us that these communications are primarily so that GPs will have relevant information when making decisions as future commissioners). Trafford Trust has also appointed a GP medical director to its board in order to ensure that they provide services that meet the needs of patients and has also appointed a primary care facilitator whose role includes building contacts with local GPs and informing them about the Trust's services and performance. Internal documents also showed that this engagement with GPs, alongside significant improvements in clinical quality at the Trust, have helped transform local GPs' perceptions of the Trust.[36]

47. The merger parties told us that the merger would reduce the number of NHS hospital trusts in Greater Manchester from ten to nine. Trafford Trust is the smallest hospital trust in Greater Manchester, accounting for 2.7 percent of all admissions, and 3.7 percent of elective admissions across the conurbation. Central Manchester Hospitals has a share of 16.5 per cent of all elective admissions, and 18.1 per cent of elective admissions. Combined, the merged organisation would account for 21.8 per cent of all admissions and 19.2 per cent of elective admissions.

48. Manchester Royal Infirmary is located approximately ten kilometres to the east of Trafford hospital. Like Trafford Trust, Central Manchester Hospitals also sends marketing material to GPs in the Manchester area (as well as practice managers across the Greater Manchester area, including Trafford and Salford). This indicates that its catchment area overlaps with Trafford hospital's catchment area. Our analysis of GP referrals suggests that Central Manchester Hospitals is considered an important alternative to Trafford Trust (Central Manchester Hospitals was the most popular alternative to Trafford Trust for the top ten elective service lines in Trafford for approximately ten per cent of Trafford Trust's routine elective referrals).[37] This analysis is consistent with internal documents that show that Central Manchester Hospitals competes with the services provided from Trafford Hospital.

49. We assessed the extent to which other providers are likely to compete with the routine elective services provided from Trafford hospital following the merger. We identified that Trafford Trust uses data available from Dr Foster to benchmark the quality of its services against other providers.[38] We note that the trusts which Trafford Trust benchmarks its performance against are not trusts that provide a similar mix of services or that have a similar

[35] Trafford Trust attracts 89 per cent of its activity from NHS Trafford.
[36] The Trusts communications strategy includes: a newsletter; the creation of pathology pigeon holes in which letters and information for each GP practice are attached to the results of pathology samples; the creation of a database of GP practices in the Trust's key referral areas; practice visits by consultants; and, an education forum.
[37] See Appendix 2 for further details of our GP referral analysis.
[38] See, for example, Trafford Trust's 'Quality Dashboard' report here: www.trafford.nhs.uk/files/file/pdf/board%20papers/2011/Jan%202011/08%20Quality%20Dashboard.pdf. The measurements Trafford Trust uses to benchmark against these peers are: infection control (CDIFF and MRSA); re-admission rate (separately for elective and non-elective); hospital standard mortality rate; and length of stay.

population demographic, but instead are local trusts that appeal to patients within the Trafford catchment area. These trusts are:

- University Hospital South Manchester NHS Foundation Trust;
- Salford Royal NHS Foundation Trust;
- Central Manchester Hospitals;
- Pennine Acute Hospitals NHS Trust;
- Tameside Hospital NHS Foundation Trust; and
- The Christie NHS Foundation Trust.

50. This evidence is supported by the results of our analysis of GP referrals which suggested that University Hospital South Manchester NHS Foundation Trust is the most important alternative to Trafford Hospital for the top ten elective service lines in Trafford (University Hospital South Manchester NHS Foundation Trust was the most popular alternative to Trafford for approximately 64 per cent of Trafford's routine elective referrals). The next most important rival was Salford Royal NHS Foundation Trust (16 per cent). Central Manchester Hospitals was therefore the third most important rival.[39] Both Salford Royal NHS Foundation Trust and University Hospital South Manchester NHS Foundation Trust are large teaching hospitals with strong reputations. The strength of the constraints suggested by the quantitative analysis is consistent with Hope Hospital (of Salford Royal NHS Foundation Trust) and Wythenshawe Hospital (of University Hospital South Manchester NHS Foundation Trust) being geographically closer to Trafford than Manchester Royal Infirmary (Central Manchester Hospitals).[40]

51. This analysis is supported by the qualitative views provided by third parties. Other trusts described University Hospital South Manchester NHS Foundation Trust and Salford Royal NHS Foundation Trust as strong competitors. Manchester PCT told us that University Hospital South Manchester NHS Foundation Trust and Pennine Acute Hospitals NHS Trust both offer a wide range of secondary services, are strong providers (especially Wythenshawe), and that transport to both hospitals is good. NHS Trafford told us that University Hospital South Manchester NHS Foundation Trust is a strong competitor to the merger parties and that Salford Royal NHS Foundation Trust provides a somewhat lesser constraint. This is demonstrated by the fact that since November 2011 University Hospital South Manchester NHS Foundation Trust has distributed a fortnightly e-bulletin tailored to GPs in Trafford

52. In conclusion, we found that Central Manchester Hospitals is a competitor to Trafford Trust for routine elective services. However, Central Manchester Hospitals is not the most important competitor to Trafford Trust, and other important alternative providers, such as Salford Royal NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust Trafford, would be likely to remain post merger. We found that the existence of these alternative providers would be likely to ensure that the loss of Central Manchester Hospitals as a competitor to Trafford Trust, following the proposed merger, would not significantly reduce the competitive constraints on the routine elective services provided from Trafford hospital.

[39] See Appendix 2 for details of this analysis

[40] The merger parties told us that the drive time from Trafford General Hospital to Hope Hospital is 13 minutes; to Wythenshawe Hospital it is 20 minutes; and to Manchester Royal Infirmary it is 21 minutes. The equivalent trip by bus takes, respectively, 45 minutes; 1 hour 20 minutes; and 1 hour,

Routine Elective Services provided from Manchester Royal Infirmary

53. We assessed the effect of the merger on the competitive constraints on the routine elective care provided from Manchester Royal Infirmary. These services attract patients from the Manchester area (36 per cent of patient attendances are referred from within Manchester PCT), as well as from Salford, Trafford, Tameside, Stockport and other greater Manchester PCTs. Like Trafford Trust, Central Manchester Hospitals also sends marketing material to GP practices in Salford, Trafford and South Manchester area (as well as the greater Manchester area). This indicated that its catchment area overlaps with Trafford Hospital's catchment area.

54. We identified that Central Manchester Hospitals benchmarks the quality of its services against six other providers, including Trafford Trust.[41] These six other providers are other local trusts that are in a position to appeal to patients within Central Manchester Hospitals' catchment area (although they may be smaller hospitals with a smaller range of services or differ in the socio-demographic profile they primarily serve):
    - University Hospital South Manchester NHS Foundation Trust;
    - Salford Royal NHS Foundation Trust;
    - Tameside Hospital NHS Foundation Trust;
    - Pennine Acute Hospitals NHS Trust;
    - Trafford Trust; and
    - Stockport NHS Foundation Trust.

55. Central Manchester Hospitals told us that overall it performs well on the measures against which it benchmarks (e.g. average waiting time; re-admission rates which are measured separately for elective and non-elective; length of stay; and outpatient follow up rates). Central Manchester Hospitals explained to us that in order to sustain its position it would focus on reducing waiting times, while continuing its efforts to improve efficiency. Having established that Manchester Royal Infirmary competes with Trafford Hospital pre-merger, we next assessed the extent to which other providers are likely to compete with the routine elective services provided from Manchester Royal Infirmary following the merger.

56. Our analysis of GP referrals suggests that University Hospital South Manchester NHS Foundation Trust is the most important alternative to Central Manchester Hospitals. Our analysis shows that University Hospital South Manchester NHS Foundation Trust was the most popular alternative to Central Manchester Hospitals for approximately 33 per cent of Central Manchester Hospitals' routine elective referrals. The next most important rival is Pennine Acute Hospitals NHS Trust (18 per cent of Central Manchester Hospitals' routine elective referrals). Salford Royal NHS Foundation Trust is the third most important (7.5 per cent of Central Manchester Hospitals' routine elective referrals) and Trafford Trust is only the fourth most important rival to Central Manchester Hospitals. This is consistent with a view that the constraint that the merger parties place on one another is asymmetric i.e. Central Manchester Hospitals is a significantly stronger constraint on Trafford Trust than Trafford Trust is on Central Manchester Hospitals.

[41] See, Central Manchester Hospitals' integrated business plan. The measurements Central Manchester Hospitals uses to benchmark against these peers are: waiting times, length of stay, readmission rates, and outpatient follow-up rates.

57. The internal documents provided by Central Manchester Hospitals showed that other alternative providers of non-routine elective care exist in the relevant geographic area. In a market assessment document provided by the merger parties, four local NHS and NHS foundation trusts were identified and are considered to be in competition with Central Manchester Hospitals across a range of services. The main competitors for the services provided from Central Manchester Hospitals were identified as University Hospital South Manchester NHS Foundation Trust, Salford Royal NHS Foundation Trust, Stockport NHS Foundation Trust, and Tameside Hospital NHS Foundation Trust. We noted that Trafford Trust was not identified amongst this list of key competitors.

58. The document also identified four independent sector providers that were considered by the merger parties as likely to have a competitive impact on secondary care, in particular on outpatient, day-case and elective inpatient services. These providers included Greater Manchester Surgical Centre (now operated by Trafford Trust), Spire Manchester Hospital, BMI Cheadle and a mobile Clinical Assessment, Treatment and Support (CATS) service that is operated by Care UK.[42] We also consider that the nearby Christie NHS Foundation Trust is a strong competitor for routine elective cancer services given that it is the largest specialist cancer centre in Europe (treating more than 40,000 patients a year, 25 per cent from across England) and is well regarded by patients.

59. In conclusion, we found that Trafford Hospital is a competitor to the routine elective services provided from Manchester Royal Infirmary. However, it was not the most important competitor and there would remain sufficient choice and competition from a range of alternative providers post-merger. We found that the existence of these alternative providers means that the loss of Trafford Trust as a competitor to Manchester University Hospitals would not significantly reduce the competitive constraints on the routine elective services provided from Manchester Royal Infirmary.

Coordinated Effects

60. Coordinated effects may arise where, following a merger, providers independently recognise the mutual benefit in not competing with each other and independently decide to limit the effort placed in competing.[43] The CCP does not consider that the merger is likely to result in the creation or strengthening of coordinated effects.[44] The CCP received no evidence during its investigation of existing coordination between the merger parties. With regard to competition for patient referrals, the merged organisation will continue to differ in important ways from the other providers in the region. The merger does not significantly increase the similarity in size and range of services offered by the merged organisation compared to other providers in Greater Manchester (for example Salford Royal NHS Foundation Trust and University Hospital South Manchester NHS Foundation Trust).[45] The CCP received no evidence

[42] The mobile clinic units are located at Denton, Longsite, Stretford, Salford, Bolton, Rochdale, and Oldham.
[43] See CCP Merger Guidelines, paragraphs 6.68 to 6.73.
[44] With regard to competition for contracts, our analysis of the tenders in the area showed there to be a number of credible competitors to the merger parties. Competitors included both the local NHS trusts and a number of independent sector providers of NHS funded services. We concluded that the proposed merger is not likely to give rise to coordinated effects.
[45] For example, University Hospital South Manchester NHS Foundation Trust's and Salford Royal NHS Foundation Trust's operating income for 2010/11 was approximately £348 million and £346 million, respectively. In contrast, Central Manchester Hospitals' income was approximately £665 million.

to suggest that Trafford Trust was a provider with materially different incentives to coordinate, over and above the incentive on any other trust in Manchester. There was also no evidence that Trafford Trust had the capacity to receive a significant proportion of GP referrals in the event that it tried to take these referrals from any group of providers that tried to exclude Trafford Trust and coordinate without its participation.[46]

Conclusion on Competition for Routine Elective Services

61. For the reasons outlined above we conclude that Central Manchester Hospitals is a competitor to Trafford Trust for routine elective services. However, the Manchester Royal Infirmary was not the most important competitor to Trafford Hospital, and other important alternative providers, such as Salford Royal NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust will remain post merger. We found that the existence of these alternative providers means that the loss of the Manchester Royal Infirmary as a competitor to Trafford Hospital is unlikely to reduce significantly the competitive constraints on the routine elective services provided from Trafford Hospital.

62. We also conclude that Trafford Hospital is a competitor to the routine elective services provided from Manchester Royal Infirmary. However, it is not the most important competitor and there will remain sufficient choice and competition from a range of alternative providers post-merger. We found that the existence of alternative providers means that the loss of Trafford Trust as a competitor to Manchester University Hospitals is unlikely to reduce significantly the competitive constraints on the routine elective services provided from Manchester Royal Infirmary.

COMPETITION FOR NON-ELECTIVE SERVICES IN GREATER MANCHESTER

63. We assessed whether the merger would be likely to reduce the extent of competition between providers of non-elective services in Greater Manchester. Non-elective services are non-specialist healthcare services provided in unplanned circumstances, and include consultant-led maternity and accident and emergency services (but exclude major trauma which is a specialist service).[47]In particular, we considered whether the merger is likely to lead to a reduction in the merged organisation's incentives to maintain and improve the quality and/or efficiency of the non-elective services provided at each of its hospital sites. Trafford Trust and Central Manchester Hospitals both provide non-elective care services to patients in Greater Manchester. They provide these services from their main hospital sites: Trafford Hospital and Manchester Royal Infirmary.

64. To analyse the impact of the merger we evaluate the likely impact on commissioner choice. As patients cannot choose which provider they use for non-elective services, commissioners choose which hospital sites they want to provide these services for the local population.[48]

[46] This approach is consistent with the Office of Fair Trading and Competition Commission approach. See paragraph 5.5.18 of the joint merger assessment guidelines available at www.competition-commission.org.uk/our_role/ms_and_fm/cc2_review.htm.
[47] With the exception of pre-planned caesarean sections, consultant-led maternity services are non-elective services. We do not draw a distinction between accident and emergency and consultant-led maternity services in our competitive assessment as providers of accident and emergency services in Greater Manchester also provide consultant-led maternity services and so both services would face the same set of potential competitors.
[48] We note that some patients, in particular those who do not have life threatening injuries, will have a degree of choice as to which hospital they seek non-elective treatment.

Competition between providers of non-elective services arises if there is the possibility that commissioners might select an alternative provider, rather than an existing provider, to provide these non-elective services.

65. A merger between providers of non-elective services may reduce the merged organisation's incentive to maintain and further improve the quality of its non-elective services at each of its sites above CQC minimum standards. This is because before the merger, when making expenditure decisions, each provider would take account of the revenue it would lose if commissioners decided to stop purchasing non-elective services from it. However, following the merger and when making a similar expenditure decision the merged organisation would consider revenue on an organisation-wide basis rather than a site-level basis. This means that if the merged organisation can expect to retain a high proportion of the revenue it earns from providing non-elective services even after it stops providing those services from one of its hospital sites (because another of its hospital sites will instead capture the revenue) then the incentive to maintain or increase spending to ensure that non-elective services remain at the original hospital site will be lower after the merger than it was prior to the merger. Therefore the merged organisation may not be prepared to incur the same level of expenditure on maintaining and improving the quality of non-elective services at the original hospital site as the pre-merger hospital trust would have prior to the merger.[49]

66. In order to assess the effect of the merger on competition between providers of routine non-elective services we analysed:
- Whether commissioners in the foreseeable future would stop commissioning these services from any of the main hospital sites operated by the merger parties;
- What proportion of revenue (using patient numbers as a proxy) the merger parties could expect to gain in the event of each of the merger parties, in turn, lose the contract to provide non-elective services from its main hospital site;
- Whether there is any evidence that the merger parties are particularly close competitors in tenders for non-elective services.

67. We assessed whether commissioners in Greater Manchester would be likely to consider reconfiguring non-elective services away from any one of the main hospital sites operated by the merger parties in the future. We note that inpatient maternity and paediatric services have recently been removed from Trafford Hospital by local commissioners. Given this recent decision by local commissioners, and the proximity of alternative accident and emergency departments in Greater Manchester, it seems likely that future commissioners may reconsider the current accident and emergency provision at Trafford hospital. Similarly Manchester Royal Infirmary is located near enough to other accident and emergency departments to allow some scope for future reorganisation of non-elective services away from Manchester Royal Infirmary. The merger parties told us that any reconfiguration plans for the merged organisation are at an early stage. The current timetable is to develop proposals for reconfiguration by April and to conduct public consultation between May and September 2012. The redesign will be led by local commissioners and overseen by a Strategic Programme

[49] We discuss ways in which adjustments to expenditure can affect the quality and efficiency of service delivery in paragraph 40.

Board. The merger parties told us that no potential options for reconfiguration have been decided at this stage.

68. We assessed what proportion of revenue the merger parties might gain in the event of each of the merger parties, in turn, losing the contract to provide non-elective services from its main hospital site. [✂] Given its close proximity we consider it is likely that a larger proportion of revenue would be lost to Royal Salford Hospital NHS Foundation Trust. As a result the merged organisation would lose a large proportion of the non-elective revenue that Trafford Trust currently earns if Trafford Hospital were to lose its remaining non-elective services.

69. Given that the Manchester Royal Infirmary is located in the centre of Manchester, we consider that it is unlikely that Trafford Hospital would receive very much of the revenue that Central Manchester Hospitals currently receives from providing non-elective services (i.e. in the event of the Manchester Royal Infirmary losing its non-electives services Trafford Hospital would not gain much of the lost revenue). We consider that the merger will not change the existing incentives for the merged organisation to continue to invest in maintaining and improving the quality, range and efficiency of non-elective services that they provide from its main hospitals.

70. We also assessed whether the merger parties are particularly close competitors for tenders of non-elective services. We note that there has been only one instance of the merger parties competing for the same service in the past twelve months in the Trafford PCT area. In that tender the merger parties submitted a joint bid with Trafford Provider Services to provide oxygen. Manchester PCT told us that there have been no tenders in its PCT area the past twelve months in which the merger parties have submitted a bid.

71. For these reasons we conclude that the proposed merger is unlikely to reduce the incentives of the parties to compete to retain non-elective services. Therefore the merger is unlikely to have a material adverse effect on patient choice and competition for non-elective routine care in Greater Manchester.

OUTPATIENTS SERVICES

72. We analysed whether the merger would be likely to reduce choice and competition in outpatient services in Greater Manchester. There are two types of outpatient services: those which form part of a pathway for a specific admitted patient episode (i.e. first and follow-up appointments); and those standalone outpatient services which do not form part of a specific admitted patient pathway. This second category reflects the growing demand from commissioners for medical care that can be provided on an outpatient basis (with no requirement to admit the patient for treatment).

73. The merger parties each provide a range of outpatient services in community settings across the respective catchment areas of each trust and we consider that the merger parties are competitors for the provision of outpatient services in Greater Manchester. These services can be provided from a range of premises including GP practices, health centres and community

hospitals.[50] As these outpatient appointments are only provided in conjunction with the admitted service we considered them in our analysis of the effects of the merger on routine elective care in the area of Greater Manchester i.e. we conclude that the merger is unlikely to have a material adverse effect on choice and competition for outpatient services in Greater Manchester.

74. We consider that the provision of stand-alone outpatient services is likely to be even more competitive than routine elective services. This is because the provision of outpatient services has lower barriers to entry than the provision of hospital-based services and so a wider range of providers are likely to be able to start providing outpatient services.[51] We consider that the threat of entry by new providers will ensure that the merged organisation is unable to allow the quality of its standalone outpatient services to deteriorate without the threat of patients switching to an alternative provider. For these reasons we conclude that the merger is unlikely to have a material adverse effect on choice and competition for standalone outpatient services in Greater Manchester.

COMMUNITY SERVICES

75. We analysed whether the merger would be likely to reduce patient choice and competition in community services in Greater Manchester. The main form of competition in community services to date has been competitive tendering, or the threat of competitive tendering by the PCT commissioners of these services. In this form of competition, commissioners select a provider to provide a defined service across a set geographic area and patients from within that area use the service provided. However, in July 2011 the Government announced that patient choice would be extended into community (and mental health) services. A phased approach was proposed, with local commissioners expected by the Government to identify three or more community or mental health services in which to implement patient choice of Any Qualified Provider during 2012/13.[52]

76. Detail on how patient choice will be implemented across the full range of community services in future continues to remain unclear and so competitive tendering is the predominate form of competition in community services in the short term. With the future implementation of Department of Health policy in mind, we first analysed the impact of the merger on community services from the perspective of commissioner choice and competition and then, for those services where patient choice is expected to be introduced in 2012/13, we considered the impact of the proposed merger from the perspective of patient choice and competition.

Impact on commissioner choice

77. We considered the extent to which the merger parties might in future compete for community service contracts in the absence of the merger. Central Manchester Hospitals

[50] The location of these outpatient clinics can improve access for patients and can be used by providers to attract patients from an area when patients would otherwise be unwilling to travel to the main hospital site for both the admitted and associated outpatient appointments.
[51] Setting up these clinics requires a provider to rent space within existing healthcare facilities (e.g. a community hospital or a local GP) or rent alternative appropriate accommodation. The provider must also be able to provide consultants, nurses and administrative staff
[52] See www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128462.pdf.

currently provides a range of community services in Manchester. Trafford Trust lost its bid to operate community services in Trafford in 2010.

78. The bidding data shows that Central Manchester Hospitals bid for and won a contract to provide community Chronic Obstructive Pulmonary Disease (COPD) services in Manchester (the only contract it has participated in during the past three years). Pennine Acute Hospitals NHS Trust came second and Trafford Trust did not bid. In addition Central Manchester Hospitals bid for and won the contract to provide the majority of services that had been provided by Manchester PCT provider arm, which had previously been active in bidding for contracts:

- Manchester PCT provider arm bid for and won a contract to provide community physical activity development programme in Manchester. The Oldham PCT provider arm came second.
- Manchester PCT provider arm bid for and won a contract to provide integrated sexual health services in Trafford. The Terrence Higgins Trust came second.
- Manchester PCT provider arm bid for a contract to provide out-of-hours primary care services in Manchester. Manchester PCT provider arm did not make the shortlist of four providers. The independent sector provider Harmoni was the successful bidder.

79. In addition to the bidders mentioned above, a number of PCT community service provider arms were acquired by local trusts. Bridgewater Community Healthcare NHS Trust acquired Trafford PCT provider arm, Royal Bolton NHS Foundation Trust acquired Bolton PCT provider arm, and Salford Royal NHS Foundation Trust acquired Salford PCT provider arm. Manchester PCT provider arm was divided amongst four providers (Central Manchester Hospitals, Pennine Acute Hospitals NHS Trust, and Manchester Mental Health and Social Care NHS Trust).[53] These providers are all familiar with the needs of the local population and are near to the merger parties, making them credible alternative suppliers in any future tenders. The merger parties also identified Trafford Primary Healthcare Limited (a GP provider organisation) and Healthcare at Home (Independent Sector) as important rivals for community service contracts. Manchester PCT told us that it also considered there to be a number of alternative providers of community services in Greater Manchester.

80. We consider that commissioners have a number of alternative providers to Central Manchester Hospitals if a tender for community services was held. In addition, Trafford Trust does not appear to be a strong alternative provider and so is only a weak constraint on surrounding trusts that provide community services. For example commissioners decided against awarding Trafford Trust the contract to provide community services in Trafford. We note that Trafford Trust has not participated in any bids to provide community services in recent years. Nevertheless, Trafford Trust does provide some community based services such as Children and Adolescent Mental Health services (CAMHs).

[53] This division was largely on a geographic basis with Central Manchester Hospitals also taking the smaller services that could not be divided, see www.ccpanel.org.uk/content/cases/Mergers_of_NHS_Manchester_and_Central_Manchester_and_Pennine_Acute_and_UH_South_Manchester_and_Manchester_Mental_Health/101207_Manchester_Fast_Track_FINAL.pdf.

81. Based on this information and depending on the community service tendered, we consider that there are a range of other potential effective bidders, including other large NHS providers providing hospital-based services in the Greater Manchester area, local primary care provider groups and other Independent Sector providers. We conclude that the merger is unlikely to have a material adverse effect on choice and competition for community services tendered in Greater Manchester.

Impact on patient choice

82. We next assessed the impact of the merger on patient choice and competition in those community services where patient choice is expected to be implemented during 2012/13. PCTs in Greater Manchester, in conjunction with local clinical commissioning groups (CCGs), have identified the following services that will introduce AQP and so patient choice in 2012/13:[54]

- Adult hearing;
- Diagnostics; and
- Podiatry.

83. We found that Trafford Trust and Central Manchester Hospitals both currently provide diagnostics, audiology and podiatry. We also found there would be a range of other providers who could start providing these services on an AQP basis, including the rivals identified in relation to routine elective services (e.g. University Hospital of South Manchester NHS Foundation Trust Salford Royal NHS Foundation Trust, and Pennine Acute Hospitals NHS Trust) as well as GP provider organisations, social enterprises and the current incumbent providers of these services in Trafford (e.g. Bridgewater Community Healthcare NHS Trust).

84. We conclude that the merger is unlikely to have a material adverse effect on choice and competition for community services where AQP is expected to be introduced in the near future.

VERTICAL EFFECTS OF THE MERGER

85. In this section we assess whether the merger is likely to have an impact on the relationship between the merger parties and those providers who refer patients to them, or whom they refer patients to. In particular, we assess whether the merged organisation would have the ability and incentive to direct or otherwise influence patient referrals internally rather than to alternative providers and thus reduce competition for those referrals.

86. There are two main patient flows which give rise to referrals to and from the merger parties and which could be influenced by the merged organisation. The first is the flow of patients between community service providers and providers of hospital-based services. The second is the flow of patients between providers of routine hospital services and providers of specialist hospital services.

[54] See www.supply2health.nhs.uk/AQPResourceCentre/AQPMap/AQPMap.aspx.

Referrals between providers of community and hospital services

87. We assessed the effect of the proposed merger on the flow of patients between community service providers and providers of hospital-based services. Patients of community services are currently able to choose their provider of hospital-based services. We assessed whether the merged organisation would have the ability to direct (or otherwise influence) patients receiving community services into routine elective treatment provided from hospital sites of the merged organisation. However, we note that Central Manchester Hospitals already has this ability as it already provides a range of community services and a full range of hospital-based services.[55] The merger will therefore have no additional impact on this existing ability and so we find that the merger is unlikely to have a material adverse effect on choice and competition or undermine the GP gatekeeper function.

88. We also assessed the potential impact of the merger on patient choice and competition in community services i.e. referrals from providers of hospital-based services to community service providers. As discussed in paragraphs 75 and 82, it is proposed that patient choice is only extended into a limited number of community services for the next financial year. However, the merger parties already each have the ability and incentive to refer patients to any community services that they choose to start providing under the AQP model and we consider that it is unlikely that the merger will change this existing incentive. The merger will therefore have no additional impact and so we find that the merger is unlikely to have a material adverse effect on choice and competition.

Referrals between providers of routine and specialist hospital services

89. We assessed the effect of the merger on the flow of patients from providers of routine hospital-based services to providers of specialist hospital-based services. We note that patients are not able to choose their provider at this stage of the patient pathway and so we focus on the impact on competition between providers. Of the merger parties, only Central Manchester Hospitals provides specialist services.

90. With respect to referrals into the specialist services Central Manchester Hospitals provides, the merger parties told us that even if all referrals from Trafford Trust were redirected to Central Manchester Hospitals this would represent only a small proportion of the total number of patients requiring this specialist treatment. This is confirmed in our analysis of data on onward referrals which suggests that less than two per cent of tertiary referrals to Central Manchester Hospitals are from Trafford Trust. We consider that after the merger Central Manchester Hospitals (and other providers of specialist services) will continue to have a strong incentive to invest in quality and/or efficiency in order to attract patients. We consider it is unlikely that changes in the flow of patients for specialist hospital-based services currently provided by Central Manchester Hospitals will adversely affect competition between providers of specialist services.

91. We also assessed the effect of the merger on the flow of patients from providers of specialist hospital-based services to providers of routine hospital-based services. However, these referrals are an extremely small proportion of Trafford Trust's routine hospital-based activity.

[55] Subject to assurances they provided to commissioners upon acquiring these community services.

Therefore, the small volume of referrals will be unlikely to change the merger parties' incentive to invest in quality and/or efficiency in order to attract patients. Therefore, we consider it is unlikely that changes in the flow of patients between providers of routine hospital-based services and providers of specialist hospital-based services will adversely affect competition between providers of routine hospital-based services.

ADVICE AND RECOMMENDATIONS

92. We have found that the merger of Trafford Trust and Central Manchester Hospitals is unlikely to result in material costs to patients and taxpayers and is therefore consistent with Principle 10 of the Principles and Rules.

93. The analysis, advice and recommendations set out in this report have been given by the CCP on the basis of information it has received to date. Should there be any material change to the terms of the transaction we expect the change to be referred back to us for consideration.

Cooperation and Competition Panel
15 February 2012

APPENDIX 1: DRIVE TIMES BETWEEN HOSPTIALS

Table 1: Drive times to hospitals from Trafford General Hospital

Hospital/Service	*Drive time (minutes)*
Greater Manchester CATS (Stretford site)	13
Hope Hospital (Salford Royal NHS Foundation Trust)	13
Withington Community Hospital (Manchester PCT)	18
Wythenshawe Hospital (University Hospitals of South Manchester)	20
Royal Bolton Hospital (Royal Bolton Hospital Foundation Trust)	20
Manchester Royal Infirmary and associated hospitals (Central Manchester Hospitals)	21
North Manchester General Hospital (Pennine Acute Hospitals NHS Trust)	25
Stepping Hill Hospital (Stockport Foundation Trust)	26
Warrington Hospital (Warrington and Halton Hospitals Foundation Trust)	32
Royal Albert Edward Infirmary (Wrightington, Wigan and Leigh Foundation Trust)	32
St Helens Hospital (St Helens and Knowsley NHS Trust)	32
Whiston Hospital (St Helens and Knowsley NHS Trust)	32

Source: Merger parties

Table 2: Drive times to hospitals from Manchester Royal Infirmary

Hospital/Service	*Drive time (minutes)*
Withington Community Hospital (Manchester PCT)	10
Salford Royal (Salford Royal NHS Foundation Trust)	11
North Manchester General Hospital (Pennine Acute Hospitals NHS Trust)	14
Wythenshawe Hospital (University Hospitals of South Manchester)	16
Stepping Hill Hospital (Stockport Foundation Trust)	16
Royal Bolton Hospital (Royal Bolton Hospital Foundation Trust)	23
Trafford General Hospital (Trafford Trust)	18
Warrington Hospital (Warrington and Halton Hospitals Foundation Trust)	28
Whiston Hospital (St Helens and Knowsley NHS Trust)	30
Royal Albert Edward Infirmary (Wrightington, Wigan and Leigh Foundation Trust)	33
St Helens Hospital (St Helens and Knowsley NHS Trust	33

Source: CCP analysis using Google Maps.

APPENDIX 1

Table 3: Travelling times to Greater Manchester Hospitals via Bus-Approximate Timings

Hospital	*PCT*	*Postcode*	*Area*	*Travel times to CMFT,M13 9WL*		*Travel times to SRFT,M6 8HD*		*Travel times to UHSM, M23 9LT*	
				Changes / Mileage	*Minutes*	*Changes/ Mileage*	*Minutes*	*Changes / Mileage*	*Minutes*
Fairfield Hospital	Bury	BL9 7TD	Bury	2	90	2,3	105	2,3	130
Rochdale Infirmary	Heywood, Middleton and Rochdale	OL12 0NB	Rochdale	1, 2	90	1,2	110	1,2,3	130
Birch Hill Hospital	Heywood, Middleton and Rochdale	OL12 9QB	Rochdale	2	105	2	120	2,3	135
Royal Albert Edward Infirmary	Ashton, Leigh and Wigan	WN1 2NN	Wigan	2, 3	85	2	90	2,3	145
Royal Bolton Hospital	Bolton	BL4 0JR	Bolton	1,2	80	0,2	65	1,2	120
Royal Oldham Hospital	Oldham	OL1 2JH	Oldham	1,2	60	1,2	85	1,3	105
North Manchester General Hospital	Manchester	M8 5RB	Crumpsall	1,2	50	1	60	1,3	90
Leigh Infirmary	Ashton, Leigh and Wigan	WN7 1HS	Leigh	1,2	90	1,2	70	1,2,3	120
Hope Hospital	Salford	M6 8HD	Salford	1,2	60	N/A		1,2	90
Tameside General Hospital	Tameside and Glossop	OL6 9RW	Ashton-u-Lyne	2	70	2	90	2	110
Trafford General Hospital	Trafford	M41 5SL	Urmston	0, 1	60	0,1,2	45	1,2	80
Central Manchester Hosptials	Manchester	M13 9WL	Central Manchester	N/A		1,2	60	0,1	60
Wythenshawe Hospital	Manchester	M23 9LT	Wythenshawe	0,1	60	1,2	90	N/A	
Stepping Hill Hospital	Stockport	SK2 7JE	Stockport	0,1,2	60	1,2	100	1,3	75
Travelling Times to Greater Manchester Hospitals via Car									
Fairfield Hospital	Bury	BL9 7TD	Bury	13	33	14.6	24	23.4	33
Rochdale Infirmary	Heywood, Middleton and Rochdale	OL12 0NB	Rochdale	18.9	37	18.6	28	27.4	37
Birch Hill Hospital	Heywood, Middleton and Rochdale	OL12 9QB	Rochdale	20	38	21.5	30	30.3	38
Royal Albert Edward Infirmary	Ashton, Leigh and Wigan	WN1 2NN	Wigan	24.1	43	18.8	30	27.5	38
Royal Bolton Hospital	Bolton	BL4 0JR	Bolton	16.4	33	11.1	20	19.9	28
Royal Oldham Hospital	Oldham	OL1 2JH	Oldham	12.9	26	18.5	26	19.1	27
North Manchester General Hospital	Manchester	M8 5RB	Crumpsall	5.8	25	5.4	25	22.3	37
Leigh Infirmary	Ashton, Leigh and Wigan	WN7 1HS	Leigh	15.6	35	10.3	22	19	30
Hope Hospital	Salford	M6 8HD	Salford	6.4	21	0	0	13.7	26
Tameside General Hospital	Tameside and Glossop	OL6 9RW	Ashton-u-Lyne	8.8	23	21.2	29	15.8	24
Trafford General Hospital	Trafford	M41 5SL	Urmston	8.4	28	6.1	15	10.2	20
Central Manchester Hospitals	Manchester	M13 9WL	Central Manchester	0	0	6.4	21	8.8	24
Wythenshawe Hospital	Manchester	M23 9LT	Wythenshawe	8.8	24	13.6	23	0	0
Stepping Hill Hospital	Stockport	SK2 7JE	Stockport	7.7	20	18	26	9.4	18

APPENDIX 2: GP REFERRAL ANALYSIS

1. In this analysis we used GP referral patterns to gain an insight into the relative competitive constraints that different providers exert upon a particular trust. From observed GP referrals to the merging trusts, and to a range of other trusts in the area, we calculated different measures which provided us with information about the competitive threat to a provider's volumes that is imposed by the other merging party, relative to the threat posed by a range of other potential rivals. This allowed us to identify those providers that appear likely to exert the greatest competitive constraint on each one of the merger parties by competing for a large volume of its current elective activity.

2. However, we note that this analysis is not informative about how likely it is that a referral will actually be switched in response to a given change in relative quality. Nevertheless, recent research on English hospital data suggests that if a hospital provider's quality were to decrease, this would be associated with a decrease in demand.[1] For example, one finding suggests that a ten per cent increase in mortality rates is associated with an 11 per cent decrease in demand.[2] We also note that the insights drawn from the analysis within this Appendix formed just one part of the full competitive effects analysis that is described in the report.

3. Throughout this Appendix, we considered two groups of routine elective services: what we refer to as top ten HRGs, as well as an individual high volume elective routine.[3] The group of all elective services includes all referrals for an elective service made by GPs to the trusts under consideration. The group of top ten HRGs consists of the ten largest elective services (as measured by volume) that Central Manchester Hospitals and Trafford Trust provide. We only considered routine elective services given that Trafford Trust does not provide any specialist services and there is no realistic prospect that it is capable of providing these services on a standalone basis. The analysis showed that the merged organisation faces strong competition from University Hospital South Manchester and Salford Royal NHS Foundation Trust.

4. The remainder of this appendix explains the methodology used to analyse GP referral patterns and then reviews the GP referral analysis centred on Trafford Trust and followed by Central Manchester Hospitals.

ANALYSING THE DATA

5. We first conducted a GP practice level analysis in which we created a ranking of providers for each GP practice based on the number of referrals to each provider from that GP practice. From this we inferred which provider each GP appeared to prefer. We identified the

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[1] Gaynor, M., Propper, C. And Siedler, S. (2011), 'Free to choose: reform and demand response in the British National Health Service', mimeo, London School of Economics; Beckert, W., Christensen, M. And Collyer, K (2011), 'Choice of NHS-funded hospital services in England', Economic Journal, forthcoming.

[2] Beckert, W., Christensen, M. And Collyer, K (2011): 'Choice of NHS-funded hospital services in England', Economic Journal, forthcoming.

[3] For Central Manchester, for example, the top ten services were: B13 Phakoemulsification Cataract Extraction and Insertion of Lens, B16 Oculoplastic Low Complexity, B30 Surgical Retina Intermediate Complexity, C58 Intermediate Mouth or Throat Procedures, F06 Diagnostic Procedures, Oesophagus and Stomach, F35 Large Intestine - Endoscopic or Intermediate Procedures M05 Upper Genital Tract Minor Procedures, M06 Upper Genital Tract Intermediate Procedures, S27 Malignant Disorder of the Lymphatic/ Haematological Systems with length of stay of fewer than two days, S98 Chemotherapy with a Haematology, Infectious Disease, Poisoning, or Non-specific Primary Diagnosis.

preference of the GP practice as a whole by aggregating individual decisions of different pairs of GPs and patients within the GP practice.[4] We aggregated referrals to the GP practice level because the characteristics of the different pairs of GPs and patients within a practice that make decisions are likely to be relatively homogeneous given their common location and their need for the same set of treatments.[5]

6. Using these rankings we make the assumption that the first ranked provider (i.e. the provider a GP referred to most often for the set of services considered in the period of analysis) is the favoured provider for each GP and patient pair within that GP practice, and that the second ranked provider (i.e. the provider a GP referred to second most often for the set of services considered in the period of analysis) was, for that GP practice, the best alternative provider.

7. We take two approaches to this analysis. In the first (Approach One) we assumed that, if a GP and patient pair within the GP practice were, following a change in the quality of service, to decide against referring to their current favoured provider,[6] they would instead refer to the GP practices' second ranked provider. Similarly, following a change in the quality of service at the second ranked provider, if a GP practice were to decide against referring some patients to that provider, they would instead refer to the first ranked provider.[7]

8. We considered it reasonable to assume that GPs would switch to hospitals to which they already refer. Firstly, this is because patients and GPs cannot perfectly observe the quality of the service that they select but instead need to use the experience they and others have had in order to inform their choice of provider. Therefore GPs are more likely to have experience on which to base their decision if they have previously referred patients to a given hospital (e.g. they may know the consultants). Secondly, we consider that the choices made by patients and GPs at a particular GP practice in the past will reveal something about the providers that they would choose in the future.

9. However, since Approach One made a key assumption within the analysis we also relax it and repeated the analysis using a second approach (Approach Two): we assumed that following a change in the quality of service at the first, second or third ranked provider, if a GP practice were to decide against referring some patients to that provider, they would instead refer to either of the remaining providers ranked within their top three.

10. The value of doing this is that it allowed us to account for the possibility that a GP could distribute the referrals it switches to two other providers (the second and third ranked

[4] Each referral from a GP practice can be seen as a decision made by a patient and their GP. A GP practice is therefore constituted of a large number of potential pairings of GP and patient.

[5] Note that the set of treatments when we consider all elective care is more heterogeneous. Although preferences will differ between individual GPs and between individual patients, evidence suggests that the GP and patient characteristics that are most important for determining choice of hospital are location (i.e. distance to each available hospital), patient age and level of health, and income deprivation in the local area. These characteristics will tend to be very similar for GPs working in the same practice (See Beckert, W., Christensen, M. And Collyer, K (2011): 'Choice of NHS-funded hospital services in England', *Economic Journal*, forthcoming).

[6] This is observed from the provider to which their referral was made. As noted this may or may not be the expected favoured provider for the whole of that GP practice.

[7] However, if we have a provider that does not perform all services in the basket of HRGs considered, its constraint can be overstated as it will be considered an alternative for *all* referrals to the hospital in question (Trafford Trust or Central Manchester Hospitals) when in fact it is only an alternative for a subset of these referrals. This is not an issue in this case.

[7] Consistent with this assumption, evidence suggests that the higher is the GP's referral frequency to a particular hospital, the more likely the patient is to go to that hospital (See Beckert, W., Christensen, M. And Collyer, K. (2011): 'Choice of NHS-funded hospital services in England', *Economic Journal*, forthcoming).

providers) following a reduction in quality at the preferred provider, as opposed to only counting the GP's best alternative provider (the second ranked provider) as was the case under Approach One.

11. To illustrate our two approaches, consider an analysis of the relative competitive constraints imposed by Central Manchester Hospitals on Trafford Trust as an example. We calculated the proportion of Trafford Trust's referrals that come from GP practices that have referred most often or second most often to Trafford Trust and Central Manchester Hospitals (this proportion is informative under Approach One). We also calculated the proportion of Trafford Trust's referrals that come from GP practices that have referred to Trafford Trust and Central Manchester Hospitals most often, second most often and third most often. Similarly, we calculated whether other hospital providers were ever referred to most often or second most often (as well as third most often in the second approach) for those referrals received by Trafford Trust to determine the competitive constraints upon Trafford Trust imposed by every other hospital provider in the area. We then compared the proportion of referrals received by Trafford Trust for which Central Manchester Hospitals was the preferred alternative provider with those of the other hospital providers in order to identify which providers were likely to be Trafford Trust's most important competitors for referrals.

12. All of the analysis that follows in this appendix was carried out on data for the period January 2009 to December 2010. We conducted the analysis for both the top ten HRGs and for a single high frequency routine elective service. We considered referrals from all GPs in the following PCTs: Manchester, Trafford, Tameside and Glossop, Stockport, Salford, and Bury.

Trafford Trust

13. We began by considering the competitive constraints upon Trafford Hospital for the top ten HRGs. For this group of services Trafford Trust received a total of 12,222 referrals. The Table 1 shows the results of the analysis.

APPENDIX 2

Table 1: GP level analysis for the top ten HRGs at Trafford Trust*

	Approach 1		*Approach 2*	
Hospital	*Referrals*	*Per cent*	*Referrals*	*Per cent*
The Christie NHS Foundation Trust			68	0.6
Central Manchester Hospitals	1,301	10.6	8,274	67.7
NU			92	0.8
Pennine Acute Hospital NHS Trust			18	0.1
Royal Bolton Hospital NHS Foundation Trust			7	0.1
Salford Royal NHS Foundation Trust	1,980	16.2	3,120	25.5
Spire Healthcare			6	0.0
University Hospital of South Manchester NHS Foundation Trust	7,790	63.7	11,028	90.2
Warrington & Halton Hospitals NHS Foundation Trust	5	0.0	66	0.5
Other	17	0.1	497	4.1
No one	3	0.0	3	0.0
Trafford Trust not in top two	1,151	9.4	809	6.6
Duplicates	-25	-0.2	-11,766	-96.3
Total	*12,222*	*100*	*12,222*	*100*

Source: Dr Foster
Note: *The numbers reported for each hospital is the number of referrals to York for which that hospital is an alternative first for or second choice i.e. these numbers are not referrals to the individual hospitals.

14. Under approach one, the key result is that University Hospital of South Manchester NHS Foundation Trust appears to be the strongest constraint on Trafford Trust. For example, following a change in the quality of service at Trafford Trust during the period January 2009 to December 2010, University Hospital of South Manchester NHS Foundation Trust would be the first or second choice for 63.7 per cent of the 12,222 referrals that Trafford Trust received. The next closest rival to Trafford Trust is Salford Royal NHS Foundation Trust which would be the first or second choice for 16.2 per cent of referrals. Central Manchester Hospitals is the third strongest constraint on Trafford Trust. For example, 10.6 per cent of GPs appear to consider Central Manchester Hospitals to be their first or second preferred provider.

15. Under approach two, the less restrictive approach, University Hospital of South Manchester NHS Foundation Trust remains the strongest constraint on Trafford Trust. Following a change in the quality of service at Trafford Trust, 90 per cent of the patients might, if they switch anywhere, consider switching to University Hospital of South Manchester NHS Foundation Trust. However, Central Manchester Hospitals becomes the second strongest constraint (Central Manchester Hospitals is the first, second, or third preference for 8,274, or 67.7 per cent, of the referrals that Trafford Trust received). Salford Royal NHS Foundation Trust is the third ranked provider. The evidence suggests that, whilst Central Manchester Hospitals is an important competitive constraint on Trafford Trust, it is not *the* most important constraint, and both University Hospital of South Manchester NHS Foundation Trust and Salford Royal NHS Foundation Trust are also important options remaining for Manchester patients and GPs post-merger.

16. We tested the sensitivity of the results by selecting a high volume routine HRG (code F54: 'Inflammatory Bowel Disease - Endoscopic or Intermediate Procedures; aged under 70; without complications'). This is on the list of routine HRGs that providers on the extended

choice or free choice network (now the regional AQP contracts) can provide subject to having CQC registration. The below table shows the results.

Table 2: GP level analysis for HRG F54 at Trafford Trust*

	Approach 1		*Approach 2*	
Provide	*Referrals*	*Percent*	*Referrals*	*Percent*
BMI Healthcare	2	0.6	2	0.6
The Christie NHS Foundation Trust	9	2.5	30	8.4
Central Manchester Hospitals	79	22.1	175	49
East Cheshire NHS Trust			3	0.8
Lancashire Teaching Hospitals NHS Foundation Trust	1	0.3	1	0.3
Mid Cheshire Hospitals NHS Foundation Trust			2	0.6
Pennine Acute Hospital NHS Trust	24	6.7	26	7.3
Royal Bolton Hospital NHS Foundation Trust	9	2.5	10	2.8
Salford Royal NHS Foundation Trust	145	40.6	257	72
St. Helens and Knowsley NHS Trust	1	0.3	1	0.3
Stockport NHS Foundation Trust	7	2	14	3.9
Tameside Hospital NHS Foundation Trust			1	0.3
University Hospital South Manchester NHS Foundation Trust	122	34.2	212	59.4
University Hospital of North Staffordshire NHS Trust	0	0.0	1	0.3
Warrington and Halton Hospitals NHS Foundation Trust	1	0.3	4	1.1
Wrightington Wigan and Leigh NHS Foundation Trust	1	0.3	1	0.3
No-one	1	0.3	1	0.3
Others	6	1.7	12	3.4
Peripheral	22	6.2	6	1.7
Duplicates	-73	-20.4	-402	-112.6
Total	*357*	*100*	*357*	*100*

Source: Dr Foster
Note: *The numbers reported for each hospital is the number of referrals to York for which that hospital is an alternative first for or second choice i.e. these numbers are not referrals to the individual hospitals.

17. The table shows that the closest competitor to Trafford Trust for this service is Salford Royal NHS Foundation Trust. We interpret the data to mean that, following a decrease in quality at Trafford Trust, nearly 41 per cent of the 357 patients receiving treatments classified as F54 would, if they switched anywhere, switch to Salford Royal NHS Foundation Trust. This suggests that Salford Royal NHS Foundation Trust is Trafford Trust's most important competitor for this treatment. University Hospital of South Manchester NHS Foundation Trust appears to be the next most important constraint on Trafford Trust. Similarly, under approach two Salford Royal and University Hospital of South Manchester NHS Foundation Trust are the strongest constraints on Trafford Trust. The analysis shows that the majority of Trafford Trust's patients would, in response to a change of quality of service at Trafford Trust, be likely to divert, if anywhere, to either University Hospital of South Manchester NHS Foundation Trust or Salford Royal. This suggests that post-merger there may be limited scope for the merged parties to

reduce investment in quality or efficiency at Trafford Trust,[8] knowing that those GP practices that, when quality changes, will redirect their patients to other sites are likely to redirect them towards Central Manchester Hospitals, meaning that the merged trust will retain the revenue associated with those referrals while saving the cost of investing in quality or efficiency at Trafford Trust. The key conclusion therefore is that Trafford Trust faces strong constraints from University Hospital of South Manchester NHS Foundation Trust and Salford Royal NHS Foundation Trust.

Central Manchester Hospitals

18. Next we considered the relative competitive constraints upon Central Manchester Hospitals. We first ran the analysis on the top ten HRGs at Central Manchester Hospitals. The below table shows the results. Central Manchester Hospitals treated a total of 34,408 adult elective patients in its top ten HRGs during the period January 2009 to December 2010.

19. University Hospital of South Manchester NHS Foundation Trust appears to be Central Manchester Hospitals' most important competitor, posing a threat for 33.6 per cent of referrals. Pennine Acute, Tameside, and Stockport combined also appear to be important competitors for a significant proportion of Central Manchester Hospitals' referrals. Trafford Trust ranks joint third in terms of the constraints imposed on Central Manchester Hospitals.

Table 4: GP level analysis for the top ten HRGs at Central Manchester Hospitals*

	Approach 1		Approach 2	
Hospital	Referrals	Per cent	Referrals	Per cent
The Christie NHS Foundation Trust	63	0.2	3,807	11.1
East Cheshire NHS Trust	535	1.6	815	2.4
Mid Cheshire Hospitals NHS Foundation Trust	-	0.0	201	0.6
Others	1,186	3.4	6,668	19.4
Pennine Acute Hospital NHS Trust	6,318	18.4	10,765	31.3
Royal Bolton Hospital NHS Foundation Trust	197	0.6	2,468	7.2
Salford Royal NHS Foundation Trust	679	2.0	6,224	18.1
Stockport NHS Foundation Trust	2,518	7.3	6,963	20.2
Tameside Hospital NHS Foundation Trust	2,581	7.5	5,714	16.6
Trafford Healthcare NHS Trust	2,578	7.5	6,750	19.6
University Hospital South Manchester NHS Foundation Trust	11,572	33.6	18,162	52.8
Wrightington Wigan and Leigh NHS Foundation Trust	90	0.3	617	1.8
No one	52	0.2	52	0.2
Central Manchester Hospitals not in top 2	6,100	17.7	1,322	3.8
Duplicates	-61	-0.18	-36,120	-105.0
Total	34,408	100	34,408	100

Source: Dr Foster
Note: *The numbers reported for each hospital is the number of referrals to York for which that hospital is an alternative first for or second choice i.e. these numbers are not referrals to the individual hospitals.

[8] This reduction in investment might take the form of increased waiting lists, reduced staff numbers, reduced skill-mix within the staff, shorter opening hours, fewer appointment slots, longer length of stay (of other reductions in efficiency which may necessitate additional income support or bailout from commissioners), reductions in case-mix treated on the site, the negotiation of an uplift in Market Forces Factor, or reduced capital spend on site maintenance and investment in equipment, accommodation or buildings.

20. As in the case of Trafford Trust, we tested the sensitivity of the results by selecting a high volume routine HRG (code F54: 'Inflammatory Bowel Disease - Endoscopic or Intermediate Procedures; aged under 70; without complications'). The below table shows the results. Notably, University Hospital of South Manchester NHS Foundation Trust, Salford Royal NHS Foundation Trust, and Pennine Acute Hospital NHS Trust are stronger constraints on Central Manchester Hospitals than Trafford Trust. Moreover, these are not the only trusts that are stronger constraints on Central Manchester Hospitals than Trafford Trust. It would appear that the vast majority of Central Manchester Hospitals' patients would be likely to divert, if anywhere, to someone other than to Trafford Trust. This suggests that the merger parties would not have the incentive to reduce investment in quality or efficiency at the Royal Manchester Infirmary since the merger parties would thereby lose revenue to other providers.

Table 5: GP level analysis for HRG F54 at Central Manchester Hospitals*

	Approach 1		*Approach 2*	
Hospital	*Referrals*	*Per cent*	*Referrals*	*Per cent*
The Christie NHS Foundation Trust	38	4.8	49	6.1
Pennine Acute Hospital NHS Trust	112	14.0	178	22.3
Royal Bolton Hospital NHS Foundation Trust	10	1.3	14	1.8
Salford Royal NHS Foundation Trust	142	17.8	338	42.4
Stockport NHS Foundation Trust	76	9.5	121	15.2
Tameside Hospital NHS Foundation Trust	75	9.4	134	16.8
Trafford Trust	68	8.5	114	14.3
University Hospital of South Manchester NHS Foundation Trust	223	27.9	324	40.6
No one	78	9.8	82	10.3
Central Manchester Hospitals not in top 2	88	11.0	17	2.1
Others	31	3.9	101	12.7
Duplicates	-143	-17.9	-674	-84.5
Total	*798*	*100*	*798*	*100*

Source: Dr Foster
Note: *The numbers reported for each hospital is the number of referrals to York for which that hospital is an alternative first for or second choice i.e. these numbers are not referrals to the individual hospitals.

APPENDIX 3: SERVICES PROVIDED BY TRAFFORD TRUST AND CENTRAL MANCHESTER HOSPITALS

Table 1: Services provided by Central Manchester Hospitals and not provided by Trafford Trust

Service	*Royal Manchester Children's Hospital*	*University Dental of Manchester*	*Manchester Royal Infirmary*	*Manchester Royal Eye Hospital*	*Saint Mary's Hospital*
Critical care medicine			IP, OP		
Audiological Medicine			IP, OP		
Cardiac Surgery			IP		
Child & Adolescent Psychiatry	IP, OP				
Clinical Genetics	DC, IP, OP				OP
Clinical Immunology and Allergy			IP, OP		
Clinical Neuro-Physiology			IP		
Clinical Oncology			OP		
Dental Medicine		OP			
Diabetic Medicine			IP		
Dietetics			IP		
Gynaecology Oncology					IP, OP
Hepatology			IP, OP		
Immunopathology	DC, IP		DC, IP		
Infectious Diseases	IP		OP		
Medical Oncology	DC, IP, OP		OP		
Medical Ophthalmology				OP	
Neonatology	DC				IP
Neurosurgery	DC, IP		OP		
Paediatric Burns Care	DC, IP, OP				
Paediatric Cardiology	DC, IP				
Paediatric Clinical Immunology and Allergy	IP, OP				
Paediatric Dentistry	DC, IP, OP	DC, IP, OP	DC		
Paediatric Diabetic Medicine	DC, IP				
Paediatric Endocrinology	DC, IP, OP		OP		
Paediatric ENT	DC, IP, OP		IP, OP		
Paediatric Gastroenterology	DC, IP, OP				
Paediatric Haematology	DC, IP, OP		OP		
Paediatric Infectious Diseases	DC				
Paediatric Intensive Care	IP				
Paediatric Metabolic	DC, IP, OP				OP
Paediatric Neurology	DC, IP, OP				IP
Paediatric Neurophysiology	OP				
Paediatric Neurosurgery	DC, IP, OP				
Paediatric Ophthalmology	DC, IP, OP			IP, OP	
Paediatric Plastic Surgery	DC, IP, OP				
Paediatric Radiology	IP				IP
Paediatric Respiratory	DC, IP, OP				
Paediatric Rheumatology	DC, IP, OP				

APPENDIX 3

Paediatric Surgery	DC, IP, OP			
Paediatric Trauma Orthopaedic (Complex Spines)	DC, IP, OP		IP, OP	
Paediatric Urology	DC, IP, OP		IP, OP	
Plastic Surgery		OP	OP	
Radiology	IP, OP		IP, OP	IP
Renal Transplant			DC, IP, OP	
Research	DC		IP	
Telephone Clinics			OP	

Note: Inpatient (IP), Outpatient (OP) and Day Case (DC) services.

Table 2: Specialised services commissioned from Central Manchester Hospitals by North West Specialised Commissioning Teams

1.	BMT/MUDs	2.	ACHD	3.	PICU
4.	Haematology	5.	HIV/AIDS	6.	Specialised Pathology
7.	IVF	8.	CLaP	9.	Respiratory
10.	Womens Health	11.	Immunology	12.	Vascular
13.	Neuro Rehab	14.	Hepatobilary	15.	Cochlear/BAHA
16.	Cystic Fibrosis - Paeds	17.	Medical genetics	18.	IMD
19.	Nephrology	20.	Haemoglob	21.	PDT
22.	Nephrology Transplantation	23.	Paediatric - Burns	24.	Paediatric -Non Spec
25.	TPN	26.	NIC	27.	Ophthalmology
28.	Cardiac	29.	Paediatric -Spec		

APPENDIX 3

Table 3: The merger parties' overlapping inpatient, outpatient and day-case services

	Central Manchester Hospitals					*Trafford*		
Service	*Royal Manchester Children's Hospital*	*University Dental of Manchester*	*Manchester Royal Infirmary)*	*Manchester Royal Eye Hospital*	*Saint Mary's Hospital*	*Trafford*	*Stretford*	*Altrincham*
Accident and Emergency	IP, OP		IP, OP			IP		
Anaesthetics	IP, OP		IP			DC, IP, OP		
AntiCoagulant Service	IP		OP			OP		
Cardiology	IP, OP		DC, IP, OP		IP, OP	DC, IP, OP		OP
Cardiothoracic Surgery			IP, OP			OP		
Chemical Pathology			DC, IP, OP			OP		OP
Clinical Haematology	DC, IP		DC, IP, OP			DC, IP, OP		OP
Dermatology	IP, OP	OP	IP, OP			OP	OP	OP
Diabetes			OP			OP	OP	OP
Ear Nose Throat	DC, IP		DC, IP, OP			DC, IP, OP		OP
Elderly Care			DC, IP, OP			DC, IP, OP	OP	OP
Endocrinology	DC		DC, IP, OP			OP		OP
Gastroenterology			DC,IP, OP			DC, IP, OP	OP	OP
General Medicine	IP		DC, IP, OP			DC, IP, OP	OP	OP
General Surgery	DC, IP		DC, IP, OP			DC, IP, OP		OP
Genito-Urinary Medicine			IP, OP			OP		
Gynaecology					DC, IP, OP	DC, IP, OP		OP
Nephrology	DC, IP, OP		DC, IP, OP			OP		
Neurology			DC, IP, OP			DC, IP, OP		
Obstetrics					IP,OP	OP		
Ophthalmology	DC, IP, OP			DC, IP, OP	IP		OP	OP
Oral Surgery	DC, IP, OP	DC, IP, OP	DC, IP	DC, IP		DC, IP, OP		
Orthodontics	DC, IP, OP	OP				OP		
Paediatrics	DC, IP, OP				DC	DC, IP, OP		OP
Pain Management			IP			OP	OP	OP
Palliative Medicine			OP			OP		
Rehabilitation			IP, OP			IP		
Respiratory Medicine			DC, IP, OP			DC, IP, OP	OP	OP
Restorative Dentistry		DC, IP, OP	DC			OP		
Rheumatology	IP		DC, IP, OP			IP, OP		OP
Trauma Orthopaedics (inc Physiotherapy)	DC, IP		DC, IP, OP			DC, IP, O P		OP
Urology	DC, IP		DC, IP, OP			DC, IP, O P	OP	OP

Note: Inpatient (IP), Outpatient (OP) and Day-Case (DC) services.