CMA
Competition & Markets Authority

# CENTRAL MANCHESTER UNIVERSITY HOSPITALS/UNIVERSITY HOSPITAL OF SOUTH MANCHESTER MERGER INQUIRY

## Summary of hearing with Manchester Health and Care Commissioning (MHCC) on 26 April 2017

### Healthcare devolution in Greater Manchester

1. MHCC said that NHS England had been convinced by Greater Manchester local authorities and clinical commissioning groups (CCGs) that a comprehensive approach to healthcare was needed to address Greater Manchester's poor health outcomes. This resulted in the adoption of a devolution and integration approach, based on the ten locality plans, one of which the Manchester Locality Plan. As part of devolution, the Greater Manchester Combined Authority will exercise delegated health responsibilities from NHS England alongside local authorities and commissioners. The Sustainability and Transformation Fund for Greater Manchester is also controlled at Greater Manchester level.

### Healthcare reform in the City of Manchester

2. MHCC said that the Manchester Locality Plan involves a single commissioning function, which has been established as MHCC; a single local care organisation, which is being procured; and a single hospital service. The Manchester Health and Wellbeing Board commissioned Sir Jonathan Michael to review the best way to improve outcomes and implement the Single Hospital Service. This review concluded that the merger between Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospitals South Manchester NHS Foundation Trust (UHSM) would be the best way to deliver it in the context of the health needs of the city of Manchester.

3. MHCC said that on 1 April 2017, Manchester Clinical Commissioning Group and Manchester City Council formed a partnership MHCC. MHCC is responsible for NHS, social care and public health commissioning. MHCC said that one benefit of the combined commissioning function is that it can allocate health care and social care funds as is most appropriate, which will allow more care to take place in a community setting which is likely to lead to

better health outcomes and reduced costs. Another benefit is that MHCC can make use of the shared assets of both organisations.

4. MHCC said that the outcome of the procurement process for the local care organisation is still uncertain. The aim of the process is to create an integrated system of social care and community health services, involving mental health providers, the health trusts, the Council and primary care providers, with a single contract bringing together all these services. There is a significant overlap between the arrangements for a local care organisation and the single health service, which will need to work together, particularly around A&E care, outpatients relating to patients with long-term conditions and hospital discharge procedures.

5. MHCC said that one reason that a single hospital service is appropriate for Manchester is to address unacceptable variation of care between existing providers. By allowing providers to establish shared clinical models, a single hospital service would be intended to improve care at poorer performing services.

6. MHCC said that another reason that a single hospital service is appropriate for Manchester is to improve providers' recruitment and use of staff. Recruitment of medical and nursing staff is very difficult, but there is a shared desire to reduce the use of locum staff. By sharing staff across a single system, a single hospital service would allow them to be used more efficiently, making scarce expertise more widely available.

7. MHCC said that a single hospital service would encourage providers to work more effectively with community care provision. At the moment, hospitals face a tension between their own desire to generate income, and the systemic need to move more care out of hospitals and into the community. Having a larger footprint to take savings from will make this more manageable, and will allow commissioners to save money.

**The merger between CMFT and UHSM**

8. MHCC said that it is possible that options other than the merger of CMFT and UHSM could achieve some of the benefits of the single hospital service, at a slower pace. However, a much larger range and quantity of benefits can be achieved at a much quicker pace through the merger. Although CMFT and UHSM also plan to merge with North Manchester General Hospital, for the areas covered by CMFT and UHSM, the merger is expected to achieve its full benefits even excluding the merger with North Manchester General Hospital.

9. MHCC said that it expects UHSM and CMFT to achieve savings by merging. MHCC said that it has confidence that the UHSM and CMFT management teams will deliver these. CMFT has a track record of success: for example through its acquisition of Trafford it achieved real savings. For example, MHCC expects to be able to free up wards at Manchester Royal Infirmary by moving activity to other sites.

10. MHCC said that following the merger there will remain considerable competition and choice available for patients in Greater Manchester because of the availability of services from elsewhere in the conurbation, such as Salford, Oldham and Stockport.

11. MHCC said that Manchester has high levels of deprivation and low car ownership, so accessibility of services is important. MHCC wants to maintain critical care provision on all three hospital sites within the city of Manchester to maintain access for people who otherwise struggle to access services.

12. MHCC said it sees no downsides from the merger of CMFT and UHSM.

**Patient choice and competition**

13. MHCC said that patient choice has not eliminated the variations in outcomes in Manchester. Patients tend to choose hospitals by familiarity or ease of transport links. However, where services do differ in quality, better performing hospitals do have longer waiting times as there is higher patient demand.

14. MHCC said that CMFT and UHSM do not compete in practice across most services. Although a few years ago they may have competed more, hospitals now have such long waiting times they do not want to attract patients.

15. MHCC said that competition does exist for research and development grants, and that UHSM and CMFT may be better placed to win these together.

16. MHCC said that UHSM and CMFT do compete to attract staff. The merger will allow a more efficient approach to recruitment.

**Commissioning contracts**

17. MHCC said that Manchester CCG has used year-long block contracts in the past. This has helped commissioners and providers to have financial certainty when planning. It also helps to improve incentives when, for example, a commissioner wants to reduce activity. A block contract does remove payment-by-results incentives for a year, but if targets have not been met in that time then the situation will be very different when contracts are renegotiated. MHCC's ambition is to move away from 'payment-by-results'

towards a system which prioritises outcomes: it wants to incentivise health, rather than admissions.

18. MHCC said that it intends to commission a single hospital service through a single contract, whether or not the merger takes place (although this would be suboptimal without a merger). This might involve a prime provider or subcontracting arrangement. This would be a huge administrative burden, and involve tricky relationship management. A single standardised decision-making procedure is the aim, and this would be compromised without a merger: cooperation and service transformation would be more difficult. There have been efforts over previous years to establish a similar type of collaboration (eg in cardiac services) which have been unsuccessful. MHCC has not worked through the administrative, procedural and relationship issues which would need to be addressed in detail if it were to rely on a subcontracting arrangement, and has no plans for how it would address these absent the merger.