Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

MANCHESTER CITY COUNCIL

NHS Manchester Clinical Commissioning Group

Chair and Chief Accountable Officer
Parkway 3, Parkway Business Centre
Princess Road, Manchester, M14 7LU
www.mhcc.nhs.uk

5th July 2017

Dear Colleague

Re: CMA provisional findings regarding the merger of CMFT & UHSM FTs

CMA Findings

We are writing on behalf of Manchester Health and Care Commissioning as commissioners of health, social care and public health services and Manchester City Council in respect to its wider leadership role in the City of Manchester. This letter responds to your provisional findings with regard to the proposed merger of CMFT and UHSM. We welcome your report and its conclusions. We are writing with some comments regarding your findings and to reiterate our strong support to the merger. We recognise the areas in which you demonstrate there is loss of competition as a result of the two trusts merging. The report rightly identifies the dynamics within the NHS which temper some of these losses through regulatory arrangements, current financial and workforce challenges and existing cross provider working. We are pleased that the local and national strategy for health and social care integration is recognised as a key determining factor for the decision.

Countervailing measures

Our view is that the establishment of Manchester Health and Care Commissioning, which brings together the former three Manchester CCGs and Manchester City Council's adult social care and public health functions, all of whom held significant contracts with the two trusts, into a single organisation creates a countervailing buyer power not referenced in the report.

Whilst a number of barriers may exist to alternative providers for elective and maternity services, e.g. economy of scale for equipment or support services, there still remains a significant element of elective care which independent sector or community NHS or independent providers can compete for. In direct reference to the clinical specialties noted in table six these may include outpatient services for chronic conditions including diabetes, COPD/Asthma (respiratory medicine), pain management and cardiology. There are numerous examples of enhanced community based services of this nature. Similarly there is a growing role for care of older, frail people with complex conditions who can be better managed in the community through multi-disciplinary health and social care with consultant support accessed when necessary.

Benefits

Our Clinical Director, Dr Manisha Kumar, has attended the Single Hospital Service Programme Clinical Advisory Group which oversaw the development of this benefits case. The benefits cover a number of areas. Our view of these cover a number of themes:

- Avoidance of deterioration of current service quality due to increasing financial and workforce constraints e.g. urgent and emergency care.
- Opportunity to improve quality of services through developing best practice and more focussed use of specialist workforce, resource and equipment. For example, kidney stone removal, gynaecology surgery and acute aortic surgery.
- Opportunity to improve quality in services where minimum thresholds, considered to be needed to ensure quality outcomes, are not currently reached e.g. urology and vascular services.
- Patient experience benefits can be derived from the above as well as the ability to offer services across a 7 day period, rather than 5 or less, or to offer services on more than one site e.g. urology.
- Financial benefits can be derived from being able to make changes to services across sites; reducing the capital cost requirements to increase activity at one site, and unfunded stranded costs at another. The capital and stranded costs resulting from the Healthier Together programme will be reduced if the trust merger takes place as opposite flows of activity can be enabled to reduce the additional ward space required.

The benefits case, submitted by USHM and CMFT, is comprehensive and diverse and, as such, enabling these changes through a single contract, as opposed to an organisational merger, would be administratively difficult and create more complex arrangements for assurance of quality and safety. Whist it might be an improvement on current bilateral contractual arrangements it would delay the pace at which benefits could be derived. It would be impossible to contract on a prime contractor basis on a specialty by specialty basis due to the above factors. The only option would be to contract the full range of services from one of the two hospitals. This would create a lessening of competition, a disproportionately diminished opportunity to derive benefits and an undesirable means by which the Trusts would wish to operate organisationally.

Again, we support the provisional findings of the CMA, endorse the potential benefits outlined by CMFT and UHSM and reiterate our support to the merger.

Yours sincerely,

Sir Richard Leese
Leader
Manchester City Council

Dr Philip Burns
Chair
Manchester Health and Care Commissioning

Ian Williamson
Chief Accountable Officer
Manchester Health and Care Commissioning

Joanne Roney
Chief Executive
Manchester City Council