NHS Improvement

NHS Improvement advice to the Competition and Markets Authority

Proposed merger of Burton Hospitals NHS Foundation Trust and Derby Teaching Hospitals NHS Foundation Trust

February 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

1. Summary

The merger of Burton Hospitals NHS Foundation Trust (Burton) and Derby Teaching Hospitals NHS Foundation Trust (Derby) (the trusts) is the proposed solution to longstanding and significant challenges in delivering high quality and sustainable healthcare at Burton.

Burton is a small acute trust that does not have sufficient numbers of patients nor the workforce necessary to sustain delivery of good outcomes for patients across all of its services. For a number of services, Burton has been unable to employ the staff necessary to deliver high quality care. Burton's acute medicine department, for example, should have a total consultant team of six whole time equivalent (WTE) consultants but has just one consultant in a substantive post and three locums. Burton's radiology department has 2.2 WTE substantive consultants but should have a total of 10.2, which makes all the services relying on radiology more fragile. Vacancies mean that existing staff are stretched and Burton struggles to offer the sub-specialist and out-of-hours care that patients need.

Across a range of services, Burton relies on other trusts to provide staffing support or parts of a pathway. This has resulted in a patchwork of provision that makes it difficult for Burton to implement and maintain a cohesive and strong clinically-led vision and drive for improvement. Its workforce challenges have also led to high agency and locum costs, which have contributed to a financial deficit.

Since 2011, NHS Improvement[1] and the Care Quality Commission (CQC) have taken numerous regulatory actions, including placing Burton in special measures, to address concerns about governance, finances and quality of care.[2] Although these measures led to some improvements, NHS Improvement has concluded that Burton cannot continue to provide high quality, safe services in its current form, nor is it

[1] Since 1 April 2016, Monitor and the NHS Trust Development Authority have operated as a single integrated organisation known as NHS Improvement. This document is published in exercise of functions conferred on Monitor by the Health and Social Care Act 2012. A reference in this document to NHS Improvement is a reference to Monitor.

[2] Special measures apply when NHS trusts and foundation trusts have serious problems and where there are concerns that the existing leadership cannot make the necessary improvements without support. Trusts may be placed in special measures as a result of serious failures in quality of care and/or serious financial problems. Special measures consist of a set of interventions designed to remedy the problems at a trust within a reasonable timeframe.

able to address its challenges on its own. Based on this conclusion, we took further regulatory action as described below to ensure that Derby and Burton would work together to find a solution through a form of partnership.

The proposed merger is an opportunity to create a larger organisation that will provide more robust and resilient services for patients across East Staffordshire and South Derbyshire. We anticipate that the merged organisation will be more able to ensure that its services are provided in a safe, more clinically optimal and sustainable way, will be better able to recruit and retain staff, and will develop more efficient pathways of care for patients.

Our analysis found that there are relevant patient benefits in relation to the proposed merger that will affect a large number of patients and address some of Burton's challenges outlined above. For example, trust-wide patient benefits would flow from the merged organisation's ability to strengthen its workforce. Improved recruitment and retention, and less reliance on agency staff and locums are likely to ensure services are better staffed, safer and more resilient. The workforce improvements have the potential to benefit many patients at both trusts through strengthened out-of-hours care and access to sub-specialist consultants, although we expect the improvements to be most significant for patients at the Burton sites.

The trusts have also demonstrated relevant patient benefits in relation to cardiology, stroke, renal, trauma and orthopaedics, radiology and cancer services.[3] For some patients, these benefits will mean reduced mortality, improved clinical outcomes, shorter stays in hospital and reduced waiting times for treatment. These benefits are summarised in Table 1 below.

The merger also presents an opportunity to improve Burton's and Derby's finances; both trusts are in deficit. The trusts have identified potential savings as a result of the merger. Our assurance process is testing the financial case for merger, as well as other potential benefits and risks. We expect to complete this process by 1 April 2018.

Further, in our view competition is not an important driver of quality for Burton, and the Competition and Markets Authority (CMA) should take this into account in its review. The challenges that Burton faces mean that it does not have the ability to

[3] The term 'relevant patient benefits' is defined on page 7.

meaningfully respond to any potential competitive constraints posed by its larger neighbouring hospitals, including Derby.

The merger proposal is the result of more than two years of work in which the leadership of both trusts, with NHS Improvement's support, worked with clinical teams to identify opportunities and develop plans to improve services for patients. While there is more work to do, it is our view that the trusts have laid a strong foundation for building on their existing relationship.

2. Introduction

The CMA has a statutory responsibility to review mergers involving NHS foundation trusts when they fall within its jurisdiction to ensure that they do not have adverse effects for patients by reducing competition between providers. The CMA merger review process allows for both the effects on competition and the potential benefits of mergers to be taken into account to determine what is in the overall best interests of patients.

On 18 January 2018, the CMA formally notified NHS Improvement under section 79(4) of the Health and Social Care Act 2012 (the 2012 Act) that the CMA had decided to carry out an investigation under Part 3 of the Enterprise Act 2002 of the proposed merger of Burton and Derby.

Under section 79(5) of the 2012 Act, as soon as reasonably practicable after receiving such a notification from the CMA, NHS Improvement is required to provide the CMA with advice on:

- the effect of the merger on benefits (relevant customer benefits[4]) for people who use healthcare services provided for the purposes of the NHS
- such other matters relating to the merger as NHS Improvement considers appropriate.

This document presents our advice to the CMA regarding the merger of Burton and Derby. In it we use the term ‘relevant patient benefits’ instead of ‘relevant customer benefits’, but with the same meaning.

[4] As defined in section 30(1) of the Enterprise Act 2002.

3. Background to the merger

3.1 The trusts

Burton is an acute local hospital that provides services from Queen's Hospital Burton and an adjacent treatment centre. It also provides services at community hospitals in Tamworth and Lichfield. The trust has about 544 inpatient beds and employs about 2,700 staff, treating 420,000 patients annually (in terms of patient spells). It had operating income of £197.2 million in 2016/17 and ended the 2016/17 financial year with an underlying deficit of £15.7 million. It has a rating of 'requires improvement' from CQC, after emerging from an 'inadequate' rating and special measures in October 2015.

Derby is an acute teaching hospital that provides services from the Royal Derby Hospital site (which includes the Derbyshire Children's Hospital) and the London Road Community Hospital. It also offers clinics at a variety of community hospitals operated by other providers. Derby has more than 1,100 beds and employs over 8,000 staff, treating about a million patients each year (in terms of patient spells). It had operating income of £538.3 million in 2016/17 and ended the 2016/17 financial year with a deficit of £25.4 million. Derby has a CQC rating of 'good'.

More information about the trusts and the types of services they provide is provided in their notification submission to the CMA.

3.2 Problems at Burton and sustainability reviews

Since 2011/12, NHS Improvement has needed to take a series of regulatory actions to address problems at Burton. In 2016 the Chair of Derby, John Rivers, was appointed as the Chair of Burton (Mr Rivers continues to hold both roles). At the same time, Helen Scott-South, Chief Operating Officer of Derby, was seconded to the role of Chief Executive of Burton. These actions were taken to address persistent governance, financial, clinical and strategic problems at Burton, and our desire for the trusts to work together to find a long-term solution through a

partnership. The regulatory actions we have taken to date are outlined in this section and in Section 3.3.

Burton was authorised as an NHS foundation trust in November 2008. It has been in financial deficit since the financial year 2011/12. NHS Improvement took enforcement action against the trust in November 2011 in relation to financial and governance concerns. In April 2013, NHS Improvement agreed undertakings with Burton to address these concerns.

In July 2013, Burton was identified in the Keogh review as one of 14 persistent outlier trusts in measures of hospital mortality.[5] The Keogh review found that Burton did not have a systematic approach for collecting, reporting and acting on information on the quality of services. The trust had also not identified all of the causes behind its excess mortality. The review found a number of urgent issues, including staffing levels, which increased the risk in the trust and impacted on the organisation's ability to provide consistently high quality and safe care and treatment to patients.[6]

NHS Improvement placed the trust in special measures in July 2013 following the Keogh review, and agreed further undertakings to support the actions required by Keogh. Reports on Burton's delivery on these actions were made in 2014 and 2015, with Burton exiting special measures in October 2015.

Burton sustainability review

In 2015, NHS Improvement undertook a review of financial sustainability and clinical risks at Burton.[7] Our review concluded that Burton faced significant challenges in becoming financially sustainable within the next four years (meaning achieving a breakeven position with positive cash). At that time there was a forecast 2014/15 underlying deficit of 12.7%, some of which was caused by the trust's need

[5] This was part of a review by Professor Sir Bruce Keogh carried out in response to the Francis Inquiry into poor care at Mid Staffordshire Hospitals NHS Foundation Trust.

[6] These issues included unsafe clinical rota practices; inconsistent safety checks of medical equipment; issues with clinical practice including escalation, delegation and supervision; examples of poor communication with patients and staff, particularly junior doctors, many of whom felt unsupported; and a lack of trust-wide understanding of quality objectives.

[7] In identifying clinical risks to future financial sustainability, we considered local demand and commissioner support for services, whether volumes were sufficient to sustain safe services and the ability to hire and retain staff and overcome cultural challenges.

to provide greater staff coverage to meet safety and quality requirements following the Keogh review and CQC inspection.

Clinical risks to future financial sustainability were identified in maternity, paediatrics, elective surgery, urgent and emergency care, and acute care, and across the wider workforce. Our review found that low volumes of patients and a general trend in the NHS towards increasing sub-specialisation meant that the trust would struggle to continue to deliver some services, there was poor operational efficiency across some services, and the trust had difficulties recruiting sufficient medical and nursing staff to sustain rotas and services.

Our review noted that Burton already relied on networks and partnerships with a number of other trusts to provide services. This included support from Derby to provide care for patients needing some renal, oral maxillofacial surgery, oncology and some imaging and histopathology services. Our review found that Burton "has had difficulty in forming collaborative working partnerships at the required pace across a range of services, given the complexities of agreeing partnerships and revenue sharing arrangements". We also had concerns about the lack of medical leadership at the time and the board's slow response to regulatory intervention. Our review recommended that NHS Improvement and Burton consider options for developing a sustainable solution.

Derby sustainability review

In 2015, NHS Improvement also conducted a financial and clinical sustainability review at Derby. We concluded that there were no significant clinical risks but found that achieving financial sustainability would be a significant challenge for Derby; its underlying deficit was £37 million. This deficit was found to be largely structural, with Derby's PFI contract accounting for nearly half of it.

NHS Improvement recommended Derby undertake further work to improve efficiency and that it explore opportunities for the wider local health economy through closer working with Burton, as the two hospitals already work together to deliver some services and they serve some of the same population along the Staffordshire/Derbyshire border.

3.3 NHS Improvement's support for collaboration and the case for merger

Burton was taken out of special measures in October 2015 but was rated 'requires improvement' by CQC, and the undertakings agreed in April 2013 relating to finance and governance remained in place. A new medical director was appointed at Burton in late 2015. Subsequent to the sustainability reviews, NHS Improvement asked the trusts to collaborate to address the challenges that they both faced. This request was particularly important for Burton given the review's conclusion that it faced significant risks to its sustainability and needed to move faster to develop partnerships.

The executive teams of both trusts began work to understand what benefits could be gained through closer working. This work identified potential clinical and financial benefits to closer collaboration. However, by February 2016, NHS Improvement's view was that Burton's leadership had not demonstrated the required commitment to exploring whether closer working could address its problems, but rather was pursuing other complex strategies which were not considered credible.[8] At the same time, multiple senior level resignations at Burton raised concerns about executive team stability.

In early 2016, Burton was in the process of appointing a new chair, with the existing chair as one candidate. Derby's chair was appointed as chair of Burton in March 2016 and the chief operating officer of Derby was also seconded to the chief executive role at Burton in March 2016.[9]

Following appointment of these posts, the trusts gained renewed momentum to use collaboration as a way to achieve clinical improvements and address their sustainability challenges. The trusts established a strategic collaboration board to test options and liaise with NHS Improvement. Beginning in April 2016, NHS Improvement supported the development of the trusts' strategic outline case for a partnership. NHS Improvement helped develop a programme of work and governance structure to prepare the case. The programme consisted of seven

[8] NHS Improvement's view was that the plans prioritised aggressive cost improvement programmes over service reconfiguration, and lacked detailed consideration of organisational form change. We also thought the plans were complex and had significant delivery risks.

[9] The trusts continued to operate separate management teams and to be run separately. The purpose of the joint chair was to encourage work to assess how further collaboration could address the trusts' challenges.

workstreams, one of which was the clinical workstream reporting to the two medical directors. Both medical directors ensured that this work was led by frontline clinicians, who identified the realistic benefits of collaboration and designed the opportunities and proposals for improvement.

The strategic case was approved by the boards of both trusts in October 2016. With additional support from NHS Improvement, the trusts prepared an outline business case (OBC) for the boards to decide whether the best way to achieve the improvements identified would be a merger or lesser forms of collaboration.

The OBC recommended a merger as the preferred option, as the trusts' assessment suggested it would produce the greatest improvement to quality, sustainability and finances. The trusts' boards approved the OBC in June 2017 and approved moving on to produce a full business case outlining the plan for merger by December 2017. The merger is proposed to be achieved through acquisition of Burton by Derby.

3.4 NHS Improvement's view of the strategic rationale for merger

NHS Improvement has been instrumental in supporting the trusts to explore whether there are benefits to closer collaboration, including providing resource to the trusts to help them do so. We helped the trusts develop their strategic outline case and OBC. The result of this work is that the trusts have proposed a merger, having concluded that it offers the best opportunity to produce financial, clinical and strategic benefits.

Our view, informed by our long-term regulatory support and the results of the sustainability review, is that the merger is necessary to address many of the problems faced by Burton. We think the merger is likely to ensure that Burton patients will continue to have local access to some services at Burton, higher quality provision of some existing services and some new services at Burton's sites. We do not think these outcomes are likely without the merger.

4. Framework for assessing relevant patient benefits

In carrying out our statutory duty to provide advice to the CMA, we assess whether the benefits proposed by merging trusts would be relevant patient benefits by examining the following three questions:

- Is the proposal likely to represent improvements in quality, choice or innovation of services for patients or in value for money for commissioners?
- Are the improvements likely to be delivered within a reasonable period as a result of the merger?
- Are the improvements unlikely to accrue without the merger or a similar lessening of competition?

Our advice regarding relevant patient benefits is one input into the decision to be taken by the CMA. The CMA decides whether the merger may be expected to result in a substantial lessening of competition and patient choice. If the CMA finds a substantial lessening of competition, it will take our advice into account when considering whether the relevant patient benefits outweigh the lessening of competition and patient choice.

Detailed information on our approach to assessing merger benefits is set out in our guidance, *Supporting NHS Providers: guidance on merger benefits*.[10]

[10] www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers

5. Overview: assessment of proposed patient benefits

The trusts' patient benefits submission describes the rationale for the merger and sets out seven main proposals for patient benefits: six proposals in different service specialties and one proposal for cross-cutting improvements in the workforce of the merged organisation that the trusts say will bring widespread benefits to patients.

In this section, we provide an overview of our assessment of the proposed benefits, applying the CMA's relevant patient benefits framework. **In Annex 1, we set out our more detailed analysis of each proposed patient benefit.**

5.1 Are the proposals likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?

Based on our assessment of the trusts' proposals, our view is that the merger is likely to result in improvements for patients, in the form of reduced mortality, better clinical outcomes, shorter stays in hospital and reduced waiting times for treatment.

Table 1 below outlines the proposals that the trusts say will be realised by the merger, whether we accept them as a likely improvement for patients, how they are likely to affect patients and how many patients we expect to benefit from the improvements.

Table 1	Proposals	Improvement?	Impact on patients	Number of patients[11]
Workforce	Merger to enable greater opportunities for recruitment, arising from more opportunities for sub-specialisation, less time on call and greater prestige. Improved resilience of the workforce and reduced reliance on agency staff and locums.	Yes	Improved access to sub-specialists Improved access to seven day services Improved outcomes with greater staff morale and engagement with improvement culture	A large proportion of the 1.4 million patient spells across the merged organisation
Cardiology	CT coronary angiograms (CTCA) introduced for Burton patients with stable chest pain, instead of exercise tolerance tests as a first line of testing.	Yes	More accurate diagnostic test Fewer invasive angiographies as a result	790 298 (a subset of 790)
	CTCA introduced for Burton inpatients with chest pain or suspected coronary artery disease, replacing invasive coronary angiography.	Yes	Fewer invasive angiographies	230 (a subset may go on to require invasive coronary angiography)
	Rather than patients transferring to another provider for planned and urgent percutaneous coronary intervention (PCI), PCI to be provided at the Burton site for patients:	Yes	Eliminates need for some patients to undergo two separate invasive procedures as coronary angiography and PCI can be done at the same	A majority of the 80 to 90 urgent PCI patients A majority of the 270 planned PCI patients

[11] Numbers of patients expected to benefit from improvements per year are approximate and based on 2016/17 numbers of patients provided by the trusts, except for radiology numbers which we estimated using HES data for 2016/2017 and urgent PCI patient numbers which we estimated based on six months of activity for 2017/18.

	• with non-ST segment elevation myocardial infarction (NSTEMI; a type of heart attack) or unstable angina needing urgent PCI • patients identified from chest pain clinic by CTCA and invasive coronary angiography as needing planned PCI • patients identified following an outpatient appointment with a cardiology consultant as needing planned PCI • inpatients identified as needing an urgent or planned PCI following CTCA and/or coronary angiography.		time at Burton Eliminates 24 to 48-hour delays that can occur with transfer to another provider	(A small subset of patients may still require two separate procedures)
	Burton patients requiring complex pacing devices will be treated at Derby, instead of University Hospitals of North Midlands NHS Trust (University Hospitals of North Midlands) or University Hospitals of Leicester NHS Trust (University Hospitals of Leicester).	Yes	Small improvement in time for some patients to travel to Derby instead of University Hospitals of North Midlands or University Hospitals of Leicester	30 to 40 (likely to be a subset, ie those patients who live closer to Derby than University Hospitals of North Midlands or University Hospitals of Leicester)
Renal	High-performing Derby renal unit to provide renal consultant presence at the Burton site, a formal 24/7 on-call service and implementation of Derby's electronic acute kidney injury (AKI) care bundle.	Yes	Reduced mortality, improved morbidity and lessened progression of AKI, and shorter lengths of stay	2,000

	High-performing Derby renal unit to take over Burton's haemodialysis service currently provided at the Samuel Johnson Community hospital in Lichfield and promote uptake of home haemodialysis.	Yes	Reduced mortality, improved self-management, better quality of life and reduced travel time due to increased rates of home haemodialysis Reduced risk of infection and need for an invasive procedure each time they dialyse due to increased rates of permanent vascular access for new haemodialysis patients	5 (more in long-term)
Stroke	Centralising services for hyperacute stroke patients at the Derby hyperacute stroke unit; treatment and care for hyperacute patients no longer provided at the Burton site.	Yes	Reduced mortality Reduced complications and improved outcomes	400
	Combined stroke service to enable seven-day, consultant-led ward rounds and improved access to stroke consultant-led out-of-hours care for patients at Burton, and improved access to therapists (for both Burton and Derby patients).	Yes	Reduced complications and improved outcomes	Likely to be at least two-thirds of the 400 patients above and an unspecified number of Derby and Burton patients
	Combined stroke service to implement single point of access to transient ischaemic attack (TIA) clinics, with Burton patients gaining weekend access to the TIA clinic at the Derby site	Yes	Reduced risk of stroke due to patients accessing weekend TIA clinic within 24 hours of symptoms	70 to 80

Trauma and ortho-paedics	Emergency trauma services centralised at the Derby trauma unit (except for patients needing a stay of less than 23 hours).	Yes	Improved outcomes for Burton patients with access to a designated trauma unit and greater access to sub-specialist surgeons	1,000
	Elective inpatient surgery centralised at the Derby site.	Yes	Reduced waiting times Improved outcomes	700
	Day-case surgery centralised at the Burton treatment centre.	Yes	Reduced waiting times and cancellations Reduced risk of infection for day-case patients due to separation from inpatient wards/areas Patients supported to recover and go home sooner in a clinically safe way due to implementing an enhanced recovery programme and preoperative assessments	3,225 (Derby patients) 1,988 (Burton patients)
Radiology	Merger to stabilise radiology services and address workforce shortages at Burton that make the service unsustainable.	Yes	Reduced waiting times for diagnostics Improved quality of radiology service	Improved service for 170,000 patient spells per year

	Implementation of Derby radiology processes for patients at Burton – including zero wait and coupled diagnostics first in selected patient magnetic resonance imaging (MRI) and dual energy X-ray absorptiometry (DXA) scan pathways, and then rolled out for others in line with Derby's high-performing service.	Yes	Improved access to diagnostics Reduced waiting times for diagnostics Improved quality of radiology service	6,868 (some of these may be captured in the number above)
Cancer services	Merger to create smoother and more efficient pathways for patients needing complex cancer care.	Yes	Reduced time from referral to treatment	184
	Merger to enlarge catchment area and increase patient volumes for Derby specialist cancer services, thereby ensuring these services continue to be commissioned and offer patients local access.	No	Unclear at this time whether this aspect of the cancer proposal can be delivered	N/A

5.2 Are the improvements likely to be delivered within a reasonable period as a result of the merger?

In our view, the trusts are likely to deliver the proposed improvements within a reasonable time as a result of the merger. This view is based on:

- improvements the trusts have already achieved in organisational structure and clinical leadership at Burton
- Derby's experience and leadership in delivering high quality services
- the significant level of staff and clinical engagement and planning undertaken during the past two years to inform the development of the proposals.

After the appointment of Derby's chair and the new chief executive at Burton, the leadership team worked to align the organisational structures at Burton with those at Derby. The trusts told us that new medical leaders have been appointed, with newly formed divisional teams and directors. The trusts said that the new structure, as it becomes embedded, will provide greater opportunities to develop managers and clinical leaders and will make the transition to one organisation smoother. We have already seen improvements from the collaboration, such as the recruitment of renal consultants to provider greater cover at Burton.

We also find that Derby's track record of delivering high quality care is evidence of its ability to deliver the improvements. Derby has a number of high-performing services and, for some services, operates more efficiently than hospital national averages.[12] Derby has shown an ability to deliver change: many of its achievements set out in its benefits case have come about in recent years.[13] We also note that Derby successfully transferred services to its new hospital in 2010.

Finally, we have been engaging with and supporting the trusts as they developed their patient benefits submission and plans for merger. We are encouraged by the momentum as well as the detailed level of planning already achieved. We have reviewed plans for IT implementation as well as for delivering the improvements

[12] Derby is in the highest performing quartile of trusts for operating theatre utilisation and for amount of potential additional activity. NHS Improvement, Model Hospital data.
[13] See patient benefits submission, pages 36 to 37.

presented in the patient benefits submission. In our view, these plans appear to be on track to deliver the proposed improvements in the first three years after the merger. Our further views of delivery for each proposed improvement are set out in Annex 1.

5.3 Are the improvements unlikely to accrue without the merger or a similar lessening of competition?

NHS Improvement's view is that the improvements are unlikely to be achieved without the merger. Burton cannot achieve these improvements on its own. As noted, Burton does not have the patient volumes or staff to deliver clinically sustainable services and, before the involvement of Derby, the trust had not demonstrated the leadership and ability needed to implement a strategy that delivers wide-scale improvements in quality.

Burton is already heavily dependent on collaboration with other providers to provide many of its services. For example, Heart of England NHS Foundation Trust, University Hospitals of Leicester and InHealth Group all provide aspects of Burton's cardiology service. Rheumatology, dialysis and outpatient renal, interventional radiology and some oncology services are also provided under service-level agreements with other providers. This current patchwork of collaboration with multiple providers is complex to administer and in our view is not a viable long-term solution to sustain services at Burton.

At the same time, it is not realistic for Burton to independently cease providing many of the services that it is struggling to provide on its own. This would reduce access to care for local patients and impact demand at surrounding providers. What is needed is a cohesive, collaborative and strategic approach to develop improved services for patients across the local area.

We accept the trusts' submission that a lesser form of partnership or collaboration is unlikely to achieve the level of clinical engagement, accountability and incentives needed to develop a culture of continuous learning, improvements in quality of care and efficient service delivery for patients.

Our detailed assessment of the extent to which the trust-wide workforce benefits and each of the specialty-specific patient benefits are dependent on the merger is set out in Annex 1.

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