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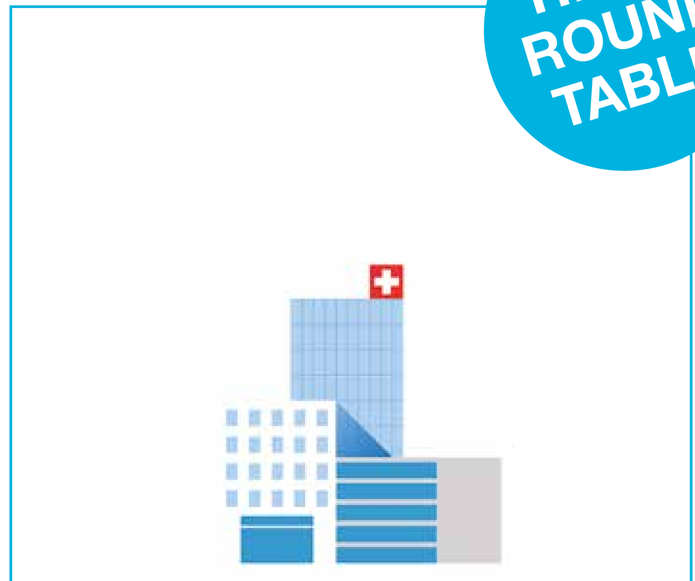
Sizing it up

A recent roundtable looked at the issues facing small hospitals and how they can adapt to create a sustainable future. Seamus Ward reports

HFMA ROUND TABLE



Small hospitals have been a concern for a number of years. Can they be clinically sustainable, offering services that are of expected quality, while balancing the books? Can they remain viable at a time when much of secondary care is either moving into larger, specialised centres or being devolved out of hospital and into the community?

A recent HFMA/Grant Thornton roundtable sought to set out the issues faced by small hospitals and plot a course for their future. Before it became part of NHS Improvement, regulator Monitor defined small hospitals as those with fewer than 700 beds or less than £300m income. And, as discussions opened, it quickly became clear that while small hospitals experience similar problems as those in their larger counterparts, the impact of the issues can be disproportionately greater.

HFMA policy director Paul Briddock said the association had completed informal research on the financial position of 40 small to medium-size hospitals at the end of 2015/16. This showed the majority were in deficit, and this was in line with the position outlined in the quarter three report for 2015/16 issued by Monitor.

Clinical staffing is a major issue for all hospitals, but the roundtable participants agreed that it is difficult for small hospitals to recruit and retain doctors and other clinicians. This had a knock-on effect of increasing the need for agency staff, but even temporary staff were difficult to attract at capped rates.

Rebecca King, deputy director of finance at Dorset County Hospital NHS Foundation Trust, said it can be a struggle to keep up staffing ratios. The trust has challenges in recruiting to some key medical posts and medical locum costs are high. Although it was determined to hit its agency cap, it was hard to get staff to come to the trust at capped rates.

'We have to have them, as otherwise we couldn't run a safe service,' Ms King said. 'Being small, we have some services that are single-handed or run by two consultants, so it can be a struggle for them to run on-call rotas. This puts pressure on costs and is something that is not reflected in the tariff.'

In a small hospital, with some services run by one or two consultants, on-call services can be difficult to arrange without locums. The same is true for absences or if one consultant decides to take a post elsewhere.

HFMA immediate past president Shahana Khan, who is finance

Roundtable participants

- Clive Andrews, associate director of finance, Wye Valley NHS Trust
- Paul Briddock, policy director, HFMA
- James Cook, director, Grant Thornton
- Karen Edge, deputy director of finance, Mid Cheshire Hospitals NHS Foundation Trust
- Shahana Khan, finance director and deputy chief executive, George Eliot Hospital NHS Trust
- Rebecca King, deputy director of finance, Dorset County Hospital NHS Foundation Trust
- Mark Stocks, partner, Grant Thornton

director and deputy chief executive at George Eliot Hospital NHS Trust, said medical sub-specialisation was exacerbating the issue. This added to the complexity of potential solutions, such as sharing clinical posts across different organisations.

Ms King agreed – a doctor was more likely to pick a whole-time contract in one hospital over a role shared across hospitals. 'Unless they have a link to your location, or it's where they want to live, they won't want to work across two or maybe three hospitals when they can be whole-time in another,' she said.

Clive Andrews, associate director of finance at Wye Valley NHS Trust, said that as well as financial issues, his hospital had experienced diminishing flexibility as it ran at almost maximum capacity all year – a difficulty felt more acutely in a small trust than one with more beds.

Despite these issues, the roundtable highlighted areas of good practice, and solutions to problems faced by small hospitals. Chief among these was the need to collaborate and integrate. Collaboration could mean contracting out services to another provider or working with others to allocate activity to the most appropriate hospital. Though the roundtable stressed the need for this to be clinically led and in patients' best interests, practitioners also pointed out that transferring services can leave trusts facing stranded costs.

Karen Edge, deputy director of finance at Mid Cheshire Hospitals, said difficulties often lay in medical specialties. Sometimes changes needed a push, such as in the national vascular consolidation work. 'It was a catalyst for clinicians and it is better for patients, but we ended up with a £500,000 loss on the vascular changes,' she said. 'We needed to lose 1.5 ITU beds and six surgical beds – you can't dispose of those costs easily, but you do lose all the income. This can be a particular problem for small hospitals.'

Also, in considering new arrangements, roundtable delegates said trusts should be aware that sometimes patients are comfortable receiving care in their local hospital and simply do not wish to travel to another town or nearby city to get the care they need.

Grant Thornton partner Mark Stocks said trusts were using different models of collaboration. Clinical pathways were being examined to allocate work to the best placed provider or to deliver elective care – by moving large parts of the elective workload to specialist facilities or satellite hospitals, say, leaving the main site to focus on emergency care.

Role of STPs

But with sustainability and transformation plans (STPs) highlighting the need for collaboration more generally, could they have a role in helping small hospitals increase their sustainability? While the roundtable agreed it was early days for STPs, Ms Khan said some small hospitals were already pushing ahead with different models.

Other participants were implementing networking or collaborative arrangements, sharing staff or facilities. The Mid Cheshire trust buys in consultant time from other trusts under different models. So, in haematology and cardiology, 'bought in' consultants from another provider see inpatients at trust premises. But, as it is unable to fill weekend ENT rotas, the trust offers a 24-hour weekday service until 5pm on Fridays. The weekend service is then provided at University Hospitals of North Midlands NHS Trust. However, Ms Khan and others cautioned against wholesale shift of activity to larger hospitals. Many services in small hospitals have excellent outcomes, while some larger providers struggle to cope with the demand they face, she said.

For a small hospital with good-quality services and spare capacity, it made sense to understand opportunities available to provide services locally and to have a more joined-up approach across the system.

Wye Valley 's Clive Andrews said STPs were the best way forward for the service as it develops medium- to long-term strategies. 'They will help plan some of the changes that will undoubtedly have to happen and bringing all the health organisations and local authorities together has got to be helpful. But we have to get the public on board – that's the big issue we are going to face.'

Merger questions

While many of the potential solutions to clinical and financial sustainability lie in working with external partners, Ms Khan said this did not necessarily mean mergers and acquisitions. Grant Thornton director James Cook agreed. He said: 'We have seen that mergers haven't always worked. However, trusts are looking at vertical integration with primary care or with social care to see where they can get synergies.'

Ms Khan's trust is looking to build sustainability on three concentric circles. She said: 'The first is that we need to drive through more efficiencies internally, through tackling waste and waiting etcetera. The second is around collaboration with our partners, such as pharmacy services and other non-frontline services. In the third circle we are looking at building a health and care hub because we have the opportunity to gain a better return from the physical estate.'

The hub could potentially include the third sector, social services step-down centre and key worker accommodation. 'We are talking to several organisations. So the future of the hospital site isn't necessarily just as a hospital – it's as a health and care hub.'

It is not alone in looking at integrating services. Ms King, from Dorset County Hospital, said it was developing plans for an integrated care hub with step-up and step-down beds.

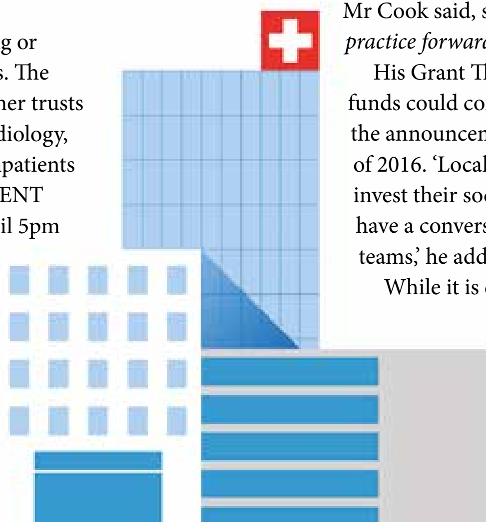
Mid Cheshire Hospitals recently acquired community services, which it hopes will help improve issues over delayed transfers of care. It is working on plans to redesign pathways and integrate the workforce to create community teams, pulling patients out of hospital.

Mr Andrews said Wye Valley manages community services and has some community beds on three sites. 'The trust's priority remains avoiding delayed transfers of care to aid pressure on acute beds. We are looking to use our existing bed base as flexibly as possible.'

Mr Briddock wondered if small hospitals would need capital funds to adapt their estate to provide integrated services. However, Ms Edge suggested it might not be needed. 'Community services can operate from anywhere. You are supporting the patient to be at home and wrapping services around them.' If funds are needed, Mr Cook said, some had been identified in the *General practice forward view.*

His Grant Thornton colleague, Mark Stocks, said funds could come from local government following the announcement of increased funding at the end of 2016. 'Local authorities are thinking about how to invest their social care money and there's a chance to have a conversation about step-up and step-down teams,' he added.

While it is clear small hospitals face similar issues to their larger counterparts, these can have a disproportionate impact. But, as the roundtable demonstrated, they have identified the issues and are seeking to address them through collaboration, integration and innovation.



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