HSJ LOCAL briefing

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MID YORKSHIRE HOSPITALS TRUST FINANCIAL WOES

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue Mid Yorkshire Hospitals Trust's financial position and the fact it is unsustainable in the medium to long term mean significant health economy change is needed.

Context The trust recorded a £20m deficit at the end of 2011-12. It was the first year it began payments for a significant private finance initiative scheme, and it did not meet cost improvement plans. It is not on course to gain foundation status independently. The trust got strong new turnaround leadership in March.

Outcome The turnaround team is likely to deliver improvement in short term finance and performance. Later, there will be an attempt at major reconfiguration. There is a possibility the trust will be split in three and joined with other local providers.

Introduction

Mid Yorkshire Hospitals Trust, having struggled with moderate performance problems for a longer period, now finds itself among the small group of the most visibly troubled providers nationally.

Actions which will be taken to try to address the situation will have a significant – potentially very significant – impact in the West, mid-, and South Yorkshire health economies, with Leeds among the areas affected.

In the next six months, a strong new chief executive and chair, who both joined in March, are likely to take robust action to try to tackle its problems locally. Beyond that, more far-reaching changes are likely, depending on political and public reaction, as well as other factors.

Problems

Mid Yorkshire has met a succession of serious problems in the past few months.

Most severely, late in 2011-12 it changed its prediction it would break even at the end of the year to predict a £19m deficit.

The shortfall was exacerbated by the requirement to pay an enormous £4.5m following an employment tribunal decision against the trust in December, although it is believed the Yorkshire and the Humber Strategic Health Authority funded at least some of that cost.

The scale of the problem was revealed by in depth examination of the trust's finances during the winter, including investigations led by the SHA. The investigations were precipitated by signs of deteriorating finances, and failure to make progress towards foundation trust status.

The trust has received various subsidies from the health economy, via the SHA, over the past year.

This has frustrated other organisations. Providers privately argue money is being wasted on a failing trust. Commissioners have been able to pay but know they may not be able to continue to do so. Some GP commissioners, if given control, will be less willing to bankroll it.

The fact the problems were not realised earlier suggests an earlier management failure, although senior leaders in the area chiefly blame the trust's difficult set of circumstances.

These circumstances are critical to its position and future. The trust, which has a modest annual turnover of around £430m, runs three acute centres with accident and emergency units in a 15 mile area of Mid Yorkshire.

The main site is Pinderfields Hospital, in Wakefield, which as well as standard DGH services including consultant-led maternity, has some specialist facilities covering burns, spinal injuries and orthopaedic trauma, and neonatal intensive care.

The Dewsbury and District Hospital also has a consultant-led maternity unit and a broad range of DGH inpatient and outpatient services.

Pontefract Hospital is the smallest and has fewer inpatient services but they include an A&E and midwife-led maternity unit.

The health economy is one of the most deprived in the country with associated problems, particularly long term conditions leading to early acute illness. It means there is a heavy demand on general acute services. These can often have a lower – if any – earnings margin for the trust compared to elective procedures. At the same time, the trust sees relatively less demand for the financially beneficial elective work. There is very little opportunity for the trust to ease its finances with private patient income.

Anecdotal evidence suggests that because of the trust's problems and deteriorating reputation some GPs around the borders of its patch are now preferring to refer to other hospitals, for example Barnsley Hospital and Doncaster Royal Infirmary to the south. Such a move would exacerbate Mid Yorks' situation further.

Very significantly, the trust is also now paying for a £311m private finance initiative capital scheme for Pinderfields and Pontefract Hospitals, completed in 2010.

An SHA analysis in mid-2011 observed: "2011-12 is the first full year of the PFI unitary payment, which coupled with the 4 per cent tariff efficiency requirement, creates an efficiency requirement in the region of £45m."

In addition, the trust faces performance concerns which, although not dramatic, are among the worst in the region.

The NHS North of England SHA cluster's most recent performance report shows the trust is failing to meet both elective referral to treatment waiting targets –it is clearing a "backlog of long-wait incomplete pathways" – and A&E waiting times.

Meanwhile, despite these problems, the most significant issue according to local public interest and press coverage has been the closure in November last year of the A&E at Pontefract between 10pm and 8am.

The decision was announced as a temporary measure "in the interests of patient safety... due to a shortage of experienced (middle grade) emergency doctors".

It suffers from the national shortage of A&E doctors, causing particular difficulty attracting them to relatively minor and unappealing sites. It remains closed at night.

Local and national context

Some of Mid Yorks' closest neighbouring providers have relatively stable finances but, as small FTs, are likely to need to change dramatically to ensure survival in coming years.

Barnsley Hospital Foundation Trust, between Wakefield and Sheffield, predicted a very small turnover of £153m for 2011-12, reducing the follow year, and is known to be exploring partnerships with other trusts.

Calderdale and Huddersfield Foundation Trust, west of Dewsbury, was expecting £332.6m turnover in 2011-12. It has sought to develop close relationships with other providers, and has formed a partnership with East Lancashire Trust, on the other side of its patch.

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South West Yorkshire Partnership Foundation Trust is now running most community services in Barnsley, and some across Mid Yorks' patch, and is keen to develop relationships with hospital providers.

The Department of Health's payment policy – which has in recent years reduced providers' income for emergency services – exacerbates Mid Yorks' position, and looks unlikely to change in coming years.

At a national policy level, there is growing sentiment in favour of rationalising services to specialist centres which, where pursued, is likely to mean further reductions at Mid Yorks, as a large district trust.

A practical example is the ongoing development of major trauma centres in Leeds, Hull and Sheffield. This will increase serious cases dealt with away from Mid Yorks, probably reducing its income and making it even more difficult to attract A&E doctors.

National NHS management and health ministers have also expressed intention to support major unpopular service closures, although individual cases in the past six months have seen senior government and Opposition politicians fight changes.

The government is ramping up efforts to abolish all NHS trusts, with all NHS providers in some form becoming foundation trusts.

When trusts fail to move through the pipeline the Department of Health has a series of policies including replacing chairs and chief executives, seeking for the trust to be merged with or acquired by others, and, seeking a management franchise.

An interim chair and interim chief executive joined Mid Yorks as a turnaround team last month. They replaced Ed Anderson and Julia Squires who stepped down following months of speculation about their positions.

Interim chair David Stone held the same post at Sheffield University Hospitals Foundation Trust for a decade until late last year, where he oversaw it gaining FT status.

Interim chief executive Stephen Eames – a chief executive for nearly 30 years – has overseen major service reorganisation and high performance during four years at County Durham and Darlington Foundation Trust. Prior to that, he achieved a successful turnaround at Mid Cheshire Hospitals Trust.

Mr Eames move to Mid Yorks is believed to have been arranged by the outgoing NHS North of England chief executive Ian Dalton, who himself has a reputation for a robust approach to underperformance.

In a statement announcing the move Mr Dalton said: "Stephen Eames' track record speaks for itself – and it [is] for this reason that he has been asked to take on a key leadership role for a trust that is facing a critical period."

Several senior figures in the health economy said that the task for the new leadership team was to identify whether the trust is sustainable in its current organisational form and potentially, if it is not, to help explore the alternatives.

One local NHS leader said: "The question is, is it possible for Mid Yorkshire to continue on its own? If not, what are the options?"

Immediate financial and performance position

The new chief executive believes he can reasonably quickly improve the financial situation and performance against targets at the trust. Given his record he is likely to succeed.

Well-placed sources said Mr Eames believes a set of relatively straightforward moves can improve waiting time target performance.

It is understood his planned approach is to improve the productivity and efficiency of service provision across a set of areas, so they are in the top quartile of performance nationally. The trust has a plan to make £23m cost improvements in 2012-13 and achieve breakeven.

It announced at the beginning of this month a series of moves to reduce workforce cost. They are bold – including reduced hours and offering unpaid leave - but appear to have received a reasonable reception from the staff side. If the plan fails, any alternative is likely to involve redundancies.

Mr Eames is also looking at partnerships outside the trust to make savings.

Senior figures in partner organisations say the trust has begun better engagement on approaches to reducing inpatients, for example through better preventative services and greater community provision.

Early work on strategy at the trust under the new chief executive, presented to the March board meeting, includes a focus on "integration".

However, it is also acknowledged at the trust and in the health economy, that it will not be viable in the medium term without significant service reorganisation. Work on a new clinical services strategy has been renewed.

HSJ understands proposals which had been drawn up during 2010 and 2011 but never brought to consultation will have to be reworked in light of the trust's financial problems being worse than previously thought.

Public consultation which had been expected in the first half of 2012 will now not come until the final months of the year at the earliest.

Accident and emergency

There is an outstanding question about how the new leadership will deal with Pontefract A&E, given the need for it to be downgraded in the relatively near future.

Although they are being reworked, future reconfiguration proposals are likely to a large extent to reflect recommendations made by the National Clinical Advisory Team, which advises on reconfigurations, in 2010, and ideas subsequently developed locally in 2011.

According to slides from autumn last year seen by HSJ (See attached), those ideas all include downgrading the Pontefract A&E to a minor injuries unit and urgent care centre.

But trust is currently under significant political pressure to reopen the full A&E at night and has indicated it will seek to do so.

Mr Eames' strategy presentation to the March board identifies the need to "think services not sites" and "take swift action to implement plans to make better use of Pontefract Hospital". (See page 37 of papers.)

The possible implication is that the trust could grasp the nettle of downgrading Pontefract more quickly than expected. That would partly be as necessitated by the lack of doctors and partly as planned to become clinically and financially sustainable.

Another likelihood is there will be attempts to arrange an interim alternative – where the A&E is staffed by GPs and specialists – before a formal downgrading of the unit over the next 18 months.

The current night-time closure – and any future downgrade – are likely to impact on Leeds Teaching Hospitals Trust – which is already beginning to receive serious cases from a wider area as its major trauma centre is developed.

If changes are made at Pontefract

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a larger number of patients are likely to go to one of the two Leeds A&Es, which are nearly as fast by road as Wakefield, and for some a familiar journey.

Major service change

Other changes likely to be brought forward in a consultation, given previous work and indications from sources in the area, include:

- Extension of out-of-hospital care, preventative and step-down services for people with long term conditions, end of life care, and paediatrics
- That will allow rationalisation of hospital services.

This would include:

- Centralise inpatient children's care at Pinderfields in Wakefield
- Centralise acute surgery at Pinderfields
- Develop step-down and stroke rehab care at Dewsbury and Pontefract
- Possibly downgrade Dewsbury maternity services to a midwife-led unit.

Changes on this scale, regardless of detail, are likely to provoke significant public and political opposition. That is the reason some of the necessary changes have not happened in the past, and could still prevent them being made this time.

Pontefract is represented by Labour MP and shadow home secretary Yvette Cooper. Other parts of the trust's patch are also represented by influential Labour MPs including Ms Cooper's husband, shadow chancellor Ed Balls. Local politicians are blamed locally for some of its current problems, as they have pressed for capital development and resisted service changes aimed at improving quality and financial sustainability. A key task for the new leadership team will be convincing them.

Such influential local politicians also create an additional incentive to reconfigure now while Labour is out of office and less able to block the changes.

One senior figure in the area said it meant that: "If you're ever going to do this, now is the time to do it."

Alternatives to Mid Yorks Foundation Trust

The new leadership team is working to the theoretical target of making a successful foundation trust application in April 2014, the latest possible date in the government's preferred schedule for abolition of NHS trusts.

If it quickly becomes clear they are failing that trajectory – or they make an early decision that the trust's current organisational form is unviable – the DH or NHS Trust Development Authority will seek to order an alternative.

One option in that case is for the whole trust to be taken over by another provider. There are no obvious local candidates to take over such a large and struggling trust. However, similarly troubled North Cumbria University Hospitals Trust attracted NHS bids and a takeover was arranged in February. A takeover could involve successful local mental health and community trust South West Yorkshire Partnership Foundation Trust, potentially partnered with a hospital trust.

More likely, though, is a break up of Mid Yorks with constituent parts taken over by surrounding organisations. No formal discussions are known to have taken place, but several senior sources suggest a similar approach to that process.

Several of the relatively small FTs in the area could be interested.

Calderdale and Huddersfield – to the west – could consider taking on Dewsbury Hospital.

Barnsley Hospital Foundation Trust, which is between Wakefield and Sheffield, may be interested in running Pinderfields Hospital.

The most likely to takeover Pontefract, therefore, would be Leeds Teaching Hospitals Trust. Leeds is already a huge organisation but the changes would anyway see Pontefract downsized.

One senior director at a provider in the patch said: "For some of these existing FTs – when they look at their size and financial profile going forward – it is clear it is going to get extremely difficult if they stay as they are. [They need to think about] what the best organisational configuration is going forward."

Conclusion

In the short term, under strong new leadership, Mid Yorks looks likely to improve its position through a series of cost improvement and performance programmes.

It is also certain to move ahead with some small scale non-controversial service changes over the next six-12 months, working more closely with community and primary care services.

In addition, the recent crystallisation of Mid Yorks' severe shortfall, combined with the wider NHS financial outlook and a certain amount of national momentum for service change, means a further effort at significant reconfiguration is almost inevitable.

Over 12-18 months it will become clear whether these reconfiguration attempts are likely to succeed.

The new pattern of services – according to likely changes which are outlined above – will have impact on commissioners and providers in and beyond West/Mid Yorkshire.

In roughly the same period, local leaders and national bodies will decide whether they believe the organisation is being turned around, and can therefore become a foundation trust in 2014 or slightly later, and recover its reputation.

If they decide it is not, an alternative may be mandated, which is fairly likely to take the form of the three-way split described above. This would mean a significant reshaping of local organisations' business models.