A solution to failure or a sticking plaster?

Examining what to do with trusts where there is an adequate population base but deep-rooted financial problems

Last year, my article “What will the private sector do with failed hospitals?” (hsj.co.uk, 17 March 2011) considered the options for a trust subject to a trust special administrator (TSA) intervention. It was predicated on an assumption that merging or acquiring a hospital/trust with deep-rooted and significant problems would be unattractive to other NHS providers because of the risk that those problems would drag down the acquiring/merging organisation. Since then we have had the opportunity to see the TSA in action at South London Healthcare Trust.

This proves the danger of predictions. Next to none of the events the article warned would take place post-TSA intervention occurred. The recommended way forward for South London consisted not of a private takeovers but of a series of NHS acquisitions, plus service changes to a neighbouring trust (Lewisham). Seemingly, hospitals with a long history of financial issues can still be attractive to their neighbours.

Many trusts are struggling to make FT status and, at the time of writing, there are 19 trusts deemed by Monitor to be in significant breach of the terms of their licence. This takes place against an operating background for providers of tariff deflation, marginal payment for additional emergency activity, commissioners transferring money to the community and a policy of holding back part of the NHS allocation. This generates one of the paradoxes of the NHS: a large underspend at a macro level while a number of providers (and some commissioners) are in financial distress.

That number looks set to grow as trusts implement clinical standards that will increase costs while national terms and conditions for staff predominate.

The inability – real or imagined – by trusts to significantly alter the pay and working patterns of NHS staff acts as a fundamental constraint. The majority of any trusts’ costs (about 65 per cent) relate to staff. Unlike in many other industries, healthcare productivity remains

Mahatma Gandhi’s autobiography was subtitled Experiments with Truth. He saw himself not only as a trained lawyer but also as a scientist, searching out truth.

In the NHS, one might expect that truth would be easy to find. However, there is often a lack of transparency, especially where errors have occurred. Patients may have difficulty finding out the truth about wrongdoings relating to their care. Staff who have genuinely raised concerns (whistleblowers) may not be listened to or be badly treated.

As health secretary Jeremy Hunt recently said, there seems to be an instinct in some parts of the NHS for institutional self-preservation to supersede the need to be honest and transparent about failings.

Managers need to be open, apologetic and ready to learn from management failings, just as most clinicians are open, apologetic and ready to learn from failings in medical practice.

Trusts spend a huge amount on legal proceedings involving compensation to patients or lawsuits brought by NHS staff unfairly dismissed. But there is little transparency about such expenses, nor independent scrutiny as to whether such expenses are justified or could be avoided.

Those who are privileged enough to have power in the NHS should realise that with power comes responsibility; with responsibility comes accountability; and with accountability comes transparency and a duty to be completely truthful.

Gandhi once remarked: “It is not our patient who is dependent on us but we who are dependent on him. By serving him we are not obliging him; rather, by giving us the privilege to serve him, he is obliging us.”

Gandhi showed compassion for his fellow human beings, especially those who were downtrodden (“untouchables”) or who suffered injustice. When Gandhi wrote about healthcare, he emphasised the importance of “service before self”. Sadly, in the NHS, compassion and tolerance have sometimes been subjugated to business priorities, management demands, or internal power politics.

For Gandhi, means were more important than ends; unfortunately, some staff in the NHS have behaved as if the end justifies the means, even if this has compromised compassion and truth.

From the time he was thrown out of the first-class carriage of a train in South Africa simply because of the colour of his skin, Gandhi fought against injustice. Justice can be seen as a coalescence of truth and compassion. Both patients and
To one site combined with improvement in length of stay, productivity, and so on, which significantly reduces beds and headcount. The models produce a balanced budget but the question is, are the underpinning assumptions realistic?

To what degree will either franchising or mergers and acquisitions tackle this? As I noted previously, if the terms of the franchise leave the bulk of staff on NHS contracts then the potential for change is considerably reduced. Historically mergers have been the preferred way forward for the NHS. The literature on the success of mergers is that they fail in their declared objectives more often than they succeed. The attraction of mergers appears to be that they hold out a promise of making easier service rationalisations that previously were stymied, at least in part, by the existence of separate organisations.

Leaving aside that this “gain” rarely forms part of the public rationalisation for such mergers (and that in future some may fall foul of competition rules), there remains the fact that service reconfigurations have a pronounced tendency to take much longer than originally planned and often have higher costs and lower benefits than were initially envisaged.

A feature of the South London review was that it extended out to cover the viability of another acute provider (Lewisham). Would this option have been available if all the local trusts had been FTs, or indeed if the financial modelling had shown all the surrounding trusts to be in surplus in future years?

Whatever the shape of future TSA interventions we are left with the same questions that were posed back in 2011. What do we do with trusts where there is an adequate population base but deep-rooted problems with their finances – and typically a plethora of other performance issues? Will mergers or franchising really solve that problem or are we merely repackaging failure?

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