OPINION

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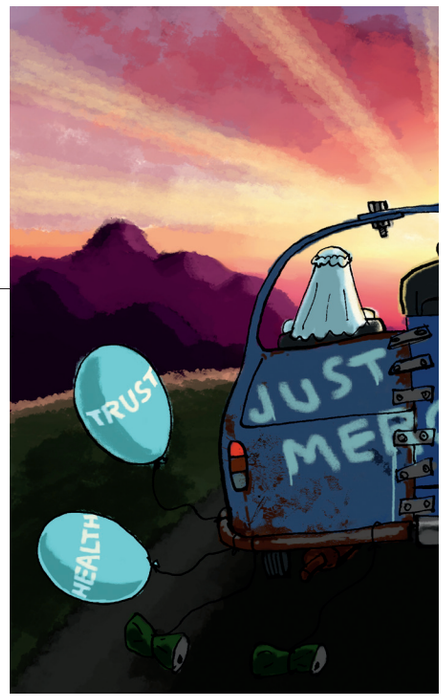


ROBERT ROYCE ON TRUST MERGERS

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

NARINDER KAPUR

WHY NHS LEADERS SHOULD HEED GANDHI'S MESSAGE

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.

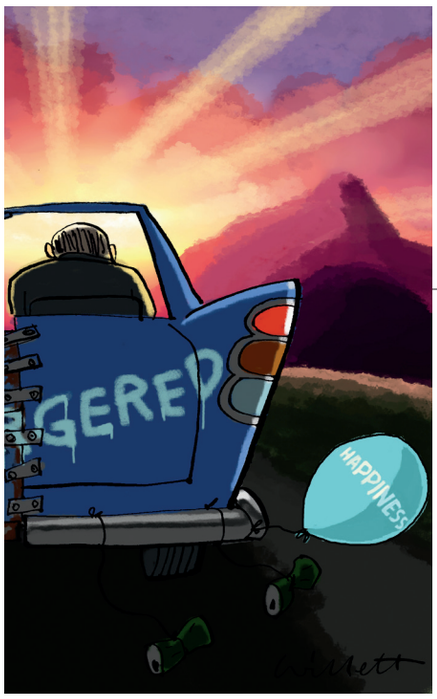
Those who are privileged enough to have power in the NHS should realise that with power comes responsibility; with responsibility comes accountability; and with accountability comes transparency and a duty to be completely truthful.

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



overwhelmingly related to human – not machine – actions.

A lot of what is now taking place in the NHS reflects a view that it is easier to tackle the NHS's financial issues through organisational and service reconfigurations than it is to reduce the cost base by tackling what staff actually do and what they get paid.

There are trusts that have long-term financial models that state they can be viable if they undertake a significant reconfiguration of their services to concentrate acute activity on 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 you 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? ●

Robert Royce is an independent healthcare consultant.

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● Read the full version of this article at **hsj.co.uk/royce-mergers**

staff have a right to justice.

We are all patients at some time in our lives. At these moments we are at our most vulnerable and least able to ensure that we receive justice. Yet justice may be elusive.

Professor John Hendy QC has provided a critical appraisal of the injustices in current NHS and legal procedures: there needs to be a recognition that the frailties of the human mind can lead to difficulties in discovering truth and implementing justice in judicial and semi-judicial settings. This affects patients and carers and also affects NHS staff who find themselves having to pursue litigation.

In a variety of legal settings, trusts can employ the most expensive lawyers, whereas patients or bereaved carers who have been wronged, and staff who believe that they have been unfairly disciplined, do not have similar resources. NHS disciplinary hearings may often be cases of the "police investigating the police", ignoring the key concepts of independence of the panel from management, relevant expertise in the panel and plurality (more than one key decision-maker).

Staff are sometimes offered huge sums of money in compromise settlements along with gagging clauses. Not only does this lead to injustice, it also holds back improvements in quality of patient care because unsatisfactory practices are not acknowledged and corrected, and money is unnecessarily diverted from clinical needs.

Finally, there is one other important lesson that Gandhi can impart to the NHS, that of leadership. As the eminent Harvard psychologist Howard Gardner noted, Gandhi was unique in showing individual courage, creating moral organisations and displaying moral leadership.

"Be the change you wish to see in the world" was Gandhi's simple but profound message: the more privileged the position one holds in the NHS, the greater the responsibility to set a shining example to others of courageous and principled leadership. Those who hold senior NHS positions should pay heed to Gandhi's message. ●

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Readers' Feedback

Letters to the editor are published online at www.hsj.co.uk/feedback
Email hsj.feedback@emap.com

'That is an unusual definition of success from NHS England. I'm sure Mid Staffs could demonstrate that they were spending less money'
John Coakley

'Can any system cope with the loss of 42 per cent of its organisational memory at a stroke?'
via hsj.co.uk

Online comments

Go to www.hsj.co.uk/readerscomments to join the debate on each story. Here is a taster of what readers have been talking about this week

"NHS 111 failures have 'let patients down', NHS England admits", hsj,co.uk, 12 April
"If they had listened to the people on the ground they would have known it wasn't going to work from the off."
● "Foundation of a system to first apology in 12 days – is that some sort of record?"

"Non-foundation trusts to face 5.1 per cent saving target", hsj.co.uk, 10 April
"Is this the same David Flory who said he was concerned about so many senior people leaving? This squeeze should ensure a few more do. Such pressures must inevitably endanger safety and quality."
● "Our trust is looking at something like a 9% CIP to balance the books after two years of 8% – sorry, but the barrel is pretty dry now."

MALCOLM WILLETT