Partnership or bust

The case for change of management culture in Mid & South Essex NHS Foundation Trust

A report commissioned by the three UNISON branches covering the Trust.

Introduction

The report has been commissioned by the three UNISON branches representing thousands of members in Mid Essex, Southend and Basildon & Thurrock Hospital Trusts that were merged in March 2020 into the Mid and South Essex Foundation Trust. With over 15,000 staff and a budget of over £1 billion in 2021-22, the Trust is one of the largest in the country – and should aim to be one of the best.

Union representatives and members are convinced that with large and intractable problems on the agenda, the management culture in the merged Trust is an obstacle to the partnership working that is essential if the Trust is to develop efficient and high quality systems to respond to these challenges.

Trust under pressure – deficits and high vacancy rates

The Trust merged with financial deficits in all three combining trusts, and long standing problems in performance, some of which have been significantly worsened by the Covid-19 pandemic.

The most recent data also show that MSEFT is a long way from its key "Strategic Objective" of becoming the "employer of choice" in a sector with chronically high vacancy rates where qualified staff have choices of potential places to work. MSEFT's April Workforce Performance Report shows an overall **vacancy rate** in March of 13.3%: by comparison the most recent NHS Vacancy Statistics[1] show the East of England acute sector average was just **6.9%**.

That would be worrying enough, but the picture is worse again for **nursing** and for **medical** vacancies. While MSEFT reported a **16.7%** vacancy rates for nurses in March (more than **one in six** nursing posts vacant), the East of England acute sector average was less than **HALF** this level – at 7.9%. And while MSEFT reported the same level of medical posts vacant (**16.7%**), the East of England acute sector average for this sector of staff was even lower, at 7.5%.

So whatever Trust directors are doing, and whatever plans they may be formulating to address the staffing crisis, it's clearly not working, since neither doctors nor nurses are finding MSEFT an attractive, let alone a favourite place to work compared with other nearby NHS employers.

UNISON believes that vacancies on this scale raise serious concerns for the current and future safety of patient care – and for the welfare and wellbeing of the staff who are left in post attempting to run under-staffed services.

[1] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---march-2021

Another Mid Staffordshire?

UNISON members told us their view that the working environment in the Trust has become so poor that they fear MSEFT could become another tragic example of where a failed management regime obsessed with balancing spending rather than patient care could catastrophically collapse – as happened in Mid Staffordshire Hospitals Foundation Trust in the mid 2000s[2].

The resulting Public Inquiry, summed up in the Francis Report, emphasised the need for team work and partnership to ensure standards of care were maintained. UNISON urges MSEFT directors to take note of this, urgently. Its Executive summary stated (p66)[3]:

> "… there needs to be a relentless focus on the patient's interests and the obligation to keep patients safe and protected from substandard care. This means that the patient must be first in everything that is done: there must be no tolerance of substandard care; frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations.
>
> 1.119 To achieve this does not require radical reorganisation but re-emphasis of what is truly important:
>
> - Emphasis on and commitment to common values throughout the system by all within it;
> - Readily accessible fundamental standards and means of compliance;
> - No tolerance of non compliance and the rigorous policing of fundamental standards;
> - Openness, transparency and candour in all the system's business;
> - Strong leadership in nursing and other professional values;
> - Strong support for leadership roles;
> - A level playing field for accountability;
> - Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation.
>
> 1.120 By bringing all this together, all who work to provide patient care, from porters and cleaners to the Secretary of State, will be working effectively in partnership in a common and positive culture."

Recommendation 237 summed up:

> **"Teamwork**: There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued." (p110)

Failing to prepare

UNISON was alarmed to find that the lengthy run-in period prior to the merger was not used, as would have been expected, to lay a firm basis of collective agreements and policies that move towards harmonisation of staff terms and conditions and partnership working.

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[2] https://www.theguardian.com/society/2013/feb/06/mid-staffs-hospital-scandal-guide

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

After that preparatory period had been effectively wasted, the trust merger was carried through in the crisis conditions of the NHS response to the Covid-19 pandemic, which effectively blocked any progress along these lines for the first year.

The list of unresolved issues that could potentially cause problems for the Trust grows longer every week management fail to recognise the need to treat unions and the staff they represent with respect, and work with them as partners rather than as subordinates to be ordered into line.

Issues that need to be addressed include the mobility clause that has been included, without discussion with the unions, in the contract for new staff employed by the merged Trust. **This contract now means there are FOUR tiers of staff terms and conditions within the Trust, in addition to the historical differences in the way the former trusts evaluated the same job, and the resulting pay bands.**

The Trust has also inherited three separate negotiating frameworks, which are left with no employer to negotiate with now the Trusts have merged into one. Union reps who have previously had good working relationships with their own trust's HR now find there have been no proper negotiations on issues for the year since merger.

Management by panic and pressure cannot deliver the results management say they want. Reps need more time to consult members on how to respond and reply to draft policy documents, some of which need considered amendment. They also need time to discuss between the three sites to agree a joint response – without which the Trust cannot hope to move to any more streamlined process for negotiations.

Some of the issues concerning staff were reflected in the official NHS staff survey last year, which showed the merged trust rated consistently below average and well below the best performing trusts on almost every measure. The concerns raised by staff in that larger survey have been echoed in the more focused survey of UNISON members conducted as part of this report as the Trust goes into its second year. In each case the results confirm that the problem is not one between the new trust management and the unions, but a failure of the trust to win the confidence of its staff.

Calling time

UNISON has decided to call time on this management style which has left already stressed and over-worked staff whose dedication kept services going through the depth of the Covid pandemic frustrated, and wasted time and energy that should now be focused on tackling unresolved quality improvement issues, bringing down the long waiting times for treatment and improving staff morale.

Without proper treatment of the workforce any hopes of 'rebuilding better' after Covid are empty dreams. MSEFT's most recent Integrated Performance Report states clearly that:

> **"Staffing remains a risk across all care groups from the perspective of; delivering the requisite activity levels set out in the Trust's plan, workforce resilience due to further Covid surges and in the implementation of the Future Operating Framework."**

This report is a wake-up call to senior management to make the changes necessary: but it will also be shared with the local and national news media and with members and the wider trust workforce in order to maximise the pressure for positive change in attitude and in thinking, to ensure systems and services can be improved to benefit patients and staff alike.

UNISON notes and shares the Trust's concern for RTT targets (Referral To Treatment): but this also means it's time for **the other RTT** to be taken seriously by senior trust management: Respect, Transparency and Truth.

Overview

This report contains sections designed to point to the context and emergence of the key issues now facing the Trust:

- **How we got to this** -- Brief history of the evolution of Mid & South Essex NHS services and the merged trust management – "Success Regime," STP, moves towards ICS, merger, current unresolved issues over scale and boundaries of ICS.
- **Problems faced by MSEFT:** Financial pressures, staffing shortages, waiting list and other performance figures and trends, £29m backlog maintenance at Broomfield Hospital, etc.
- **Quality concerns** – unresolved problems (CQC concerns etc) that require a change of management attitude
- **Morale issues and management culture** – as revealed by NHS Staff Survey results and the separate UNISON survey of members.
- **What should have been done to prepare merger** – previous experience and issues in trust mergers, guidance on good practice, and the agenda senior management could and should have followed in preparing a smooth merger process in partnership with the unions
- **What Mid and South Essex trusts did instead** – issues that have arisen during and since the merger process. Examples of delay, lack of sincerity, lack of transparency, poorly drafted documents, and conduct that undermines confidence in the Trust senior management.
- **Principles to guide the way forward** – UNISON's roadmap to a healthy, honest and productive partnership between unions and management – focused on Respect, Fairness, Honesty, Transparency, Consistency, and Compassion.

How we got to this: countdown to the merger

The prelude to the merger that formed Mid & South Essex Foundation Trust goes back to evident financial and performance issues in 2014 and 2015.

In 2014 NHS England's *Five Year Forward View* abolished the highly contentious "Unsustainable Provider Regime"[4] for chronically challenged NHS Trusts. Imposing this regime in South East London had brought a major local protest and a successful legal challenge to plans from the Trust Special Administrator to effectively close emergency and acute services at Lewisham Hospital, and in Mid Staffordshire attempts to tackle chronic clinical and managerial failures in the Foundation Trust had brought a costly and inconclusive process.

Instead NHS England adopted a new concept of "Success Regimes," which were announced as ways of delivering enhanced support for challenged trusts. In June 2015 Essex was named as one of the three designated for this special treatment, with subsequent reports and discussion highlighting both clinical and financial/organisational issues.

The Success Regime

A *Guardian* report six years ago highlighted the problems of the Mid Essex trust, where "accumulation of an estimated £32m deficit, serious difficulty attracting staff and, especially, a catalogue of appalling failings in patient safety – some of which have caused serious harm and

[4] https://www.nuffieldtrust.org.uk/news-item/size-versus-quality-examining-hospital-mergers

death – have made it a cause for major concern for both NHS England and the NHS Trust Development Authority."[5]

According to NHS England's own account in June 2015[6], Essex was a "challenged local health and care system," in which:

> "the quality of care commissioned and provided to patients requires improvement; where services do not meet the expectations of the public, as enshrined in the NHS Constitution; or where the cost of providing services is greater than the financial resources available, meaning that there are sustainability risks in the medium and long-term.
>
> "The problems in these health and care economies are often deep-rooted, long-standing, and spread across the whole system as opposed to individual organisations. Local and national organisations may have worked hard for some time to improve services for patients and the public, but not made the required progress. Transformation is therefore now required, and this will only be achieved if national and local leaders take a different approach to those taken previously, which have not yet delivered the expected improvements for patients and the public."

In other words, a Success Regime was a *remedial measure,* bringing external resources to bear, to tackle chronic failures of management and financial problems:

> "The regime will be overseen by the relevant regional directors of Monitor, the NHS Trust Development Authority and NHS England, acting in concert and drawing in partner organisations as required. While the regime will operate to a consistent national framework … detailed decisions on the scope and objectives of the regime and the specific interventions and support deployed in each health and care economy will be taken at regional level. The day-to-day oversight of the regime will also sit at regional level. As part of the *Forward View,* the regime will ultimately report to the Board of the seven Chief Executives."

In Essex in particular:

- "There are operational and quality challenges which present risks to clinical sustainability.
- There are financial sustainability challenges across the local health economy.
- There is a recognition that additional levers and regulatory mechanisms may be required, in order to introduce new ways of working and new models of care.
- There are workforce challenges across primary and secondary care in the local health economy.
- Mid Essex was one of the 11 challenged health economies which received support with its strategic planning from national bodies in 2014/15. The Success Regime will build on this work."[7]

[5] https://www.theguardian.com/society/2015/jun/03/nhs-essex-longstanding-problems-success-regime

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/432130/5YFV_Success_Regime_A_whole_systems_intervention_PDF.pdf

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/432132/5YFV_Success_Regime_The_first_health_and_care_economies_Annex.pdf

A smaller Success Regime

However within a few months the apparent ambition for an Essex-wide Success Regime had been scaled right back to Mid and South Essex, triggering furious complaints from West Essex CCG, who wrote on November 4 2015 to NHS England's Regional Director in a vain effort to reverse the decision:

> "We are duty bound to convey to you the huge disappointment and frustration we feel at being cut adrift from the Essex Success Regime today, with no alternative package of support identified to take our work forward.
>
> "… In addition you have made local CCG leaders, who have welcomed the Success Regime publicly and privately, look very foolish to our members.
>
> "Exclusion from the regime we are sure will play very badly with our MPs, local authority partners, and perhaps most importantly with the many staff who work for the NHS in west Essex.
>
> "The recommendations today have entirely played to the historic perception that west Essex is the forgotten part of the county and the socio-political isolation we always feel."[8]

Essex County Council's health and Wellbeing Board, in November 2015 also took a dim view of the exclusion of both West and North East Essex from the 'Essex' Success Regime:

> "Members of the Board expressed concern and disappointment that West Essex and North-East Essex had been excluded from the Success Regime and considered that their exclusion jeopardised the sustainability of the project.
>
> "… Members also expressed concern about the governance of the project, ill-defined goals, finance, the impact on the forthcoming integration of Health and Social Care and the need to commence."[9]

The committee resolved to write to relevant bodies in order to:

- Understand the aims of the Success Regime,
- Express the desire that the project should not exclude West Essex and North-East Essex, and
- Define success.

The complaints – and the key question – were ignored, and by January 2016 a meeting of Monitor, Trust Development Authority and NHS England noted that:

> "One of the main outcomes of the phase 1 review was a recommendation that the Essex Success Regime should cover the health and care systems of mid and south Essex. This decision was taken as the population served by the NHS in this area was deemed to have a more manageable size and complexity, but still allowing change at a large enough scale to have a positive impact. Other means of support would follow for west and north east Essex."[10]

By March 2016 the now renamed Mid and South Essex Success Regime was moving to bring the three acute hospital trusts into a formal group, headed up by Basildon & Thurrock University Hospital NHS Foundation Trust CEO Clare Panniker:

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[8] https://westessexccg.nhs.uk/news-and-publications/publications/ccg-board-papers/2015/november-2015/1766-11-app-1-success-regime-board-report-26-nov-2015/file

[9] https://bit.ly/3g5ZWf9

[10] https://southendccg.nhs.uk/about-us/key-documents/1318-essex-success-regime-progress-update/file

> "The hospital trusts in the Mid and South Essex Success Regime have agreed the appointment of a chair and lead chief executive for the team that will ensure collaboration and improvements to patient care across the three hospitals.
>
> "…Further details are still being developed and will be subject to formal approval by the three trust boards and national regulators.
>
> "… The three trusts involved (Basildon and Thurrock University Hospitals NHS Foundation Trust, Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS Foundation Trust) have so far agreed that there will be a joint committee to oversee and support collaboration between the hospitals, including the development of options for service redesign.
>
> "Sheila Salmon, chair of Mid Essex Hospital Services NHS Trust will chair the joint committee. Alan Tobias, chair of Southend University Hospital NHS Foundation Trust will take up the role of vice chair. Clare Panniker, chief executive of Basildon and Thurrock University Hospitals NHS Foundation Trust, will lead the change programme for the acute hospital trusts and will be the lead chief executive."[11]

The STP (Sustainability and Transformation Plan)

2016 was also of course the year that Sustainability and Transformation Plans were demanded by NHS England, and in Mid and South Essex this process was effectively merged with the Success Regime.

The driving force behind many STPs was the yawning, exaggerated "do nothing" financial gap between likely income and rising demand (allegedly £407m by 2020/21 in Mid and South Essex[12]), designed to force local NHS leaders in many areas to contemplate reconfiguration, centralisation and merger of hospital services to save money, and as a result triggering anger from local communities fearing the loss of local access.

The rapid pace at which plans were required also meant many, if not most STPs turned to management consultants to draw up their proposals[13], while to minimise the scale of protests the preparation of many plans and the evaluation of them took place behind closed doors, with press, public and staff trade unions excluded.

This was the case with the Mid & South Essex Success Regime (MSESR), as the report of the October 2016 Clinical Senate review of the plans revealed:

> "Once the potential panel members had been invited and accepted they made declarations of interest and signed a confidentiality agreement. The panel members were then provided with the documents and evidence provided by BCG [Boston Consulting Group] as the evidence for the panel review."[14]

The Clinical Senate was supportive of one of the more controversial MSESR proposals, for a designated specialist emergency hospital for more challenging and complex emergency work; indeed it went even further, arguing that the potential hospital changes could be "bolder with

[11] https://uclpartners.com/news-item/mid-and-south-essex-success-regime-trusts-agree-arrangements-in-principle-for-group-model/

[12] https://healthcampaignstogether.com/pdf/Mid%20and%20South%20Essex%20STP.pdf

[13] https://healthcampaignstogether.com/pdf/sustainability-and-transformation-plans-critical-review.pdf

[14] http://www.eoesenate.nhs.uk/files/5214/8518/8086/MSESR_Clinical_Review_Panel_Report_OCTOBER_16_FINAL.pdf

greater potential benefits if there was less focus on continuing to provide virtually all current services on all three sites."

While this rumbled on out of sight, ***Eastern Eye***, UNISON's regional newspaper for NHS staff in October 2016 expressed concern at the lack of any meaningful action from the Success Regime, and the loss of contact with local management:

> "One of the more obvious results so far is senior managers dividing their time between more than one trust, and more and more meetings – with no clear benefit.
>
> "A new HR Transformation Manager for the success regime has been appointed, no doubt tasked with tackling one of the six priority areas singled out as objectives – developing a 'flexible workforce' that can work across organisations and geographical boundaries.
>
> "… Questions over recruitment and retention of staff, resources and terms and conditions also spring to mind, along with the fact that in the absence of a merger of the three trusts such objectives can be complicated to achieve.
>
> "It's clear to UNISON that without proper engagement with staff and the health unions the success regime will wind up talking to themselves with little effect.
>
> "The regime is cagey about any engagement with the unions. A copy of the letter sent by the regulator NHS Improvement to STP leads was only released to the unions six weeks later."

UNISON noted that instead of the expected consultation on proposed changes, Regime leaders were holding a series of "pre-public meetings" telling people who turn up the reasons for what they might do, without saying what it they have planned. As a result:

> "It may be a bit early to brand the success regime a failure: but its main successes so far are confined to creating new management titles and posts."

The protests

During 2017 campaigners, with backing from a few consultants at Southend, stepped up their protests against any downgrade of A&E services at Southend and Chelmsford to centralise services in Basildon[15].

This policy also divided local politicians, especially after Theresa May's narrow victory in the election left the possibility of another election at any point, and commissioners. At a meeting of the Joint CCGs STP Committee on November 29, three out of the five clinical commissioning group chairs in mid and south Essex abstained rather than voting to support publishing a consultation on plans to reconfigure local hospital services. [16]

In January 2018 the first formal announcement was made of plans to merge the three trusts[17] – by April 2019. Three months later the most contentious downgrade plans had been dropped; under the new plan each A&E was to continue to receive blue light ambulance patients, while Basildon would effectively act as the specialist trauma centre for the most serious emergencies.

In the summer of 2018 a Decision Making Business Case was eventually published outlining 19 proposals for reorganising services between the three hospitals.

[15] https://healthcampaignstogether.com/pdf/HCTNo7.pdf
[16] https://healthcampaignstogether.com/pdf/HCTNo9.pdf
[17] https://www.heart.co.uk/essex/news/local/three-essex-hospital-trusts-look-to-merge/

However in March 2019 it was announced that the merger was to be postponed by a year because Southend and Thurrock councils, after nodding through the DMBC reconfiguration proposals at a Joint Health Oversight and Scrutiny Committee, had belatedly exercised their right as scrutiny bodies to object to two of the 19 proposals, holding up the plan.

The councils referred the reconfiguration plan to the Secretary of State and the Independent Reconfiguration Panel – freezing access to £118m of capital funding which was key to the plan.[18]

Nonetheless in April 2019 the first moves began to centralise the office support staff for the three merging trusts in a Southend office, raising questions over the future of staff who were unwilling or unable to travel the extra distance to the new centre.[19]

The 3-way trust merger

The merger eventually went ahead in April 2020, in the midst of the Covid-19 pandemic, with many key questions undiscussed and unanswered.

According to the final Annual Report from Basildon & Thurrock FT extensive documentation was developed:

> "Between January 2018 and March 2020, we developed a Merger Strategic Case, a Merger Business Case, a Patient Benefits Case and a Post Transaction Integration Plan (PTIP). These documents were assessed in detail by our main regulator, NHS Improvement (NHSI) against statutory requirements to ensure that a merger was the right move for patients, staff and taxpayers."

However these documents appear only to have been shared with NHS Improvement, and not with the trade unions. As a result, no benchmark is available that sets out the initial aims and objectives of the merger and shows why the significant allocation of management resources to this project was deemed worthwhile.

It's clear that for over six years the future shape of health services in Mid and South Essex has been in doubt, and that while all of the reorganisation and reshuffling of management names and titles has continued, the underlying financial and performance issues identified in setting up the Success Regime back in 2015 have remained unresolved.

Continuation of Success Regime

Much of the activity of the Success Regime, and then the STP (which had been confusingly named the Mid and South Essex Health and Care Partnership) appears to have been senior managers meeting with each other.

In March 2016 an Operational Briefing on the Success Regime listed **SIX** meetings with regional directors, **SIX** with Acute trust CEOs, **FOUR** with Acute trust chairs, **TEN** with Medical Directors, **FOUR** with senior leadership group, **EIGHT** with CCG Accountable Officers, **FOUR** with CCG chairs, **TEN** with Directors of Finance and **FIFTY (50)** meetings with "SR workstreams" – but **NOT ONE** with staff side, local government or GPs.

Nor did they meet with any community or patient groups, despite the proposed model of care involving what soon proved to be a highly controversial reconfiguration of hospital services[20].

[18] https://www.echo-news.co.uk/news/17511758.mid-essex-southend-basildon-hospitals-trust-merger-hold/

[19] https://www.echo-news.co.uk/news/17578115.mid-south-essex-hospital-office-staff-merger-underway-500-move-southend-centre/

The Operational Briefing noted the need to focus on six areas including "enable greater flexibility of workforce across organisations" but showed no inclination to discuss this with the unions and staff involved.

UNISON is concerned to note that this same approach appears to have been adopted by the merged organisation. The 'high level objectives' set back in 2016 ignored completely the issue of staff shortages, recruitment and retention: there is little evidence this has been taken more seriously since.

Perhaps it is therefore not surprising that as yet there is no evidence that the merger that emerged from the Success Regime and the STP has delivered a more efficient system, a more responsive and coherent leadership, or improved access to services for patients.

Undisclosed but no doubt large payments will have been made to management consultants, and huge amounts of management time and attention have been devoted to reorganising rather than leading health care services – but even now there is little sign of any success emerging from the Success Regime.

Integrated Care System – a hesitant start

In February 2021, with the pandemic still impacting on health services across the country, ministers published a White Paper[21] proposing a new, substantial reorganisation of the NHS less than ten years after the last massive upheaval. England's NHS is to be carved up into 42 "integrated care systems" (ICSs), consolidating changes that have been carried out since STPs were established back in 2016 – effectively ignoring the existing legislation.

In March 2021 it was announced that Mid Essex NHS providers, commissioners and local government "partners" had been designated as an ICS[22] in the penultimate wave of authorisations prior to the widely expected legislation proposed in the White Paper, to give statutory powers to ICSs from April 2022.

Apparently the STP (aka Mid and South Essex Health and Care Partnership (MSEHCP)) had been "working towards the milestone for the past four years in a bid to strengthen local relationships and improve patient care" – raising questions of how bad those relationships had been when the process started.

Similar questions arose from MSEHCP chair Professor Mike Thorne's statement:

> "Our ICS designation is an important next step on our journey as a maturing health and care system and a demonstration that our partner organisations are committed to working together to improve the health and wellbeing of local people, delivering care our local communities and staff can be proud of."

However it seems that after four years in the making the Mid and South Essex ICS might well be the most short-lived of all 42 proposed ICSs, since less than 3 months later the new Tory leader of Essex County Council, highlighting a largely ignored section of the White Paper, once again raised the call for a single ICS to cover the whole of Essex rather than the 3-way split established by STPs.

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[20] https://southendccg.nhs.uk/news-events/governing-body-papers/2016-archive/march-2016/1381-item-13-success-regime-operational-briefing-310316/file

[21] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

[22] https://midessexccg.nhs.uk/news/1179-mid-and-south-essex-becomes-an-integrated-care-system-helping-join-up-care-for-1-2m-people

Back in 2016 West Essex had been forced into a joint STP with Hertfordshire[23], and North East Essex pushed into an STP with Suffolk,[24] with a subsequent merger of acute trusts to form the East Suffolk and North East Essex Foundation Trust[25].

But the White Paper made clear Health Secretary Matt Hancock's preference[26] for ICSs to be coterminous with the boundaries of the principal local authorities, regardless of the opposition from both of the major acute trusts involved. This has led to some Essex Tories raising questions over a solution involving a giant Essex-Suffolk ICS, including a Parliamentary debate on June 29 led by Sir Bernard Jenkin, MP for Harwich and North Essex[27].

The issue needs to be decided one way or the other in the next few months, before the (still-awaited) Bill to establish ICSs completes its way through Parliament. However the uncertainty over the future does not help focus the minds of MSEFT senior management on the still unresolved issues of the merger.

Stubborn problems facing the merged Trust

Finance

In March 2016 the Operational Briefing noted a combined in-year deficit of £94m in Mid and South Essex, £92m of which was held by the three acute trusts (Mid Essex £43m, Basildon & Thurrock £32m and Southend £18m). The MSE system was said to require "recurrent savings of £70-£80m a year to be in balance in 2018/19 (£30-ff5m per year to correct the current in-year deficit plus a further £35-£44m per year to meet new growth in demand and rising costs.)[28]

Later that same year the STP[29] gave a very different set of figures, identifying a "Do nothing deficit of £407m" to 2020-21, along with hopes of generating a huge £309m towards this through Cost Improvement Programmes and QIPPS savings, in addition to £53m of savings somehow from "Local health and care & SR savings" and undefined "In hospital savings" of £28m.

None of those highly speculative projected figures can now be compared with the outcome, since the merger appears to have eradicated the websites and annual reports of the three original trusts.

However a UNISON report on the progress of STPs in compiled in June 2018[30] noted that not much had changed:

> "The merging acute hospital trusts are all running substantial deficits, totalling almost £100m. Mid Essex Hospital Services trust wound up 2017-18 with a deficit of £55.9m, reduced by a "bonus" payment of £1.8m from the STF.
>
> "Basildon & Thurrock ended the year £29.3m in deficit, and received a £3.1m bonus from the STF. Southend University Hospital ended £14.4m in deficit prior to a £6.4m STF bonus."

[23] https://healthcampaignstogether.com/pdf/Herts%20&%20West%20Essex.pdf
[24] https://healthcampaignstogether.com/pdf/Suffolk%20and%20North%20East%20Essex.ppt
[25] https://www.esneft.nhs.uk/
[26] https://www.hsj.co.uk/policy-and-regulation/trust-chiefs-complain-to-hancock-over-his-restructure-on-a-whim/7029671.article
[27] https://hansard.parliament.uk/commons/2021-06-29/debates/0B1D5C1C-24BA-4F35-BAB1-B40D63F86EE9/NHSIntegratedCareSystemBoundaries
[28] https://southendccg.nhs.uk/news-events/governing-body-papers/2016-archive/march-2016/1381-item-13-success-regime-operational-briefing-310316/file, page 11
[29] https://healthcampaignstogether.com/pdf/Mid%20and%20South%20Essex%20STP.pdf
[30] https://healthcampaignstogether.com/pdf/Whatever-happened-to-the-STPs-3-web.pdf

The merger did not mean the Trusts were by any means out of the financial woods. The Basildon Annual Report for 2019/20[31] noted that:

> "Prior to -COVID related adjustments, all three trusts in the MSE Group delivered their control totals for the year and therefore full Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) monies were achieved by the organisations."

This ambiguous phrase does not make clear that Basildon's "control total" target for 2019-20 was a deficit of £10.8m after receiving additional funding of £22.3m – in other words a deficit of £33.1m. Mid Essex was even further adrift with a control total deficit of £47.2m "inclusive of PSF, FRF and MRET [Marginal Rate Emergency Tariff] central funding"[32]. Southend had agreed a breakeven position and delivered a surplus of £0.3m after receiving central funding of £21.2m[33] – in other words a deficit of £20.9m.

So after six years of 'Success Regime' and similar measures aimed at balancing the books the three trusts merged in April 2020 with a combined underlying deficit of £101.2m, slightly higher than the combined deficit for 2015/16.

The first year's combined budget looked to continue a similar pattern:

> "For 2020/21 MSE is required to deliver a break-even budget after receipt of Financial Recovery Funding (FRF) of £89.2m and Marginal Rate Emergency Tariff payment of £10.6m.[34]

In other words a deficit of no more than £99.8m; hardly any change since 2018, and slightly worse than 2016.

The chaotic impact of the Covid pandemic through the 2020-21 financial year makes further comparisons impossible, and the 2021-22 budget has not been published in Board papers. But it's clear that despite the Success Regime and subsequent measures the Trust still faces an extremely serious financial challenge.

Capacity, waiting lists and waiting times

While MSEFT has been comparatively less affected than some other trusts by Covid-linked bed closures that have hit the rest of England, the latest bed availability and occupancy figures (Quarter 4 2020-21) show the Trust had just **1,387 beds occupied** (80% of 1,683 general and acute overnight beds) – a drastic reduction from the equivalent (pre-Covid) figures from Quarter 4 of 2018-19, when **1,655 beds were occupied** in the three pre-merger trusts, equivalent to 95% of the larger total of 1,736 beds available[35].

In other words in the most recent quarter MSEFT's hospitals averaged **53 fewer beds available** – but **268 fewer occupied beds** than in 2019 (a reduction of one in six front line beds in use). This big reduction in capacity explains the latest performance figures showing lengthening queues and waiting times, and indicates testing times ahead for patients and for hard-pressed staff.

[31] https://www.mse.nhs.uk/download.cfm?doc=docm93jijm4n797.pdf&ver=1090
[32] https://www.mse.nhs.uk/download.cfm?doc=docm93jijm4n795.pdf&ver=1087
[33] https://www.mse.nhs.uk/download.cfm?doc=docm93jijm4n796.pdf&ver=1088
[34] https://www.mse.nhs.uk/download.cfm?doc=docm93jijm4n769.pdf&ver=1032
[35] https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/

It's already quite clear that the merged trust is one of the worst in the country for waiting times, with over 7,000 waiting over a year for treatment according to the most recent figures,[36] down from a peak of 8,051, but up 28% from 5,496 patients last November.

Back in March the Trust admitted to NHS England that it stands no chance of eliminating the backlog of 1-year waits by the end of this financial year,[37] and the most optimistic projection is MSEFT reducing those waiting over 52 weeks to 3,700 by March 2022.

But a look at the steadily worsening figures over the years shows that the current problems are by no means solely a product of the Covid pandemic.

In 2017, with the Success Regime still in place, Mid-Essex waiting list almost doubled from **24,382** waiting for treatment in April (with 90.6% within the 18 week maximum) to **46,100** in December, of whom just 69.4% were waiting less than 18 weeks – **after which the Trust published no further waiting list figures until the three trusts merged in April 2020.**

Basildon and Southend continued to publish their waiting list figures, with a combined 53,058 in March 2018, 83% of whom were within 18 weeks, rising to 60,590 in March 2019, with 77% within the 18 weeks, and 64,499 just before merger in March 2020 (69% within 18 weeks).

The merged trust began life in April 2020 reporting a combined total of 75,272 patients waiting for treatment, just 58.5% of whom had been waiting less than 18 weeks: the longest waiting 8% of patients had waited almost 39 weeks. **And by March 2021 the queue had grown almost 17% to 87,869 – with a massive leap in the long waiting patients, with the longest waiting 8% of patients waiting over 52 weeks**

This indicates that as in many other trusts, numbers of new referrals were substantially reduced during the lockdown and the peak of the pandemic, as patients avoided hospitals for fear of contracting Covid-19: but at the same time those already on the waiting lists had their treatment further delayed as staff, beds and operating theatres were reallocated to combatting the pandemic.

The causes of the delays during the pandemic were clearly beyond the control of the Trust: but the consistent and significant rise in the waiting list and waiting times prior to the pandemic are a consequence of a decade of under-funding by government combined with year after year of unrealistic planning by the Trust and its predecessors.

The upshot is a major trust floundering amid a rising tide of patients waiting increasing length of time for elective care. The Trust's own Board papers in January revealed that extremely long waits – echoing those of the grim Thatcher and Major years prior to the 2000 NHS Plan – have also returned. The Board decided to establish weekly Director of Operations oversight on patients waiting **18 months – 2 years** (78-104+ weeks) and "additional oversight" for patients waiting **over two years** for treatment.[38]

Quality concerns

The Trust and its pre-merger component trusts have a number of outstanding issues as yet unresolved with the Care Quality Commission, a reminder of the ways in which staffing levels and the need for leadership and sound systems are crucial to the quality of patient care.

[36] https://www.echo-news.co.uk/news/19334401.south-mid-essex-hospitals-7-000-patients-wait-year-treatment/
[37] https://www.hsj.co.uk/hsj-local/mega-merger-trust-tells-nhse-it-cannot-eliminate-year-long-waiters-by-next-year/7029750.article
[38] https://www.mse.nhs.uk/download.cfm?doc=docm93jijm4n1001.pdf&ver=1461

Southend hospital was rated "requires improvement" on "safe services" and "responsive services" in CQC inspections in December 2017, and again November 2019. The most recent (March 2020) report explained the rating in this way:

> "• We rated safe and responsive as requires improvement; and effective, caring and well-led as good.
> • We took into account the current ratings of the three core services at Southend University Hospital NHS Foundation Trust not inspected at this time.
> • We rated two services as requires improvement across the trust overall. We rated the remaining three acute services as good.
> • The overall rating for the trust remained the same.
> • The trust was rated requires improvement for use of resources."[39]

Last year following an unannounced June inspection of maternity services at Basildon Hospital the CQC called in August for action to improve services having identified several concerns, including: high risk women giving birth in the low risk area; insufficient numbers of staff with the relevant skills and experience to keep women safe and provide the right care and treatment; and dysfunctional multidisciplinary team-working which had impacted on the increased number of safety incidents reported.

Additionally the CQC reported incidents were not always graded correctly according to the level of harm, lessons learnt were not always implemented and care records were not always securely stored.

A follow up meeting in September led to a further CQC report, this time rating Basildon's maternity services as "inadequate" on safe, effective and well-led.[40]

> "Following our inspection in September 2020 we issued an urgent notice of decision, under Section 31 of the Health and Social Care Act 2008, on the 7 October 2020, to impose conditions on the trust's registration as a service provider in respect of the regulated activity: maternity and midwifery services. The conditions set out specific actions to enable the improvement of safety within the service."

The concerns raised by the CQC in explaining their decision to lower the rating of the service to inadequate were wide ranging:

> "Staff did not always complete training in key skills, they did not identify and escalate safety concerns appropriately. **The service did not always have enough staff to keep women safe and to provide the right care and treatment.**
>
> "Multidisciplinary team working continued to be dysfunctional which had impacted on further safety incidents reported. The service did not always use systems and processes to safely prescribe, administer and record medicines.
>
> "… Staff did not always work well together. **Some staff did not feel able to approach some colleagues which was not to the benefit of women and babies.** There was poor structure to the safety handover on the delivery suite and confusion to what constituted a safety huddle.
>
> "Leaders did not have the skills and abilities to effectively lead the service. The pace of change was ineffective, and the service did not operate effective governance processes. **The service did not have an open culture where staff could raise concerns without fear**

[39] https://api.cqc.org.uk/public/v1/reports/c6c16f89-4238-43fe-9502-5ecdf70f585d/Use%20of%20Resources?20210114084219
[40] https://www.cqc.org.uk/location/RAJ12

of reprisal. Leaders and teams did not always use systems to manage performance effectively."

More recently (January 2021) the *Health Service Journal* highlighted the Trust itself warning of the danger of 'Catastrophic' threat to cancer performance as waiting times for cancer treatment rose alarmingly[41]. The Trust's Board papers revealed 337 patients had been waiting 62-days to start treatment and 68 for 104 days,[42] in part because cancer clinics were closed in January to help cope with the covid surge.

However the waiting list problems pre-date the Covid pandemic, and the Trust's two-week cancer performance had also deteriorated due to capacity constraints at all three hospitals:

- Breast service and Endoscopy capacity at Mid Essex,
- Head & Neck service capacity at Southend.
- Urology, Skin and Breast capacity at Basildon

In May Mid and South Essex was one of 42 trusts named and shamed[43] by the Patients Association, doctors' leaders and the campaign group Transparency International for their secretive approach, and refusing to disclose how many of their patients died after catching Covid on their wards or complying fully with a freedom of information request for figures on hospital-acquired Covid infections and deaths.

Also in May the Royal College of Surgeons, in a review ordered by NHS England, warned the trust of the need for urgent action to remedy staff shortages and weaknesses in its cancer treatment at Southend Hospital, and pointed to risks in the system that required patients needing interventional radiology in Southend to be transferred to Basildon Hospital[44].

If the Trust Board is really committed to tackling these problems and delivering the improved quality of care that should be the central aim of the merger, they will need to grasp the importance of partnership working with the trade unions and action to tackle the cultural problems within the Trust that the CQC has warned deter staff from raising concerns and which impede proper multidisciplinary team working.

Morale issues

NHS 2020 Staff Survey

Last year's NHS Staff Survey showed Mid and South Essex, the country's third largest trust, consistently rated below the England average by its staff, and in many cases lagging a long way behind the best performing trusts.

On Equality, Diversity and Inclusion, for example, MSEFT registered just 80.4% of staff saying "yes" to "Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? This is below the national average of 84.9% – and almost 14% below the best trust.

On Question 15b "In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?" 10.3% of MSEFT staff responded "yes",

[41] https://www.hsj.co.uk/hsj-local/catastrophic-threat-to-cancer-performance-at-englands-third-largest-hospital-trust/7029395.article?utm_source=t.co&utm_medium=Social&utm_campaign=newsfeed
[42] https://www.mse.nhs.uk/download.cfm?doc=docm93jijm4n1001.pdf&ver=1461
[43] https://www.theguardian.com/world/2021/may/25/unnecessary-secrecy-42-nhs-trusts-criticised-over-covid-deaths-data
[44] https://www.hsj.co.uk/acute-care/trust-told-to-take-urgent-action-over-risks-to-cancer-patients/7030146.article

compared with an average of 7.9% – and well over double the percentage of the 4.0% in the best trust.

On Health and Wellbeing, just 24.7% of MSEFT staff – less than a quarter – agreed that the organisation takes positive action on health and wellbeing, compared to an average of 31.7% and more than half of staff (51.1%) in the best trust.

Almost a third of MSEFT staff (30.2%) said they often think of leaving the Trust, above the average of 26.7% and 13% higher than the best trust.

Almost one in six MSEFT staff (16.1%) said they will leave the Trust as soon as they can find another job, more than double the 7.5% in the best trust and above the national average of 13.2%.

The NHS Staff Survey also reveals worrying figures on bullying and harassment, with 14.5% saying they have experienced at least one incident of bullying, harassment of abuse at work from managers, again more than double the 6.2% in the best trust, and above the average of 12.6%.

On Safety Culture, while over two thirds of MSEFT staff said they would feel secure raising concerns about unsafe clinical practice, **only just over half were confident that the organisation would address their concern – compared with three quarters of staff in the best trust.**

Only two thirds of MSEFT staff thought the Trust "acts on concerns raised by patients/service users" – compared with 87% in the best trust.

Again, while more than two thirds said they were able to make suggestions to improve the work of their team or department, just half (50.5%) thought they were able to make improvements happen in their area of work, compared with 63.5% in the best performing trust.

70% of MSEFT staff thought care of patients was the top priority of the trust, well below the national average of 79%, and 21% below the best performing trust on 91%.

And just two thirds of MSEFT staff (66%) said they would be happy with the standard of care provided by the trust if a friend or relative needed treatment, compared with more than nine out of ten in the best trust (92%).

MSEFT senior management need to take serious note of these survey findings, and work with the unions to find ways to improve morale and confidence in the Trust and its services if it is not to face more serious problems.

The Survey was conducted in the autumn of last year, in a relative lull in the Covid pandemic and before the devastating second wave in the new year, so there must be fears that morale has been further eroded since then with the impact of burn out and stress – as flagged up by the new report from the Commons Health and Social Care Select Committee.[45]

UNISON's survey

In preparation for this report, UNISON conducted its own smaller-scale snapshot survey to gauge the view of our members across the Trust. Around 20% of the responses were from new employees of MSEFT since April 2020, with other responses were almost equally divided between members transferred from each of the three merging trusts.

[45] https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/22/2202.htm

Although the sample size is small and inevitably weighted towards those who are more dissatisfied with the Trust, the findings echo the concerns of UNISON reps on the ways in which the merged Trust leadership is perceived by staff, and the culture prevailing in MSEFT.

Strikingly, of the total responses, only 3% said they felt MSEFT was operating as one team, and 61% "seldom" or "never" felt the Trust was a single team.

Of those who had been in need of HR support (Sickness absence management; Grievance; Disciplinary or Reorganisation of the area of work you work in) only 15% felt very or slightly satisfied with the support from HR, while 48% were either very or slightly dissatisfied.

Of the minority (29%) who had been through a consultation process in the past 4 years the overwhelming majority (82%) thought the consultation had been handled poorly or very poorly by the Trust concerned.

When we asked members to give more details on the issues concerning them there were more grounds for concern. In answer to a question on what positive changes members had seen from the merger, only 6 answers of 93 were actually positive. When asked about negative changes from merger, 10 reported 'no,' 'none,' 'nothing yet' or 'not yet': 4 reported "no change," one "no better".

Looking at the comments on the questions that allowed freer answers, while many of the responses overlap several issues, the largest numbers focus on the feeling that the Trust is not one team, with almost as many concerned with staffing levels; next most common were comments lamenting the lack of compassion from managers and perceived lack of respect for staff, followed by HR failings and problems over payroll.

Next came remote management lacking links to specific workplace and communication failures.

Topic of concern	**Number of points raised**
Trust is not one team	22
Staffing levels/increased workload/morale	21
Management lack of compassion/respect for staff	16
HR failings	14
Payroll issues and pay	13
Fragmented/remote management not relating to workplace	11
Communication failures	10
Bullying	5
Confusing structure – lack of leadership	5
Lack of consultation/transparency	3
Safety/quality of care	3
Training	3

Comments on the Trust not feeling like one team included:

- "We are really one trust in name only"
- "Very disjointed; total lack of collaboration"
- "There is less communication on the vision and the progress of the new MSEFT. A huge amount of process that is still site oriented."
- "Our department has ended up with some of their middle management"

- "It feels like there is more of a divide between staff now rather than all working for one trust. It worked much better when we were all separate."
- "No longer feels like one team, no direction, overworked."
- "Feels less like a merger, more like a takeover".

Asked to suggest changes that might improve matters, responses included:

> "A clearer chain of command and more harmonising of the three sites before pushing the 3 teams together when they were all working so differently beforehand – and to have our staff side more involved in the process."

> "Equality throughout the hospitals. All work together and help each other. However it seems each hospital is out for themselves."

On staff shortages comments included:

- "Staff morale at the lowest I have ever seen."
- "My team are under immense pressure as now they have patients from all hospitals and we don't have enough staff or clinic capacity."
- "Unsafe staffing numbers allocated to caring for patients – leading to exhaustion, which has increased sickness and ultimately affects patient care."
- "Increase in workload due to effective reduction in headcount in merged department"
- "Increasing workload without the increase in staffing levels…"

Asked to suggest changes, comments included:

> "Enough staff to safely cover operating lists and allow for breaks. Operating lists to be realistically filled, not overfilled causing multiple overruns."

> "More staff. Management on site daily and not across 3 sites."

> "Greater effort to fill vacancies. An understanding that staff shortages have a huge impact on staff that remain.

> "Re-establish service so we have a full team to improve the service we provide. Improve working conditions so all team together in an appropriate environment …"

On lack of management compassion and respect for staff comments included:

- "Staff feel totally undervalued, disrespected, over loaded with work, expectations are too high for individuals, employees told to just get on with it. … Staff feel certain senior management are not compassionate or respectful to staff. I have never known working for the hospital to be this awful. Totally unacceptable."
- "We need more respect from our managers. Clarification of our job roles. No bullying us to do more jobs. Staff under pressure to take on roles they're not happy with."
- Listened to? No. Short staffed? Yes. Unreasonable and impossible target dates for workload to be achieved? Yes. Compassion for staff returning from shielding? No. Compassion for all staff? No, the senior management don't seem to care. …"

Asked to suggest changes, comments included:

> "The staff to feel valued, after the last 15 months, it just seems like the attitude from above is "get on with it" not a thought of what we've all been through."

"More understanding for sickness. People are at work with the lurgies, giving it to other staff and patients because they can't afford or scared to go of sick."

"An employer that actually gives a flying fruitcake about its staff."

"Opportunities to help with mental health initiatives that are not blocked by your line manager because they can't cover your job."

On HR failures the examples included:

- "While I was off having contracted Covid they gave my job to someone else with the excuse my job was evolving. It has not evolved it has dissolved …"
- "HR and salaries have been so frustrating and disappointing since the merger. No one seems to take accountability, you get passed from person to person and mistakes are being made. Numerous staff affected by sudden termination of contract, wrong payment. New staff starting with no email, IT log in or mandatory learning."
- "Maternity leave, haven't been able to contact anyone, not knowing who is who now for HR, have been left totally in the dark about my maternity."
- "Stupid new working hours, involving being expected to work six days a week for five days' pay, to work until 8pm and start work at 6am."
- "Being redeployed to all sorts of strange environments and not being given any orientation on wards: sometimes two wards on one shift. Not even shown where the resuscitation trolley is kept, given patients' names or told why they're in. … but you have no choice because management 'say so'."
- "If I didn't have a colleague who worked in HR … I would still be waiting for my start date, my name on the roster, my payroll the lot. Everything is so hard to sort out. As a new starter you have to find your own way through all the systems and no-one in the ward has time to explain these things to you…."
- Increase in bullying/harassment. Demotivated staff: unfriendly and less care for current staff. … A lot of ideas but no connection with staff on the ground."

Other comments summing up a level of frustration and disenchantment with the way in which the merged Trust is led include:

"Organisation has a Harrods-style corporate message alongside a market stall delivery."

"I do appreciate that from time to time there has to be change, but if employees are not included in the transition and change it is a very depressing and demoralising experience. It actually makes me want to give up working here!"

"I'd like to see us not bring expected to travel across sites whilst still on the same pay and having to claim travel expenses back afterwards. I chose to work at a hospital that is local to me, not one that takes almost 1.5 hours there and back in my own time."

"We need an area where staff can sit and have their lunch away from the ward/department they work in. The cafe at Broomfield is tiny and the staff area in the atrium is nowhere big enough. When questioned before we were told to go and sit in our cars!"

"More staff parking would make a difference too. Very stressful driving around looking for a space when you start after 08.00. Often results in some very dodgy parking because otherwise patients are kept waiting."

"We need senior managers to actively listen and respond to concerns by actually doing something rather than writing another action plan that gets filed."

It's clear from UNISON's survey that the trust has a long way to go to win the confidence of staff and develop the kind of culture and morale that can centre on improving patient safety and quality of patient care – both of which in turn give staff a pride in the work they do and establish confidence in the management.

Our members want to be part of a successful, efficient, high-performing Trust: but they don't want their dedication and skills to be taken for granted or exploited by policies that assume they can instantly shed or reorganise personal lives and commitments to work "flexibly" over different sites, or assimilate new skills to work in unfamiliar departments without appropriate support – and prior agreement.

MSEFT senior management have to recognise the need for two sides to work together to create a productive, caring partnership, and that this can only be achieved through consent rather than diktat or pressure from the top.

MSEFT and the Greensill scandal

Nor will staff confidence in the Trust's senior management have been increased by the revelations in April that MSEFT was one of a small handful of Trusts[46] to have signed up for the controversial 'Earnd' app that was being hawked around by former Prime Minister David Cameron on behalf of his former advisor and failed financier Lex Greensill.

MSEFT's Chief Executive Clare Panniker had links with Cameron and the Conservative Party going back to her platform speech at the 2014 Tory conference, just prior to then Health Secretary Jeremy Hunt, where Ms Panniker was introduced as "one of the 50 most inspirational women in healthcare"[47] – but no details have been revealed of the meeting between MSEFT trust representatives in January that led to the deal with Greensill.

The *Echo* reports having seen leaked emails in which Ms Panniker insisted "proper and appropriate" processes were followed,[48] but these have not been reported to the trade unions or the Trust.

The Earnd app was supposed to pay staff facing financial difficulties daily instead of monthly, and was mainly targeted at lower-paid staff.

Although the app was provided free of charge to the NHS, Earnd would be able to share data from the trust on any staff who signed up, with these transactions invisible to the staff. *Financial Times* and other reports[49] suggest that the scheme, which collapsed when the parent company went bust, was seen by Greensill as a lever to secure other more lucrative work with the NHS.

MSEFT promoted the service just weeks before Greensill collapsed, sending an email to staff in February which carried glowing endorsements from NHS employees.

> "I think Earnd makes you feel more relaxed and gives you an added dimension to the structure of your finances," said one quote attributed to a staff member on a maternity ward. "It just gives you an added sense of freedom."[50]

[46] https://www.ft.com/content/b76df097-8f3c-4310-92ac-b0aaa2fa5646
[47] https://www.hsj.co.uk/hsj-live/hsj-live-30092014-reaction-to-jeremy-hunts-conservative-party-conference-speech/5075287.article
[48] https://www.echo-news.co.uk/news/local_news/19252865.mid-south-essex-nhs-trust-signed-deal-earnd-app/?ref=wa
[49] https://www.telegraph.co.uk/business/2021/04/14/former-met-police-chief-drawn-greensill-scandal/
[50] https://www.ft.com/content/b76df097-8f3c-4310-92ac-b0aaa2fa5646

A 6-page document of Frequently Asked Questions was also circulated, bearing the MSEFT Trust logo on each page.

It's not known how many NHS employees had their data shared with Earnd without their consent, and despite questions from the 3 staffside leads asking what was in the deal for the Trust, no answers have been forthcoming.

What should have been done to prepare merger

There is little in the way of useful guidance for trusts on how to carry through a merger process, although MSEFT appears unique in the extent to which some of the key stages required by NHS England were done by senior management behind closed doors rather than publicly[51].

However there is a substantial literature questioning the wisdom of large-scale hospital mergers and the benefits than can be derived from them.

Back in 1997 Roy Lilley, in a sadly out of print book offering *101 Questions on Mergers, Management and Mayhem*, warned the "two turkeys don't make an eagle," and quoted the authority of a McKinsey study of US mergers from 1972-1983 that found only 23% were successful in terms of increasing shareholder income.

He also quoted *Business Week* in 1992 warning that the average bank merger in the 1980s "didn't cut costs, didn't raise productivity and actually made the bank less profitable."

Lilley notes "mergers are a dangerous pastime that have demolished more organisations than they have built." Many of the book's 122 main questions have relevance for the merger to form MSEFT in April last year, not least

> "Will the merger provide better services, better job opportunities and improvements for all? The temptation for managers – particularly middle managers who may be unemployed as a result of the merger – is to promise everyone everything."

And the follow up:

> "If the merger is coming about because of poor management of one of the merger partners, or because of resource problems – are both partners strong enough to see a merger through without something collapsing?
>
> "…What are the service implications?
>
> "What is the likely impact on morale and the knock-on impact on the quality of the organisation's performance?

Another key question is:

> "Can you create a climate where people will admit they 'have not done that very well'?
>
> "… Do you have a non-blame culture in your organisation?
>
> … How do you create an atmosphere of honesty and openness?"

Lilley's approach stresses the need to win the hearts and minds of staff, to consult them often, and the need for a communications strategy that recognises staff will feel anxious and concerned and promotes listening and sharing.

[51] https://www.england.nhs.uk/wp-content/uploads/2021/04/transactions-guidance-2017.pdf

> "Some answers … may not be flattering and not the news you may want to hear. That is exactly the news you must listen to."

The purpose of the merger needs to be spelled out, "a shared direction, something all staff believe in and respect". Senior management need to make themselves accessible and approachable:

> "Do Board members go out of their way to meet with and talk to staff?"

The merged organisation will need its own new HR agenda and will need to address the concerns of staff who may be expected to work differently:

> "What discussions have there been with affected staff groups and their representatives?"

And perhaps most important of all in a health care setting, the question of quality has to be at the centre of the Board's concerns and the trust's activity:

> "Setting quality standards involves everyone and requires ownership and commitment. A newly merged organisation will need to agree a new philosophy and a new shared agenda. It is not acceptable to muddle through with old practices."

Sadly Lilley's advice is not only out of print, but clearly at variance with the approach of the MSEFT management team, who have consistently chosen the opposite path to this sound approach.

More recently NHS Employers[52] also gave sound advice on taking plenty of time to sort out potential problems over equalisation of pay and job evaluation across a merged trust, beginning the section on First Practical Steps:

> "At the outset of the exercise it is important to:
>
> "**Establish partnership arrangements.** The principles and practices of the original Agenda for Change implementation should also apply to post-merger/reconfiguration exercises. Experience shows that it is important to get such arrangements established as quickly as possible. An early task for the new partnership groups could be to review the locally determined Agenda for Change procedures and to agree those to be adopted by the new organisation. This will save delays at later stages.
>
> "Devise a communications strategy. Employees in the new organisation are likely to be particularly anxious about the future of their jobs, so it is imperative to ensure there is good communication to keep all staff informed of progress." (emphasis added)

Why has the merger been driven through?

There are lingering doubts over what the merger seeks to achieve.

The merged Trust published no Business Case setting out publicly for all local stakeholders the key aims and objectives of the merger, and conducted no consultation.

Instead they have left staff to draw their own conclusions on why their trust has been roped in to an uneasy new structure, and what the longer term implications might be for their jobs, working conditions and work-life balance.

[52] https://www.nhsemployers.org/job-evaluation-handbook/chapter-4/merger-and-reconfiguration-of-health-service-organisations

Many previous mergers have been a prelude to rationalisation/centralisation of services and associated hospital and departmental closures. However the constraints on resources and on capital for new development, and the recent history of powerful political opposition to centralising emergency care at Basildon mean this is unlikely at least in the short term in MSEFT.

Is it an effort to strengthen management or resolve management problems at one or more of the merging trusts? This seems unlikely, not least because some of the most serious quality concerns have been at Basildon, and yet Basildon management has emerged as the dominant force in the merged Trust.

Is it an attempt to solve staffing problems by creating one large Trust to recruit and train new staff? If so, much more serious attention needs to be paid to the negative implications of requiring staff to work "flexibly" across sites many miles (and minutes) apart – and to the experience of previous mergers (see below).

Is the merger a response to the fact that all three pre-merger trusts were too small to be financially viable? Health economist Anita Charlesworth, then of the Nuffield Trust, warned back in 2012 that a merger on this basis might be ill-conceived:

> "If it's because they are too small to be viable financially or clinically, a merger may deliver better outcomes for patients and taxpayers. But if size isn't the problem and the issue lies in wider health economy problems, or transforming efficiency through clinical leadership, increasing the size of the organisation is unlikely to deliver."[53]

A money-saving exercise?

So is the merger primarily aimed at saving money? Given the experiences of previous mergers, in which expected and promised savings failed to materialise (see below) any hopes of generating major savings are misguided.

Moreover, if the range and distribution of services is to remain largely unchanged, any substantial savings could only come from reducing and increasing the exploitation of the workforce.

The conduct of the Trust in its first year in the midst of the pandemic has not made clear if this is the objective: but if it is the long term aspiration to sweat savings from staff it will of course impact on recruitment and retention of sufficient staff, and make for a prolonged period of conflict with the trade unions rather than the partnership working that is the only reliable way to build high quality services.

There has certainly been no proactive HR process to win hearts and minds or reassure staff: nor has there been any effort made by senior managers to make themselves approachable or listen and respond to uncomfortable points raised by staff.

Some senior managers have sought an easy life by giving union reps assurances that turned out to be worthless – and which simply fuel frustration and mistrust, when honest answers and negotiation would have been much more productive.

The Staff Survey as well as UNISON's more recent survey confirm that only a small minority of staff believe that concerns over safety and quality of care – whether raised by staff or patients – will be taken seriously by management, or that staff themselves have any real chance to improve the services they deliver to patients. So if quality and safety are the main focus, MSEFT has spectacularly failed to convey this to the staff at the front line.

[53] https://www.nuffieldtrust.org.uk/news-item/size-may-not-be-everything-reviewing-hospital-mergers

More studies on mergers

In 2002 the BMA published a major study of nine recent trust mergers in London's NHS[54], which warned that:

> "Important unintended consequences need to be accounted for when mergers are planned. Mergers can cause considerable disruptions to services, and require greater management support than previously acknowledged."

Each of the mergers – unlike the MSEFT merger – had been subject to a public consultation, in which the stated reasons for the merger, included a need to make internal savings in management costs and invest savings into services for patients, to safeguard specialist units, and guarantee developments in services.

Unstated reasons included a need to impose new management regimes on trusts perceived by health authorities or regional office as 'undermanaged' or 'lacking control,' or to deal with 'accumulated deficits of one of the constituent trusts'. However:

> "Mergers had a negative effect on the delivery and development of services. Interviewees from inside and outside the trusts reported that the loss of managerial focus on services during the merger had some detrimental effects on patient care. Service developments were delayed by at least 18 months, and senior management had underestimated the timescale and effort involved in the mergers."

While there were some benefits from a larger organisation ("the presence of a larger pool of professional staff" allowing large teams to be developed and clinical excellence achieved; and "previously fragmented specialist services can become unified and enhanced"), this came with the downside of disadvantages that had not been foreseen, not least that:

> "staff felt that (senior) managers had become remote, and service managers felt cut off from the services that they were managing. Staff in the acute trust felt that senior managers did not devote enough time to them and that their needs for help from the managers were ignored.
>
> "… Large trusts were seen as unresponsive and slow to make decisions."

There were also issues relating to the way the new merged management was perceived:

> "Although the competition for management posts followed NHS guidelines, the new senior management team tended to consist predominantly of staff from one of the constituent trusts; this created the impression of a "takeover" for many staff…"

Mergers proved not to be the magic key to recruitment:

> "Findings to date have not revealed a substantial improvement in staff recruitment or retention during the early stages of mergers, despite this being a prominent stated driver."

The promised financial savings also proved elusive: the researchers calculated that the management cost savings (due to reduced numbers on management boards) was between £179,000 and £378,000 per year, well short of the expected £500,000 or more:

[54] Fulop, N, Protopsaltis, G, Hutchings, A, King, A, Allen, P, Normand, C & Walters, R 2002, 'The process and impact of mergers of NHS trusts: multi-centre organisational study and management cost analysis.', BMJ, vol. 325, pp. 246 - 249. *https://doi.org/10.1136/bmj.325.7358.246*

> "The low savings in management costs achieved, particularly in the first year after the merger, suggest that the implementation of mergers needed more management support than had been anticipated."

Bristol University

Ten years later pro-market researchers from Bristol University's 'Centre For Market And Public Organisation' also found little benefit to be gained from hospital trust mergers:

> "The literature on mergers between private hospitals suggests that such mergers often produce little benefit. Despite this, the UK government has pursued an active policy of hospital mergers, arguing that such consolidations will bring improvements for patients. We examine whether this promise is met.
>
> "We exploit the fact that between 1997 and 2006 in England around half the short term general hospitals were involved in a merger, but that politics means that selection for a merger may be random with respect to future performance. **We examine the impact of mergers on a large set of outcomes including financial performance, productivity, waiting times and clinical quality and find little evidence that mergers achieved gains other than a reduction in activity**."[55] (emphasis added)

The study concludes with a warning that "waiting times rose post merger," and where mergers led to centralisation of services on fewer sites "travel distances may also rise when hospitals are closed."

> "… Given this, it seems the English government should carefully consider potential losses before allowing more mergers between short term general hospitals."

Nuffield Trust

Also in 2012 a Nuffield Trust research report *Can NHS Hospitals do more with less?*[56] – which was committed to the notion that competition somehow improves quality and efficiency – also took a negative view of the side-effects of mergers, noting:

> "Studies have suggested that the impact of hospital mergers on efficiency is mixed, because any management failure to focus on the human impact of major change can bring about a dip in performance. Likewise, there are limits to the economies of scale possible through mergers; these may be better achieved by cooperation between hospitals to reduce the duplication of services and concentrate buying power."

NHS Confederation

In 2013 the NHS Confederation also published guidance urging caution on hospital mergers and advocating "healthcare groups" as an alternative, warning:

> "There is a growing consensus that NHS trusts in general, and the acute sector in particular, are about to enter a new phase of organisational consolidation.
>
> "A combination of system pressures may mean a wave of mergers, as trusts look to increased scale as a means of weathering staffing pressures, declining tariff payments, long-term shifts in demand and, for some, the foundation trust pipeline.

[55] http://www.bristol.ac.uk/media-library/sites/cmpo/migrated/documents/wp281.pdf
[56] https://www.nuffieldtrust.org.uk/files/2017-01/can-nhs-hospitals-do-more-with-less-full-web-final.pdf

> "Yet the track record for mergers and the "bigger is better" view is not good. Evidence suggests that objectives are rarely achieved or, if they are, are outweighed by the downsides of a larger, less agile entity."[57]

King's Fund

In 2015 the King's Fund published a review of 20 mergers involving NHS trusts and foundation trusts from early 2010 to mid-2015[58]. Almost all were initiated by regulators or administrators, with the aim of helping NHS trusts to gain foundation trust status or to rescue providers from financial challenges.

Once again the key question was what was the objective of the merger, and was merger the best way to achieve the objective?

> "Our review revealed serious weaknesses in organisations' assessment of alternative options and articulation of the case for merger. In a number of cases, we were unable to identify any clear rationale for merger. In many cases, the parties cited benefits that did not appear to be directly attributable to the merger or seemed unlikely to materialise.
>
> "There appears to be widespread belief in the benefits of achieving 'critical mass', which is not supported by the available evidence. Conversely, there appears to be little recognition of the disadvantages of creating larger, more complex organisations with conflicting cultures or business models."

The report gives a scathing summary of the reckless resort to merger without properly assessing the alternatives:

> "In short, NHS leaders appear to be betting the farm on time-consuming, costly and risky transactions for failing providers, often based on faulty argumentation, and in the absence of evidence that mergers typically help to create more sustainable organisations.
>
> "While mergers will continue to play a role in the NHS, the national bodies should rule out mergers as a route for NHS trusts to gain foundation trust status or as a response to failure, focusing instead on supporting actual service improvement and system-wide transformation. "

The King's Fund's proposed route to service improvement in place of merger sounds more like what is now described as an Integrated Care System:

> "One alternative approach, […] is for groups of providers to develop place-based systems of care, with the emphasis on collaboration across organisational and service boundaries to meet the needs of a defined population, while ensuring financial and clinical sustainability."

KPMG – emphasis on collaboration

Also in 2015 management consultants KPMG published a study on Hospital Collaboration in the NHS[59]. Drawing on evidence from the Netherlands (where "82 percent of respondents to KPMG's study of Dutch hospitals state they have yet to realise the intended benefits") as well as England,

[57] https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Healthcare-groups-alternative-to-merger-mania.pdf?dl=1
[58] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Foundation-trust-and-NHS-trust-mergers-Kings-Fund-Sep-2015_0.pdf
[59] https://assets.kpmg/content/dam/kpmg/pdf/2015/03/hospital-collaboration-report.pdf

it took a rather different view of merger, focusing on quality of care rather than financial objectives:

> "Mergers and other forms of collaboration can enable hospitals to transform care delivery, which explains why around two thirds of the Trust and Foundation Trusts in our study are, of have been, involved in one or more forms of collaboration over the last year and a half. Quality of care – rather than financial sustainability – is the main driver."

However it does not always go according to plan, and many trusts fail to realise the benefits of mergers:

> "This is due to a number of factors including: unrealistic expectations of short-term gains; underlying problems that existed pre-merger; unwillingness to invest in the new organisation; … and a lack of attention to cultural integration and good communication during implementation."

KPMG again point to what has been signally lacking in the MSEFT merger:

> "Our review of best practice in the UK and around the world reveals common themes of a strong, experienced leadership team; a shared vision between all parties; clear, regular and consistent communication; and a genuine attempt to build a culture of equality. … Above all, collaboration needs to be given time, with longer-term clinical benefits taking priority over immediate financial gains."

What Mid and South Essex trusts did instead

This report will not labour the point: we have already explained that the Trust needs to adopt a partnership approach and recognise the need to develop this over a period of time – which has been restricted up to now by the pressures of responding to the pandemic.

This means giving UNISON and staff side unions adequate time and opportunity to read, critique and discuss policy documents with members before entering into binding commitments. This process is essential to ensure that policies are clear, consistent, unambiguous and provide a framework for effective working.

Sadly this has not been the approach. One example is the policy on rostering that was published on the Trust intranet without going through the proper process of review, comment and ratification, and is riddled with unresolved issues that have subsequently been flagged up by three UNISON reps, and is now having to be rewritten.

This type of process leads to confusion and frustration amongst staff, saves no management time, and indicates a lack of any comprehension of partnership working.

Self-deception on culture and wellbeing

Another example is the process which led to the 'Culture and Wellbeing update' presented to the Board on May 12. It states that:

> "The aim of the culture programme is to create the cultural conditions in which staff are healthy, supported and engaged, are part of highly effective teams and can provide high quality care to patients."

However the process has been one that avoided any engagement with staff side unions, shared information through the Hub, which a majority of staff lack time and computer facilities to access, and appears to have regarded engagement with staff in the most superficial way possible.

The document claims, without evidence, to have "Feedback from over 5000 staff during the Discovery phase of the culture programme," which "identified a number of values staff considered most mattered to them." UNISON is not convinced that anything like this number were involved at all.

There is no breakdown of which groups of staff were involved, how they were involved, or in what way their "feedback" was recorded: but we do know that the much smaller "virtual workshops" that followed consisted of choosing between pre-selected and pre-grouped "options" for 3-word value statements.

UNISON is also concerned that in gatherings that mix more senior and lower-band staff there is less chance of an open discussion of any issues – which should surely be the basis for any serious attempt to develop "highly effective teams".

If senior management of the Trust really believe this kind of exercise is adequate to establish a common culture and win the confidence of staff, UNISON fears for the future.

Lack of clarity on Critical Care

UNISON is also concerned at the Trust's deceptive presentation of statistics on the performance of Critical Care services, which appears to give a wilfully distorted view, making use of the excellent performance of the dedicated CCU attached to the Essex Cardiothoracic Centre (CTC) (the tertiary care provider at Basildon that serves the region) to obscure the much less impressive performance of the general critical care services in the main part of Basildon Hospital.

The management of Basildon provide the staffing and manage the CTC on behalf of the region, which has its own dedicated Critical Care to support the surgery/emergencies that come in from the region.

All Cardiothoracic critical care units report their data separately to the national reporting centre – ICNARC. Cardiothoracic critical care units are relatively young so have been reporting for less years.

General Critical care units also submit to ICNARC and have been doing so for 30+ years. These units provide the secondary care for acute general hospitals.

BTUH management chose to report internally; the key indicators data (as reported to ICNARC); is a combined dataset with General Critical Care data.

However UNISON is aware that the general critical care has been 'failing to meet expected standards' and has previously had CQC improvement notices.

In 2016 and 2017 the CTC Critical Care management team requested that their key indicator data, be reported separately for the BTUH monthly/annual reports. This request was declined.

In 2018 – the request was made again by the management team to the execs. They were advised that this would not be done until after the merger.

To date the separate reporting has not yet occurred.

UNISON is concerned that obscuring the poorer performance in the General Critical Care unit is holding back the necessary remedial action to ensure the quality of the service is improved.

This is not the kind of managerial culture that can deliver the high quality services people in Essex should have a right to expect.

Principles to guide the way forward

This report has highlighted advice from a number of sources emphasising the need for the senior management of merging organisations to prioritise working in such a way as to build a culture of equality and inclusion, in which consistent communication is coupled with consistent engagement with staff and consistent decision-making.

UNISON notes that the NHS Constitution pledges to:

> "engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families."[60]

We have already seen Staff Survey results and UNISON's own survey showing that the second part of this commitment is not seen as convincing by staff in MSEFT. But UNISON wants also to stress the importance of the first part – because without serious commitment to partnership working the Trust will not be able to deliver on promises of improved quality and safety in patient care.

UNISON is committed to work towards genuine partnership with MSEFT senior management: but to do so we need a fresh approach from the Trust to embrace the key principles that can ensure staff are treated fairly and patients are treated safely and receive high quality care.

Our six key principles are Respect, Fairness, Honesty, Transparency, Consistency, and Compassion.

Respect means management treating all trust staff, in all of the various departments, as part of a single team and playing a role in the success of the Trust. It means giving staff the opportunity to raise concerns, listening to them, and taking action where necessary to address those concerns.

Fairness means working to harmonise terms and conditions, job evaluations and the way staff are treated, ensuring staff are not placed under unreasonable pressure to work at particular times or across sites if this interferes with their family responsibilities or work-life balance, and that changes are as far as possible negotiated and agreed with trade unions.

Honesty means recognising and addressing weaknesses and failures in policy and in quality of patient care, not seeking to disguise poor performance or inflate performance, so that issues can be properly discussed, causes identified and remedial action taken. It also means not making casual verbal agreements as an easy way out of a potential problem only to renege on the agreement at a later date.

Transparency means more openness from the Board and senior management in sharing information with staff, local and national media and the wider public in Mid and South Essex. The Business Case for the merger and related documents and plans that have so far been kept under wraps should be published: and unions should be included as partners in discussing strategies and plans that involve changes and challenges for staff so that potential problems can be identified and addressed at an early stage rather than at the point where a plan is about to be implemented.

Consistency means a coherent response by middle and site-based managers as well as senior management with trust-wide responsibilities, and the Trust taking the same position both

[60] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

internally in dealings with staff and externally in comments to the press and other partner bodies in the STP/ICS.

Compassion means not only ensuring that individual patients, carers and relatives are treated with sensitivity and kindness, but also means senior management need to ensure that MSEFT staff at every level, who endeavour to deliver the best quality care to patients, but who also face their own personal problems and responsibilities, feel valued and that their concerns are important. UNISON's survey and the Staff Survey both underlined the fact that staff do not feel they are treated this way by MSEFT management.

With these six principles, combined with a genuine commitment at the top to partnership working, MSEFT can begin as a trust to address the historical and practical problems that have driven the merger, and which still face the Trust in these challenging times.

We urge the Trust to take these concerns seriously and work with us, our members and the staff side to turn a page and move from these **long years of failure** into a new period of partnership and progress towards better, safer, more efficient and effective patient care delivered by a committed and valued workforce.

Updated July 2 2021