Special Measures for Quality and Challenged Providers: Evaluation of the Impact of Improvement Interventions in NHS Trusts

Summary of findings for NHS Trusts and stakeholders
Rapid Service Evaluation Team (RSET)
June 2020

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Aims

- To analyse how Trusts respond to special measures for quality (SMQ) and challenged providers (CP) regimes
- Impact of interventions on Trusts' ability to achieve quality improvements
- Interventions = 3 NHSI:
  - Improvement directors
  - Buddying
  - Opportunity to bid for central £ for QI
  - + in context of other 'interventions' i.e. leadership change, 'deep dives' and other support from NHSI

Methods

- Rapid literature review using systematic methods
- Mixed methods evaluation of national and local level data:
  - SMQ/CP performance trajectories over time (July 2013 – Oct 2019) (n=62)
  - National interviews (CQC, NHSI, DHSC) (n=6)
  - 8 multi-site case studies
    - Qualitative fieldwork; interviews, observations, documents
    - Quantitative exploration of data usage by trusts
    - Cost-consequence analysis
- Study timeframe: Dec 2018 - Jan 2020

Rapid review

Gap	Limited understanding on whether & how improvement interventions are effective in improving the quality of care.
Aim	Examine underlying concepts guiding design of interventions; processes of implementation; unintended consequences: and impact on costs and quality of care.
Design	Phased rapid review: *Phase 1*: exploratory review - theoretical framework *Phase 2:* targeted review of interventions **across 3 sectors.**

Rapid review findings

Successful interventions included restructuring senior leadership teams, inspections (in schools), internal reorganisation by external organisations.

Interventions designed & implemented at organisational level, without considering system context.

Potential ***negative*** consequences and lack of attention paid to ***costs***.

Limited scope

One size fits all

Recycling without adaptation

Implications for our study

- Dominant concepts of failure/turnaround shape interventions
- Interventions aimed at organisational or system-level
- Internally driven vs. externally driven interventions
- Negative/unintended consequences

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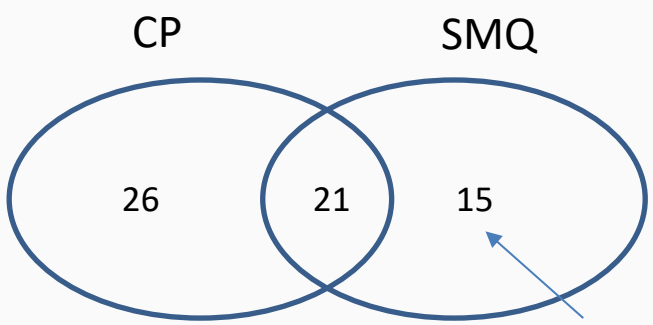
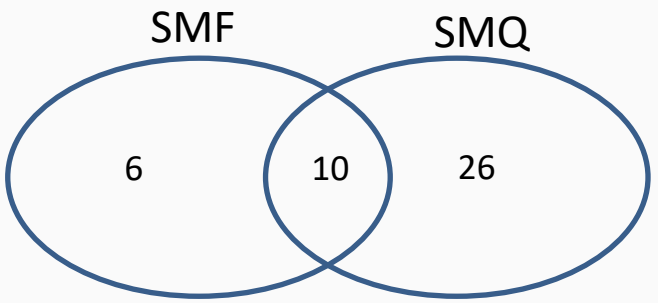
SMQ and CP Trusts - overview (n=62)

62 trusts		
36 (58%) entered special measures for quality	26 (42%) challenged only	
54 providing acute services (33% of all acute providers)	3 ambulance trusts (33% of all ambulance trusts)	5 mental health or community providers (7% of all MH/ community)

Trusts within each category from July 2013 to Sept 2019





Includes 9 Keogh trusts entering in July 2013

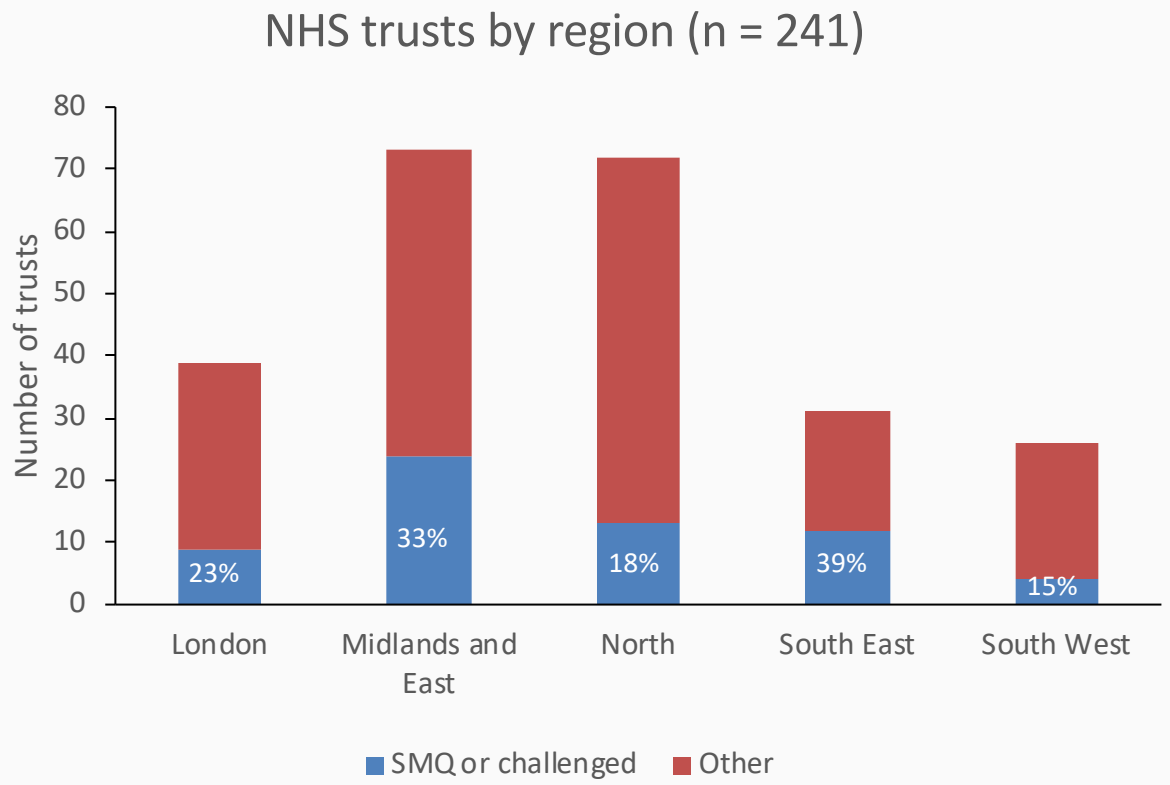
Characteristics of SMQ and CP trusts

	Trusts not in SMQ or CP	Challenged providers and SMQ providers	Case study sites
Acute trusts	*n = 98*	*n = 54*	*n = 8*
Mean age	43.9	44.1	44.1
% of admissions which are rural	17.2%*	22.7%*	19.6%
% of admissions from residents in most deprived quintile	23.7%*	20.6%*	22.7%
Average number of total beds available	696	753	819
All trusts	*n = 179*	*n = 62*	*n = 8*
Foundation Trusts	70%*	50%*	50%

*Significant differences between SMQ /CP providers and the rest at 95%

Characteristics of SMQ and CP trusts

- A higher proportion of trusts in the Midlands and East and South East regions have been in SMQ or CP



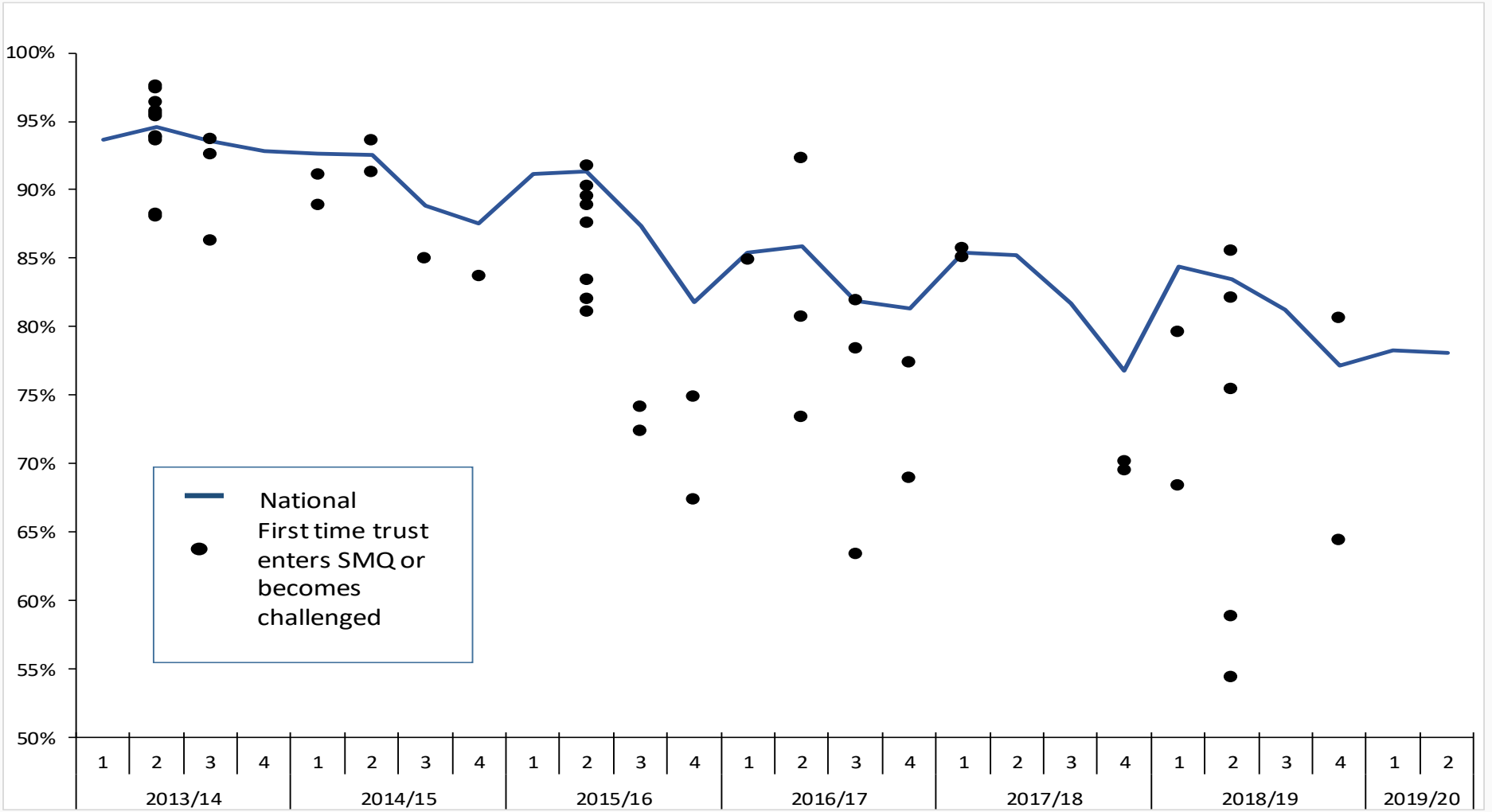
Case study sites

London	2
Midlands and East	3
North	2
South East	1
South West	0

Impact: time spent in the regime

Special Measure for Quality (N=36)	Challenged provider (N=26)
18 trusts (50.0%) not exited within 24 months	14 trusts (53.8%) not exited within 12 months
16 trusts (44.4%) exited within 24 months	12 trusts (46.2%) exited within 12 months
2 trusts (5.6%) still under the regime	
Four trusts re-enter SMQ	
Average time in SMQ = 27 months (range 5 to 49 months)	

Rates of meeting the 4-hour A&E target within type 1 units when trusts first enter SMQ or become challenged



Outcomes for a selection of indicators

	When trusts enter CP/SMQ	Trends		
		Before (n = 42 to 54)	During (n = 42 to 54)	After (n = 24 to 37)
A&E 4-hour breaches	Worse than national rate	→	↘	↘
Referral to treatment beyond 18 weeks	Similar	↗	→	→
Cancer: waits over 62 days	Similar	→	→	→
Delayed transfers of care	Similar	↗	↘	→
Mortality: SHMI	Higher	→	↘	→
Sickness absence	Similar	↗	→	↘
Nurses as % of clinical staff in post	Similar	→	↘	↗

Key:

↗ Trajectory worse than national trend

↘ Trend has improved from what it was before intervention

→ Trend is no different to what it was before the intervention

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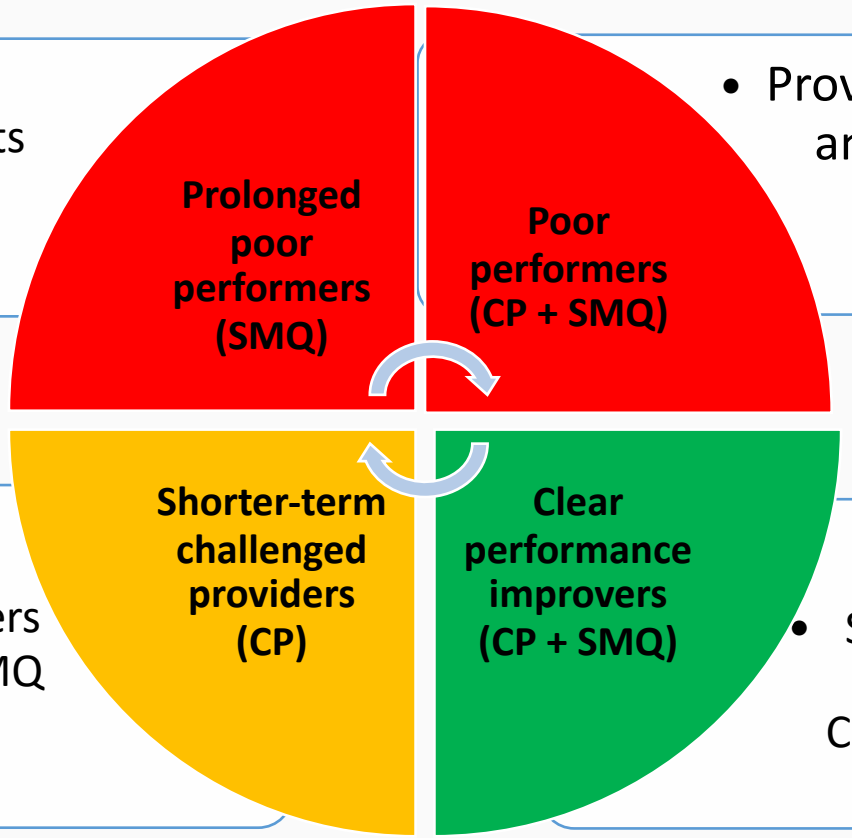
Staff survey & Financial stability results

Domain	When trusts enter CP/SMQ (n = 37 to 40)	Change from start to end (n = 14 to 17)
Engagement	Significantly worse	Improvement
Equality	Significantly worse	No change
Wellbeing	Significantly worse	Improvement
Managers	Significantly worse	Improvement
Appraisals	Similar	Improvement
Quality of care	Similar	No change
Bullying	Significantly worse	No change
Violence	Similar	No change
Safety	Significantly worse	Improvement
Financial stability (n=32)	Significantly worse	No change

Sampling – case study trusts (n=8)

- At least 2 years in SMQ, includes trusts that re-enter SMQ (n=2)

- Providers who leave CP and enter SMQ (n=2)



- Challenged providers that never enter SMQ (n=2)

- SMQ or CP trusts that later achieve strong CQC report with no re-entry (n=2)

Underlying reasons reported for entry into SMQ/CP

- Poor leadership and governance
- Instability/dysfunction in senior leadership team
- Clinical/patient safety issues not addressed
- Workforce issues e.g. turnover, sickness, agency spend
- Financial pressures
- Managing poor PFI
- Problematic staff culture e.g. poor engagement, high rates bullying reported
- System-wide issues e.g. finance, workforce

Impact of SMQ on staff

- Initial staff response described as being “shocked”, “devastated”, “angry”, “ashamed” or “mortified”
- SMQ places “enormous pressure on senior staff”
- Some staff feel “relief” as SMQ will force needed change
- Staff can ultimately view SMQ as “necessary” and as a “catalyst for positive change”

“on the whole for the [Trust] it has been welcomed… they are using it as an opportunity and a platform to drive forward improvement across the whole of the organisation.” (Case 8)

Perceptions of NHSI interventions

ID

- Helpful when using coaching style and offering tactical advice
- Seen as a ‘spy’ by some and not able to enact change
- Debates about amount of time IDs should spend in organisations

Buddying

- Worked better with buddies in similar context
- Used to learn about good practice in relation to specific problems
- Some Trusts had to arrange their own buddying

Funds

- Funds mainly used to cover posts and external consultants and experts
- Risk of “spending their way out of special measures”

Perceptions of NHSI interventions

Changes to leadership

- New leadership teams a key driver for change
- Bring new ideas and approaches
- Previous SMQ experience is helpful
- More likely to be detached from existing problems with staff and culture

Deep dives

- Intensive analysis of data on specific topics/service areas carried out with NHSI staff
- Used at OAG meetings to demonstrate QI and QA

Distribution of NHSI funds
Dec 2018 – Oct 2019 – for 5 Trusts*

The budget items**	NHSI funds that were spent (by year)*	% of the Total NHSI fund spent
Care Improvement	£252,529	14.60%
Workforce quality and safety	£374,371	21.70%
Quality Improvement Training	£201,370	11.70%
Training on cultural change	£581,301	**33.60%**
Focus on governance and assurance	£318,397	18.40%
Total	£1,727,968	100%

* No financial information for Cases 3, 4 & 7.
** Not including funds allocated to 'buddy' trusts.

How Trusts responded – key themes

- Leadership
- Governance
- Staff engagement and culture
- QI strategies and capabilities
- Role of the system

How Trusts Responded:

Leadership

- Establish effective leadership teams: stable, "visible, supportive and approachable", team working, encourage learning and acquiring new knowledge
- Ensure good clinical leadership in place:
  - Medical Director, and Chief Nurse roles key
  - Supports change at divisional levels (e.g. A&E)
- Senior teams encourage accountability for patient safety and quality at all levels – e.g. a "patient safety culture"

"We tried at the start really heavily to not just think about the small tasks, but think about how do you generate a culture and a leadership and a learning environment that would support quality improvement going forward?"(Case 7)

How Trusts Responded:

Governance

- Address poor existing structures (e.g. lack of clear lines of reporting, poor clinical engagement)
  - financial investment in improving governance (e.g. external advisors and reviews)
- Provide transparency, assurance and accountability for quality and sound financial management - “board to ward”
- Staff understand *why* specific changes to processes are necessary and become engaged in governance meetings and structures

How Trusts Responded:

Staff engagement and culture

- Improvement relies on better staff morale and culture

> *"a culture of, you know, not hiding from it but working out what's going wrong, working together to improve it, being open and transparent, no blame culture." (Healthwatch CEO)*

- Positive engagement and investment in staff
  - Strategies for better communication / listening to staff concerns
  - Tackle "bullying" or "insular" culture
  - Staff appraisals, celebrate staff success, education and training
  - ➢ Can lead to improvements in staff surveys
- Address problems with staffing levels to ensure patient safety
  - Difficulties recruiting staff can be due to the SMQ label

How Trusts Responded:
Financial Stability

Changes in financial stability indicators after being in the SMQ/CP regimes

Description	Decrease	The same	Increase
Prolonged poor performers (SMQ)	1	-	-
Poor performers (CP + SMQ)	1	-	1
Shorter-term challenged providers (CP)	-	2	-
The total	2	2	1

- In total 60% of the trusts (3 out of 5) participating in the SMQ/CP regime kept the same or increased the financial stability.
- Trusts with a decreased financial stability while in the SMQ/CP regime were prolonged poor performers (1 trust) or poor performers (1 trust).

How Trusts responded

QI Strategies and Capabilities

- Trusts typically develop a Quality Improvement Plan / Strategy
  - NHSI Improvement Directors support this
- Different QI techniques and models adopted (e.g. Lean, Root Cause Analysis, Safety Huddles)
- Strategy and senior leadership promote “continuous quality improvement” and ownership for QI and change (“bottom up” and “top down”)
- Use of data significant (e.g. visualise trends, benchmark)
- Develop deeper understanding of problem areas and causation

“if what you do is, in your improvement plan you put, “Improve statutory and mandatory training,” that is the outcome measure. What you are not doing is unpicking why” (Improvement director)

Role of the system in provider performance

May need to address system wide issues for a Trust to exit SMQ

> *"One of the big failings, I think, about organisations going into special measures, is the organisation goes into special measures, not the system"* ***(????)***

Facilitators of improvement

- Positive engagement with system partners
- Whole system response to quality issues
- Supportive OAG – system partners all sitting around the table
- Financial sustainability planning across the system
- Quality assurance that is linked to strong governance and data collection processes across the system
- Integrated care systems – providers already working together

Role of the system in provider performance

Barriers to improvement

- Takes time to build/rebuild external relationships
- System-wide issues that are difficult to address eg workforce, financial pressures
- OAG meetings can be a “ritual stoning” for the Trust

SMQ can make it difficult to participate in local system development

- Time and focus on SMQ
- SMQ label can limit regional opportunities

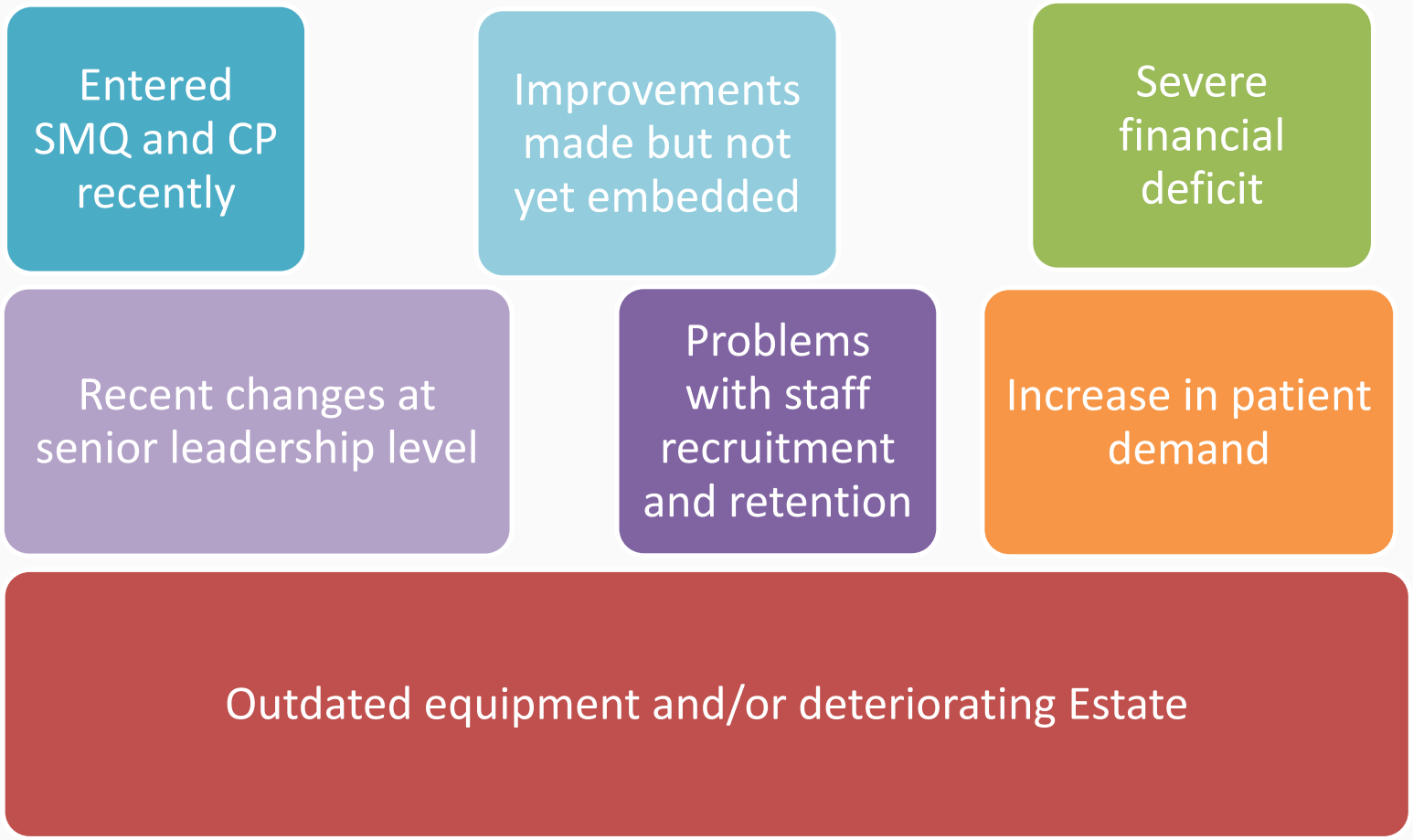
*“we could have probably played a more prominent and active role in the STP and possibly even more of a leadership-type role but you, once you’ve got that badge of SM, it’s very difficult to do that”**(?????)***

Summary of priorities for improvement

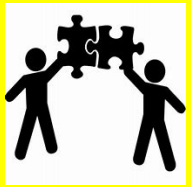
Eight domains of QI and performance related activity (Trust level)	Example
Governance, accountability and leadership	Good working between CEO and Board. Effective CEO, Chief Nurse and Medical Director leadership. Staff involved at governance meetings at multiple levels.
Service delivery	Improve poor areas and national targets, like ED.
Data monitoring and better use data	Monitor and respond to staff survey feedback.
Organisational culture and staff engagement	Address bullying; invest in staff training and development.
Workforce	Ensure safe staffing levels.
QI interventions and methods	Strategic plans supported by knowledge, training and tools (e.g. PDSA, 'safety huddles').
QI Plan / Strategy	Formulate a vision and plan for QI with Improvement Director and/or external support.
Invest in updating estates and equipment	Scanners (e.g. causing delays to RTTS due to poor diagnostic service).

Features of organisations that have sustained improvement

Features of organisations that *have not* exited SMQ or CP regimes (at time of the evaluation)



Lessons learned for Trusts



Staff needed to be considered the top priority

Stable and mature leadership was required to make sustainable changes

Need to look beyond standard metrics, measure impact of wider system, & collect data to measure QI

Improvements depended on the capacity to develop healthy relationships with the regulators

Improvement considered at a system-level, through collaboration with other organisations

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Lessons learned for regulators

- Need to understand **emotional cost** of SMQ
- Difficult to prioritise large no. of CQC recommendations
- Strategies to support improvement need to be **more Trust specific**
- Reporting to multiple bodies is time consuming and overwhelming – **avoid duplication**
- Organisations need **time and head space** to address objectives
  - min. 2-3 years
  - Stability of leadership
- Support is needed to make **system wide** improvements
  - **Include CCGs** alongside Trusts in improvement planning
  - SMQ / CP Trusts need **support from neighbouring organisations**

Team and funding

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