

Rapid Evaluation of the Special Measures for Quality and Challenged Provider Regimes: A Mixed-Methods Study

Executive Summary

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Background

Healthcare organisations in England rated as inadequate in terms of leadership and one other domain enter the Special Measures for Quality regime (SMQ) to receive increased support and oversight. A 'watch list' of challenged providers (CPs) at risk of going into SMQ also receive support. Interventions for trusts in SMQ/CP typically vary between trusts and may include appointment of an Improvement Director (ID); review of the trust's leadership capability; access to financial resources for quality improvement; an improvement plan; buddying with other trusts and commissioning external expertise. These may be delivered in conjunction with other interventions, and within a context of significant senior leadership changes. There is limited knowledge about whether these interventions drive improvements in quality, their costs, and whether they strike the right balance between support and scrutiny. Our evaluation sought to understand how trusts respond to being placed in SMQ/CP and whether and how the interventions provided impact the trusts' capacity to achieve sustainable quality improvement.

Objectives

Analyse the responses of trusts to the implementation of a) interventions for trusts in SMQ and b) interventions for trusts in CP to determine their impact on these organisations' capacity to sustain and achieve quality improvements.

The study focused on the main interventions that NHS Improvement (NHSI) has identified as forming part of the SMQ/CP regimes:

1. appointment and use of an Improvement Director;
2. buddying with other trusts;
3. the opportunity to bid for central funding to spend on quality improvement.

We also remained open to any other interventions participating trusts identified as being part of the SMQ/CP regimes and considered these interventions within a wider context of any leadership changes.

Our research questions (RQs) were:

1. What are the programme theories (central and local) guiding the interventions delivered to trusts in SMQ/CP regimes?
2. How and why do trusts respond to SMQ/CP regimes and the interventions within these regimes?

3. Which features of trusts in SMQ/CP regimes, and their wider context, contribute to their differing performance trajectories?
4. What are the relative costs of the interventions and how do these compare with their benefits?
5. How are data used by trusts in SMQ/CP regimes, and how does data contribute to their understanding of improvements in quality and service delivery, especially in areas where performance concerns have been raised by the Care Quality Commission (CQC)?
6. Do trusts in SMQ/CP regimes find it more difficult to recruit and retain staff?

Methods

We conducted a multi-site, mixed-methods study combining qualitative and quantitative approaches. Data collection and analysis followed a rapid research design involving teams of field researchers, and iterative data collection and analysis. The protocol was developed with input from relevant Department of Health and Social Care (DHSC) and NHSI teams, scoping of relevant documents and feedback from academic peers and patient representatives. The evaluation was formative, with findings shared and discussed with key stakeholders during the study.

The study comprised five inter-related work streams:

1. Literature review using systematic methods on the implementation of improvement interventions from education, local government and healthcare.
2. Analysis of policy documents and interviews at a national level to understand the origins, evolution and intended purpose of the SMQ/CP regimes.
3. Eight multi-site, mixed method case studies (four 'high level', four 'in-depth') purposively sampled from 59 trusts that entered SMQ or CP between July 2013 and September 2018. Interview, observational, documentary and quantitative data from the case studies were triangulated and analysed thematically and comparatively.
4. Quantitative analysis at a national level to explore relationships between being in SMQ/CP and performance (4-hour waiting time target for Emergency Departments / 62-day cancer target / staff survey) and workforce (mix of staff employed at each trust / sickness absence / staff vacancy rates) indicators.
5. Economic analysis to quantify the costs and benefits of the SMQ/CP interventions; direct costs (national and case studies) were determined and a Cost-Consequence Analysis conducted for primary consequences (entry to and exit from SMQ/CP) and secondary consequences (staff experiences / cultural changes from the NHS staff survey 2014-2018 and trust financial stability).

Results

The rapid review found dominant definitions of success/failure and turnaround, which impacted on the design and implementation of improvement interventions. Successful interventions included restructuring senior leadership teams, inspections (in schools), and internal reorganisation by external organisations. The review also found that most interventions were designed and implemented at organisational level, without considering system context and very little attention was paid to the potential negative consequences of the interventions and their costs.

National perspectives and the programme theories underpinning the SMQ/CP regimes (RQ1) were explored through national level interviews and documentary analysis. National stakeholders perceive the SMQ/CP regimes as “support” programmes that aim to enable organisations to bring about improvements. Quality Improvement (QI) Plans are a central element in SMQ/CP and an essential role of IDs is to proactively engage organisational leaders and support the development of the improvement strategy.

Through our case study analysis we identified stakeholder perceptions of SMQ/CP and the NHSI interventions (RQ2). While SMQ/CP could be viewed positively, with some trusts feeling they received the right support or were allowed space to make changes, others saw SMQ as heavy-handed scrutiny or punishment. Over time, and in hindsight, as a trust went on to improve and if in receipt of support, there could be a shift to a more positive view of SMQ/CP as a needed catalyst for positive change. We also found that there was an emotional impact on staff of the trust being labelled as failing and being placed in SMQ/CP.

The perceptions of NHSI interventions of IDs, buddy trusts, funding and deep dives were mixed overall and it was highlighted that trusts will have individual issues and needs for support that mean specific tailoring of the interventions is required. Leadership teams were found to be a key driver of change and in terms of senior level oversight, the Medical Director and Chief Nursing roles appear vital for communication between divisional and executive leadership tiers, promoting trust-wide clinical engagement and overseeing improvement planning. It was noted at a national and case study level that local system-wide issues may need to be addressed for a trust to exit SMQ/CP.

We examined how trusts responded to the SMQ/CP regimes (RQ2) and found that the case study trusts focused their efforts to improve across eight domains:

1. **Governance, accountability and leadership:** Review of governance and accountability; increased “board to ward” interactions; development of sustainable strategies for QI and patient safety; stronger clinical leadership at senior, divisional and ward levels.
2. **Service delivery:** Prioritising improvements that ensure patient and staff safety, focus on compliance with national standards and improved Emergency Department (ED) performance and referral to treatment (RTT) times.
3. **Data monitoring and use of data:** Improving the use of data by addressing how it is being collected, analysed and how findings are shared.
4. **Organisational culture and staff engagement:** Addressing problems with organisational culture (e.g. bullying); recognise and celebrate staff; improve lines of communication between senior team and staff.
5. **Workforce:** Addressing staffing levels, skill mix and retention. Ensuring safe staff levels; introducing strategies to reduce staff turnover and improve staff retention.
6. **QI Plan or Strategy:** Working with ID to develop a plan/strategy. Setting a vision for culture change and continuous improvement.
7. **QI interventions, methods or techniques:** A range of QI methods and tools (e.g. PDSA, WHO checklists) and broader interventions used to drive improvement. Leadership and resource commitments to embed these trust wide.
8. **Estates and equipment:** Improvements in working and patient environments to ensure safety, improve capacity and modernise services.

Our analysis of trusts’ performance trajectories (RQ3) using national level data found that relative to national trends, entry into SMQ/CP regimes corresponded to positive changes in 4-hour waits in emergency departments, mortality and delayed transfers of care. Trends in sickness and absence improve after trusts leave the regime. There was also some evidence that staff survey results improve over the period trusts are in the regime (significant improvements in five of nine domains). SMQ/CP does not, however, influence referral to treatment times or cancer waiting times.

From the case study analysis we identified several key internal and external factors that contributed to positive performance trajectories (RQ3):

- **Internal factors:** Characteristics of trusts that exit SMQ, including trusts that have sustained quality improvements over time; systematic use of data for QI; use of QI method(s) and dedicated resources; safe workforce levels; focus on staff engagement and recognition;

integrated quality, financial and risk management with clear lines of accountability; and an embedded open and listening improvement culture.

- **External factors:** Established good working relationships with the regulators; collaborating with external partners and peers; and have had time to embed change.

We identified several key internal and external factors that contributed to our case study trusts not yet exiting SMQ/CP (RQ3):

- **Internal factors:** Instability and churn at senior leadership level; absence of an organisation-wide QI methodology and culture; poor governance and risk management at all levels; poor staff engagement and issues with harassment and bullying; outdated equipment and/or deteriorating estates; and problems with staff recruitment and retention.
- **External factors:** Financial pressures in the regional health economy; recent entry into SMQ or CP; or improvements made but not yet embedded.

The cost consequence analysis (RQ4) was based on case study and national data. Mean funds spent on trusts in the SMQ regime at the national level during 2018-2019 were more than twice as high as the mean funds spent during the same period for trusts under the CP regime. The largest components of NHSI spending for our case studies were identified as interventions directed at 'training on cultural change' (33.6%), 'workforce quality and safety' (21.7%) and 'governance and assurance' (18.4%). CP trusts were four times more likely to exit within the time limits (12 months) than SMQ trusts (24 months). The interventions delivered to trusts as part of the SMQ/CP regimes showed a positive effect on staff-based measures whilst there were fewer improvements in the context of 'promotion of staff's health & wellbeing', 'staff's satisfaction with quality of care' or 'organisation's actions on quality, diversity & inclusion'. The impact of SMQ on financial stability was equivocal, as we found that most of the trusts that exited SMQ experienced the same financial stability before and after exiting, while this share was lower for the group remaining in the regime.

Our case study analyses found that trusts recognised the importance of use of data in quality improvement processes (RQ5). Trusts focussed on a standard set of nationally agreed metrics for high-level reporting. The limitations, such as inadequate monitoring of the impact of QI activities, were acknowledged. Trusts increasingly recognised the importance of triangulating different indicators and information sources, including "soft data" from staff and patients, to obtain a more holistic view of quality.

Our analysis of the impact of SMQ/CP on the recruitment and retention of staff (RQ6) was based on national and case study level data. National level analysis found that sickness absence, staff vacancy rates, proportions of consultants and nurse/doctor ratio were not significantly different to national means at SMQ/CP trusts when they enter the regime. Workforce issues such as staff turnover, recruitment and retention and sickness and agency spend were identified as underlying reasons for why case study trusts enter SMQ/CP. In turn, workforce investment was a key component of case study trusts' response to being in SMQ/CP, with trusts striving to address gaps in staffing levels, particularly in ED, and skill mixes, reduce staff turnover and improve staff retention. Stigma from the SMQ label was perceived as having a negative impact on recruitment and retention of staff.

Conclusions

Supporting poor performing healthcare organisations to improve is essential and we have added to the limited knowledge base on the implementation and impact of improvement interventions. Through our evaluation we have delivered a greater understanding of the programme theory, impact, and staff views and experiences of the SMQ/CP regimes, with formative feedback shared with key stakeholders. We have demonstrated the value of mixed-methods approaches that combine quantitative and qualitative data from local case studies alongside quantitative indicators derived from nationally available routine data.

The key overarching lessons for regulators, policy makers and trusts are:

Regulatory bodies

- Time is needed to implement and embed sustainable changes, 2-3 years not one year, and staff should be given 'slack' to develop and implement changes.
- Strategies to support improvement need to be more trust specific.
- Duplication of reporting requirements to different regulatory bodies should be reduced.
- Consideration should be given to the provision of sustainable funds required to improve patients' outcomes.

Trust leadership

- Stable leadership is needed once the new team is established because of the time it takes to make improvements – otherwise problems are perpetuated.
- Inclusion of people with previous experience with SMQ in senior leadership teams can help manage regulatory requirements and bring knowledge and confidence to enacting change.

Staff and culture

- Staff engagement and an organisational culture that supports learning are key to sustainable improvement.

Emotional costs and stigma

- Ways to mitigate the emotional cost and stigma of SMQ are needed.

QI strategies and capabilities

- Development of organisational-wide QI strategies and capabilities is important.

Local systems

- Poor organisational performance needs to be considered at both organisational and system levels.

Patients and the Public

- Engagement with patients and the public should be emphasised as an important part of the process of making improvements.

Key areas and considerations for future research include:

- Prospective evaluation of the impact of the new NHSI/E operating framework.
- Focus on SMQ/CP at the local system level and expand the range of stakeholders external to the trust giving viewpoints on SMQ/CP.
- Prospective studies could use sequential monitoring techniques to allow “real-time” assessments of the impact of interventions.
- Study of trusts in special measures for finance (SMF) and link between SMQ and SMF.
- Further research to understand the impact of SMQ on financial stability.
- Prospectively link financial stability to changes in direct/indirect costs and additional opportunity costs using indicators that are part of routinely reported data.
- Longitudinal studies to look at the sustainability of improvement and where trusts re-enter SMQ.
- Tailoring data collection to trust-specific concerns and areas highlighted for improvement that can feed into the overall evaluation framework.

Study registration

Review protocol registered with PROSPERO (CRD: 42019131024).

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