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NHS ENGLAND MIDLANDS REGION 'LOOK BACK EXERCISE'

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ON BEHALF OF JMB HEALTH CONSULTANCY LTD

Acknowledgements

The reviewing team would like to express their appreciation to the individuals who met with the team and were willing to share their experience through verbal feedback, in addition to all the documentation that was provided. This enabled the team to have invaluable insight, which added considerably to the overall findings within the report.

The Reviewing Team

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ABBREVIATIONS

The following are a list of abbreviations that are utilised within the timeline.

Director of Nursing (DoN)
Care Quality Commission (CQC)
Quality Surveillance Group (QSG)
Northumberland, Tyne & Wear NHS Trust (NTW)
Clinical Commissioning Group (CCG)
NHS England & Improvement (NHSE/I)
Midlands Psychology (MP)
Midlands Partnership Foundation Trust (MPFT)

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1. Introduction and what led to the look back exercise

From 2011 to 2014, diagnostic services for people with autism spectrum disorder across Staffordshire were provided by Midlands Psychology Community Interest Company, a not-for-profit social enterprise. In 2014 the services from Midlands Psychology were re-procured for a further period of three years, with an optional extension enacted for 2 years, meaning that the contract would end on 30 September 2019, and once again be up for tender.

Throughout this time, the service was commissioned by South East Staffordshire and Seisdon Peninsula CCG as the host commissioner on behalf of Cannock Chase CCG, East Staffordshire CCG and Stafford and Surrounds CCG ("known as the CCGs").

In 2019, NHS England and Improvement (Midlands) commissioned an independent review to understand the processes that had been used to manage the contract with Midlands Psychology, and, how the interim contract with Midlands Partnership Foundation NHS Trust in October 2019 had been procured.

The overall aim was for NHSE/I to identify lessons that could be learned for the commissioning CCGs as well as for the wider health system.

The Terms of Reference for the 2019 review had two key lines of enquiry:

- How the commissioners monitored the quality, activity and finance elements of the Midlands Psychology contract; considering the effectiveness and strength of the commissioner's oversight and governance frameworks and;
- To review the governance and procurement processes that led to the awarding of the interim contract to MPFT from 1 October 2019.

1.1 Areas of Concern

Following issue of the draft independent review in 2020, concerns were raised by several carers who had lived experience of the ASD services in South Staffordshire. This posed a number of questions in relation to NHSE/I's handling of their concerns, which were summarised as:

- Was NHSE/I's approach to the concerns raised about the ASD services in South Staffordshire appropriate, and were they documented?
- What were the mechanisms by which NHSE/I was made aware of these concerns?
- What steps were taken by NHSE/I to manage the concerns, for example, was there a standard operating procedure or formal process followed?
- What actions were put in place to address the issues, taking into account internal NHSE/I governance arrangements and processes?
- Was the time it took NHSE/I to address the concerns appropriate?

At an extraordinary Regional Quality Board ("RQB") meeting on 28 October 2020, further specific service-related issues were also presented (as recordings) to the board which were noted as:

- The access criteria for the ASD service;
- The use of parenting courses and;
- The processes used for safeguarding.

One of the outcomes of the RQB meeting was for NHSE/I regional team (Midlands) to undertake a 'look-back exercise' to explore how the independent review of 2019 was commissioned, and the time it took to complete, a key action that forms the basis of this particular review.

A separate outcome to explore how the views of carers should be captured in future commissioning of services was also recommended, however, this line of enquiry was suggested to be reviewed separately, and therefore sits outside of the scope of this report.

2. Key Lines of Enquiry

In response to concerns raised, and with a desire to reflect inwardly upon the governance processes used to commission the original independent review in 2019, NHSE/I (Midlands) elected a critical analysis approach, intended as a tool for learning.

To facilitate this, NHSE/I (Midlands) recruited the support of an independent organisation (JMB Health Consultancy Ltd) to work alongside them in reflecting back on the processes as a whole. The pre-determined and ratified confidential key lines of enquiry for this review were shared with JMB's reviewing team in a meeting on 13/04/2022 as: -

- How the terms of reference for the initial independent review in 2019 were developed and approved by NHSE/I?
- How the independent review of 2019 was commissioned?
- How the independent investigator [for the independent review] was sourced and appointed?
- What were the processes put into place by NHSE/I to manage the review, including governance arrangements and management of any conflicts of interest?
- Whether the independent review of 2019 addressed, or should have addressed, the concerns raised by the carers evidence.
- Whether NHSE/I currently have the correct processes in place which would enable an improved approach to 'concerns of this kind' in the future?

3. Method of review

The approach agreed for this review was one of 'critical and summative reflection', combining the contributions of key individuals who had been involved in commissioning the independent review of 2019. The use of explorative interviews enabled the reviewing team to elicit empirical recollection relative to the key lines of enquiry.

Perhaps due to the length of time that had lapsed, and indeed the notoriety of the issues and concerns in the lead up to and including the review process, the interviews presented individual personal self-reflection for those being interviewed. There were collective common themes; specifically, around the positive changes and improvements that had emerged since the review of 2019 began but notwithstanding the inherent challenges and sometimes contentiousness and delicate nature of the issues.

Additionally, the reviewing team were provided with a range of documents and correspondence relating directly to the proceedings of the independent review of 2019. This informed a timeline of events, including an opportunity to understand what if any systemic changes were occurring during this period.

A two-pronged approach provided the reviewers with a greater understanding of the organisational landscape and processes at that time. This enabled some analysis and judgement about how contextual factors both internal and external, had inadvertently contributed to and influenced the outcomes of the initial review.

3.1 Limitations

As with any reflective piece, there are often limitations to the outcomes derived through 'unintentional bias'; for example, limits in the scope of participation due to the availability of key individuals and timely access to documents within a defined timeframe.

In this instance, there were some gaps in evidence and supporting information. Subsequently, the reviewing team drew upon the experience of those individuals who it was felt could be 'objectively subjective' within the context of the key lines of enquiry.

There were also some challenges in locating people who had progressed into different roles and or organisations, and were therefore no longer accessible. Additionally, some of those contacted expressed limited involvement in the independent review of 2019 and felt unable to affectively contribute to the key lines of enquiry of this particular review, which further reduced intellectual opportunities.

Organisational changes and incompatible Information Technology systems across, also resulted in some documents being unavailable, however, anecdotal clarity from those individuals interviewed provided some credible assumptions regarding the gaps. It should be noted that the impact of this as a possible bias to the conclusions and suggestions for improvement as outputs of this review is minimal.

4. Timeline and key events

To collate a better understanding to the history and background, the reviewing team developed a timeline of significant events, formulated through interviews and various documents submitted, which provided some of the detail necessary within the context of the key lines of enquiry.

Much of this information pre-dates the timeframe within which this review is based however it was important to have the holistic perspective in relation to the rational of the review.

Information that has been highlighted yellow within the table below bears particular relevance to the discussions within the key findings section of the review. Copies of any documents made available to the reviewing team have been identified within the table.

Date	Relevant and significant events	Evidence produced
Sept 2009	Contract for ASD diagnostic services formerly re-tendered	
Oct 2010	Contract removed from Midlands Partnership NHSFT and awarded to Midlands Psychology	
Oct 2014	Contract re-tendered and awarded again to Midlands Psychology	

2015	In 2015, MP raised a formal complaint against South Staffordshire and Shropshire Foundation Trust (SSFT) alleging that SSFT (MPFT predecessor) had breached the Integrated Care, Choice and Competition aspect of the provider licence. Following an investigation, Monitor made the decision to address the complaint informally. It concluded that the difficulties in joint working had been exacerbated by ambiguity in the contractual arrangements underpinning the two services and made a set of recommendations to both providers and SESS CCG to resolve the issue.	
April 2016	CCG received a complaint from the parent of a service user, which again raised concerns about the service arrangements between MP and the local CAMHS service.	
Sept 2017	Contract with Midlands psychology extended for a further 2 years	
Feb 2017	CQC report rates Midlands Psychology 'good' in all domains	
Nov 2017	New Accountable Officer appointed for Staffs CCG's (commissioners of Midlands psychology)	
July 2018	Northumberland Tyne & Wear Trust conduct an external evaluation of both CAMHs and ASD services on behalf of the CCG's.	Appendix 1 Report
Aug 2018	Unannounced visit by the Nursing & quality team to Midlands Psychology on the back of quality issues raised by NTW during their evaluation	
Sept 2018	Agreement at a meeting with CCG that the concerned carers would be involved in developing the new service specification for the re-procurement of ASD services due to commence in Oct 2018	Appendix 2 Minutes
Oct 2018	Letter from CEO of MP refuting many of the outcomes and findings of the review undertaken by NTW (draft)	Appendix 3
Nov 2018	CCG respond to concerned carers to advise that no amendments to the statements included in the NTW report would be made	Appendix 4 E-mail
Nov 2018	MP informed in writing that the ASD contract was coming to an end	
Dec 2018-March 2019	CCG's membership groups agreed to go through a full procurement process as part of the upcoming contract renewal due to the expiry of the maximum contract period. The CCG recognised that an interim arrangement needed to be put in place as the procurement would not be fully concluded by October 2019	

April 2019	Letter from AO to one concerned carer explaining that MP had been asked to extend their contract whilst procurement exercise takes place for ASD services and also that a revised report from NTW was due July 2019	Appendix 5 - Letter
April 2019	Contract negotiations between CCG and MP regarding extending the existing contract for an interim period, however existing terms rejected by MP	Via briefing statement
May 2019	Final version of NTW report is shared	Appendix 6 Email
June 2019	Concerns continue to be raised by carers, this time to NHSE/I (Interim DoN) regarding the content and publication of the NTW report. NHSE/I respond to suggest the risk review process has now been triggered and will include a series of formal meetings under statutory QSG format. Procurement support from NHSEI was also offered to the CCG. CQC were alerted and Healthwatch included in quality concerns raise in the report.	Appendix 7 – Email from Patrick Nyarumbu
July 2019	CQC inspection of Midlands Psychology. The Inspection Report was published on 10th September 2019 and rated Midlands Psychology as ‘Good’.	
July 2019	Email sent form a concerned parent to all organisations and senior Government Ministers regarding concerns, prompting a series of safeguarding issues	Appendix 8 – Email from JC
July 2019	Email from JC to CCG concerned that the carers are no longer able to bring their own scribe to meetings as CCG will now minute.	Appendix 9 - emails
July 2019	Jacqueline Barnes discusses the summary of actions from the QSG meeting with Dave Briggs – Dave suggests a letter with details and an email to CCG highlighting a ‘must do now’ list	Appendix 10 - Email
July 2019	Risk review meeting held - highlighted a number of concerns; 1. Risk documentation and escalation; 2. Patient hand overs between providers; 3. Provision of medications 4. Report production for the education service. At this meeting, NHSE/I signed off a jointly agreed action plan between the CCG’s, MPFT, MP, CQC and Health Watch to resolve pathway interfaces and quality concerns	Appendix 11 - Minutes
Aug 2019	CCG Governing Body meeting announce they rejected a counter offer from MP because of increased financial coverage and the ask for £200K up-front payment.	
Aug 2019	CCG Chairs a joint action plan meeting in response to the independent review by NWT to oversee implementation of action plan	

Aug 2019	CCG's procure MPFT to provide an interim service	
Sept 2019	Social media post from CEO at MP regarding losing the contract and reassurance regarding handover and contact with all families.	Appendix 12 - screenshot
Sept 2019	MP raised a formal complaint to CCGs about how the CCGs had re-procured the service. MP also disputed the process by which interim contract arrangements were secured	
Sept 2019	Letter developed by MP and sent out to existing clients regarding contract termination and the way cases would be handled	Appendix 13 – Letter (jpeg only)
Sept 2019	Evidence of Q1 and Q2 budget statement highlighting funding for the interim service	Appendix 14
Sept 2019	Paper developed regarding special measures at Staffordshire CCG largely around finance and governance and highlighted the support Staffordshire CCGs had received including a capability and capacity review by Deloitte	Appendix 15 Email chain
Sept 2019	NHSE/I recommend an independent review of CCG internal commissioning processes (separately from the carers concerns)	Appendix 15 Email chain
Sept 2019	Briefing statement prepared for Claire Murdoch outlining the NHSEI's proposal to commence the independent review (above)	Appendix 16
Oct 2019	Contract for CYP ASD service transferred to MPFT until the successful permanent contract could be awarded	
Oct 2019	Further concerns raised by carers regarding the governance process for transferring files across services	Appendix 17 Email
Oct 2019	A social media post emerges on MP's social media criticising the CCG's handling of the contract termination, and inviting former service users/carers to an event in November to discuss what other services' MP could offer going forward (? Duty of candour)	Appendix 18 social media screenshot
Nov 2019	Service Procurement opportunity closed (29th)	Appendix 19
Nov 2019	First contract monitoring meeting held with MPFT chaired by South Staffs CCG	Appendix 19
Nov 2019	Terms of reference for the independent review developed	
Dec 2019	Salma Ali (SKSN Consultancy and Support) engaged and commissioned to deliver the independent review	

Feb 2020	South Staffs Autism partnership group meeting held to discuss the interim contract award and file transfers. It was suggested by parents that some diagnostic information and assessments were missing from files when MP have released them. Also concern that those CYP without a working diagnosis from MP would not be on a waiting list to be seen by MPFT as they were classed as 'inactive' which parents object to. Also a suggestion that information sent to parents was inaccurate and some files contained documents not relating to their own child. Requested apologies from CCG. Concerned parents also requested 24hr crisis line via MPFT; data dashboard of complaints/themes and parent experiences to be put onto datix.	Appendix 20 Minutes
Feb 2020	Letter from Dave Briggs to Claire Dowling	Appendix 21
06/06/2020	First draft of the independent review report produced	
July 2020	Letter from CCG to carers as a response to their concerns	Appendix 22
01/07/2020	Request from concerned carers for a meeting with CCG to discuss the circumstances around the commissioning of a care package for one individual, the oversight of services involved in this package and allegations of poor care. This was an additional complaint addressed at RQB and reported as a safeguarding issue.	
11/07/2020	First NHSEI led risk summit meeting held	
04/08/2020	Extraordinary (confidential) meeting took place to discuss/review the independent report	
14/08/2020	Amended version of independent review report sent to CCG and MPFT for comments	
25/08/2020	Independent review report by NWT published on NHSEI website (25th)	
26/08/2020	Concerned carers unhappy with report being published on NHSEI website without their knowledge and outlined factual inaccuracies and alleged defamatory statements.	
09/09/2020	NHSEI agreed to review the alleged factual inaccuracies	
09/09/2020	Dr Dave Briggs met with the concerned carers to discuss the report and their concerns (9th)	
29/09/2020	Follow-up meeting with Dr Briggs and the concerned carers (29th)	
09/10/2020	Concerned carers received a list of agreed amendments within the report	
14/10/2020	Updated draft report received by NHSEI	
22/10/2020	Meeting took place with Regional Medical Director, NHSEI CCG and MPFT	
26/10/2020	Letter received from Amanda Milling Member of Parliament (response generated on 27/10/2020)	

27/10/2020	Concerned carers request an update on the amendments of the report and an apology for the defamatory aspect. Advised the report needed to be approved by the governance boards before circulation. No apology offered.	
28/10/2020	Report presented to Regional Quality Board for advice. carers given opportunity to present further evidence to the board. RQB recommended: · A region wide review to involve service users. Devise TOR led by Robert Ferris. Independent reviewer to cross reference further evidence received. CCG to manage complaint via their complaints process and to conduct a Look back exercise	
04/11/2020	Confirmed to carers that NHSEI would commission a review into autism services in Staffordshire	
13/11/2020	Progress update provided to NHSEI Midlands Regional Director	
10/12/2020	Carers remained unhappy with direction of travel of the commissioned review	
11/12/2020	Progress update provided to NHSEI Midlands Regional Director	
14/01/2021	Further 'evidence' submitted to Salma Ali for review	
25/01/2021	Salma Ali met with carers to discuss submission of additional evidence and further amendments to the report	
29/01/2021	Legal advice sought by NHSEI but not utilised/required	
04/02/2021	Draft addendum to the report received	
05/02/2021	Draft report submitted to NHSEI	
08/02/2021	Caldicott questions logged re carers being identifiable in report. Caldicott Guardians felt this did not meet the threshold as carers were not identified personally	
10/02/2021	Final report sent to carers, CCG and MPFT inviting comments	
11/02/2021	Meeting between Dr Briggs and the carers	
04/03/2021	Report presented to RQB	
23/02/2021	Carers complain that the report is on CCG website. CCG confirmed that anyone wishing to access the report was directed to comms and that the actual report was not available for view	
26/02/2021	Independent Report sent to MP for comment	
04/03/2021	MP request an extension of time to enable a full response to the report	
23/03/2021	Carers request to know the cost of the independent review and an update on progress of the look back exercise	

21/04/2021	NHSEI deputy director (Midland's region) confirms that Terms of Reference were being drafted for look back exercise	
21/04/2021	Further in-depth information requested re cost of review – referred to Freedom of Information Team	
22/04/2021	Final version of the Independent Review report is shared with CCG	
11/05/2021	Response prepared for Bill Cash (Member of Parliament)	
20/05/2021	Salma Ali meets with concerned carers again to discuss their complaints around the evidence submitted not being utilised	
Aug 2021	Final draft of the report issued	Appendix 23
Nov 2021	Final Report circulated to all stakeholders	
10/02/2022	Development of a Terms of Reference for a Look Back exercise regarding the independent review	Appendix 24
08/03/2022	Initial interview between NHSE Midlands Medical Directorate and JMB Health Consultancy Ltd regarding the proposals for the review and sharing Terms of Reference	
11/03/2022	Introduction of Prof Ashok Joy and Julie Butterworth to undertake the review jointly	
25/03/2022	Project proposal submitted to NHSE Midlands including CVs for consideration	Appendix 25
13/04/2022	NHSE Midlands interview jointly with Professor Roy and Julie Butterworth	
14/04/2022	NHSE&I Midlands formerly engage JMB Health Consultancy Ltd and Professor Roy to undertake the look back exercise	Appendix 26
03/05/2022	Project commenced	
19/08/2022	First draft submitted	

5. Key findings

The following section addresses the key lines of enquiry in succession, and includes anecdotal views and responses of those interviewed; formulated and corroborated where possible within the context of documents provided and listed within the timeline.

The reviewing team have presented the findings under the subheadings of the key lines of enquiry, and are in chronological order of time.

5.1 How where the Terms of Reference for the initial independent review in 2019 developed and approved by NHSE/I.

It was initially brought to the attention of NHSE/I Director of Nursing (North Midlands) by several concerned families in June 2019, that a review of Children and Adolescent Mental Health (CAMH's) services (including autism spectrum disorder provision) had been undertaken by NTW, which had highlighted a number of concerns regarding how the CAMH's pathway in Staffordshire was being commissioned and provided. To this end, the families were requesting to meet with the Director of Nursing for the North Midlands region to gain an organisational response position to the issues raised.

The reviewing team were informed that following this meeting, NHSE/I uncovered extensive and complex historical issues relating to the commissioning of CAMH's services in Staffordshire, stretching back over a decade. In generating the independent review, NHSE/I saw this as an opportunity for clarity and resolution and to almost create a 'point of reset' for all individuals and organisations who had been involved. With this in mind, it was crucial that NHSE/I captured all of the key issues, so as to develop a set of terms of reference that would achieve this objective.

Fundamentally, the review report produced by NTW had a key focus around risk and risk escalation and additionally the quality of services that were being provided for citizens of Staffordshire, particularly the provision of ASD services by Midlands Psychology. The report concluded that critically, service interfaces and pathways between Midlands Psychology, and Midland Partnership Foundation Trust who delivered CAMH services were fragmented, which contributed to the subsequent impact upon the experiences of those accessing the services.

NHSE/I was also keen at this point to understand why the CCG had commissioned one small service that appeared disconnected from the overall pathway for children and young people and their families. It emerged that the relationship with Midlands Psychology was a historical arrangement, however it was unclear who was managing and overseeing the contract for this.

NHSE/I also echoed the concerns raised around the way in which the contract for ASD services had been 'rolled over' beyond the end date, accompanied by what was described as a 'vague specification', and a lack of evidence as to how the contract was being monitored by the CCG, including processes for relationship management. Midlands Psychology were also suggested to have had sizeable backlogs, and had requested additional funding to address this. At that time, the CCG was battling financial deficits whereby prioritising one service such as ASD wait-times, would have been at the expense of another.

In September 2019, NHSE/I was informed that despite a review by Deloitte's around capacity and capability, Staffordshire CCG had ultimately been placed into special measures.

It was also inferred that NHSE/I had been alerted to licencing concerns raised by the CQC in connection with Midlands Psychology as a family-owned business and the potential conflictive nature of relationships between the owners and partners.

In consideration of the intelligence that was emerging, discussion was held at NHSE/I North Midlands Quality Surveillance Group, following on from which a series of risk review meetings ensued. These were chaired by executive team members from within NHSE/I North Midlands and included relevant representation from Staffordshire CCG, Midlands Psychology, Midlands Partnership Foundation Trust and the CQC.

The risk review meetings of July 2019 and September 2019 were suggested to have been quite timely, as Staffordshire CCG were about to announce a new procurement exercise for ASD services. The CCG informed NHSE/I that the contract extension with Midlands Psychology as the provider of ASD services had not been approved by the governing body, and that a different interim organisation had been chosen. At this point, questions were raised as to whether the actions arising from the risk review meetings were therefore still applicable, or if they had been replaced by new, lesser or greater risks following a change in provider. Nevertheless, NHSE/I agreed to work with the CCG to clarify this, which at the time, was accepted as a reasonable way forward.

The contract for caretaking agreement was formally escalated to NHSE/I national team in Late autumn of 2019, and was suggested as being one of several drivers for the terms of reference of the initial independent review. Alongside this was NHSE/I North Midlands directors' own concerns regarding the processes that had been used by the CCG to commission the initial contract with Midlands Psychology. This was later expanded to include how the service had then been reprocured.

Collectively, the commissioning and operational issues that had been highlighted, perhaps gave some validity to the earlier allegations made by the families, which had started to increase in volume. This provided challenges around managing and substantiating some of the claims, but did present NHSE/I a platform upon which to commission an independent review. This was put forward in a briefing statement to Claire Murdoch in September 2019 as a key action point for NHSE/I to take forward

In the initial stages, the Medical Director for the North Midlands region alongside the Director of Nursing North Midlands jointly developed a high-level term of reference, which was advised to have been 'shared but not approved' by a committee in November 2019. The alignment of NHS England and NHS Improvement in shadow form had also taken place in the summer of 2019 wherein a Midlands regional quality board had emerged. It was at the regional quality board meeting that it was agreed the independent review would commence in December 2019.

Due primarily to the significant time constraints this presented, the final terms of reference did not appear to have gone through any process of formal sign off by the regional quality board before being finalised. The terms of reference were however shared for comment, and to ensure a collective agreement that all key issues were being addressed. The terms of reference were also shared with Regional Surveillance Oversight Group, and were eventually ratified by the regional Chief Nurse and Director of Transformation for the North Midlands Region.

5.2 How the independent review of 2019 was commissioned and how the investigator was sourced and appointed.

Due to the overlap and similarity in some of the responses, the reviewing team have merged feedback for how the review was commissioned with how the investigator was sourced and appointed into one section, presented under sub-headings below.

5.2.1 The process for sourcing the reviewer

One observation arising as a theme from all the interviews, were the difficulties faced in sourcing and appointing a reviewer, with three stand out challenges; timeframes to appoint; the need for the reviewer/reviewers to be competent; and capacity to commence the work immediately.

The criteria for undertaking the review were appropriately framed within the set of terms of reference from November 2019, with expectations that the review would commence the following month in December. This left limited time for NHSE/I to source an individual with the appropriate level of expertise and capabilities, who was independent, and who had sufficient and imminent availability.

Initially, NHSE/I North Midlands reached out to the mental health networks and to the Commissioning Support Unit who were unable to suggest any immediate solutions. Within the process of selection, the directors also considered individuals and organisations they knew personally to have the necessary experience to undertake a review of this scope, however in most cases there was either a conflict of interest identified, and or a lack of capacity.

5.2.2 Appointing the reviewer

NHSE/I eventually successfully appointed a lead reviewer through SKSN Consultancy and Support Ltd, an organisation that had been incorporated in June of the same year.

Some members of the selection team were familiar with the lead reviewer from previous roles held, and also through detailed CV that had been submitted for due consideration.

An initial telephone conversation over several hours, clarified that the reviewer had previously held the role of Accountable Officer for a CCG albeit outside of the geographical scope of the review, and who had also worked within NHSE as a commissioner of specialist services prior to retirement. In the interest of any conflicts, and following an initial meeting with SKSN, the group were satisfied that the lead reviewer was sufficiently independent.

The reviewing team were also able to corroborate that the lead reviewer had no prior knowledge of the events and or the issues with either the commissioning of ASD services within Staffordshire, nor the ongoing complaints from the concerned families.

The appointed reviewer also held the necessary skills and expertise both as a former Director of commissioning within North Midlands region, and having undertaken several high-profile investigations and reviews throughout her career. Of particular note was the independent reviewers understanding and particular skills in working collaboratively with families and carers, and the importance and validity of co-production in this process.

5.3 What processes were put into place by NHSE/I to manage the review, including governance arrangements and management of any conflicts of interest.

It was suggested that initially the independent reviewer had been provided with NHSE/I legal guidance, and an agreement that on-going support to deliver the review would be offered by the Medical Director for the North Midlands.

Although no specific due diligence documents detailing how conflicts of interest had been managed had been completed, the reviewing team established that the executive team were satisfied that at the time, appointing SKSN was as 'robustly independent as it could be' within the context of the time frames and key deliverables.

Despite the terms of reference being developed with the right people involved, forming a sub-committee to oversee and monitor progress of the review could perhaps have been formed quicker. The reviewing team were given assurance that similar reviews completed by NHSE/I since the independent review of 2019 appear to have followed the learning from this.

Due to the various areas of dissatisfaction and contention within both the commissioning and provider landscape at that time, NHSE/I felt it vital to protect the independent reviewer from individual exposure and to avoid tainting the overall review. To mitigate this, and to ensure that any arising issues were actioned in a timely way, regular meetings were held between the reviewer and the Medical Director for North Midlands. The contents of these discussions were not presented to the reviewing team in any written format, but all parties were able to recollect and corroborate the regularity with which this support occurred. The reviewer did express however that being alerted to some of the background beforehand may have provided greater assistance to the process.

5.4 Whether the independent review of 2019 addressed, or should have addressed, the concerns raised by the carers evidence.

As highlighted in the timeline, NHSE/I North Midlands directors, did provide several opportunities to meet with the concerned families throughout the summer of 2019. Fundamentally, the underlying sense at the time from NHSE/I was that the CCG appeared to have failed in its statutory duty to effectively manage relationships as responsible commissioners, which resulted in the families feeling their concerns had not been satisfactorily dealt with.

The reviewing team perceived NHSE/I's inability to substantiate the facts behind some of the concerns, particularly as these were subject to continual change, and often dealt with as issues came to light. For example, during a meeting in July 2020, there were clear frustrations vocalised by the families, who raised the issue of a child whose risk had allegedly not been adequately assessed and who had subsequently attempted suicide. This would not have been appropriate for NHSE/I to address, and therefore became the subject of a safeguarding matter. Other examples of family concerns were suggested to have been a lack of involvement of parents in medication reviews, and lengthy wait times for accessing an assessment. As a result, one particular family had funded an assessment privately, and been refused reimbursement by the CCG. Although it is NHSE/I's statutory responsibility to oversee the CCG's and their commissioning obligations, it is the CCG's statutory responsibility to address individual concerns, therefore NHSE/I wanted a greater understanding as to why in this case, this had not happened.

To adequately deal with the emerging concerns, NHSE/I developed five main areas that were then to be included in the terms of reference for the independent review.

At this point, the families were requesting that they be involved in all aspects of the review which NHSE/I felt would not be appropriate.

During one particular meeting, the concerned families were reported to have requested that a formal clinical review of provider services be undertaken, and made recommendations to engage the expertise of a specific clinician from Oxford to undertake this. Subsequently, NHSE/I felt it necessary to make suggestions for how the families would be involved going forward, which was sense checked, agreed by all stakeholders, and then shared with the independent reviewer.

NHSE/I also maintained the stance that although they had listened to the issues raised by the concerned families, there were limitations in the level of detail in what they would or should be expected to know about provider performance. The families were advised that this would fall within the remit of CCG contract management and commissioner/provider relationships.

Consequently, the final terms of reference produced were explicitly confined to addressing commissioning processes and contract management and excluded scrutiny of the provider. The independent reviewer was instructed to include the views of the families within the context of how services were commissioned, but that any direct criticism as to how the services were being provided be regarded as outside of scope.

Initial contact by the independent reviewer with the families was made by telephone, and a subsequent face-to-face meeting was arranged. During this meeting, key lines of enquiry were developed intending all parties to work within the boundaries of the terms of reference that had been set. The reviewing team were advised that this first meeting with the families had elicited information easily, as all interviewees were keen to provide their own specific point of view.

From the onset it became apparent to the independent reviewer that the families wanted to discuss and critique Midlands Psychology as a provider, which required constant discipline to bring conversations back into scope.

Overall, much of the verbal feedback provided by the families at this point was suggested to have been anecdotal, and often targeted towards certain individuals. It is assumed, that despite the key lines of enquiry for the terms of reference of the review, the families continued to pursue issues arising from sustained periods of frustration at having felt consistently ignored.

The constructive content provided by the families that could be evidenced, transpired to be that which had already been shared through engagement with the CCG as a component of the review.

The families were however asked directly what they wanted to see come out of the review. They proposed that all of their views be captured within the report regardless of the scope, and that recommendations of the review should be to hold key people to account, including the dismissal of particular individuals. There was also anecdotal allegation that NSE/I as a regulator had failed to do its job effectively.

The families were advised that the majority of their concerns were outside of the remit of the terms of reference and therefore could not be included in the final report. However, agreement was reached to formerly escalate the issues with the providers as a separate entity to be shared with NHSE/I. This ultimately led to a separate review.

It is important to note that any forthcoming evidence which validated the concerns were reflected in the final report, and despite the difficulties in managing the process, the independent reviewer felt assured by the families overall genuine desire to bring about improvements and affect change.

The independent reviewer also wanted to understand if the views of the families were reflective of other parent carers, or based solely on their own individual experiences. Although the families did not seek to prevent the reviewer engaging other peoples' experience of services in the review, they felt this to be unnecessary as they felt they were able to 'sufficiently represent' all views. The reviewer did however triangulate the viewpoints of the carers with Healthwatch reports, and CCG service user feedback but this did not correlate, and there was a sense that regardless of the unique viewpoint they held, the families initially wanted to be regarded as championing on behalf of others.

When the first draft report was submitted to NHSE/I for comment in June 2020, it was purported that there had been some oversight in distribution, and unfortunately the families involved were not provided with a copy of the draft report.

Within the context of delivering a review, the expectation would be, that as the owners of the report, the process of version control, distribution and publication would be the responsibility of the commissioner of the review. The independent reviewer stressed that in this case this should have been undertaken by NHSE/I.

There was also anecdotal suggestion, that restricting the circulation list had been intentional, so as to limit the potential of draft versions finding their way into the public domain. Due to the sensitivities around the content and the political landscape at that time, this would undoubtedly have resulted in challenging consequences where this to have occurred however, the reviewing team found no hard evidence to substantiate any deliberate or malicious intent toward the families.

When eventually being provided with the draft report, the families expressed their dissatisfaction as it did not appear to reflect the entirety of their conversations. This was despite having previously been informed by the reviewer that any anecdotal and unsubstantiated allegations and information could not be included; nor any direct reference to or specific criticism aimed at the provision of services, as this was outside the scope of the review.

The families were suggested to have also insisted an additional sixty pieces of information had been submitted for inclusion in the review, but that this had not been reflected in the report. The evidence was said to have been sent electronically, but never received, and some assumptions were made at that time that the files may have been too large to transmit. This information was therefore only provided to the independent reviewer following issue of the first draft. When the additional information was eventually obtained, the reviewer did suggest there to be no 'new evidence', with the majority of it having been the same information as that submitted previously for the purposes of the review by the CCG. The families requested to see copies of all information provided by the CCG, however they were advised by the reviewer that this would not be appropriate and the request was therefore denied.

Sometime before the second draft was produced, the reviewer agreed to meet with the carers again to go through the report and review what had been included.

During this meeting, the families produced what they considered to be ‘further evidence’. This was then followed up by the reviewer, and found to be in connection with existing and on-going complaints against the provider that were already within the system and therefore not appropriate to cite. To give greater clarity, the reviewer provided the families with a written point-by-point explanation of the methodology for a review, and what constituted evidence. This did not appear to satisfy the families, moreover there was a suggestion that the reviewer was ‘siding with the CCG’.

The families were also alleged to have implied that the draft report was libellous, despite insisting initially that their individual contributions be cited. Throughout the report, they had been referred to as ‘the carers’, which they claimed would make them identifiable by default, due to information they had previously shared regarding the CCG within the public domain. At this point they expressed that they no longer wished to appear explicit within the report, nor did they want to be referred to as ‘the carers’ or ‘several carers’, moreover just ‘carers’. The reviewer advised them this term was ambiguous and not grammatically correct and therefore not possible. The reviewer did make reference to the sample size as being small within the report however it was sensed the families remained unhappy.

Due to the allegations of libel, the reviewer engaged the services of a proof reader within the context of Caldicott principles who concluded that the report was not litigious. Subsequently when the second draft was presented, it retained the original findings and recommendations but included an addendum that highlighted any changes that had been made between versions for auditable purposes.

The families then wrote to the reviewer requesting to understand what qualifications they held to be able to carry out the review, and how much they had been paid. It was also implied that the reviewer was not independent or impartial from the CCG as they held an NHS net email account. The families were assured that this had been provided for the purposes of the review only, and to ensure effective governance processes were retained utilising a secure network upon which to send and receive confidential information.

The independent reviewer’s final involvement in the process was in April 2021.

The reviewing team concluded that throughout the process, despite the challenges, the independent reviewer appeared to remain disciplined and acted within the scope of the terms of reference that had been set. However, as a result, many of the families' contributions were not addressed within the final report, due to information submitted being anecdotal, unsubstantiated and or out of scope of what they had been set. This does not suggest however that the families' concerns were ignored, moreover, they were investigated in alternative ways outside of the review, and addressed in other more appropriate forums.

Although omitting certain information from the report may have failed to heal the trauma felt by the families, many of the outputs of the review were implemented as the project progressed. This was partly attributable to a new provider being in place, but should not lose sight of the valuable contributions and feedback from the families leading up to this. Although not all the families' concerns were addressed or should have been addressed directly by the independent review, ultimately, they were influential in making positive change.

5.5 Whether NHSE/I currently have the correct processes in place which would enable an improved approach to 'concerns of this kind' in the future?

The reviewing team were informed that processes to manage similar situations and support a timelier escalation have improved since the independent review. This is due to an extension of regional oversight and inclusive membership of key governing bodies such as the General Medical Council, Nursing and Midwifery Council and the Care Quality Commission.

From a governance perspective, the reviewing team were advised that conflicts of interest are now recorded, reviewed and addressed on an appendices template contained within all project initiation documents. This provides validity in terms of assurance back to the system should this be called to question. Conflicts of interest are also noted at regional board level rather than restricted to relevant subgroups.

Although governance was an indirect consideration in the independent review, arrangements for how updates and progress would be reported, were not made clear prior to publication. Arguably this could have been agreed and documented

prior to the review commencing and avoided further unnecessary 'distrust' by the families.

It was also suggested that NHSE as a single entity (inclusive of NHS Improvement) had the potential to allow systems to tailor the approach to similar situations through "freedom to speak up processes" and allow an element of independence to make judgements regarding when and what they lead on.

It should also be noted that Staffordshire CCG now forms part of the Staffordshire and Stoke-on-Trent Integrated Care Board who have a collective responsibility to commission ASD services on behalf of its population, with a much greater emphasis on co-production of services and commissioning models

6. Summary of observations

In relation specifically to the process of selection, NHSE/I could have factored in to the initial reviewer engagement process, whether they had all of the necessary skill sets to deliver the outputs, and perhaps capacity to be able to respond, should the review become larger than expected. Due to the way the context spiralled from being a rapid review project into more somewhat complex issues, it would have been advantageous and productive for the independent reviewer to have had access to increased capacity much earlier in the process however it is accepted that this has not been anticipated. It is felt that the overall journey of the review may have been more favourable, particularly around timescales and document control, if the review had therefore been conducted by a larger organisation, with access to multiskilled sets, that could be flexible in their response to increased demand.

Another key challenge to the selection process, was the absence of a 'go to' list or framework of individuals and organisations that could have been approached. This would have considerably assisted NHSE&/I, particularly within the time limitations, and in reducing the level of scrutiny concerning independence, potential conflicts and credentials.

The limitation on the outcomes a review such as this permits, were observed, particularly through the scope of a terms of reference that considers a commissioning arrangement in isolation of the provision.

The reviewing team understood the primary focus had been to look at how the commissioners responded to concerns about services rather than explore how the provider changed the services they delivered, therefore subsequently opportunities may have been missed.

In answering the questions that the terms of reference of the independent review posed, the focus remained relatively strategic around how the contract was being managed, as opposed to understanding how the provider delivered, thereby inadvertently minimising and limiting the contributions that could be considered important by the families. This approach could be viewed as both credulous and insensitive, particularly when ultimately, there was an overwhelming shared desire from all individuals involved to achieve the same outcomes.

Although the reviewing team are not suggesting families have a role in commissioning and contract management processes, the valuable contribution co-production has on shaping how services are provided and evaluated should not be overlooked. It is anticipated that any lessons learned from the review will be a catalyst for greater openness and inclusivity.

There was also difficulty in version control, and the management of circulation particularly around early drafts, and it was unclear to the reviewing team if this was intentional or an oversight due to a variation in responses in the interviews. The development of good governance in relation to version control and sharing of reports ensures that all contributors are included, and have similar rights to comment and should be considered in future projects.

In this case, the approach appeared to be focused more around managing the publication process, rather than maximisation of the outputs, which did not take into consideration the “fall out” and impact of exclusion.

In considering governance, it was also noted that despite the ongoing concerns of the families, there was no formal written complaint ever made. All organisations should be utilising and making public their complaint processes, so that they are accessible and widely available. In doing so, families and service users will be aware of the correct processes in place to address concerns, including an algorithm of what they can expect in terms of responses and timeframes.

It was clear that for the families, this was another chapter in the journey for them. Having felt let down over a considerable time trying to navigate complex systems and changes in people's roles, the families' frustrations and dissatisfaction, continued, making it a difficult mission for both NHSE/I and the independent reviewer to overcome.

In addition, the high profile and sensitive nature of the issues appeared to affect people's judgement, resulting in an adverse impact on decision making and the ability to arrive at objective balanced conclusions. The particular issue of reimbursing the family for the costs of an assessment was also never satisfactorily concluded, however NHSE/I could do little to compensate, due to the potential precedent this could set for the organisation in the future.

It is also suggested as a fundamental flaw in the maximisation process with the decision not to involve everybody in the review, including Midlands Psychology.

In summary, the independent review did consider the terms of reference in an adequate, thorough and timely way, and this did lead to an improvement plan that was monitored, evidenced, and delivered. NHSE achieved these objectives and as a result, clear areas of improvements were identified for both the provider and the commissioner, with an action plan developed that was jointly owned by the system, and overseen by NHSE. This ultimately led to delivery of a recovery action plan and a resolution and de-escalation of the issues.

The ASD service specification that was implemented as a result, has since been referred to as best practice, with waiting times cited as being some of the best in the Midlands region.

Although Staffordshire CCG appear to have accepted and actioned the recommendations from within the report, ASD services remain largely underdeveloped and under resourced on a national scale, with scope for improvement.

7. Recommendations and considerations

Due to the time that has elapsed between the commencement of the independent review and the current look back exercise, many of the necessary improvements have already been taken into consideration by NHSE and embedded into practice and governance processes. The reviewing team therefore had no concerns that required any immediate escalation and or response.

In view of this, the following are suggestions that NHSE may consider as a list of initiatives and priorities for improvement that would considerably assist in planning services and reviews in future.

❶ Support for the development of a regional database or framework of independent contractors that can be accessed centrally, and contains key intelligence such as specialisms; access to additional capacity and skill sets, and provide links to examples of past projects and references, as due diligence. This would need to be considered within the context of IR35 and procurement processes.

❷ When undertaking similar reviews in the future, NHS England should ensure that ICB's complaints processes are robust and systematic to include written evidence of the key issues raised. This will ensure that there is an audit trail, and enable sufficient and satisfactory exploration of each individual concern raised.

❸ All future reviews commissioned by NHS England should demonstrate inclusivity through robust policies and governance processes for conducting evaluations and retrospective reviews. This should include effective version control and distribution management for transparency.

❹ NHS England should consider adopting a process for escalation including the governance structures and forums that would be used to support this.

❺ NHS England should ensure transparency in addressing and recording conflicts of interest within the selection process of future reviews.

❻ Where NHSE England are required to input into or lead reviews of this nature, process and outputs need to consider all opportunities for co-production.

❼ NHSE should seek ways to ensure that given the ever-evolving changes in both organisations and individuals working within them, that potential and future evidence is readily available, such as through the development of shared drives for key documents and communications.

❽ When delivering projects in the future, NHSE should develop an infrastructure that will enable recording of key documents and evidence bases within the scope of what is considered inside and outside the terms of reference to ensure a transparent approach. This should be given careful consideration, and form a key part of any project initiation document. Any additional information that is submitted, should be considered, and detailed in addendums within final reports.

❾ Commissioning of reviews in the future need to have a greater emphasis on capacity and mitigation as part of project initiation. This would ensure that contingency is built into procurement and engagement processes to enable a satisfactory response if a project has the potential to become bigger than originally expected.

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