System response to quality concerns in providers

Learning from North Middlesex University Hospital NHS Trust

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Contents

1. Summary

1.1. This report provides a response to a learning review commissioned by NHS Improvement, NHS England and Health Education England (HEE) to consider how the system responded to concerns about poor quality of care and poor trainee experience in some areas at North Middlesex University Hospital NHS Trust (NMUH) between 2014 and 2016 (the review period). The report does not focus on the specific circumstances at NMUH during this period, but rather provides important learnings and recommendations for national arm's length bodies (ALBs) and organisations with oversight and regulation responsibilities in the healthcare system, particularly in the London region where the trust is located.

1.2. National and regional colleagues from NHS England, NHS Improvement and HEE, together with the Care Quality Commission (CQC) and the General Medical Council (GMC), have reflected on the learnings and recommendations from the review. This has provided an opportunity to look at current system oversight, support mechanisms and approaches, as well as generating valuable lessons and insights for the future. Although the learning review focuses on how ALBs and regulatory bodies in the London region responded to concerns at the trust, the learnings and recommendations are applicable beyond this region, so these are also considered in the context of other regions' quality surveillance and support functions.

1.3. The learning review was conducted at a time when the oversight and regulatory system was undergoing significant changes. These included the establishment of NHS Improvement (which has integrated Monitor, the NHS Trust Development Authority, the National Patient Safety and Healthcare Safety Investigation Branch, and the Advancing Change and Intensive Support Teams) and CQC's introduction of a new approach to inspecting and rating providers. At the time the learning review report was completed (December 2017) many actions were already underway to address the recommendations it made.

1.4. The way in which ALBs and regulators operate together – both at national and at regional level – has changed significantly since the review period. In particular:

- Senior quality leadership across different NHS England and NHS Improvement regions has been strengthened, including clinical leads with board-level experience and joint chief nurse appointments.
- All regional teams have started to use, and continue to develop, risk surveillance tools, such as the quality risk profile tool, and local and

regional quality surveillance groups (QSGs) to identify quality concerns, share intelligence across organisations and co-ordinate interventions to support providers.

- New forums and mechanisms have been established to share intelligence, develop aligned approaches to support trusts and exchange learning across the system, such as the Joint Strategic Oversight Group (JSOG), which convenes senior representatives from NHS Improvement, NHS England, CQC, HEE and GMC. The JSOG currently operates at national level but will soon be established across all regions.
- Building on the commitments made in *Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services*,[1] CQC and NHS Improvement have been working together to better align and reduce overlap in their provider monitoring and regulatory approaches, particularly through the development and implementation of the well-led framework.[2]
- CQC has also been reviewing its approaches to inspecting and regulating providers. Its aim is to implement a more targeted, responsive and collaborative approach to regulation, engaging and working with other ALBs to share intelligence on risks.
- NHS Improvement has been developing approaches to better use available resources in its central and regional teams, to ensure it reflects priorities and support needs across the country, and to better gather soft intelligence about leadership and culture in providers.
- HEE has reviewed its approach to supporting providers that have failed, or are at substantial risk of failing, to meet its standards for education and training. It has developed and published a revised quality framework[3] together with enhanced guidance and a framework for supporting providers affected by substantial quality issues.
- A joint emerging concerns protocol[4] has been developed by national organisations with provider oversight and regulation responsibilities. This provides a clear route for organisations with a role in quality of care to share information and intelligence about quality risks or cultural issues in

[1] *Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services*. Available at: https://improvement.nhs.uk/resources/developing-people-improving-care/
[2] Well-led framework. Available at: https://improvement.nhs.uk/resources/well-led-framework/
[3] *HEE quality framework 2017-2018*. Available at: https://www.rcpe.ac.uk/sites/default/files/files/hee_quality-framework.pdf
[4] *Emerging concerns protocol*. Available at: https://www.cqc.org.uk/sites/default/files/20180726_emerging-concerns-protocol.pdf

health and social care settings that would not necessarily be raised through alternative formal systems.

1.5. National bodies are therefore confident that the system is now in a better position than during the review period to identify quality risks and concerns, and to intervene to support providers in the most appropriate and co-ordinated way to address their needs. Nevertheless, national bodies acknowledge that there is still work to do, both to support NMUH and to improve how the system might address similar situations arising in other trusts in future.

1.6. Although many of the issues and challenges identified at NMUH between 2014 and 2016 have been addressed since the review period, some remain. The most recent CQC inspection report of the trust describes where the trust has improved and where there are still challenges, and NHS Improvement and other national bodies continue to support the trust in its ongoing improvement journey.

1.7. At a national level, oversight and regulation bodies continue to work together to improve information and intelligence sharing across the system. This knowledge enables them to effectively co-ordinate oversight and support interventions in providers and to ensure a rapid, co-ordinated response to immediate challenges and pressures. In particular, these national bodies will continue to work to:

- Streamline their interactions with providers to minimise multiple data requests and cumulative regulatory burden. This will include improving national bodies' collective knowledge of what information about providers is already available, what further information or evidence is required, and which national body is best placed to request this from providers.
- Review approaches to monitoring leadership and cultural issues in providers, sharing intelligence about risks and concerns across the system, and identifying support needs around leadership, culture and improvement capability (particularly through regional teams).
- Ensure the approaches to using provider quality surveillance tools such as the quality risk profile tool, QSGs and risk summits (in situations where risk is escalated) are consistent across each region. This includes ensuring there are robust processes for implementing actions resulting from QSGs and risk summits.
- Ensure effective and co-ordinated communication approaches and consistent handling of messages to stakeholders where national bodies intervene to support providers with quality issues.

1.8. The planned new operating model for joint working between NHS England and NHS Improvement will also help ensure that these national bodies interact with providers in a more co-ordinated and effective way. It provides an opportunity to align national and regional oversight and support, ensuring commissioners and providers receive consistent messages and have a single point of contact for both national bodies at a regional level.

2. Introduction and background

2.1. Between 2014 and 2016 North Middlesex University Hospital NHS Trust (NMUH) experienced significant quality challenges about which regulatory and oversight bodies and other healthcare organisations across the system had concerns. There were known reports and intelligence (eg from the Care Quality Commission's (CQC) Intelligent Monitoring) across the system about:

- poor quality of care and outcomes in some areas (eg higher than expected mortality rates)
- low patient satisfaction with services (as measured by CQC's patient surveys and the A&E Friends and Family Test)
- poor trainee experience (as reported by the General Medical Council's (GMC) national training survey),[5] particularly in anaesthetics and A&E.

2.2. In response to these concerns, the bodies responsible for overseeing the trust began additional monitoring and implementing support interventions. Actions included risk summits,[6] unannounced CQC inspections of the trust's emergency department, Health Education England (HEE)/GMC meetings with trainees at the hospital and bespoke external clinical support from NHS England.

2.3. System leaders involved in overseeing and supporting the trust identified an opportunity to assess the speed and effectiveness of their combined response. NHS Improvement, NHS England and HEE were therefore keen to ensure that lessons could be learned for the future and in March 2017 commissioned a learning review from Deloitte to help the system understand:

a) how the bodies responded to quality, leadership and cultural concerns at NMUH during the period June 2014 to August 2016

b) whether the way they responded provides valuable lessons to inform how arm's length bodies (ALBs) and regulatory organisations work together to support challenged providers.

2.4. It was not intended that the learning review would revisit issues experienced at the trust itself. As such, the recommendations are directed at ALBs and regulatory organisations, not the trust.

[5] National training survey. Available at: https://www.gmc-uk.org/education/how-we-quality-assure/national-training-surveys/national-training-surveys-reports

[6] Risk summits are a process that can be triggered by QSGs if 'serious, specific risk to quality' is identified, including where quick action is needed to protect patients or staff. Risk summits are the highest level of QSG surveillance and they are usually triggered by local QSGs.

2.5. The final learning review report, received by NHS Improvement, NHS England and HEE in December 2017, set out 12 key learning points (see Appendix 1) and 14 corresponding recommendations (see Appendix 2). These focused on:

- how ALBs, regulators and commissioners responded to concerns about leadership and service quality in the trust
- the effectiveness of key system forums in addressing these concerns
- the ways in which relevant intelligence about the situation was gathered and used
- the clarity of roles and responsibilities across the various organisations involved.

2.6. NHS Improvement, NHS England and HEE, along with colleagues in the wider system, have together considered and reflected on the findings and recommendations from the learning review. These organisations share the view that the way in which ALBs and regulators operate together has changed significantly since the review period. This corresponded to the time when NHS Improvement was being formed, relationships between the national NHS bodies were still being established, and CQC was introducing a new approach to inspecting and rating providers.

2.7. At the time the learning review report was submitted in December 2017 actions were already underway to address many of the recommendations. Building on these, colleagues have jointly reviewed current approaches to responding to concerns about providers' service quality and reflected on where there is still work to do to improve how the system acts in similar situations in future.

2.8. This report is a joint response from NHS Improvement, NHS England and HEE to the learnings and recommendations identified in the learning review. It discusses opportunities to further improve the system's approaches to overseeing and supporting providers with quality challenges. It also incorporates reflections from CQC and GMC: both were involved in the response process but did not formally commission the learning review. The reflections in this report relate predominantly to circumstances in the NHS London region, but the learnings and the changes across the system have applicability beyond London. Colleagues in other regions have therefore been involved and national and regional intelligence has been included where relevant.

3. The learning review of the system's response to events at North Middlesex University Hospital

3.1. Deloitte's approach to the learning review consisted of reviewing documentation from key forums held during the relevant period and conducting interviews with individual stakeholders from organisations involved in overseeing and supporting NMUH during that time. The organisations were: CQC, NHS Enfield Clinical Commissioning Group (CCG), Enfield Council, GMC, NHS Haringey CCG, Haringey Council, Healthwatch Enfield, HEE, NHS England, NHS Improvement, NMUH, the Royal College of Emergency Medicine (RCEM) and the Royal Free London NHS Foundation Trust.[7]

3.2. The learning review report was designed to be "developmental in nature with a view to identifying learnings for the future rather than apportioning blame for the past". It sought to answer the following questions:

- What key pieces of available data or information were the best indicators of the underlying issues at NMUH, including soft intelligence? Could any other information have been collected and provided strong evidence on which to act earlier?
- Were the monitoring mechanisms used by NHS England and NHS Improvement sufficiently robust to identify the emerging issues in the NMUH emergency department and/or issues with Haringey CCG's oversight of NMUH? How could these mechanisms be improved?
- Are there any indicators which can be used in future to predict or ascertain whether a trust has enough capability and resource to address the situation?
- Were mechanisms (such as risk summits) to co-ordinate a response across the system effective?
- What interventions were the most effective in driving improvement? What interventions were less effective or counterproductive?
- What key enablers to an effective response should be installed as a priority in similar situations?

[7] In September 2017 NMUH joined the Royal Free London (RFL) group as its first clinical partner. The two trusts had already been working closely for two years to develop consistent approaches to designing and delivering care, sharing expertise and improving standards of care. Under the partnership, NMUH kept its own board, but Sir David Sloman, RFL Group Chief Executive, became accountable officer at NMUH.

- How can NHS Improvement and NHS England identify situations that require more proactive/collaborative intensive communications handling?
- How can communications teams in different organisations work more effectively together to ensure co-ordinated handling of messages to stakeholders?
- How can the system engage better with stakeholders including politicians, patient representatives and the public? Is the current balance of transparency appropriate?

3.3. The learnings and recommendations from the learning review are given in Appendices 1 and 2. The complete learning review report is published separately.

3.4. The organisations to which the recommendations are addressed acknowledge the issues and challenges highlighted in the learning review. They have worked, and continue to work, together to collectively reflect on progress made and further actions needed across the system. They recognise that some of the learning review recommendations may not accurately reflect current system roles and responsibilities but have carefully considered and responded to all the recommendations collectively rather than individually.

4. Setting the learning review's learnings and recommendations in the present

NHS Improvement, NHS England, HEE, CQC and GMC have jointly considered the learning review findings and recommendations, and reflected on the system's approach to overseeing and supporting providers. These organisations share a collective view that the way they operate together has improved significantly since the review period.

These organisations agree there is further scope to develop a more co-ordinated and effective approach to overseeing and supporting providers, and are continuously identifying opportunities to improve their joint response to challenged providers.

4.1. Some recommendations in the learning review refer to the ability of national organisations to carry out their provider oversight and support roles effectively. In particular, the learning review challenged aspects of the operating model in place during the review period, including the:

- level of resources available across organisations in the system, nationally and in the London region more specifically, to support challenged providers to address quality issues, and how these are deployed
- ability of ALBs and regulators to monitor provider performance across multiple areas, gather intelligence, identify concerns and act on these in a joined-up way
- mechanisms for dealing with serious concerns about the quality of medical trainees' training experience
- clarity of roles and responsibilities in ALBs at regional and national level, and how this affects their ability to work together effectively.

4.2. The learning review acknowledges that at the time the report was submitted (December 2017) actions had already started to fully or partially address many of the recommendations. On that basis, the London region representatives from the learning review's commissioning organisations focused on how the recommendations can inform next steps, building on developments since the review period. NHS Improvement, NHS England, HEE, CQC and GMC have reflected that since the review period:

- Organisational and system approaches to quality oversight, monitoring and information sharing have improved, with strengthened support resources and new and revised mechanisms for sharing intelligence.
- Relationships with providers have matured. Learning from the situation at NMUH was used in the response to subsequent quality concerns at the trust in late 2017, and in other recent work with challenged providers in the region that has required a rapid, co-ordinated system approach. One example of this is the use of the quality risk profile tool (see paragraph 4.24) across other challenged providers, which allows a more cohesive approach to quality surveillance.

4.3. The next section is NHS Improvement's, NHS England's and HEE's response to the key themes of the learning review recommendations rather than to each individual recommendation, as there is considerable overlap between them.

Governance arrangements

4.4. One recommendation reflects on whether organisations with responsibilities for trust oversight allocate sufficient resources to supporting challenged providers in tackling structural issues.

4.5. As the body with lead responsibility for directly overseeing and supporting NHS trusts and NHS foundation trusts, NHS Improvement has significantly developed the ways in which regional teams work and how they are resourced to support trusts since the review period. The organisation's approaches to provider oversight across the quality, governance and finance domains are now more aligned and, combined with improved partnership working, enable regional teams to intervene when there are concerns about key quality indicators (although these may not be detailed enough to expose routine quality issues). NHS Improvement continues to strengthen the capacity of its regional teams to better diagnose and respond to challenging issues within trusts.

4.6. NHS Improvement oversees and supports providers through its central teams, and both NHS Improvement and NHS England provide support more directly through their regional teams, which currently cover five geographical areas: North, Midlands and East, London, South East and South West. All NHS Improvement regional teams have the same aims and responsibilities in managing relationships with providers, assessing and diagnosing issues, and supporting improvement. However, they vary somewhat in how they are structured and operate in practice. For example, the South East and South West regions already operate jointly across both organisations and run joint executive level meetings.

4.7. In the NHS Improvement London regional team specifically, senior leadership of its quality team has been strengthened since the review period, with both a regional chief nurse and a medical director now in post. Senior clinicians with board-level experience have also been appointed to the regional team. In a commitment to enhance system leadership and partnership working, the London regional chief nurse is a joint appointment across NHS England and NHS Improvement, an approach replicated in the North and both South regional teams. In the North region, in addition to the jointly appointed regional nurse director, there are other integrated roles, such as a joint infection control lead between NHS England and NHS Improvement for an individual trust, and a joint post between NHS England and NHS Digital.

4.8. The approach to cross-organisational appointments is not yet standardised across regions, but NHS Improvement and NHS England are developing a joint operating model that will facilitate standardisation of processes and integrated working at a national and regional level. A single regional director will be appointed jointly by NHS England and NHS Improvement in each of the seven new regional geographies. Each region will have an integrated team responsible for overseeing and supporting both commissioners and providers, ensuring a single view of performance and outcomes in their area and a system-wide approach to improvement and intervention.

4.9. A system-wide communications group was established in 2018 as part of the system response to events at NMUH. The group was led by NHS Improvement and included NHS England, HEE, CQC, GMC, the local CCG, NMUH and the Royal Free London NHS Foundation Trust. It focused on establishing a memorandum of understanding to ensure consistent messaging from all system partners regarding issues at the trust. This group has provided a template for future system communications groups to use in similar circumstances.

Capturing and sharing intelligence about providers

4.10. One of the main concerns originally highlighted at NMUH was the poor experience of junior doctors at the trust. The learning review recommendations raise challenges around the system's effectiveness in sharing information about this issue across organisations and responding to these concerns. In particular, the learning review recommends that CQC and NHS Improvement better incorporate intelligence from HEE and GMC in their monitoring processes.

4.11. There is a commitment nationally to ensure that issues raised by GMC and HEE are considered and several mechanisms currently enable information sharing across organisations. One of these is the Joint Strategic Oversight Group (JSOG), set up in May 2017. This is a group of senior representatives

from NHS Improvement, NHS England, CQC, HEE and GMC who meet every two months to:

- develop and agree an aligned and consistent approach to joint working to ensure timely and appropriate intervention and support for trusts in special measures[8] for quality reasons and for challenged trusts
- exchange learning, intelligence and information to aid future improvement, particularly in providing support and interventions for trusts with significant quality issues.

4.12. One area where JSOG members regularly share intelligence is the quality of education and training and service provision. This allows HEE and GMC to highlight and discuss any concerns with other regulators and ALBs for a concerted response. Additionally, HEE regularly shares information with partner organisations through local and regional quality surveillance groups (QSGs)[9] and local networks and relationships. In addition to JSOG meetings, medical directors at NHS Improvement have quarterly meetings with GMC. These are another opportunity to raise concerns about providers and trainee experience.

4.13. Within regional teams there are additional mechanisms for sharing information and data. For example, the NHS Improvement Midlands and East regional team uses an intelligence dashboard – including monthly quality metrics on mortality, CQC ratings and Single Oversight Framework (SOF) intelligence – to identify where providers may have quality issues. This team is exploring how best to incorporate soft intelligence (eg results from trainee surveys and staff experience data), including from other organisations such as GMC, into the dashboard, and how it can best share information with regional teams in other organisations. The South East and South West regional teams in NHS Improvement and NHS England (which have been working in an integrated way since autumn 2017 as a precursor to the joint working arrangements being planned across all regions) use a similar quality dashboard to share relevant information and data.

4.14. One recommendation focuses on CQC's monitoring system and its ability to capture material intelligence about providers. In 2017 CQC implemented its Insight trust monitoring model,[10] which provides intelligence about trusts based on a range of metrics. It gathers comprehensive information about

[8] **Special measures** are a set of interventions designed to remedy a trust's problems within a reasonable timeframe. They apply when NHS trusts and foundation trusts have serious problems and there are concerns that the existing leadership cannot make the necessary improvements without support. Trusts may be placed in special measures as a result of serious failures in quality of care and/or serious financial problems (CQC, NHS Improvement 2017). **Challenged providers** are providers deemed to be at risk of entering special measures for quality reasons.

[9] See paragraphs 4.17 to 4.21 below.

[10] *CQC Insight*. Available at: https://www.cqc.org.uk/location/1-2650278775

providers in one place, including: contextual information about activity, staffing and finances; overview of CQC ratings and performance monitoring indicators (including benchmarking against other organisations); and data from national surveys, incident reports, mortality ratios and outliers. CQC uses Insight to monitor the quality of care that trusts provide, and to decide when to inspect a provider and which services to inspect. The monitoring reports are shared with trusts and with NHS England, NHS Improvement, CCGs and Healthwatch.

4.15. Overall, ALBs are confident that information sharing across national bodies and by trusts has improved since the learning review period, and that more effective early warning mechanisms are now in place. National bodies also continue to develop a common understanding of what information and evidence provide an appropriate level of assurance, and how this is collated and shared across ALBs to ensure they maintain an overview of providers' performance and support needs.

4.16. Additionally, there is ongoing work to identify and eliminate duplication of data requests and monitoring. NHS Improvement, NHS England and CQC have streamlined their interaction with providers to collect data once wherever possible; share information received where requests overlap; and minimise data collection where data needs are separate. For example, the Midlands and East region uses a memorandum of understanding between any organisations requiring compliance actions from the same trust to ensure that ALB statutory duties are met for individual providers that are persistently challenged. Using one set of actions and requesting one set of information ensures that the metrics are reported in a single board report.

Quality surveillance and risk identification mechanisms

Quality surveillance groups

4.17. Some of the recommendations suggest the need to review the format and effectiveness of risk summits and QSGs as mechanisms to survey provider quality of care. QSGs are a key mechanism for information sharing and quality surveillance across the system. They bring together different parts of the health and care system across a healthcare economy to:

- share intelligence gathered through performance monitoring, commissioning and regulatory activities about risks to quality
- identify these risks as early as possible

- ensure that action taken to mitigate existing risks is aligned and co-ordinated.[11]

4.18. QSGs take place at regional (four regions) and local (28 localities) level (see Appendix 3). Representation on QSGs comprises NHS England, CCGs, CQC, NHS Improvement, relevant local authorities, Public Health England (PHE), HEE and the relevant local Healthwatch. Regional QSGs also include representatives from GMC and the Nursing and Midwifery Council (NMC). These groups enable shared oversight of challenged systems or organisations and collective agreement on the most appropriate system response when a risk is identified. This is the forum where the need for a focused CQC inspection, for example, could be discussed.

4.19. While QSGs are a consistent feature across all regions, their boundaries, membership and way they work in each region can vary to reflect local circumstances. For example, in the North region each of the five sub-regional directors of nursing routinely meets CQC to share intelligence in the context of local QSGs, and this then feeds into a single regional QSG. Similar local conversations take place in the London region. They facilitate communication between the regions and CQC about providers, and enable CQC to respond to concerns raised by intervening in specific providers where necessary.

4.20. In 2017 the National Quality Board (NQB) issued revised guidance about national expectations on the management and running of QSGs and risk summits.[11] The review was led by a working group that included representatives from CQC, HEE, Healthwatch England, NHS England, NHS Improvement, PHE, GMC, NMC, the Local Government Association (LGA) and the Association of Directors of Adult Social Services. The guidance also builds on the *Shared commitment to quality* framework,[12] published by the NQB in 2016, which provides a nationally agreed definition of quality across the NHS, public health and social care.

4.21. In London, a workshop was held in October 2017 to discuss how to ensure that future risk summits comply with the NQB guidance. A process is in place for senior representatives from all relevant ALBs and CCGs to share information ahead of any decision to hold a risk summit (which is the highest level of risk escalation). This includes:

- Local information-sharing meetings, where ALBs, the relevant CCGs and other relevant system stakeholders (eg GMC, NMC) can discuss problems

[11] National Quality Board (2017) *Quality surveillance groups: National guidance*. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/07/quality-surveillance-groups-guidance-july-2017.pdf

[12] *Shared commitment to quality*. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf

at providers that have raised concerns at QSG level. These meetings happen between QSG meetings and focus on monitoring specific providers and deciding whether risk escalation is needed.

- Single-item QSG meetings, chaired by NHS England and involving relevant CCGs and the provider, for identified specific risks and concerns (eg poor staff experience) that have been escalated. These can identify specific actions for the organisation to implement to address its concerns, and the effectiveness of their adoption can then be monitored: for example, through quality contract meetings or monthly quality surveillance meetings with the provider. Single-item QSG meetings are the last step before deciding to hold a risk summit, and often avoid further risk escalation.

4.22. In London, NHS England and NHS Improvement have also established a joint London Quality Committee that enables greater sharing of information and scrutiny of trusts and systems that may require additional support. Support needs are regularly explored as part of the committee's monthly meetings and all ALBs have access to the support that can be given to trusts where appropriate.

4.23. System partners have also implemented other key recommendations from the NQB guidance, including the use of intelligence-sharing conversations. For example, the Chief Nursing Officer at NHS England and the Executive Director of Nursing at NHS Improvement hold quarterly meetings with the NHS Improvement/NHS England regional nurse directors from all the regional teams and the local Directors of Nursing from NHS England; representatives from HEE also regularly attend these meetings. Regional nurse directors also regularly speak to their counterparts at NMC and HEE.

Quality risk profile tool

4.24. As part of the QSG process, NHS England (initially in the North and then disseminated to other regions) has developed with HEE and other national organisations a quality risk profile tool to assist QSGs and commissioners in assessing providers' quality risks (see Figure 1). The tool combines qualitative (that is, local intelligence from stakeholders) and quantitative (eg data from NHS England's quality dashboards) intelligence and provides a framework to ensure a consistent approach to assessing risk. It enables routine surveillance based on specific criteria, and identification of significant quality risks and where action needs to be escalated. The tool can be used, for example, when persistent or increasing quality concerns have been identified in a provider but

routine or enhanced quality assurance processes and targeted quality assurance visits have not given assurance they will be resolved.[13]

Figure 1 – The quality risk profile tool and the trigger tool

NHS England has developed a quality concerns trigger tool and quality risk profile tool (QRPT) to assist commissioners and QSGs in assessing risks to quality. These tools provide a framework to ensure a consistent approach to assessing risk by all stakeholders. They provide:

- a systematic risk-based methodology, which identifies areas where further assurance or support may be required
- the basis for shared decisions about a managed and proportionate response to quality concerns.

Where commissioners or other QSG members have concerns about quality in a provider or wider system, the trigger tool provides a framework for making decisions about appropriate risk escalation and may include working through the QRPT.

The QRPT is worked through in partnership with the relevant provider, to enable all parties to reach a shared understanding of where there are risks to quality, as well as identifying areas of good practice. The tool provides a structured way to consider a wide range of data and information, to reach a balanced assessment.

Source: National Quality Board (2017)

4.25. ALBs must ensure their responses align with the QSG and risk summit guidance, and that these are used in a focused way to discuss specific areas of concern with providers and to help them by developing co-ordinated system solutions and support. Organisations must also ensure that providers are supported to deliver the actions agreed at risk summits and are held to account for their delivery. In some regional teams, for example, the usual process after holding a risk summit is to set up a multiagency 'oversight risk group' to monitor progress with the implementation of the summit's response plan.

[13] National Quality Board (2017) *Quality surveillance groups: National guidance*. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/07/quality-surveillance-groups-guidance-july-2017.pdf

Other risk identification and escalation mechanisms

4.26. In 2017 health and social care professional and system regulators – including NMC, GMC, General Pharmaceutical Council, Health and Care Professions Council, Parliamentary and Health Service Ombudsman, Local Government and Social Care Ombudsman, General Dental Council, CQC and HEE – developed a joint emerging concerns protocol for health and social care.[14] The document, published in July 2018, clearly defines a mechanism for organisations with a role in quality of care provision to share information and intelligence that may indicate risks to users of services, their carers, families or professionals. This could include situations that indicate future risks rather than an immediate emergency; or cultural issues in health and social care settings that are noticeable but may not necessarily be raised through alternative formal systems. Use of the protocol starts with the identification of a concern by one or more of the organisations holding information. These then organise a regulatory review panel to share information and develop an appropriate co-ordinated intervention. NHS England and NHS Improvement support this protocol but as they are currently in transition to closer joint working – including the establishment of seven new regional teams, which will play a critical role in implementing the protocol – they intend to wait until their seven new regions are operational before signing up to it.

Assessing support needs in providers

4.27. CQC and NHS Improvement have been working to increase their alignment and reduce duplication in their monitoring and regulatory approaches, with a particular focus on their joint approach to assessing leadership and use of resources in trusts. The two organisations have jointly developed and implemented the well-led framework, providing a single and integrated approach to the assessment or review (including self-review) of the leadership, management and governance of an organisation.

4.28. Since 2017, NHS Improvement and CQC have used a single well-led framework,[15] which supports providers to maintain and develop the effectiveness of their leadership and governance arrangements, and underpins CQC's regulatory assessments of the 'well-led' key question. CQC has begun regular well-led assessments of providers, with NHS Improvement working alongside CQC's inspection team to assess the financial governance component. NHS Improvement and CQC's view of providers' governance arrangements and where they can be supported to improve are therefore increasingly aligned. The use of the framework has also encouraged greater

[14] *Emerging concerns protocol*. Available at: https://www.cqc.org.uk/sites/default/files/20180726_emerging-concerns-protocol.pdf
[15] *Well-led framework*. Available at: https://improvement.nhs.uk/resources/well-led-framework/

transparency from providers and generated insight for national bodies and regulators into providers' support needs around leadership and governance.

4.29. As part of the well-led framework, providers are also encouraged to carry out developmental reviews of their leadership and governance arrangements every three to five years. The aim is to ensure providers identify potential risks before these turn into issues and share any material concerns with NHS Improvement. When undertaking these reviews, providers are also encouraged to reflect on learning, improvement and innovation as part of their continuous improvement. CQC may discuss the outcomes of these developmental reviews with trusts as part of its well-led inspection.

4.30. Since 2016 CQC has also been reviewing its approaches to inspecting and regulating providers, with a focus on supporting "a more targeted, responsive and collaborative approach to regulation". Under CQC's *Next phase of regulation*,[16] work is ongoing regarding how its regional inspection teams engage and work collaboratively with other ALBs, including sharing risks in trusts.

4.31. As part of this work, CQC holds regular engagement meetings with providers, with an agreed agenda based on known risks. Inspection teams also join a range of quality meetings as part of their investigation of potential risks, and CQC's inspection managers hold cross-organisational meetings to discuss risk.

4.32. NHS Improvement's Single Oversight Framework (SOF) was introduced in October 2016 to help identify where providers may benefit from, or require, improvement support to meet the standards required of them in a safe and sustainable way. It sets out how NHS Improvement identifies providers' potential support needs and determines the way it works with each provider to ensure appropriate support is available where required. The SOF uses several information sources to assess provider leadership and governance, including CQC well-led inspections and the outcomes of developmental reviews conducted by trusts. NHS Improvement's regional teams additionally consider information from third parties (eg Healthwatch, MPs, whistleblowers or coroners) to identify any staff engagement or cultural issues, such as the level of senior executive turnover and staff survey results.

4.33. NHS Improvement also encourages trusts to use tools such as the medical engagement scale to identify how clinicians are engaged in key decisions and takes an interest in the results to help organisations improve. The medical

[16] CQC (2016) *Our next phase of regulation: A more targeted, responsive and collaborative approach – Cross-sector and NHS trusts*. CCQ's work with NHS Improvement on the well-led framework is included as part of this. Available at: http://www.cqc.org.uk/sites/default/files/20161220_Next-phase-of-regulation_consultationdocument.pdf

engagement scale can be used by any trust, but those that are considered to be challenged or are in special measures for quality[17] are required to use it, as it is essential to understanding the level of engagement and by which staff groups.

4.34. These actions reflect the commitments made by national bodies as part of the *Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services* framework[18] to develop more supportive and aligned approaches to regulation and oversight that focus on building the capability of people across the health and care system. The framework has been developed by CQC, the Department of Health and Social Care, HEE, LGA, NHS Clinical Commissioners, NHS Confederation, NHS England, NHS Improvement, NHS Leadership Academy, NHS Providers, the National Institute for Health and Care Excellence, PHE and Skills for Care. It aims to help the NHS and social care to develop: system leadership for staff working with partners to 'join up' local health and care systems for their communities; established quality improvement methods to improve service quality and efficiency; inclusive and compassionate leadership; and talent management to support NHS-funded services to fill senior current vacancies and future leadership pipelines.

More effective ways of supporting providers with quality issues

4.35. NHS Improvement has been exploring how to better co-ordinate available resources in its central and regional teams to ensure their allocation reflects priorities and support needs across the country. One new approach to supporting providers with the most significant financial, quality and operational challenges streamlines all NHS Improvement interactions with each provider. Each trust has an executive sponsor who oversees and co-ordinates all the work with that trust, as well as a relationship manager who works closely with the executive sponsor to co-ordinate all the support work. The impact and outcomes of this approach are being assessed to inform the future model for working with providers and how to ensure an effective whole-system response from all national bodies.

4.36. Since NHS Improvement was established in 2016, its regional delivery and improvement teams have been building their capacity to support trusts, including deploying staff to trusts. These teams are responsible for overseeing a group of trusts within a defined footprint, agreeing the level of reporting required and support provided to trusts, and working with NHS England to

[17] See paragraph 4.11 for definition of special measures.

[18] *Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services*. Available at: https://improvement.nhs.uk/resources/developing-people-improving-care/

ensure messages to healthcare systems are consistent. By NHS Improvement refining its improvement support offers across the quality, finance and operational areas, these teams are better able to gather soft intelligence about leadership and culture in providers, concerns that trust staff may have about this, and actions being taken to address them. For example, NHS Improvement conducts joint visits to trusts with colleagues from NHS England and the local CCG to discuss current performance and any issues and concerns with staff and feedback recommendations. Trusts report finding this approach helpful: they gain an external viewpoint when, for example, preparing for a CQC inspection or care pathway review. Through its national and regional professional networks, NHS Improvement also provides leadership and support to providers and opportunities for their leadership to raise issues.

4.37. NHS Improvement's regional teams have developed tailored quality and improvement support approaches, such as quality committees undertaking 'deep dive' initiatives with responsibilities shared between the quality leads and regional nurses. The North and the Midlands and East regional teams, for example, use 'system improvement boards' where commissioners, providers and CQC come together to focus on quality concerns and work on helping 'higher risk' providers improve. They look at areas of risk, undertaking 'deep dives' into specific areas (eg urgent care, sepsis, mortality) and following up on progress on the trust's improvement programme. In the South East and South West regional teams, NHS England and NHS Improvement colleagues hold a joint meeting fortnightly with all partner agencies, including the deanery, as part of their support to trusts requiring increased surveillance. NHS Improvement's support to providers also includes other specific and targeted support offers, such as the Emergency Care Improvement Programme (ECIP) to help organisations improve patient flow, and support from the leadership and quality improvement team to help trusts develop effective leadership.

4.38. Through this type of engagement NHS Improvement is further developing the insight and expertise necessary to respond to issues at an operational level, and to understand the quality of leadership throughout providers. Improvement support capacity has improved but there is still scope to look at the level of resources allocated to delivering improvement, particularly for providers that need more support. The new operating model being developed between NHS England and NHS Improvement will enable the sharing of knowledge, expertise and capacity to develop and deliver future support offers.

Supporting providers that have issues with quality of training and educational experience

4.39. One of the main areas of focus in the learning review was how national organisations responded to reports of poor medical trainee experience at NMUH, and the fact that HEE and GMC considered withdrawing trainees from the trust in response. HEE recognises that the removal of any learners, but especially junior doctors, from a training environment is a substantial and significant step, and is clear that this is a last resort. However, specific provider circumstances may require the removal of junior doctors from a training environment where there are no prospects of improvement.

4.40. Following the events at NMUH, HEE reviewed its approach to supporting providers that have failed, or are at substantial risk of failing, to meet the HEE standards for education and training. HEE has developed and published a revised quality framework[19] to consistently "measure, identify and improve quality in the education and training environment", together with enhanced guidance and a framework for supporting providers affected by substantial quality issues. HEE also undertakes risk-based visits to trusts where significant concerns have been raised about the quality of medical training. In the London region, these visits (including at NMUH) are attended by NHS Improvement's Regional Medical Director to ensure a joint approach with HEE and GMC. Additionally, NHS Improvement has supported a joint approach to resolving training concerns through working with trust medical directors and HEE when concerns are raised and in London, the Regional Medical Director has led risk meetings with HEE in relation to training across the London region.

4.41. Additionally, recognising that the approach to the publication of quality management information across England is still inconsistent, HEE is reviewing the historical positions on the publication of reports associated with quality management activity, reflecting on how it can make its reports more visible to other ALBs. This review should lead to consistent levels of published information and more accessible information.

[19] *HEE quality framework 2017-2018*. Available at: https://www.rcpe.ac.uk/sites/default/files/files/hee_quality-framework.pdf

5. Areas for further improvement in system approaches

5.1. Despite the considerable progress described above, NHS Improvement, NHS England and HEE, as well as CQC and GMC, acknowledge further work is needed to ensure that oversight and support from national bodies and regulators is effectively co-ordinated, particularly as sustainability and transformation partnerships (STPs) and integrated care systems develop. National bodies will continue to work together to address opportunities for further improvement. This includes minimising the cumulative regulatory burden on providers and ensuring that the good work done collaboratively to date informs opportunities to improve any joint response to challenged providers in the future at an STP level.

5.2. There is scope for ALBs to further co-ordinate and streamline interactions with providers to avoid trust leadership teams having to provide data and assurance to multiple external organisations. Existing intelligence and risk-sharing forums should enable relevant ALBs and regulators to identify what information is already available, and agree what further information or evidence is required and which organisation is best placed to request this from providers. ALBs must continue working with providers to ensure a rapid response to immediate challenges and pressures, while also focusing on helping providers develop a recovery plan to tackle underlying issues.

5.3. NHS Improvement will review its approaches to monitoring leadership and cultural issues at an operational level in providers. This will involve reviewing how regional teams are using the well-led framework in their regular interactions with trusts, and identifying potential support needs around leadership, culture and improvement capability.

5.4. Existing arrangements for sharing information about risks and concerns across different regions need further review. There is also room to explore whether any additional processes could ensure that support is collectively planned, and its impact reviewed regularly, in more challenged healthcare systems.

5.5. Some of the learnings from the learning review focused on more effective and co-ordinated handling of messages to stakeholders. Regulatory and oversight bodies working with providers should therefore involve communications teams from early in the process, and consider if additional dedicated resource is needed to ensure proactive communications handling. This is particularly relevant in situations where it is vital to communicate alternatives to A&E attendance to the local population.

5.6. At regional level there is scope for reviewing the use of QSGs and tools such as the quality risk profile tool, to ensure a standardised, effective approach for assessing risks to quality across regions. Some NHS Improvement regional teams feel that, despite the revised guidance for holding QSGs and risk summits, certain areas could be improved, such as the focus on specific services or single providers, rather than whole systems (eg exploring quality issues with ophthalmology services across multiple providers), and the process for implementing and closing down actions resulting from QSGs. As a result, some local areas within NHS Improvement regions have been reviewing and improving their process for holding QSGs. National bodies will have to continue to work together to ensure all future risk summits are conducted in line with the new NQB guidance[20] in all regions, and ensure that the quality risk profile tool is used in accordance with national best practice. Review should also include the extent to which CQC uses the quality risk profile tool as part of its intelligence monitoring processes to capture material intelligence.

5.7. The new operating model being developed between NHS Improvement and NHS England provides an opportunity to align national and regional oversight and support, through a consistent structure at senior level across regions and across the national medical and nursing teams, and having senior leadership accountable to both organisations. Each of the new seven regions will also have its own JSOG; these are currently being developed. These new arrangements should strengthen the way the two organisations work together to oversee and support providers, including further improving intelligence sharing, identification of risks and co-ordinated support interventions.

Links to other work

5.8. The recommendations from the review led by Dr Bill Kirkup into events at Liverpool Community Health NHS Trust between 2010 and 2014 (the Kirkup report)[21] highlight some issues similar to those from the NMUH learning review regarding the need for co-ordination between national bodies and the effectiveness of their joint oversight of the sector. NHS Improvement, NHS England and CQC will therefore consider the recommendations from the Kirkup and NMUH reviews and, where appropriate, in a co-ordinated exercise further test current system oversight and escalation arrangements in response to both. This will be completed later in 2018 through facilitated workshops with relevant stakeholders across ALBs.

[20] National Quality Board. *Risk summits: national guidance*. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/07/risk-summit-guidance-july-2017.pdf

[21] Kirkup Bill (2018) *Report of the Liverpool Community Health Independent Review*. Available at: https://improvement.nhs.uk/documents/2403/LiverpoolCommunityHealth_IndependentReviewReport_V2.pdf

6. Conclusion

6.1. The way in which ALBs and regulators operate individually and collectively has changed significantly since the learning review period. Deloitte's review covered a period when NHS Improvement was being formed, relationships between the national NHS bodies were still being established and CQC was introducing a new approach to inspecting and rating providers. NHS Improvement, NHS England and HEE have now established ways of working, and CQC has continued to develop its strategy for delivering a more targeted, responsive and collaborative approach to regulation, working alongside national partners.

6.2. The system therefore now works in a more cohesive way, with increasingly proactive and collaborative procedures to oversee and support providers. National policy and guidance have also changed since the review period, including updated guidance from the NQB on operating QSGs. Therefore, many of the recommendations relevant to specific circumstances at a particular point in time have been or are being addressed through the new ways of working described.

6.3. NHS Improvement, NHS England and HEE, as well as CQC and GMC, acknowledge there is further scope to develop an even more co-ordinated and effective approach to overseeing and supporting providers, building on progress made to date to ensure that the collective activities across the system continue to have a positive impact. The new operating model being developed between NHS England and NHS Improvement will make a significant difference in how these bodies interact with providers, and creates an opportunity to ensure greater consistency in national oversight and support approaches in the future. At the same time, NHS England and NHS Improvement will take into account learning from previous organisational change processes to ensure that the transition to the new operating model does not affect the collective oversight of the provider sector.

6.4. While this report focuses on the response from the system oversight and regulation bodies, it should be noted where NMUH currently stands regarding the issues it faced over the review period. NHS Improvement continues to support the trust to build a resilient leadership team and to work with HEE and GMC to monitor the quality of medical training. The trust has been improving since 2016, but some challenges remain. This is reflected in the latest CQC inspection report, published in September 2018, which indicates that the trust still needs to strengthen some of its governance arrangements and improve its approach to overseeing risk, which can be embedded in the new divisional

structures. However, there were several changes to the trust's executive team which accelerated improvement.

6.5. National oversight and regulation bodies are confident that, as a system, they now have more effective systems and processes to support the trust in its ongoing improvement journey, as well as to respond to similar situations in the future.

Appendix 1 – Learnings from the learning review report

Ref	Learning
L1a	External stakeholders, and NHS Improvement in particular, should have taken more concrete steps during 2015 to address the known leadership issues at NMUH and to support the trust. We recognise that there were resource constraints at NHS Improvement (TDA until 1 April 2016) but, in our view, there was also a lack of appetite to tackle the issues.
L1b	NMUH should have been more explicit regarding the scale of the problems it was facing and asked for more specific help at an earlier stage rather than being defensive and giving the impression that action plans were addressing the issues. However, the regulatory environment did not promote a culture that incentivises open and honest behaviours.
L2a	The response of the system to a range of material quality concerns in July/August 2015 was not commensurate with the information available and the outcome was perceived by a number of interviewees to have been unduly influenced by capacity constraints at regulators and that an independent perspective may have been helpful.
L2b	The risk summit and extended roundtable design proved to be ineffective forums given the number of people, format and size of agenda. They also place too much reliance on assurance and action plans from the trust.
L3a	The system did not place sufficient emphasis and value on HEE and GMC intelligence in July/August 2015, to the extent that it missed a significant opportunity to crystallise the scale of the cultural and leadership challenges at NMUH.
L3b	The conclusion of a “critical” review by Dr Simon Eccles was shared with the key system stakeholders in October 2015 but no direct action was taken in response, thus presenting another missed opportunity for the system.
L3c	HEE did not push its intelligence as assertively after the 1 July 2015 visit as it subsequently did post the March 2016 visit, with limited impact between the two visits. Furthermore, HEE reports are not accessible even though they are technically published.

L4a	There was enough intelligence in the system during 2015 to alert CQC to the fact that there were significant quality issues at the trust and there was opportunity for CQC to have re-inspected before April 2016.
L4b	CQC was not formally asked to re-inspect by any organisation until after the HEE visit in March 2016. There was enough concern in the system to have prompted others to formally warn CQC prior to this point and the experience highlights the importance of expressly outlining concerns between regulators rather than relying on them interpreting the data.
L5	NHS Improvement, NHS England and CCGs are too reliant on CQC, and HEE in this case, to provide them with softer intelligence regarding what is actually happening on the ground. NHS Improvement in particular would benefit from a greater level of scrutiny at the operational level as part of its ongoing operations.
L6	Quality surveillance groups were ineffective in tackling system-wide issues in the context of NMUH and stakeholders question their value in the current form.
L7	The perception from numerous interviewees was that the system was initially slow in reacting to HEE/GMC concerns in March 2016 to the extent that it was nearly a month before CQC did its unannounced visit and apparently HEE spent several weeks debating with NHS England over the appropriate response. In retrospect, the HEE concerns were valid and there should have been a more immediate response from the system.
L8a	The situation following the HEE visit further highlighted challenges with the NHS Improvement resourcing model but also exposed a level of ambiguity over the respective roles and responsibilities of NHS Improvement and NHS England in such a situation. Specifically, while recognising that NHS England assumed the lead role in the context of resilience planning, there are numerous accounts from interviewees that this arrangement was also influenced by resourcing constraints at NHS Improvement and 'strong characters' at NHS England.
L8b	There was not a formal contingency plan in place to respond to the situation which required a level of improvisation and also led to some resistance from the trust.
L9	The system focus on attracting doctors became all-consuming for several months to the extent that there was less focus from ALBs and the trust on the more fundamental leadership and cultural issues until July/August 2016.
L10	HEE and GMC clearly played a critical role in resolving the situation at NMUH but there is a widespread view across stakeholders interviewed that the withdrawal of trainees should be the 'nuclear option' and that HEE and GMC

	need to work in a more collaborative and supportive manner with trusts and other regulators long before reaching this point.
L11	Expectations placed on HCCG[22] by NHS England were unrealistic under the circumstances and HCCG was forced into a role to compensate for weaknesses at NHS Improvement. HCCG came under a level of criticism undeservedly in our opinion. However, there may be scope in future for the terms of reference for committees such as CQRG[23] to be refined to allow them to take on a more strategic role in identifying and managing situations similar to the one at NMUH.
L12	The system response to events led to a positive outcome at NMUH but it is important to recognise that the underlying issues remain and therefore the system should not become complacent as the job is only partially done. Sustainable change will take time and the trust will require ongoing support.

[22] Haringey Clinical Commissioning Group.
[23] Clinical quality review group.

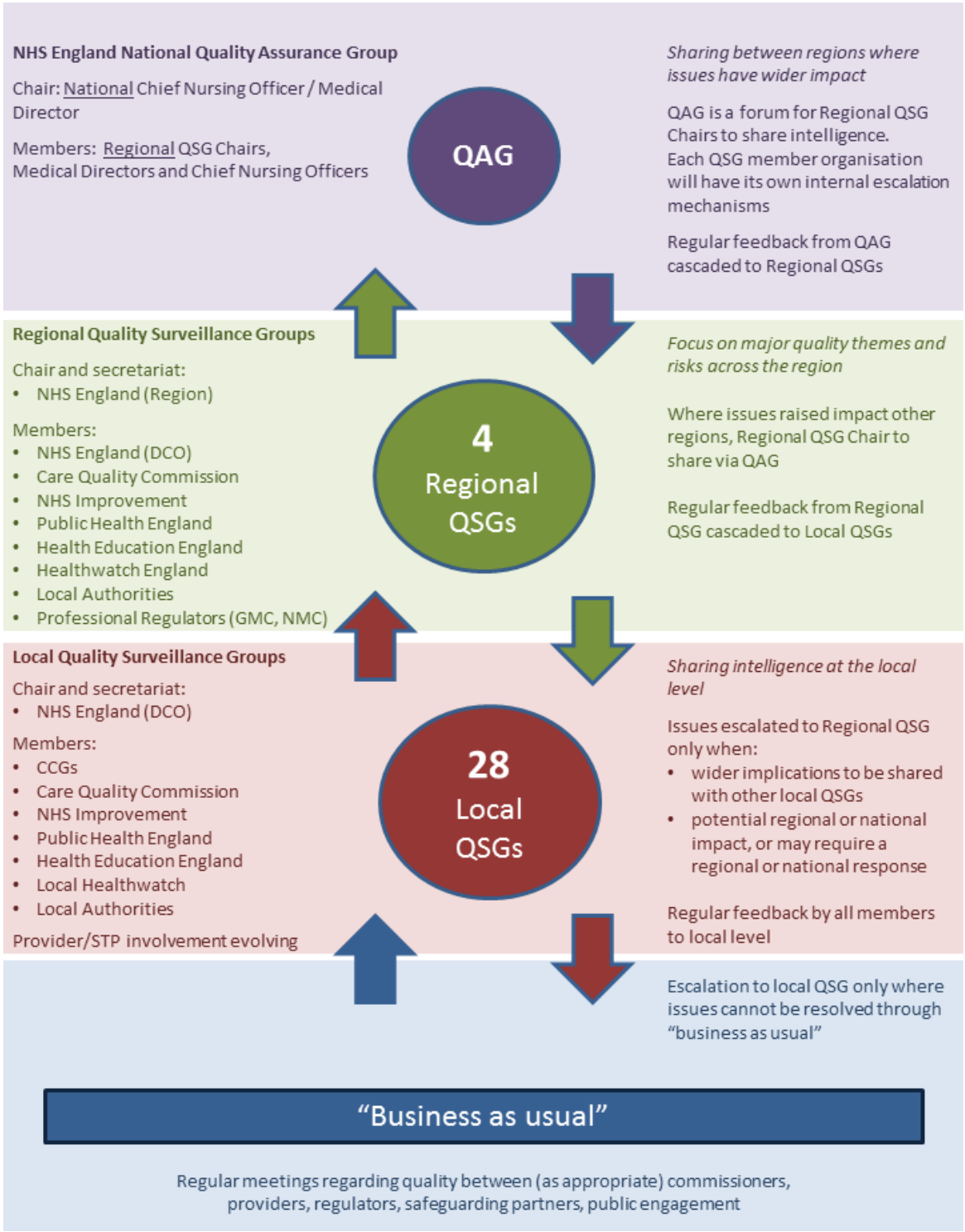
Appendix 2 – Recommendations from the learning review report

Ref	Recommendation
R1	NHS Improvement should reflect on whether its current resourcing model provides sufficient coverage to tackle structural issues at some of the more challenged trusts, specifically based on its experience at NMUH from around August 2015 to March 2016.
R2	The system should reflect on whether it has the right balance between support and assurance post the review period and whether the environment incentivises failing trusts to be open and honest about their circumstances.
R3	The system should consider the appointment of independent chairs for cross-system forums to ensure that the outcome is based on the available information and not influenced by pressures facing individuals and their respective organisations.
R4	The risk summit design needs to be addressed as a priority as it proved to be ineffective in tackling the underlying issues at NMUH.
R5	HEE and GMC intelligence and post-review actions should form an integral part of intelligence monitoring by CQC and NHS Improvement, and concerns should be given the same prominence as from other regulators and ALBs.
R6	HEE should consider mechanisms for proactively raising the levels of awareness around its reports with other ALBs and making them more accessible through improved website navigation.
R7	CQC should reflect on whether its monitoring system was effectively capturing the material intelligence that was in the system during the review period.
R8	All system stakeholders should recognise there may be a need at times to formally request a re-inspection by CQC when there are fundamental concerns over quality and CQC has not responded directly.
R9	NHS Improvement should consider whether its current arrangements for monitoring leadership and cultural issues at an operational level provide sufficient insight to potentially identify similar situations to NMUH in the future. Particular consideration should be given to cases where NHS Improvement has material concerns and there has not been a CQC visit for a period of

	time. This should be done in the context of how NHS Improvement could join-up with inspectorates while minimising duplication.
R10	The system should fundamentally revisit the function and format of quality surveillance groups as they proved to be ineffective in the context of NMUH.
R11	NHS Improvement and NHS England should consider whether the current resourcing models and contingency planning arrangements would enable a more co-ordinated response from NHS Improvement and NHS England should a 'crisis' situation, similar to that in Spring 2016, arise in future.
R12	The system should consider how future situations could be managed in a more balanced manner to ensure that single issues are not allowed to distract ALBs and providers from the wider agenda. This should specifically consider the pressures placed on trust leadership teams to provide continuous assurance to multiple external organisations.
R13	HEE and GMC should reflect on whether their operating models could evolve to be more solutions focused, where the withdrawal of trainees would be the option of last resort.
R14	NHS England should reflect on whether expectations regarding the role of CCGs in managing system-wide issues are clearly communicated and understood, particularly their role relative to NHS Improvement. NHS England should also consider the benefit in refining the terms of reference for CQRG[24] type committees to enable a more strategic focus.

[24] Clinical quality review group.

Appendix 3 – Quality surveillance of health and care services in England



(Source: National Quality Board 2017)[25]

[25] National Quality Board (2017) *Quality surveillance groups: National guidance*. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/07/quality-surveillance-groups-guidance-july-2017.pdf