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North Middlesex University Hospital NHS Trust

Learning review in relation to the system's response to events at NMUH from June 2014 to August 2016
Final Report for publication

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Learning review in relation to the system's response to events at North Middlesex University Hospital NHS Trust from June 2014 to August 2016

In accordance with our engagement letter dated 01 March 2017 (the 'Contract'), for an independent learning review in relation to the system's response to events at North Middlesex University Hospital NHS Trust (the 'Trust' or 'NMUH') from June 2014 to August 2016, we enclose our final report for publication dated 26 October 2018 (the 'Final Report').

The Final Report has been prepared for your sole use and shall be subject to the restrictions on use and other terms specified in the Contract. Whilst we have agreed that the Final Report may be published on the NHSI website, such publication may only be made on a non-reliance basis since no person except the addressees are entitled to rely on the Final Report for any purpose whatsoever and to the extent permitted by law we accept no responsibility or liability to any other person in respect of the contents of this Final Report. Should any person other than the intended parties choose to rely on this Final Report, they will do so at their own risk.

The addressees are responsible for determining whether the scope of our work is sufficient for their purposes and we make no representation regarding the sufficiency of these procedures for the addressees purposes. If we were to perform additional procedures, other matters might come to our attention that would be reported to the addressees.

We have assumed that the information provided to us and interviewee's representations are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness or reliability.

The matters raised in this report are only those that came to our attention during the course of our work and are not necessarily a comprehensive statement of all the learnings that exist. Any recommendations for improvements should be assessed by the relevant parties for their full impact before they are implemented.

Yours faithfully

Deloitte LLP

Contents

Introduction

Introduction

Context

- Over the period June 2014 to August 2016 (the Review Period), there was considerable interest and concern in relation to quality issues at North Middlesex University Hospital (NMUH) from a range of regulators and other healthcare organisations including the Trust Development Authority to 31 March 2016 (TDA), NHS Improvement from 1 April 2016 (NHSI), NHS England (NHSE), the General Medical Council (GMC), Health Education England (HEE), Care Quality Commission (CQC) and Haringey and Enfield Clinical Commissioning Groups (HCCG and ECCG, respectively). These concerns led to a series of events over the period, including: inspections; intelligence sharing meetings; risk summits; an extended round table; and ongoing assurance meetings. The quality concerns were well known and covered a range of areas but included: higher mortality rates; CQC intelligent monitoring showing increased elevated risk; negative GMC trainee survey results; poor results in CQC patient surveys; poor response to A&E Friends and Family Test (FFT); and concerns regarding anaesthetic and A&E trainees raised by HEE.
- The sequence of events is complex and evolved over a two year period but, in essence, the situation culminated in the GMC warning NMUH in Spring 2016 that they were prepared to remove accreditation for training a significant cohort of doctors at the Trust, which would have led to a significant breakdown in the emergency network across London. These events are well documented and, as such, we do not provide a detailed analysis in this report. A summary of the key events in our timeline for reference are as follows:
- **21 August 2014**: A CQC report was published which rated the Trust as Requires Improvement. The Accident & Emergency department was also rated Requires Improvement. Inspection took place 3-6 June 2014 and 23 June 2014.
- **17 March 2015**: A risk summit was convened by NHSE to consider issues raised by HEE in relation to the anaesthetics trainee environment at NMUH. This resulted in HEE taking action to suspend training and remove trainees from the anaesthetics department from 1 April 2015.
- **1 July 2015:** An HEE 'Conversation of Concern' visit to NMUH raises leadership and behavioural issues within the Emergency Department (ED).
- **3 July 2015:** A 'stakeholder quality concerns meeting' was convened by HCCG to consider a number of emerging quality issues and to share intelligence.
- **31 July 2015:** An intelligence sharing meeting was hosted by HCCG to further consider the emerging quality issues and to decide on the appropriate course of action.
- **13 August 2015:** An extended round table was chaired by NHSE to discuss the emerging quality issues and to agree actions.
- **7 September 2015:** A one day visit was conducted by Dr Simon Eccles, appointed by NHSE, to review ten case summaries which caused concern to HEE during the 1 July 2015 visit. The conclusion, although not the report, was shared with system players on 13 October 2015.
- **30 November 2015:** An informal visit by HEE to NMUH indicates that the situation with trainees is improving.
- **13/14 December 2015:** Undetected patient death in ED at NMUH.
- **12 January 2016:** HCCG convenes a quality 'stock take' to review progress since the extended round table. Decision taken to move to risk summit, partly driven by deterioration in A&E performance.
- **20 January 2016:** Intelligence sharing call arranged in advance of the risk summit.
- **8 February 2016:** A&E risk summit hosted by the TDA.
- **15/16 March 2016**: HEE quality visit raises further concerns regarding leadership and cultural issues in ED at NMUH. HEE and the GMC subsequently warned NMUH that they were prepared to remove trainees, and the approval for the Trust to train in the ED at NMUH, respectively.
- **14 April 2016** and **4/5 May** – CQC unannounced visits lead to NMUH ED being rated as inadequate and a warning notice is served. Report published on 7 July 2016.
- **25 May 2016** – Risk summit convened by NHSI, at request of the GMC, to consider the situation in relation to the removal of trainees from NMUH.
- **21 June 2016** – Follow-up visit to meet with trainees, including senior representatives from a range of stakeholders.
- **6 July 2016** – Press release from the GMC/HEE announcing that they are satisfied with the actions taken to address concerns over the training environment at NMUH and agreed to withdraw threat to remove trainees subject to a number of conditions.
- **July 2016** – Chief Executive and Director of Nursing step-down from the Trust, followed by the Chair and a number of other Executive Directors.
- **August 2016 onwards** - A number of experienced doctors arrive to support the ED at NMUH. Several new Board members appointed including a new Chair, CEO, COO, Director of Nursing and Director of Finance.

Introduction (continued)

Project scope

- The purpose of this review is to consider how the system responded to the concerns at NMUH over the Review Period and is not intended to revisit the particular quality, leadership and cultural issues experienced at the Trust. Furthermore, the intention of the review is to be developmental in nature with a view to identifying learnings for the future rather than apportioning blame for the past.
- The review scope included a review of the following aspects of how the system responded to concerns at NMUH during the Review Period:

Identification

  - What key pieces of available data or information were the best indicators of the underlying issues at NMUH, including soft intelligence? Are there any other pieces of information which could be collected that would have 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 ED, and/or issues with the 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?

System response

  - Were mechanisms (such as risk summits) to coordinate a response across the system effective?
  - What interventions were the most effective in driving improvement? What interventions were less effective or counterproductive?
  - What are the key enablers to an effective response which should be installed as a priority in similar situations?

Communications

  - How can NHS Improvement and NHS England identify situations which require more proactive / collaborative intensive communications handling?
  - How can communications teams in different organisations work more effectively together to ensure coordinated 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?

- We have written this report on an exceptions basis, rather than trying to summarise all events over a two year period, and as such have extracted a number of key themes where we believe there to be beneficial learnings for the system in the future. All of these learnings, and associated recommendations, are supported by detailed working papers which capture a more comprehensive and systematic review of events surrounding the period.
- Please note that communication issues did not feature prominently in our review and as such is not explicitly referenced in our exception based key learnings.

Our approach

Our approach to delivering the project scope has consisted of:

- Desktop review of documentation from key forums held during the Review Period; and
- A series of 1-1.5 hour non-attributable interviews with key stakeholders involved with the situation at NMUH over the Review Period. The interviews were conducted during April and May 2017 and we set-out a full list of interviewees in Appendix D on page 25.

Executive Summary

Executive Summary

Key findings

We have undertaken a learning review in relation to the system's response to events at North Middlesex University Hospital NHS Trust from June 2014 to August 2016, against the scope set out in our Contract dated 01 March 2017.

We outline below a summary of our key recommendations. These are based on learnings drawn from the Review Period and we acknowledge that actions are already underway in the respective organisations to fully or partially address many of these recommendations.

- NHSI 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.
- Whilst recognising that NMUH leadership should have been more open, 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.
- 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.
- The risk summit design needs to be addressed as a priority as it proved to be ineffective in tackling the underlying issues at NMUH and fundamental weaknesses were highlighted, as outlined in our narrative.
- HEE and GMC intelligence and post-review actions, should form an integral part of intelligence monitoring by CQC and NHSI and concerns should be given the same prominence as from other regulators and Arms Length Bodies (ALBs).
- 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.
- CQC should reflect on whether its monitoring system was effectively capturing the material intelligence that was in the system during the Review Period.
- 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.
- NHSI 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 NHSI 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 NHSI could join-up with inspectorates whilst minimising duplication.
- The system should fundamentally revisit the function and format of Quality Surveillance Groups as they proved to be ineffective in the context of NMUH.
- NHSI and NHSE should consider whether the current resourcing models and contingency planning arrangements would enable a more coordinated response from NHSI and NHSE should a 'crisis' situation, similar to that in Spring 2016, arise in future.
- 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 assurance to multiple external organisations.
- HEE and the 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.
- NHSE 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 NHSI. NHSE should also consider the benefit in refining the terms of reference for CQRG type committees to enable a more strategic focus.

Detailed findings

Detailed findings

Our key learnings and recommendations are set-out below.

1. Addressing leadership issues

Learning 1a: External stakeholders, and the TDA (NHSI from 1 April 2016) 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 the TDA but, in our view, there was also a lack of appetite to tackle the issues.

R1 – NHSI 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.

- The leadership issues facing the NMUH Emergency Department and at Board level were at the heart of the problems experienced at the Trust during the Review Period. These issues were well-known at the Trust and there was good awareness externally. In addition, there are numerous examples of the Trust and CCGs flagging concerns with the TDA and NHSE in relation to leadership within ED as well as problems at the Board level.
- There is a strongly held view across interviewees that the appropriate level of support was not provided by external stakeholders to help NMUH tackle these leadership issues. Specifically, the TDA as the primary regulator, could have taken more concrete steps in 2015 to address the known issues at NMUH.
- It is recognised that there were capacity constraints at the TDA during 2015 and that the resourcing model impacted on its ability to provide effective support at this point in time. However, there is a view that there was also a lack of appetite at the TDA to tackle the issues given competing pressures at other NHS trusts in London.

Learning 1b: 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.

R2 – Whilst recognising that NMUH leadership should have been more open, 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.

- Whilst the Trust did not necessarily conceal the leadership and cultural issues it was experiencing, it did have a tendency to understate the full extent of the issues and there were opportunities for the Trust to have been more open and transparent in terms of making the issues absolutely clear to external stakeholders. In particular, the Trust is described as having a tendency to explain issues away, could be defensive to challenge, be unaccepting of support and would provide assurances to external stakeholders that the issues were being addressed through detailed action plans. A more explicit approach to the TDA/NHSI from NMUH would likely have provoked a more robust response to tackling the situation.
- However, the regulatory environment is considered by many interviewees to be assurance based and unsympathetic towards failing organisations. This has in-turn created a culture and operating environment that is not conducive to promoting open and honest discussions between providers and regulators.

2. The effectiveness of key system forums

Learning 2a: 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 that an independent perspective may have been helpful.

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.

- One of the most critical points in the Review Period are the events surrounding the 13 August 2015 extended round table and the prior intelligence sharing meeting on 31 July 2015, where the system was presented with a significant opportunity to address quality issues at NMUH but did not take it.

Detailed findings (continued)

2 The effectiveness of key system forums (continued)

- Participants at the intelligence sharing meeting, chaired by HCCG and the TDA, included NHSE, CQC, HEE, ECCG and Enfield Council. The issues included on the agenda were wide ranging, including: anaesthetic trainee concerns; A&E trainee concerns; GMC trainee survey showing a strong negative outlier in anaesthetics and emergency medicine for the past 4 years; A&E FFT was the worst in London during Q4; CQC national patient survey A&E shows the Trust in the bottom 20% on many questions; complaints management issues; maternity FFT showed poor feedback in antenatal; serious incident investigations process issues, including poor quality reports and poor deadline keeping; CQC 2014 inpatient survey was worse on 10 domains compared with the previous year; a number of 2 week wait cancer breaches; higher mortality on May dashboard; CQC intelligent monitoring showing five elevated risks; and concerns about effectiveness of senior leadership, including how well sighted the Board was on the situation.
- In our view, the system response following the 31 July 2015 intelligence sharing meeting was not commensurate with the scale of quality issues presented, even allowing for dilution of the HEE intelligence discussed below. Furthermore, strong warnings from senior clinicians were not heeded. Comments at the meeting included: *"If asked whether this Trust could be the next Mid Staffs, I would not be able to say no.";* and *"If asked by a patient what we did when we had all of this information, I want to be able to say we took it very seriously and took action quickly."*
- The 13 August extended round table, chaired by NHSE, subsequently lacked impact, not helped by the fact that HEE and CQC were not invited due to an administrative error, and the outputs were inadequate and ultimately ineffective. The forum also placed too much reliance on actions provided by the Trust for assurance.
- Interviewees indicated that the outcome from these meetings may have been influenced by competing priorities at other challenged London trusts. There is a widely held view that the system could have benefited from a more objective perspective from an independent chair of these key forums.

Learning 2b: The Risk summit and extended round table 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.

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 and fundamental weaknesses were highlighted, as outlined in our narrative.

- In addition to the points discussed above, the 8 February 2016 risk summit was drawn into focusing on ED performance and while some concrete actions came out of the meeting, too much reliance was placed on Trust action plans and the meeting did not focus on leadership and cultural issues.
- Overall, the key stakeholder events proved to be ineffective at crystallising the underlying problem and agreeing an appropriate response. In particular, they highlighted a number of weaknesses in the risk summit model including: too many people around the table; too wide an agenda; difficulty in keeping discussion focused; and too much of a variation in the level of understanding around the table.
- We understand that the National Quality Board has recently carried out a review of the quality architecture and made recommendations in relation to risk summits.

3. Maximising the value from HEE and GMC intelligence

Learning 3a: 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.

R5 – HEE and GMC intelligence and post-review actions, should form an integral part of intelligence monitoring by CQC and NHSI and concerns should be given the same prominence as from other regulators and Arms Length Bodies (ALBs).

Detailed findings (continued)

3. Maximising the value from HEE and GMC intelligence (continued)

- In the absence of a CQC inspection, HEE and the GMC were the main external organisation to directly access 'sentiment' on the front line of ED at NMUH from June 2014 through to April 2016.
- Intelligence from the 1 July 2015 'Conversation of Concern' visit was one of the strongest indicators throughout the Review Period that there were fundamental leadership and cultural issues in ED, for example:
    - *"The visit team found that 15 out of the 18 trainees met by the visit team reported having to deal with situations beyond their competence without appropriate supervision on a regular basis"*
    - *"The FY2 trainees advised that they would neither recommend the ED to friends and family, nor for training to a colleague"*
- This intelligence did not gain sufficient prominence at the 31 July 2015 intelligence sharing meeting or the 13 August 2015 extended round table. This was partly due to it being consolidated with a wide range of agenda items but, also, due to HEE not having the same status as other organisations and, as such, the intelligence not carrying as much 'weight'.
- We note that a national bi-monthly meeting with HEE/GMC/CQC/NHSI/NHSE in attendance, and chaired by the Chief Inspector of Hospitals, has been established post Review Period.

Learning 3b: 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.

- A Trust initiated review into ED case summaries was conducted by Dr Simon Eccles on 7 September 2015, in direct response to the HEE report. This report concluded *"it is quite clear that you have a serious issue with the culture in the ED and the conduct and capability of some staff."*
- This review was conducted by an NHSE representative and the conclusion, although not the report, was shared with the TDA, CQC, HEE and HCCG on 13 October 2015 but was not raised in any subsequent forums, based on our review of minutes.

Learning 3c: 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 easily accessible, even though they are technically published.

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.

- HEE shared their intelligence with NHSE and the TDA directly after the 1 July 2015 visit, as well as at the 31 July 2015 meeting. However, in retrospect, it could have been more assertive, as we are not aware of HEE subsequently escalating this issue again with the system until March 2016. However, we recognise the assurance HEE was receiving via the Trust action plan and that an informal visit by HEE in November 2015 gave system partners some assurance of progress.
- The publication of HEE reports is also sub-optimal with low levels of awareness and difficulties in navigating the website they are published on.

4. CQC response to quality concerns

Learning 4a – 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.

R7– CQC should reflect on whether its monitoring system was effectively capturing the material intelligence that was in the system during the Review Period.

CQC was aware of the fact that there were problems in ED at the time of the August 2014 inspection with ED rated requires improvement and concerns raised regarding culture.

Detailed findings (continued)

4. CQC response to quality concerns (continued)

- The CQC intelligence report in July 2014 reported a total of seven risks, of which one was labelled an 'elevated risk' and none of these risks concerned the NMUH ED. In contrast, in May 2015 a total of 22 risks were identified of which five were on the 'elevated category'. Six of the risks related to ED.
- CQC was present at the 3 July 2015 Quality Assurance Meeting and the 31 July 2015 intelligence sharing meeting. The quality concerns raised in these meetings were wide ranging and material. The conclusions from the Dr Simon Eccles review were also shared with CQC.
- CQC decided to re-inspect in April 2016 following a letter directly from the CEO of HEE to the CEO of CQC. Whilst recognising the constraints on CQC resourcing during the Review Period, we are of the view that the intelligence available during 2015 should have alerted CQC to the fact that there were material quality issues at the Trust and there was opportunity for a re-inspection prior to April 2016.

Learning 4b: 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.

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.

- We are not aware of any direct requests for CQC to re-inspect until after the March 2016 HEE visit and this experience highlights the importance of expressly raising concerns with CQC rather than assuming they will interpret the indicators.

5. Accessing soft intelligence

Learning 5: NHSI, NHSE 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. NHSI in particular would benefit from a greater level of scrutiny at the operational level as part of its ongoing operations.

R9 – NHSI 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 NHSI 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 NHSI could join-up with inspectorates whilst minimising duplication.

- The TDA/NHSI tended to operate at Board level during the Review Period and therefore relied on assurance from the Board and intelligence from inspectorates, such as CQC or other bodies, regarding organisational leadership and cultural issues. Similarly CCGs, and therefore NHSE, also relied on assurances from senior trust leaders and had limited opportunity to access the operational level. The situation at NMUH was exacerbated by a breakdown in openness and trust between the Trust and CCGs.
- CQC did not inspect the Trust from June 2014 to April 2016. Therefore, HEE found itself in a unique situation where it was one of the few organisations with close access to the operational level at NMUH for nearly a two year period.
- Whilst this dynamic highlights the value of HEE data in the absence of a CQC inspection, it also demonstrates the reliance key system stakeholders, particularly the TDA/NHSI, placed on CQC for 'softer intelligence' during the Review Period. In addition, it reinforces the need for other organisations, specifically NHSI and CCGs, to proactively seek direct assurance independent of CQC, especially in the context of a trust they are worried about which has not been inspected for a period of time.
- We note that NHSI and CQC have published a joint leadership framework and assessment process post the Review Period.

Detailed findings (continued)

6. Quality Surveillance Group (QSG) effectiveness

Learning 6: Quality Surveillance Groups were ineffective in tackling system wide issues in the context of NMUH and stakeholders question their value in the current form.

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.

- Quality Surveillance Group (QSG) meetings have been universally described by stakeholders as being an ineffective forum for appropriately tackling cross-system issues due to a number of factors. In particular, they are described as having been ineffective in relation to resolving the quality issues at NMUH.
- Weaknesses in the format cited by interviewees include too many people; meeting too regularly at different levels; having too much variability and inconsistency in attendees; not being a forum for frank discussion and generally lacking focus and clarity over follow-up.
- We note that the review of the quality architecture by the National Quality Board described above included a review of QSG.

7. System response to the March 2016 HEE visit

Learning 7: The perception from numerous interviewees was that the system was initially slow in reacting to HEE and GMC concerns in March 2016 to the extent that it was nearly a month before CQC did its unannounced visit and apparently HEE and the GMC spent several weeks debating with NHSE over the appropriate response. In retrospect, the HEE concerns were valid and there should have been a more immediate response from the system.

See R5 (p11).

- The 15/16 March 2016 HEE quality visit highlighted similar staffing, leadership and cultural issues in ED to those identified previously in July 2015 and indicated that the previous action plan had not led to improvements.
- The HEE and GMC response was robust this time around and HEE and the GMC were highly proactive with regards to informing stakeholders of their serious concerns. The concerns were so material that HEE and the GMC warned that they were prepared to remove trainees, and the approval for the Trust to train in the ED at NMUH, respectively.
- The unannounced CQC visit took place on 14 April 2016 where similar leadership and cultural issues were observed and ED was rated inadequate.
- System action began to build momentum during this period although we understand from interviewees that CQC did not respond immediately and the unannounced inspection was a consequence of a CEO to CEO letter. NHSE and NHSI were described as initially being dismissive of HEE concerns. There was a sense that the system was responding to a threat rather than to concerns.

8. Regulator responsibilities and contingency planning

Learning 8a: The situation following the HEE visit further highlighted challenges with the NHSI resourcing model but also exposed a level of ambiguity over the respective roles and responsibilities of NHSI and NHSE in such a situation. Specifically, whilst recognising that NHSE 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 NHSI and 'strong characters' at NHSE.

Learning 8b: 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.

R11 – NHSI and NHSE should consider whether the current resourcing models and contingency planning arrangements would enable a more coordinated response from NHSI and NHSE should a 'crisis' situation, similar to that in Spring 2016, arise in future.

Detailed findings (continued)

8. Regulator responsibilities and contingency planning (continued)

- NHSE assumed a primary leadership role in managing the system response to the resilience problems associated with the potential withdrawal of trainees. This was a pragmatic solution given a resourcing differential between NHSE and NHSI. Executive leadership responsibility was not formally agreed but is described as happening more naturally given capacity constraints at NHSI and 'strong characters' at NHSE. While it was probably the best alternative at the time, the informal nature of the arrangements highlights a significant level of ambiguity over the respective roles of NHSI and NHSE in circumstances of this nature.
- In addition, there was not a formal protocol in place to respond to such a 'crisis' situation and therefore required a level of improvisation and also led to some resistance from the Trust given the absence of any protocol.
- We have been informed that NHSI and NHSE collaboration in London has improved as the respective organisations mature but understand there are still some ambiguities which can occasionally lead to tensions.

9. Addressing the root causes

Learning 9: 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.

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.

- Whilst the HEE and GMC intervention started a process which ultimately led to fundamental changes in leadership at the Trust, the primary focus for four months was on addressing a single issue in relation to medical staffing levels. In many ways, this was a distraction from the wider leadership and cultural issues at Board, which went unresolved for a number of months. The Trust specifically describes the significant distraction events had on leadership time given the need to consistently provide assurance to the GMC and HEE in particular.
- We understand that NHSI commissioned a governance review which was conducted in June 2016 and ultimately supported the Trust with a transition in CEO and Director of Nursing post holders in August 2016.

10. Withdrawing trainees

Learning 10: 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 the GMC need to work in a more collaborative and supportive manner with trusts and other regulators long before reaching this point.

R13 – HEE and the 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.

- HEE and the GMC played an instrumental role in highlighting the extent of the problems at NMUH and these would invariably have continued for a longer period had they not intervened in the way that they did.
- HEE and the GMC have been described as not being particularly solution focused organisations and can at times be too willing to pull trainees out of organisations.

Detailed findings (continued)

10. Withdrawing trainees (continued)

- The experience at NMUH has raised the profile of HEE and GMC intelligence and it is now more closely integrated with other regulators and ALBs. It is therefore likely that any future issues will be resolved in a collaborative way long before there is a need to withdraw trainees. However, there is a consensus across stakeholders that HEE and the GMC should relegate the option of withdrawing trainees to one of last resort as opposed to it being used as a regular lever.
- Our discussions with HEE and the GMC suggest that they too see this as an instrument of last resort but that it was the only material lever left available to them to use as they "*were not being listened to*".

11. Expectation on CCGs in relation to system issues

Learning 11 – Expectations placed on HCCG by NHSE were unrealistic under the circumstances and HCCG was forced into a role to compensate for weaknesses at the TDA/NHSI. 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 to be refined to allow them to take on a more strategic role in identifying and managing situations similar to the one at NMUH.

R14 – NHSE 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 NHSI. NHSE should also consider the benefit in refining the terms of reference for CQRG type committees to enable a more strategic focus.

Haringey CCG was placed in a central role during the Review Period and came under some criticism subsequently for its role in handling the situation. While there are aspects that HCCG could have handled differently with hindsight, stakeholders interviewed have been positive regarding HCCGs contribution and the CCG appears to have been the most proactive organisation during the early stages of the Review Period.

- The experience of HCCG raises a fundamental question regarding expectations placed on CCGs vis-a-vis regulators, and NHSI in particular, in relation to the coordination and management of issues at provider organisations.
- We do however note that the most regular forum for considering quality issues at NMUH during the Review Period was the Clinical Quality Review Group, which was chaired by HCCG. Membership of this forum included senior representatives from HCCG, ECCG and the Trust, and there was regular attendance from the TDA/NHSI. Whilst we recognise that the primary focus of this forum was on managing operational and contract issues, there would be benefit in NHSE and the respective CCGs reflecting on whether committees of this nature could be refined to help identify more strategic issues at other trusts in future.

12. The ongoing situation at NMUH

Learning 12: 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.

- Events around the HEE and GMC situation led to a period of change which appears to have had a positive impact on leadership and culture at the Trust. However, there is a sense that while the situation surrounding medical rotas and support for trainees has been addressed, cultural issues, and other issues, continue to exist to the extent that the situation is described as "fragile". It is critical in our view that there is recognition that the Trust remains vulnerable and that addressing the cultural issues in particular will take a significant period of time. It is therefore important that the system continues to provide support to NMUH, in addition to performing its assurance role.

Appendix 1:
Summary of learnings

Appendix 1 - Summary of Learnings

Ref.	Learning
L1a	External stakeholders, and the TDA (NHSI from 1 April 2016) 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 the TDA 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 that an independent perspective may have been helpful.
L2b	The Risk summit and extended round table 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	NHSI, NHSE 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. NHSI in particular would benefit from a greater level of scrutiny at the operational level as part of its ongoing operations.

Appendix 1 - Summary of Learnings

Ref.	Learning
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 NHSE 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 NHSI resourcing model but also exposed a level of ambiguity over the respective roles and responsibilities of NHSI and NHSE in such a situation. Specifically, whilst recognising that NHSE 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 NHSI and 'strong characters' at NHSE.
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 the 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 the 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 by NHSE were unrealistic under the circumstances and HCCG was forced into a role to compensate for weaknesses at the TDA/NHSI. 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 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.

Appendix 2:
Summary of recommendations

Appendix 2 - Summary of Recommendations

Ref.	Recommendation
R1	NHSI 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	Whilst recognising that NMUH leadership should have been more open, the system should reflect on whether it has the right balance between support and assurance during 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 and fundamental weaknesses were highlighted, as outlined in our narrative.
R5	HEE and GMC intelligence and post-review actions, should form an integral part of intelligence monitoring by CQC and NHSI 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	NHSI 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 NHSI 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 NHSI could join-up with inspectorates whilst 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	NHSI and NHSE should consider whether the current resourcing models and contingency planning arrangements would enable a more coordinated response from NHSI and NHSE 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 the GMC should reflect on whether there operating models could evolve to be more solutions focused, where the withdrawal of trainees would be the option of last resort.
R14	NHSE 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 NHSI. NHSE should also consider the benefit in refining the terms of reference for CQRG type committees to enable a more strategic focus.

Appendix 3:
Glossary

Appendix 3 - Glossary

Glossary of terms used throughout this report

A&E = Accident & Emergency

ALB = Arms Length Body

CCG = Clinical Commissioning group

CEO = Chief Executive

COO = Chief Operating Officer

CQC = Care Quality Commission

CQRG = Clinical Quality Review Group

ED = Emergency Department at NMUH

ECCG – Enfield CCG

FFT - Friends and Family Test

GMC = The General Medical Council

HCCG – Haringey CCG

HEE = Health Education England

MD – Medical Director

NHSE – NHS England

NHSI = NHS Improvement

NMUH = North Middlesex University Hospital NHS Trust

QSG = Quality Surveillance Group

TDA = Trust Development Authority

Trust = North Middlesex University Hospital NHS Trust

Appendix 4:
Review participants

Appendix 4 - Review Participants

Interviewees

As noted, this report is based on views expressed by a range of participants in our interviews. Below, we document the participants with which we spoke during the process of this review :

Care Quality Commission
- Nicola Wise, Head of North London
- Edward Baker, Deputy Chief Inspector of Hospitals
- David Harris, Hospital Inspection Manager London

Enfield CCG
- Aimee Fairbairns, Director of Quality

Enfield Council
- Ray James, Director of ASC
- Bindi Nagra, Assistant Director of ASC

General Medical Council
- Jessica Lichtenstein, Head of Quality Assurance

Haringey CCG
- Sarah Price, Chief Officer
- Jennie Williams, Executive Nurse and Director of Quality and Integrated Governance
- Peter Christian, Chair

Haringey Council
- Zina Etheridge, Director of ASC

Healthwatch Enfield
- Parin Bahl, Chair

Health Education England
- Elizabeth Hughes, Dean and Director of Education and Quality (London and the SE)
- Julie Screaton, Regional Director (London and the SE)
- Sanjiv Ahluwalia, Postgraduate Dean (NCEL)
- Ian Bateman, Head of Quality and Regulation (London and the SE)

NHS England
- Ceri Jacob, Director of Commissioning Organisation North Central and East London
- Vanessa Lodge, Director of Nursing North Central and East London
- Henrietta Hughes, former Medical Director North Central and East London
- Helene Brown, Medical Director North Central and East London
- Simon Weldon, Director of NHS Operations and Delivery

NHS Improvement
- Kathy Mclean, Medical Director
- Andrew Hines, Regional COO, London
- Victoria Woodhatch, Director of Delivery and Improvement ((NCEL)
- Faizal Mangera, Head of Delivery and Improvement (NCEL)
- Fran Davis, Head of Quality (formerly NCEL, currently South London)
- Lucy Barnett, Delivery and Improvement Lead (Previous NHSE)

NMUH
- Cathy Cale, Medical Director
- Richard Gourlay, former Chief Operating officer (now Strategic Development Director)
- Julie Lowe, former CEO

Royal College of Emergency Medicine (London)
- Katherine Henderson, Chair

Royal Free Hospital NHS FT
- Kate Slemeck, Chief Operating Officer

Deloitte.