



Rapid evaluation of the implementation of the Recovery Support Programme

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Rapid evaluation of the implementation of the Recovery Support Programme

Insights report

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1. Executive Summary

Launched in July 2021, the Recovery Support Programme (RSP) is available to support Integrated Care Boards (ICBs), NHS Foundation Trusts and NHS Trusts facing complex challenges by providing intensive support to embed improvement, prevent further deterioration and enable stabilisation.

The NIHR Rapid Service Evaluation Team (REVAL) have undertaken a rapid formative evaluation of RSP to understand its initial impact and identify further improvements, which can improve its efficacy. We have found that RSP is generally perceived as supportive and less punitive than the previous special measures regime it replaced. However, we have gathered insights on ways by which its delivery could be enhanced. These include:

- There is a perception that it is easier to enter Segment 4 of the NHS Oversight Framework (NOF4) than to get out. Greater transparency over measures and metrics used to determine segmentation and the thresholds for each segment is warranted.
- There is variation in how, or if a diagnostic stocktake is undertaken across regions and, in the level of granularity of information collated. As it is foundational to the improvements that follow, the process could be standardised and include structured assessment of system capability and capacity to support change.
- Collective leadership may be a core-enabling feature of improvement efforts. Establishing whether this exists or is absent should be a core function of a diagnostic stocktake. Specifically, is there evidence of: Direction - widespread agreement on overall aims and mission; Alignment - organisation and coordination of work; Commitment – evidence of collective working within the system.
- There is currently no standardised framework or approach to determining exit criteria across regions there is a consistent view that there should be a core set of standard metrics for exit and that criteria should reflect the measures and metrics used to determine the thresholds for each (NOF) Segment.
- There was a widespread view that coordination between the RSP and other national support programmes can be problematic and should be improved. RSP improvement plans should have primacy and Improvement Directors (or the national team) should take the lead in coordinating intervention by the other national support programmes.
- Entry into NOF4 can affect wider public confidence and trust in the care provided by a challenged organisation. Communication to the public matters and there may be opportunities to make entry and exit communication a more explicit part of the improvement plans and exit criteria.

2. Evaluation context

Between 2013 and 2021, healthcare organisations in England rated as inadequate by the Care Quality Commission (CQC) in terms of quality and/ or that had demonstrated a rapid deterioration in finance would enter Quality Special Measures (QSM) and/or Financial Special Measures (FSM), to receive increased support and oversight.

Launched in July 2021, the Recovery Support Programme (RSP) has replaced the QSM and FSM programmes. The RSP targets Integrated Care Boards (ICBs), NHS Foundation Trusts and NHS Trusts facing complex challenges, providing intensive support to embed improvement, prevent further deterioration and enable stabilisation. The RSP is supported by guidance which can be found in the NHS Oversight Framework (Section 6 and Annex A of the NOF 23/24 guidance).

On entry into Segment 4 of the NHS Oversight Framework (NOF4) the RSP is triggered. ICBs and Trusts are allocated a System Improvement Director (SID) for an ICB, or Improvement Director (ID) for a Trust. The (S)ID is supported by an expert multidisciplinary team, who will co-ordinate wider support from the system, national teams, the broader NHS or, where appropriate, an external third party. On entry to the RSP, it is anticipated that the (S)ID will conduct a diagnostic stocktake to:

- identify the root cause(s) of the challenges and of any structural and strategic issues that must be addressed to ensure high quality, sustainable services
- recommend the bespoke criteria that must be met to exit mandated intensive support
- review the capability of the healthcare organisations leadership.

The RSP has a system-level focus and local partners are expected to play their role in addressing system related drivers of issues and supporting system solutions to the underlying challenges.

The RSP differs from the old 'Special Measures' programmes in that it involves a system level response that seeks to address all the key underlying concerns, while still providing tailored, intensive support to individual organisations. This emphasis on a local system contribution to performance improvement reflects key findings from an earlier NIHR-funded evaluation of 'Special Measures' (Fulop 2020). This evaluation showed that despite being perceived as supportive and beneficial, some providers thought the programme was overly scrutinous. The evaluation identified that time was needed to implement and embed change, that any support strategies deployed needed to be more trust specific and that poor organisational performance needed to be addressed within local systems. Strong, stable leadership promoting a continuous learning culture was vital to drive change and that in parallel, organisation-wide quality improvement strategies and capabilities were needed. The evaluation highlighted that patient and public engagement was as an important part of the process of making improvements.

After RSP was introduced in July 2021, a rapid internal review was undertaken that aimed to identify opportunities to enhance the intensive support offer and to develop a list of priority recommendations. Phase 1 of the internal review identified five key areas for improvement, including:

- tailored support, with large but often un-coordinated support offers available and a lack of clarity of roles;
- system-wide strategic focus as providers are unable to solve long-term issues in silo from the system;
- collaboration and peer training as navigation of the system is difficult and there are few opportunities for organisations to demonstrate good work and share best practice with a peer network;
- early detection and intervention as often organisations demonstrate potential slippage into NOF4 but indicators aren't picked up and there is no clear process for prioritising, and sustainability and continuous improvement as re-entry into intensive support programmes is not uncommon.

Phase 2 focused on causes and developing solutions. Nineteen solutions were found, of which 12 were prioritised for implementation within six months. Prioritised solutions included enhanced local buy-in, coordinated support, longer-term planning, an early warning dashboard, risk-based support prioritised, clearer exit criteria and tapered support. Additionally, some longer term strategic initiatives were identified, which included clarity on roles and responsibilities of those involved in the RSP, more system-wide working, increased support for NOF3 organisations, and alignment of RSP needs with wider improvement programmes.

Since the internal review was completed, the Kirkup Review into East Kent Maternity Services has also been reported. This makes a specific recommendation that NHS England reconsider its approach to poorly performing Trusts, with particular reference to leadership. In particular, it highlighted the need to identify alternatives to the 'heroic leadership' model, including the provision of support to Trusts in difficulties and incentives for organisations to ask for help rather than conceal problems. Whilst not directly aimed at the RSP, material concerning the governance of challenged organisations, leadership, performance and improvement capability are central to any support intervention in NOF4.

As RSP is still evolving and developing, the Policy and Governance, National Intensive Support for Challenged Systems team and the Department of Health and Social Care (DHSC) requested a rapid evaluation of the RSP to understand its initial impact and identify further improvements that improve its efficacy.

The NIHR funded Rapid Service Evaluation Team (REVAL), University of Manchester was commissioned by NIHR to design and conduct the evaluation.

3. Gathering insights

This was an iterative multi-site formative evaluation designed to inform ongoing learning and to serve as a basis for future longitudinal evaluation. The evaluation focused on generating rapid insights detailing the practical implications of RSP implementation from a range of stakeholder perspectives.

We consulted with the National Intensive Support Team and the Regional Intensive Support Directors to understand the policy context for RSP implementation. These discussions helped the REVAL team understand how support is organised nationally, functions in each region as well as to gather any 'soft intelligence' relating to the proposed case sites. To complement the sense making discussions we identified any publicly available documents on RSP generally and on organisations in NOF4 specifically.

With the National Intensive Support Team, we then discussed and agreed on nine case sites. Our intention was to employ a maximum variation design to ensure variation in organisation type and area-level characteristics that might influence the experience of delivery of RSP at the local level. The final sample included:

- 2 NHS Trusts which have entered RSP since July 2021
- 2 NHS Trusts case sites who have transferred from QSM or FSM
- 2 NHS Trusts case sites who have left RSP since July 2021
- 2 Integrated Care Boards which have entered RSP since July 2021
- 1 NHS Ambulance Trust which has entered RSP since July 2021

From March to June 2023, we conducted qualitative interviews with matched samples of key informants who were involved in the delivery of or in receipt of the RSP across the system in which each case study is located. Interviewees included system improvement directors, improvement directors and various other members of the national intensive support team delivering RSP support for challenges like workforce and finance. These interviews aimed to understand the experience and delivery of RSP, including the diagnostic stock take, exit criteria and improvement plans, as well as to learn more about acceptability of the RSP. We obtained informed consent from participants and interviews were recorded. Further interviews were undertaken with NHS Providers and DHSC to learn more about the context in which RSP was implemented.

After this first round, interview data was analysed and we discussed some preliminary findings with the NIST to identify potential gaps in data. These gaps were followed up in the next set of interviews and informal conversations, conducted from July to September 2023. These interviews and informal conversations were with those in receipt of the RSP including executive board members, including chief executive and other executive board members for the improvement plan. Furthermore, we interviewed some key system stakeholders in which each case study is located.

During the interviews, we discussed the following topics:

- How the RSP is enacted on the ground and variation across regions, systems, and types of providers.
- Barriers and enablers to implementation of the RSP.
- Contextual factors impacting implementation of the RSP.
- Experiences and perspectives of providers and ICBs on the delivery of the RSP.
- Issues that remain unaddressed.
- Support after exit from the RSP.
- Regional support:
 - Main elements of support provided to those in NOF3 and NOF4: who delivers what, where why and how?
 - How do regional improvement teams coordinate and tailor support?
 - Role of the ICB in providing system oversight and support for performance improvement?
 - Support provided by region after exit NOF 4.

We utilised a rapid approach to analysis developed specifically for this evaluation. Compared to traditional qualitative methods, rapid analysis can be particularly useful within studies where there is a need to feedback to stakeholders to inform decision making in real time. Our approach involved:

- creating a summary template based on the topic guide, with space provided for other observations, unexpected findings and “key quotations”
- completing the summary template following each interview, using field notes from the interviewer; discussing the analysis as a research team
- iterative refinement of the template as data collection progressed
- transferring the summary templates to a matrix
- sharing and discussing findings and themes with the national team throughout the process

This insights report aims to provide information to support decision-making and the following section summarises insights from those delivering and receiving support via the RSP. A formal academic output will be produced thereafter a draft version of which will be circulated for comment before the end of the year.

4. Insights

4.1 Perceptions of RSP

Overall, the RSP is generally perceived as supportive not punitive and an improvement on the previous special measures regime. This is not to say that the RSP is not challenging to deliver and receive. Rather, that the approach is now less 'top down' and is perceived as attempting to provide a support that will provide organisations and their wider systems with the resource, expertise and capability to enable improvements. Interestingly, many respondents when asked if they have noticed any difference between the old and new programmes often said no, but went on to highlight aspects that are indeed different and also where improvements could be made (these are outlined in the sections that follow).

Many interviewees mentioned that it was easier to enter NOF4 than to exit and there is some confusion around where the RSP was expecting organisations to land in terms of exit. Different regional interpretations of the NOF were highlighted and there is a sense that this has led to different decisions about moving organisations into NOF4. Some also mentioned that they were unclear if the RSP's intention was to get their organisation to move to NOF3 or to become a good or outstanding organization (NOF2 or higher).

Those organisations that had been in RSP for a while mentioned that compared to organisations they consider counterparts, they were no longer in the bottom quartiles and were questioning if they should still be in RSP. Whilst the NOF provides detail on the criteria for each segment it is felt that this is not sufficiently clear on what the thresholds are for moving from one segment to another or on how these are measured. There is a consistent message that providers/ systems need to understand the measures and metrics used to determine segmentation - to better explain to the public and to staff and to benchmark their own performance against those organisations considered to be peers. There is also a view that where organisations are in each segment should be made publicly available and not just those in NOF4 as it is currently.

The lack of consistent messaging on segmentation and tiering across national programmes was also highlighted. In the RSP NOF4 is the 'worst performing segment' in other recovery programmes the worst performing organisations are in Tier 1. Again, clearer and consistent messaging around ratings and rankings would make internal and external communications around quality and performance more coherent.

4.2 Diagnostic Stocktake

The aim of the diagnostic stocktake is to involve all relevant system partners in identifying the underlying reason for an entry into NOF4. The process aims to:

- identify the root cause(s) of the problem(s) and any structural and strategic issues that must be addressed
- recommend the criteria that must be met for the system or organisation to exit mandated intensive support (exit criteria)
- review the capability of the system's or organisation's leadership

We have identified variation in how the diagnostic stocktake is undertaken across regions and in the level of granularity collated in the above areas. This reflects the lack of an overarching approach; the National Oversight Framework highlights the three broad areas listed above but provides no detail on how this should be operationalised or what should be consistently captured.

In some instances a diagnostic stocktake is not undertaken. This can be because all parties 'know' what the underlying issues are and do not want to 'overburden' organisations. Or, it can be that the information provided to explain an CQC inadequate rating –the ratings provided across the five core domains, the specific areas of improvement where actions need to be taken and what improvements need to be achieved – are deemed to be sufficient. However, doing so misses some of the wider value that the diagnostic stocktake has to offer.

The diagnostic stocktake is a key enabler of acceptance and accountability. Its conduct is important and it can be enhanced to support the development of an appropriate leadership ethos in this space. The RSP is grounded on a principle of collective leadership - all players involved need to accept and agree on what the key problems are, how they can be resolved and who will take ownership of ensuring that proposed solutions are enacted. The diagnostic stocktake could be used to establish whether collective leadership is present or absent. Where it exists, agreement can be fostered on the overall goals and aims of the RSP intervention and commitments to support the organisation and coordination of improvement efforts can be formalised. Where it is absent, the diagnostic stocktake provides a mechanism to bring local parties together to understand and accept the need for shared ownership and responsibility. Emphasising the need for collective leadership also shifts away from a 'heroic leadership' model of thinking that senior executive change will in itself reverse the fortunes of a challenged organisation; a model that the Kirkup review was rightly critical of. The role of the ID in facilitating acceptance and agreement on the respective roles of the region, ICS and national team can't be understated and this process

can (and should) take time as it is foundational to the success of improvement processes that follow.

The second area where the diagnostic stocktake could be enhanced is through structured assessment of system capability and capacity to support change. Currently, the focus is understandably on the challenges faced by the individual organisation. However, the process could also look out and consider what skills, expertise, and or improvement may be available within the system to support substantive and sustainable change. Doing so, may also surface the more intractable factors influencing organisational performance that might be operating at a system-wide level (e.g. workforce recruitment and retention; estate, wider financial pressures). Where local supports are in place, these can then be harnessed as part of improvement plans.

Finally, the diagnostic stocktake should serve as the definitive baseline account of entry into NOF4. This is important because IDs tend to move around after 12-18 months and, where new leadership teams are deployed, the organisational memory of how and why entry occurred and why specific exit criteria were set can be lost. Some respondents did mention that they did not know what the diagnostic stocktake was or whether one had been undertaken.

4.3 Exit criteria

There is no underlying framework or approach to determining exit criteria and there appears to be considerable variation in how these are set across regions - described as 'a dark art' by one interviewee. There is a consistent view across participants that there should be a core set of standard metrics for exit (and possibly for early warning signs of entry). Exit criteria should clearly specify a transition and exit pathway from NOF4 to NOF3 and the criteria should reflect the measures and metrics that are used to determine the thresholds for each of these segments.

There is a perception that in some cases, exit criteria are being set at thresholds that are too high; setting out a pathway that would be in line with what would expected of a NOF2 organisation. There was also a perception that financial exit criteria may not take account of wider financial pressures within the NHS that may impede deficit reduction efforts. Indeed others suggested that wider political factors may inhibit exit as it would 'look bad' if an organisation exited NOF4 despite having a large deficit, despite many organisations in not in NOF4 also having similarly large deficits.

To encourage collective ownership, exit criteria should be co-produced together with provider(s), system, and region, and then approved by the national team. Once approved,

mission creep on exit criteria should be avoided (unless of course additional critical or catastrophic events unfold), as adjusting exit criteria during an improvement trajectory leads to uncertainty around when they will be able to exit, which can impact morale.

In parallel with our evaluation, an internal review of exit criteria has been undertaken. This has examined the criteria used for all organisations who are, or have been in the RSP and has now reported and made recommendations. This work has identified the need to agree a standardised suite of criteria and potential evidence to demonstrate delivery for each of eight key themes (culture, leadership, governance, ICB ownership, quality and safety, operations, finance, and workforce). It is anticipated that standardised exit criteria will now be developed and an indicative timeframe for completion will be set. The internal review also recommended a shift in terminology from exit to transition.

4.4 Improvement Directors and improvement activity

The personal attributes and skill sets of IDs are crucial to the success of any RSP intervention. The role requires high-level facilitation skills (project management, leadership, relationship building, and communication) to enable and support change. From those respondents that had experience of the previous special measures programme there was a perception that in the old regime, IDs were far more regulatory in approach, were 'imposed' on organisations and were perceived to do improvement to them, instead of with them. There is a sense that this has shifted. Generally, interview participants seem to appreciate the facilitative approach adopted by most IDs, highlighting their ability to harness additional resources and funding to support the delivery of improvement plans. There is some variation in the approach taken by individual IDs and no 'manual' or overarching framework to guide the way they operate.

It can take time for the ID to build relationships with the various key stakeholders. Not all those we interviewed were enthusiastic about IDs moving organisations after being in one place for 12-18 months. While some mentioned there is a risk of 'going native' by staying for longer than 12-18 months and in some cases that the fit of the ID and organisation is not optimal so a move may be helpful, others reported that building relationships is crucial for improvement, and moving IDs can lead to delays.

In the main, interviewees appreciated the support provided as part of the RSP. However, some mentioned that too much support was provided too early in the improvement process, when the organisation was still 'grieving' and coming to terms with what had led them to being placed in NOF4. Interviewees also mentioned that some of the support was delivered before the organisation had the capability or capacity to engage with it. This was especially so when changes to senior leadership teams were being made and the new teams

need sufficient time to bed in. There also needs to be time for organisations to acquire the capabilities and capacities to improve – a finding that is consistent with those from previous evaluations of the previous Special Measures regime. Scheduling external support at the right time is therefore key.

There were some mixed views on external secondments into organisations in the RSP. Some liked it, as it allowed them to immediately fill essential roles for the improvement trajectory while allowing time to recruit suitable people into these roles. Others felt it too many transitory appointments can be very overwhelming as many different people are coming into an organisation and all need to be welcomed and brought up to speed, which takes away time and resources from implementing improvement plans. It was also mentioned that whilst external challenge can be productive and helpful, some external support could also feel like an additional level of scrutiny by NHS England. Once an organisation enters NOF4, there is understandably a higher level of scrutiny be it from the CQC, the system, region or national team. However, this scrutiny carries an administrative burden, requiring papers, presentations to be prepared, and visits to be managed which takes up time and resources.

This evaluation has not sought to establish the effectiveness of individual improvement interventions delivered as part of RSP. This is in part because interventions to support improvement need to be organisation specific and this degree of tailoring means that there is no standard offer of support that can be easily assessed. In the main, interviewees did not question or flag areas of concern in relation to the nature of support provided. Rather, the scheduling of delivery was raised as an issue.

4.5 Coordination

Coordination of the various asks from system, region and national teams is important. The RSP is not the only interventional improvement or recovery programme provided by NHS England. There was a strong and consistent view that coordination between the RSP and other national support programmes, such as the Cancer, Elective, Urgent and Emergency Care, and Maternity Services programmes can be problematic and should be improved.

It was noted that serving national improvement programmes can be ‘a job in itself’ – a multitude of governance processes with much duplication of work – and that challenged providers can’t be expected to do everything at once so there is a need to prioritise and focus on the most pressing issues. For many, this meant that the RSP improvement plan should have primacy over interventions by other national programmes. It was also suggested that the ID (or the national team) could take the lead in coordinating and gatekeeping all interactions with the other national support programmes.

Clear lines of communication, accountability and clear coordination among the various people involved in the RSP improvement efforts were perceived as enablers for improvement. However, many of the interviewees provided examples of where support was not sufficiently coordinated. In one case, the region and system were not involved throughout the improvement journey and only came in late in the exit trajectory, this made the transition more complicated as they had to be brought up to speed and any additional asks negotiated. In another case however, the system and region were involved, but did not coordinate support, nor involve the provider, which led to unhappiness and duplication of effort all around.

4.6 Transition and Sustainability

Many respondents mentioned that whilst achieving exit criteria fully is important, enabling sustainability is more important. The need for a transition period, where some national support continues to be provided to organisations was mentioned by several interviewees. Some of those delivering RSP mentioned that they felt some organisations, particularly those that had been in the RSP for a long time, may have become too dependent on the programme and the resources it provides. A transition process such a process could help ensure that organisation doesn't 'fall off a cliff' when the national supports are removed.

Transition arrangements could include a process by which national support is tapered off over time and handed over to the regional team and system. This phase could also be used to train the system and region in how to support the organisation as well as how to hold them accountable once exit out of NOF4 was achieved. Those in receipt of the RSP also suggested that a 'probation phase' that involved regular check ins with the national team but not exhaustive governance and inspection processes would be helpful. Some ongoing financial support to keep key support people in post, during the transition period, would also mitigate against the risk of any immediate risk of loss of expertise.

4.7 Public Voice

As a team, we have committed to ensuring that we actively listen to and involve citizens in all aspects of our research. As part of our public, patient involvement and engagement plans the REVAL team has consulted with members of the NIHR Applied Research Collaboration for Greater Manchester (ARC-GM) Public Engagement Panel and Young Peoples Advisory Group. We did this to ensure that a patient/ public perspective informed our evaluation plans and informed the topic guides that were used to capture insights from key informants. Both these groups have broad based representation from people with varied socio-economic and cultural backgrounds including under-represented communities.

When we discussed our evaluation plans with our public contributors, we asked what they would like to know about the RSP implementation. On the RSP, the Panels wanted to know more about the extent to which involvement or engagement with the public or patients was part of RSP delivery. They also questioned how entry and exit to NOF4 was communicated to the public more generally. It was noted that there is often very negative press associated with challenged NHS organisations, particularly in relation to care quality and patient safety. This can impact on wider community confidence and trust in the quality of care provided. Given this, our public contributors thought it was important to clearly communicate the reasons for entry, that efforts were being made to improve local situations and, when sufficient improvements were being made that Trusts would be able to exit RSP.

How entry and exit to and from NOF4 is communicated to the public matters. In our analysis, we note that communication strategies around RSP do not tend to feature in plans and other documents relating to organisations in NOF4. As such, there may be opportunities to make entry and exit communication more explicit as part of the improvement plan and or exit criteria. This could be aligned with the Quality and Performance Committee's decision making on entry, transition and exit.

5. Next steps

This briefing report aims to provide actionable insights on the initial impact of RSP to inform ongoing learning and support refinement of the programme as a whole. A formal academic output will be produced thereafter.