REVAL
NIHR Rapid Service Evaluation Team

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Evaluation of the implementation of the Recovery Support Programme

Protocol

13 February 2023

Research team contacts

Paul Wilson (Lead contact for RSP) Co-Director NIHR Rapid Service Evaluation Team (REVAL) Centre for Primary Care & Health Services Research School of Health Sciences University of Manchester **paul.wilson@manchester.ac.uk**	Jo Dumville Co-Director NIHR Rapid Service Evaluation Team (REVAL) Division of Nursing, Midwifery & Social Work School of Health Sciences University of Manchester **jo.dumville@manchester.ac.uk**
Stephanie Gillibrand NIHR Rapid Service Evaluation Team (REVAL) Centre for Primary Care & Health Services Research School of Health Sciences University of Manchester **stephanie.gillibrand@manchester.ac.uk**	Maartje Kletter NIHR Rapid Service Evaluation Team (REVAL) Division of Nursing, Midwifery & Social Work School of Health Sciences University of Manchester **maartje.kletter@manchester.ac.uk**
Cristianne Buhkari Programme Manager NIHR Rapid Service Evaluation Team (REVAL) Division of Nursing, Midwifery & Social Work School of Health Sciences University of Manchester cristianne.bukhari@manchester.ac.uk	

Evaluation summary

Title	Rapid evaluation of the implementation of the Recovery Support Programme (RSP)
Background	Launched in July 2021, the RSP is available to support Integrated Care Boards (ICBs) and NHS Trusts facing complex challenges by providing intensive support to embed improvement and prevent further deterioration and enable stabilisation. The intensive support consists of a set of tailored interventions designed to remedy the identified problems within a reasonable timeframe. The RSP is provided to all Trusts and ICBs in Segment 4 of the NHS Oversight Framework 2022/23 The RSP differs from the previous 'Special Measures' programmes in that it involves a system level response that addresses all the key underlying concerns, while still providing tailored, intensive support to individual organisations.
Aims	Our overall aim is to undertake a rapid formative evaluation of the RSP to understand its initial impact and identify further improvements which can improve its implementation. *Research questions* 1. What are the main elements of centrally delivered-support as part of RSP and is there variation across geography, health systems and organisational types? 2. How do regional improvement teams coordinate and tailor support and is there variation across geography and organisational types? 3. What are the main elements of support provided by regions for organisations in Segment 3 of the NHS Oversight Framework and is there variation across geography and organisational types? 4. Are the elements of the RSP effective at identifying and addressing the key drivers of the problems that led to a Segment 4 categorisation and if so how? 5. What evidence is there that delivery of RSP is resulting in purposeful improvement to care delivery? 6. Can key indicators be identified that can be used to assess purposeful improvement in Segment 3 and 4 going forward?
Design	Multi-site, mixed methods study. Regional and national-level interviews with matched samples of key informants who are (or were) delivering or in receipt of RSP combined with related documentary analysis in nine NHS case study sites.
Sample	2 NHS Trusts which have entered RSP since July 2021 2 NHS Trusts case sites who have transferred from SMQ or SMF 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
Timelines	Sense making and identification of case sites Nov 2022 to Jan 2023 In-depth exploration of the implementation and delivery of RSP Feb to Sept 2023
Funding	This research is an independent evaluation undertaken by the NIHR Rapid Service Evaluation Team (REVAL). REVAL is funded via a competitive review process by the NIHR Health Services and Care Delivery Research Programme (NIHR151666). The views expressed in this protocol are those of the author(s) and not necessarily those of the NIHR, NHS England or the Department of Health and Social Care.

1. Evaluation context

Between 2013 and 2021, healthcare organisations in England rated as inadequate by the 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 separate QSM and FSM programmes that were in place between 2013 and 2021. RSP is available to support Integrated Care Boards (ICBs) and NHS Foundation Trusts and NHS Trusts facing complex challenges by providing intensive support to embed improvement and prevent further deterioration and enable stabilisation. The RSP is supported by the RSP guidance which can be found in the NHS Oversight Framework (Section 6 and Annex A of the SOF 23/24 guidance).

The RSP differs from the 'Special Measures' programmes in that it involves a system level response that addresses all the key underlying concerns, while still providing tailored, intensive support to individual organisations. This emphasis of the importance of the local system in performance improvement echos key findings from an earlier evaluation of 'Special Measures' funded by NIHR Health Services and Delivery Research Programme (Fulop 2020). On entry into Segment 4 of the NHS Oversight Framework (see Fig 1), the RSP is triggered and local system partners are expected to play their role in addressing system related drivers of the concerns or supporting system solutions to the underlying challenges. On entry to the RSP, ICBs and Trusts are allocated a System Improvement Director (SID) for an ICB, or Improvement Director (ID) for a Trust, supported by an expert multidisciplinary team, who will co-ordinate support including from the system, national teams, the broader NHS or, where appropriate, an external third party. In addition, a diagnostic stocktake is carried out 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; and
- review the capability of the healthcare organisations leadership.

	Segment description		Scale and nature of support needs
	ICB	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Figure 1: Scale and nature of support need by Segments in the NHS Oversight Framework

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) have requested a rapid evaluation of the RSP to understand its initial impact and identify further improvements which can improve its implementation.

The NIHR funded Greater Manchester Rapid Service Evaluation Team (REVAL) has been asked to design and conduct the evaluation. We propose a rapid formative evaluation that can inform on-going learning and can serve as a basis for future longitudinal evaluation. This initial evaluation will focus on generating rapid insights detailing the practical implications of RSP implementation, from a range of stakeholder perspectives, and will aim to develop a framework to guide further longitudinal evaluation.

We have agreed that questions relating to how Segment 3 and 4 categorisations are determined are a function of the NHS Oversight Framework and are, therefore, outside the scope of this rapid evaluation. As such, our overarching evaluation questions focus on the implementation of RSP and are, as follows:

- *What are the main elements of centrally delivered-support as part of RSP and is there variation across geography, systems and organisational types?*
- *How do regional improvement teams (inc ID and SID) coordinate and tailor support and is there variation across geography and organisational types?*
- *What are the main elements of regional support for organisations in Segment 3 and is there variation across geography and organisational types?*
- *Are the elements of the RSP effective at identifying and addressing the key drivers of the problems that led to a Segment 4 categorisation and if so how?*
- *What evidence is there that delivery of RSP is resulting in purposeful improvement to care delivery?*
- *Can key indicators be identified that can be used to assess purposeful improvement in Segment 3 and 4 going forward?*

These questions will be explored via two concurrent workstreams focused on the impact of the two levels of regional and national support offered (depending on how serious or how complex the issues the organisations face are): mandated support provided by the regional teams and intensive mandated support by the national intensive support team.

2. Sense making ahead of in-depth exploration

Timeframe: 3 months – November to January 2023

Sense making
We are consulting with the National Intensive Support Team and the Regional Intensive Support Directors to understand the policy context for RSP implementation. These discussions are to help 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.

These are not formal interviews and are in confidence for internal purposes only. The information provided will help us (REVAL) shape and frame the data collection for the deep dive case study phase. We will record the discussions and if individuals would prefer to talk without a recording this is also possible. If an individual is uncomfortable with the recording process at any time during the

discussion we will stop the recording. All audio files will be deleted after our note taking process is complete.

To compliment the sense making discussions, we will identfy any publicly available documents on RSP, generally, and on the proposed case sites, specifically. This will include Care Quality Commission (CQC) inspection reports, Board minutes and, any news reports relating to the challenged organisations.

3. Identification of case sites

There are currently 18 Trusts and five ICBs in Segment 4. We originally developed a sampling strategy to select eight case study 'sites' for in depth exploration of RSP delivery. Our intention was to employ a maximum variation design to ensure variation in organisation type and taking into account of area-level characteristics that might influence experience of delivery at the local level. This would include:

- Two Trust case sites which have entered RSP since July 2021;
- Two Trust case sites who have transferred from SMQ or SMF;
- Two Trust case sites who have left RSP since July 2021; and
- Two current ICB case sites.

With the National Intensive Support Team, we have discussed and agreed nine cases sites. In addition to the characteristics above, we have included one Ambulance Trust and have representation from all regions. The selected case sites are presented in Table 1.

Table 1: Proposed case sites for in-depth exploration

Case Scenario	Region	ICB or Trust
Entered RSP since July 2021	N. West	NHS Foundation Trust
	S. East	NHS Foundation Trust
Transferred from SMQ or SMF	London	NHS Trust
	Midlands	NHS Trust
	S. East	NHS Foundation Trust
Left RSP since July 2021	Midlands	NHS Trust
	North East and Yorkshire	NHS Foundation Trust
ICBs in RSP	S. West	ICB
	East of England	ICB

4. Exploring implementation and delivery of RSP

Timeframe: 6-9 months – from February 2023

To understand experience and acceptability of the RSP process we plan to undertake qualitative interviews with matched samples of key informants (i.e. same roles) who are (or were) delivering or in receipt of RSP across the systems in which each case study site is located. Our intention is to focus initial interviews with each designated Improvement Director and with System Improvement Directors (and their teams). Snowball sampling will be employed to identify further key informants from across the system such as the ICB, CQC and may include other recipients of regional support.

Interviews will be guided by questions posed in the evaluation brief, from the sense making discussions with the Regional Intensive Support Directors and the ISCS team and by relevant theory (see analysis section below). Interviews will focus on the impact of the two levels of support offered: intensive mandated support by the national intensive support team and mandated support provided by the regional teams.

Questions relating to national intensive support will seek to understand:

- What are the main elements of support delivered as part of RSP and is there variation across geography, systems and organisational types?
- How is RSP enacted on the ground?
    - the diagnostic stocktake
    - the process to agree the exit criteria
    - the development of the improvement plan
    - the role played by the ID or SID in providing tailored support
    - the regional governance and oversight provided
- What are the barriers and enablers to the implementation of RSP?
- How do contextual factors influence the way RSP is implemented?
- What are the experiences and perspectives of providers and ICBs on the delivery of RSP?
- Does the system of agreeing the most pressing challenges take account of the capacity of challenged providers/systems to work on critical improvements? Do issues remain unaddressed?
- What insights do those delivering and in receipt of RSP have about (a) identifying problems and (b) developing operational solutions (c) supporting organisations after exit from Segment 4.

Questions relating to regional support will cover:

- What are are the main elements of support offered by regional teams (in each region) to those in Segments 3 and 4 - who delivers what, where, why and how ?
- How do regional improvement teams coordinate and tailor support?
- What role does the ICB play in providiving system oversight and support for performance improvement?
- Are there any "spillover effects" resulting from RSP delivery that impact on Segment 3?
    - Does the focus of central resources on Segment 4 have knock on effects on the support available to those in Segment 3
    - Does the greater emphasis on collective system performance and accountability help insulate trusts in Segment 3 from entering Segment 4.
- What insights to those delivering regional support have about strengthening their role / supporting organisations after formal exit from Segment 4.

Our exploration of the above will reflect and build on findings from the delivery and continuous improvement review and the Hewitt review when available (see: https://www.gov.uk/government/consultations/hewitt-review-call-for-evidence).

Documentary analysis
As the in-depth exploration phase progresses, we will seek to include any entry and exit documentation, diagnostic stocktakes, agreed improvement plans as well those developed by organisations to operationalise improvement efforts and recommendations from the RSP. We will use the documentary analysis to guide and then help triangulate findings from our interviews with key informants.

Data analysis
We will adopt a rapid approach to the analysis that is consistent across the nine sites. Interviews will be audio-recorded with consent, transcribed and thematically analysed using a modified framework approach (Gale 2013). This will involve:

- 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 the data collection progresses; and
- transferring the summary templates to a matrix.

The matrix of summarised data will provide a structure for analysis and interpretation which is useful for policy research and is well suited to managing large datasets such as this (Gale 2013). The coding framework will be iteratively developed as the interviews continue, through discussion at regular analysis meetings and through discussions with the ISCS team and with reference to relevant theory.

To aid our understanding of how a system level response is enacted, coordinated and then impacts on improvement, we will draw on two concepts from management theory, namely absorptive capacity and collective leadership. Absorptive capacity (Cohen 1990; Harvey 2010) refers to the ability of organisations to acquire and exploit new information to to produce a 'dynamic organisational capability' that can drive improvements in performance. Absorptive capacity is determined by two core sets of antecedents - external and internal. External antecedents are the environmental conditions, characteristics of knowledge and characteristics of learning relationships that are thought to drive incentives for developing absorptive capacity. Internal antecedents are the mental models, organisational strategies, and structures and processes within the organisation which set out how the organisation will go about achieving its aims. We will use this to help undertsand the capability and capacity of challenged organaitions to work on critical improvements.

Collective leadership (Denis 2001) proposes that a team assembling a variety of skills, expertise, and sources of influence and legitimacy may be able to achieve susbtantive change. However, collective leadership can be fragile especially in settings with diffuse power, with multiple objectives and where tensions exist between environmental pressures, organisational aims, and the characteristics of incumbent leaders. The three constructs of the DAC framework (Drath 2008) provides a means by which to explore the presence of collective leadership - Direction - Is there widespread agreement in a collective on overall goals, aims, and mission; Alignment - Is the organisation and coordination of knowledge and work structured and coherent; Commitment - Is there willingness of members of a collective to subsume their own interests in favour of the collective interest and benefit. We will use this framework to explore the extent which system leaders are working together effectively to enact

solutions to the underlying challenges faced either by individual organisations or the local health and care system itself.

Through these lenses, interviews will be analysed to understand the barriers and facilitators of delivering RSP in different environments and with a focus on the impact and sustainability of system level support. Overlaps and distinctions, across all groups of stakeholders and across case sites, will be considered through iterative analysis and constant comparison.

In the initial commissioning brief, there was a steer to explore whether resources being delivered as part of regional and national support are being appropriately used and allocated. Our intended analysis of barriers and facilitators will consider the coordination and delivery of support highlighting any areas where current activity may be sub optimal or leading to unecessary duplication of effort. Whilst our proposed analysis is primarily qualitative, if there is an opportunity to quantify the resource implications of RSP delivery, then we will harness the economic capability in the wider REVAL team to do this.

Development of programme theory / framework to guide further evaluation
Using insights from the above analysis, we think it will be helpful to develop (or modify an existing) programme theory to describe how RSP currently functions. We would seek to do this from a complexity/ systems perspective. This could then be used to guide future RSP implementation across organisational settings and potentially also future assessment and or evaluation.

5. PPIE

As a team, we have committed to ensure that we actively listen to and involve citizens in all aspects of our work. A public, patient involvement and engagmement plan for the evaluation has been developed in parternship with our REVAL public contributors.

The research team has consulted with members of the NIHR Applied Research Collobroation for Greater Manchester (ARC-GM) Public Engagment Panel to reflect on the evaluation scope from a patient perspective, and to inform the topic guides. The Panel has broad based representation from people with varied socio-economic and cultural backgrounds including under-represented communities. Members bring a range of skills, knowledge, voluntary and lived experience and will ensure that a diverse public voice informs the evaluation that we do and the methods we use.

We discussed our evaluation plans and asked what they would like to know about RSP implementation. Many responses mapped onto our questions. On RSP, the Panel 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 RSP 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. The Panel thought it was important that the public was made aware that efforts were been made to improve local situtations and also when improvements were being made and Trusts were able to ext RSP. These issues have all been incorporated into our data collection plans.

The research team will further consult with members of the NIHR ARC-GM Young Peoples Advisory Group to ensure the full breadth of age groups have an opportunity to contribute. We will continue to engage with the Panel as the work progresses.

6. Dissemination and Knowledge mobilisation

To ensure relevance to the needs of the RSP and to maximise the impact and use of findings, we intend to actively engage with key stakeholders at all stages of the research process not only to ensure efficient use of NIHR resources, but also to maximise the impact and use of findings as they emerge. Our preferece is to facilitate this relationship and to provide timely feedback loops to inform policy decision making and to provide insights from the evaluation as they emerge during the life of the study. We will do this through maintaining regular contact with the National Intensive Support for Challenged Systems Team and the Regional Intensive Support Directors via the monthly ISCS meeting and through regular Teams / email contact. We will seek opportunities to share early insights with the National Intensive Support for Challenged Systems Team, the Regional Intensive Support Directors and the National Joint Strategic Oversight Group as the work progresses. We will ensure our evaluation takes account of any changes in planned delivery for RSP.

7. Ethical considerations

The main ethical considerations for the evaluation are recruitment, informed consent; confidentiality, anonymity and data protection:

Recruitment
The contact details of IDs, SIDs and Regional Support/ Oversight Groups will be provided by National Intensive Support Team and the Regional Intensive Support Directors. This information is publicly available but as the national and regional teams hold the most up to date details, this reduces the risk of unnecessary/inappropriate contacts. Potential participants will then be approached initially by an e-mail invitation from the evaluation team that will include a copy of the participant information sheet and consent form. Those indicating interest in participation will then be contacted and interviews will be arranged at a time to suit the participant – verbal consent will recorded at this point (see below). Snowball sampling will be used to recruit other participants who meet our criteria and are thought to have a perspective on the implementation of the RSP.

Informed consent
All potential research respondents who are recruited for interviews will receive verbal and written information (participant information sheet) regarding the study and will be encouraged to ask questions prior to taking part. It will be made clear that participation is purely voluntary and respondents are able to withdraw from the study at any time, without giving a reason. We will obtain verbal consent before undertaking the telephone or Teams/Zoom interview which we will audio-record separately to the interview audio-recording.

Confidentiality, anonymity and data protection
With consent, all interviews will be audio-recorded using a secure University provided encrypted audio device. We will follow the University of Manchester's standard operating procedure for taking recordings of participants for research purposes: http://documents.manchester.ac.uk/display.aspx?DocID=38446). Recordings of the consent process and interviews will be transferred from the device as soon as possible to secure University servers (so that de-identified data is stored separately to consent data) and then deleted from the device. Transcription of audio-recordings will be undertaken by a University of Manchester approved external transcription company. Audio recordings will be uploaded to the transcription company via a secure server. We will remove any personal identifying information (such as names, places) from transcriptions once they are returned. We will securely destroy the audio-recording of each

interview, once an interview has been transcribed and the research team has checked the transcription for accuracy.

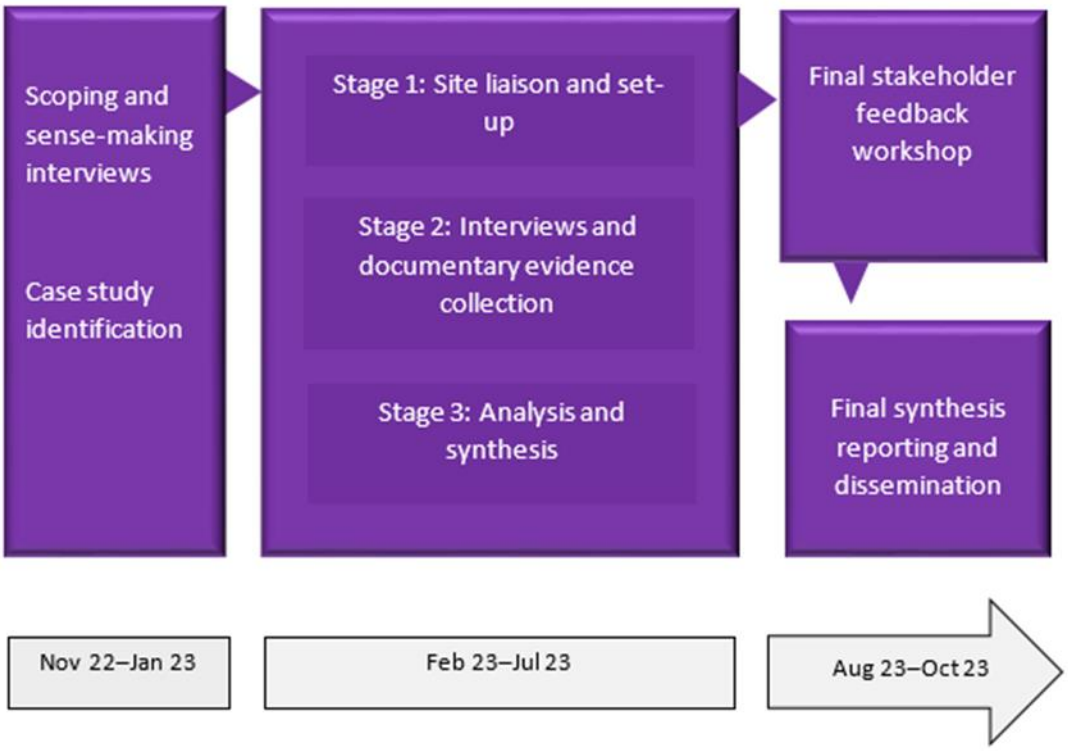
Once a respondent enters the study, they will be provided with a unique identifier. This means that data including field notes, audio recordings, transcriptions and demographic data will be identified only by their unique identifier and not by the name of the respondent. Where necessary, we may also generalise job titles to protect the anonymity of those in specialist roles or where job titles are specific to an individual organisation. The 'pseudonymisation key' to the unique identifier and respondent's details (name, contact details, site and job title), will only be accessible to members of the research team and stored electronically on a University of Manchester secure server, separate to the de-identified data. Electronic data (such as digital audio-recordings, transcriptions, field notes, and demographic data) will be stored on a University of Manchester secure server. Hard copies of consent forms and demographic data will be kept in a locked cabinet in a locked room on University premises. Once the study is finished, data will be archived securely for 10 years, after which time they will be securely destroyed.

We are aware of the sensitive nature of this research for organisations and for individuals. The research team has experience in conducting research on similar sensitive topics. We will maintain the anonymity of the participating organisations and individuals and will publish findings that are anonymised and aggregated. Individual participants are assigned a unique numerical identifier and in this instance each organisation will be given a pseudonym.

8. Ethics and governance approvals

The evaluation outline protocol and study materials were reviewed by the University of Manchester Ethics Committee and received a favourable ethical opinion by the Committee (Ref: 2023-16079-26837). Appropriate HRA approval (proportionate pilot route) will be sought ahead of any contact with individual NHS Trusts.

9. Timelines



10. Statement of Indemnity

The University of Manchester has insurance available in respect of research involving human subjects that provides cover for legal liabilities arising from its actions or those of its staff or supervised students. The University also has insurance available that provides compensation for non-negligent harm to research subjects occasioned in circumstances that are under the control of the University.

11. Funding

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