5 Years On:

How has the Francis Report changed leadership in NHS hospitals?

Easy Guide

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HEALTH SERVICES MANAGEMENT CENTRE
This is an easy guide to a research project about the changes hospital boards made in England after the Public Inquiry into Stafford Hospital.

To view the full report and the easy guide online please go to:

http://www.research.mbs.ac.uk/hsrc/

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The views expressed in this report are those of the authors and not necessarily those of the Department of Health.
What was the Francis Inquiry Report?

Between 2005 -2009 there were serious problems with how patients were looked after at Stafford Hospital. Many people did not get the care they needed at the hospital and some died because of this. For example patients in some wards were not fed or kept clean and there were not enough staff to look after patients. Staff treated patients badly and complaints were not listened to.

There have been official investigations and reports into what happened, but the two most important were set up by the United Kingdom (UK) Government. Both were led by a senior lawyer, Robert Francis.

The first was an Independent Inquiry (2010) which looked in detail at what happened inside the hospital. Then a Public Inquiry (2013) looked at what went wrong at the hospital and at a local and national level which meant that so many patients were harmed.

The report from the Public Inquiry is called the Francis Inquiry Report and it found there were many reasons why patients were not looked after properly.* Part of the problem was the hospital board who ran the hospital.

A hospital board is legally in charge of everything that happens in a hospital, including the care patients get and the people who work in a hospital. The board can have about twelve people on it and include the senior managers at the hospital (called Executive Directors) and people from outside the hospital (called Non-Executive Directors). The board runs the hospital, which includes deciding how the hospital’s budget (money) is spent, making sure that patients have good and safe care and that there are enough staff to look after patients.

Robert Francis began his Public Inquiry Report by saying:

“Building on the report of the first inquiry, the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust’s attention.”

Robert Francis made 290 recommendations (actions that could be taken) about how the Government and hospitals could make sure that the problems at Stafford Hospital do not happen again.

He said patients must be put first in everything that hospitals do.

What happened at Stafford Hospital had a very big impact on the NHS (National Health Service). Robert Francis could only look at Stafford Hospital in his Public Inquiry, but people gave him information about patients not being looked after in other hospitals too. This showed that what happened at Stafford Hospital could happen at other hospitals. The Government said that all hospital boards had to look at the Francis Inquiry Report recommendations. They have asked hospitals to take other actions as well.* It has been up to hospital boards to make sure that these changes were made.

* For more information about this go to www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response
The UK Department of Health gave money for this research to see what changes hospital boards in England have made since the Francis Inquiry Report in 2013, what hospital boards are doing well and what they could do better.

Researchers from the Universities of Manchester and Birmingham and an independent health charity called The Nuffield Trust did this research. The research wanted to:

1. Find out if hospital boards have made any changes in how they run hospitals since the Francis Inquiry Report
2. To see how these changes have made a difference to how hospitals are run
3. To see what hospital boards think about the changes they have made
4. To see if these changes have cost money or time to do
5. To see what stops hospital boards making changes and what might help them to make changes
6. To learn more about how a good board works
7. To let boards and the NHS know what might help hospital boards run hospitals well
How did we do this research?

1. First we did thirteen interviews with people who know about how hospitals are managed in the UK. These included a patient representative, a doctor and a nurse, healthcare regulators (organisations who make the rules about how hospitals are run) and the Department of Health.

2. Then we looked at other research projects about hospital boards. These looked at how boards are run and if that makes a difference to the care patients get in the hospital.

3. We held a meeting in November 2015 for people who are interested in hospital boards. There were 25 people at the meeting, including patient and public representatives, a doctor and a nurse, people from universities who study what makes a good hospital board and people who decide the rules that hospitals need to follow. We told them what we had found out so far and asked them what they thought about it to help us plan for the rest of the research project.

4. Then we asked members of all hospital boards in England to fill out a survey about the ways their board worked. We had 438 replies from 139 hospitals in England.
Then we went to six hospitals (called 'case study hospitals') to talk to hospital board members, some staff and some patients. We chose hospitals that were different from each other. They were in different parts of England, large and small hospitals, hospitals that were given high scores by the Care Quality Commission (the government organisation that checks hospitals are providing good care) and ones that did not have high scores.

We interviewed 69 people who were:

- Executive and Non-Executive Directors of hospital boards
- people from the Clinical Commissioning Group (the organisation who pays for services that the hospital provides for patients)
- hospital staff and patient representatives

We also talked to people in discussion groups. In total there were

31 people

who told us what it is like to be a patient in these hospitals and

53 people

who told us what it was like to work in these hospitals.

We went to board meetings at each hospital to find out more about them.

We looked at paperwork to do with the board and the hospital, such as

minutes of board meetings (which tell what was said at each board meeting)
and documents that say what their plans are or what they have done (such as hospital Annual Reports).

We especially looked at documents which showed how staff, patients and the public are involved in the hospital.

At three hospitals, we also did a survey of managers (people who run wards or hospital departments) to ask what they thought about their hospital board. 91 managers filled out the survey.

Then we looked at all the information that we had found out from each hospital. We talked with some senior people at each hospital to hear what they thought about it.
This research had an Advisory Group. They were a group of people who gave advice about how this research was done. There were four people on this group who were patient or public members. One of the patient members chaired the Advisory Group meetings, which helped keep the research focused on what was important to patients and the public.

At the six case study hospitals, we spoke to 31 patients and relatives in small groups to find out what they thought about their hospital board.

Then we put all the information together from these five stages of the research. We met with a group of people who are interested in hospital boards to see what they thought about what we’d found out.

We then wrote a report about our research. This report that you are reading is an easy guide to what we found out.

How were patients and the public involved in this research?

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What did our research find out?

What do boards find difficult when running a hospital?

Hospital boards have a difficult and complicated job to do. They need to make sure that patients have good and safe care, that the hospital is run well and that they provide the treatment that patients need for the budget that the Government gives them. They need to have enough staff working in the hospital and do what the regulators need them to do for the Government to be sure that they are running a good hospital.

Board members told us that:

- Keeping patients safe is one of the most difficult jobs that their hospital needs to do, but they are also worried about how to look after patients well when they must be careful about how much money they spend.

- It is very hard to work within a limited budget. Hospitals need to balance how much they spend now with having enough money to look after patients in the future. Hospitals have not been given a bigger budget even though people are living longer and more and more patients are needing treatment. There are also many new treatments that can be offered to patients and these cost the hospital more money.

- The regulators and the Government need to be sure that hospitals are giving good and safe care. They set targets (such as how long patients wait in the Emergency department) and want a lot of information given to them. Boards think that this can take up so much time that they cannot do the other jobs they need to do to make sure the hospital is well run. Sometimes what they are asked to do by different groups can contradict each other.

- There are many reports and recommendations about how to run a hospital well. Boards can find it hard to have time to know what they all are and act on them. For example, from June 2011 to December 2015 there were 179 reports to improve the NHS, which is almost one a week.

- Boards can worry about inspections from the Care Quality Commission and what it would mean if they think the hospital is not as good as it should be.

- There are not always enough nurses and doctors to look after patients well, and so hospitals need agency staff (who are employed by another organisation) to work at the hospital. This costs more money and they might not know the hospital rules as well as a doctor or nurse who is employed by the hospital.
All these problems means it is hard to...

“...keep all of the plates spinning…”

Hospital Board Chair

and plan for the future while

“trying to fix what’s in front of you today”

Hospital Chief Executive

and find time to make the leadership of the hospital better.

Good patient care
Patient safety

Increasing demand
Not enough staff
Limited budget
What do board members think is important for them to do?

Making sure all people who work in the hospital know **how to care for patients well.**

**Supporting and listening** to staff.

Dealing with **tasks from outside the hospital** (such as regulators or local media) so that the people who work in the hospital can focus on looking after patients.

Making sure the board has **good information** about what is happening in the hospital so they can make decisions about how to run the hospital well and sort out any problems quickly. The board needs to know if hospital staff are worried that patients are not being well looked after.

Since 2013, many boards believe that their main job is to make sure that **patients are safe and well looked after.**
Some hospitals believe the Francis Inquiry Report gave hospital boards the power to make changes, particularly to make sure that patients get good care and that there are enough staff to look after patients safely.

"Looking after your patients but equally looking after your staff, communication, engagement, empowerment were all important previously, however post Francis this was "accepted" as what we must do and it was not optional."

Director of Nursing

"It was a Stop moment for us."

Non-Executive Director

"The Francis report was a shock. It was clear from the report that any Board could be wrapped up in statistics and reports and fail to understand what was happening to patients on the ward. Much more emphasis is now given to Director visits and visibility and the Board holds regular conversations with its three divisions to assess the state of play in respect of patient care and safety."

Non-Executive Director
Hospitals believe they have made many changes. Some boards have made sure they have better information about what is happening in their hospital. For example knowing how many staff members are working on the wards each day or board members visiting the wards to look at the care patients are getting.

Hospitals have put in new policies. Policies are written information which guide the hospital and the staff about what they should do. They might be about what should happen if patients think the care they got was not good or about how to make sure that the hospital is a good place to work in. However for some hospitals, these new policies did not seem to make much difference for staff and patients and other hospitals had these type of policies already.

Some of the changes that hospital boards have made were for staff who work in the hospitals. For example ways for staff to let the hospital know if they were worried about the care that patients were getting.

“We were always strong on listening to patients, but since Francis we have also paid much more attention in listening to our staff.”

Hospital Board Chair
Some boards have looked at how to listen to patients and to make changes based on what they have been told. There has not been as much work getting patients views on how to change services and make the care better though.

The Chief Nurse is a board member in all hospitals and may now be listened to more by the board.

Some of the changes planned by boards have not always happened. This was for different reasons. For example, not enough trained middle managers, departments that do not work well together, lack of money and time, or the time needed to give the regulators what they need.

“My main experiences have been with what I would refer to as middle management, I feel that sometimes messages get lost at this level, almost filtered out from the ground level/front line managers and this is frustrating...”

Hospital Manager
Boards say they think good patient care is very important but what they do to make that happen is better at some hospitals than others.

In our national survey, boards felt they knew most about what was important to regulators, then staff, then patients and their families.

I think over the last few years actually that senior board level of management is much more visible than what we were used to previously.

Hospital staff member

In some hospitals patients and staff see more of the board members now. They know more about what the board does to run the hospital.
All hospitals now have a legal ‘Duty of Candour’.

This means that hospitals need to tell patients when their care has not been as good as it should have been and to say they are sorry about that.

The government put this in place because of the Francis Inquiry Report.

[The] main impact is that it has made openness and honesty part of the way we do things around here.

Chief Nurse

Hospital boards think the Duty of Candour helps patients feel more confident with the care they get and helps make sure the care they get is good.

They wanted a layperson’s approach to how they handled complaints... They were very defensive initially and we have steered them to being more open and more willing to say they’re sorry...

Public Member

Duty of Candour also applies to hospital staff, so they can let their managers and the hospital board know if there are problems in the hospital. It seems that there has been more work put into Duty of Candour for patients rather than for staff.

Patients appreciate our openness and honesty and staff feel much more comfortable in identifying, acknowledging and identifying the learning from when things go wrong or not as planned.

Non-Executive Director
What helps boards run the hospital well?

- When people who work at the hospital understand what the board does and why they do it.
- When patients, members of the local community and Foundation Trust hospital governors* work with the board to advise on how the hospital can make sure that patients get good, safe care.
- When boards learn from when patients are not well looked after and make changes and do it better in the future.
- When board members stay for some time on the hospital board, rather than often having people leaving and new people joining.
- When the people who lead the hospital act in the same way as the hospital values (values are what the hospital says that it thinks are very important, such as compassion, respect, working as a team).
- When hospital middle managers have support from the board to be able to do their job well.

*Hospitals can either be a NHS Trust hospital or a Foundation Trust. A Foundation Trust must meet national standards but is not run directly by the Government. Foundation Trust hospitals have patient, staff and public governors to check on how the board is running the hospital.
All hospitals are checked by the Care Quality Commission to see how good they are. The hospitals that the Care Quality Commission score as good or outstanding are more likely to have a board that believes they are doing well in tasks like:

- making sure that staff look after patients well
- asking and listening to how they can run the hospital better.

Hospital boards say that it has not cost too much money to make changes because of the Francis Inquiry recommendations. However, some hospitals have made sure they have more staff working in their hospital since 2013 and this has cost a lot of money to do.

Our National Survey showed that English hospitals had male and female board members. There were not many Black, Asian and Minority Ethnic members on hospital boards. This means the boards are not the same as the communities that the hospitals look after or the staff that work at the hospital.

Some hospital boards have found ways to listen to patients about the care they have had to see how they can give better care in the future.

"The one thing I’ve seen a lot of here is the learning that is taken from whether they be complaints or whether they be challenges... There’s a lot of feedback here, both in terms of governors and in terms of the boards, in terms of patient stories and kind of what’s taken from that, and it goes in much greater depth than I’ve ever experienced anywhere else."

Patient and Governor Focus Group Participant
However there is a lot more which hospitals could do to work with *patients as partners* when designing new services and looking at different ways of running the hospital. We think hospitals are between step 4 and 5 at the moment.

*based on a theory by Sherry Arnstein called A Ladder of Citizen Participation.*
What do we think boards could do?

We think there are five main tasks for hospital boards to do:

- To act as a **conscience** (to check what is right or wrong in what the hospital does). To make sure the hospital lives up to the values of the NHS constitution* and its own values even when difficult decisions need to be made.

- To act as ‘**shock absorber**’ which means to take on all the tasks that the regulators and government say the hospital need to do, while deciding what is important for the well-being of the whole hospital, rather than giving this to the hospital staff to do.

- To work well with many **different people and organisations** both inside and outside the hospital, such as patients, their families, staff, Clinical Commissioning Group, regulators, local media.

- To collect and use all **important information** to help the board learn how the hospital is being run and what the problems are.

- To act like a **sports coach or mentor**, meaning that the board needs to show the people who work in the hospital:
  - what is important to the hospital
  - what they need to do to be the best they can be
  - what is being done at the moment and what can be done better

We found that hospital boards who think they are working hard on most of these things also had higher scores from the Care Quality Commission.

*The values of the NHS Constitution are working together for patients; respect and dignity; commitment to quality of care; compassion; improving lives and that everyone counts.*
What would have made this research better?

In our National survey we asked many different people their views about hospital boards. We got back 20% of the surveys that we sent out so there were many people we did not hear from, but we did get at least one survey back from 90% of English hospitals.

In our National survey, we asked people about what they thought about their boards. This meant we only heard their view rather than what definitely happens on their boards.

We asked 9 hospitals to be case study hospitals, but they did not want to be. It is possible that different information might have come from these hospitals than from the 6 that did let us work with them.

This project looked at changes in hospital boards since the Francis Inquiry Report in 2013. We cannot say if the changes definitely happened because of the Francis Inquiry Report or whether some changes may have happened anyway.

Our patient and public Advisory Group members could have come to the 6 case study hospitals to see what they thought about how hospital boards ran the hospital.
An organisation called National Voices (a group of health and care charities) looked at how patients and the public were involved in this project, to see what we did well and what we could have done better.

National Voices thought that the patient and public view was heard through the Advisory Group but that more could have been done:

When the project was first planned.

**Patients and the public could have been asked what they thought about it and what could be done differently so that patient and public concerns were at the very centre of this research, right from the start.**

The project could have looked at *ways to hear* from people who had *long term illnesses* or *disabilities* and from *Black, Asian and Minority Ethnic communities.*

**Hearing more** from patients and their families in the 6 case study hospitals.
What research could be done next?

There is still more research to do to help hospital boards work better. For example, research looking at:

- How boards can work as well as they can for their local community and come up with better ways to run their hospital, while still making sure they do what that Government and regulators ask them to do.

- How people can join hospital boards who are similar to the people in the community that the hospital looks after. For example, having more Black, Asian and Minority Ethnic members on the board, and members with different experiences and backgrounds than hospital board members usually have.

- How patients can work as partners with hospitals to design new services and to help hospitals give better care to their patients.

- How middle managers can be helped to work better with patients, staff and the senior managers.

- How government regulation can help hospitals give better care to patients.

- To see if having patient, public and staff Governors at Foundation Trust Hospitals means that the hospital runs better and if they have more involvement with patients, the public and staff than NHS Trust Hospitals.
Hospitals are complicated organisations to run.

For some boards, managing day to day issues can be very difficult. For example finding enough staff to work in the hospitals (so that patients have good and safe care) and having enough money to do this, when more and more patients are needing care from the hospital.

Some hospitals think that these problems mean that they cannot continue working on recommendations from the Francis Inquiry Report:

“I do worry that we’re about to lose every bit of the legacy that Robert Francis could leave.”

Chief Nurse

“If anything, Francis is losing traction now. Messages from regulators appear to underline that finance and performance are more important than quality.”

Hospital Chief Executive

But other hospitals feel that Francis Inquiry Report still makes an impact in the way their hospital is run:

“The Francis report has acted as a reminder of what sort of an organisation we don’t want to be like, and continues to be a reminder.”

Non Executive Director
Hospitals have taken different actions because of the Francis Report and some actions have had more effect on how the hospital is run then others. It seems that the Francis Inquiry Report may have made the most difference in some hospitals by helping boards to focus on making the care better for patients and listening to the people who work in their hospitals.

Some hospitals have looked at what happens when patients say they are not happy with the care they have received at the hospital. Many hospitals try to meet with patients to talk about this instead of sending letters about it. The six case study hospitals all had ways to learn from when patients had bad care in their hospital and they tried to be more open with patients and their families.

Patients can still have different experiences of care in hospitals across England. Sometimes patients can have good and bad care in different parts of the same hospital:

> Some of the wards are much [sic] different from others and it does rely very much on particular individuals and particular shifts, how things are.

Patient Focus Group Participant

Hospital boards need to make sure that all patients get the good and compassionate care they need. There is more work for them to do on this but we found many examples of good practice by boards too.

> I do think in that period of time I have seen a dramatic improvement... I do believe that at point of delivery they provide quite an exceptional service, and that's certainly been evidenced in my last two visits to the hospital. I used to dread it enormously, visiting the hospital. And I used to think that's the worst possible place that somebody could go to when they were poorly...

Patient and Governor Focus Group Participant