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5 Years on:

Responses to Francis: changes in board leadership and governance in acute hospitals in England since 2013



The full report



The University of Manchester
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BIRMINGHAM

HEALTH SERVICES
MANAGEMENT
CENTRE

Responses to Francis: changes in board leadership and governance in acute hospitals in England since 2013

Full Report Version

January 2018

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Alphabetical list of abbreviations

| Term | Description |
|-------------|---|
| AG | Advisory Group |
| BAME | Black, Asian and Minority Ethnic |
| CCG | Clinical Commissioning Group |
| CEO | Chief Executive Officer |
| CN | Chief Nurse |
| COO | Chief Operations Officer |
| CQC | Care Quality Commission |
| DH | Department of Health |
| ED | Emergency Department |
| FD | Finance Director |
| FT | Foundation Trust |
| GMC | General Medical Council |
| MD | Medical Director |
| NED | Non-Executive Director |
| NHS | National Health Service |
| NICE | National Institute for Health and Care Excellence |
| NSS | NHS Staff Survey |
| NMC | Nursing and Midwifery Council |
| OD | Organisation Development |
| RTT | Referral-to-Treatment Times |
| STP | Sustainability and Transformation Partnership |
| TDA | Trust Development Authority |

Executive summary

Background

The Francis Report identified serious dysfunctions in the NHS and recommended fundamental culture change: ‘Aspects of a negative culture have emerged at all levels of the NHS system. These include: a lack of consideration of risks to patients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions of trust, acceptance of poor standards and, above all, a failure to put the patient first in everything done’ (Francis 2013a: 1357). There was a multi-pronged response by government to the Inquiry Report and its recommendations. Trusts were required to act on a flurry of guidance, and comply with new legislative duties, such as the Duty of Candour, at the same time as getting to grips with fledgling commissioning bodies and a revamped care quality inspection process. The deteriorating finances of the NHS have also played into this turbulence, resulting in all acute hospital trusts boards being required to look for challenging efficiencies and savings each year since the Francis Report was published, at the same time as demand for services has grown

The Department of Health, in its response to the Francis Inquiry, emphasised the critical role of the board: ‘The leadership of an NHS provider organisation is the job of the board of that organisation’ (DH 2014a). The key question which is faced by boards is how best to fulfil this role.

Study aims

This research explores what organisations have done to respond to Francis and the lessons to be drawn from our findings. The overall purpose is to help policymakers and practitioners to understand how leadership and governance of NHS trusts and foundation trusts can be improved, how this might enable better management of organisations and better staff engagement, and hence safer and higher quality care.

The aims of the study were as follows:

1. To identify the different ways in which the boards of NHS acute hospital trusts and foundation trusts have sought to implement the recommendations on organisational leadership in response to the Francis Inquiry Report in 2013
2. To establish which policies and practices have resulted in improvements
3. To explore the intended and unintended effects of implementing recommendations of the Francis Inquiry
4. To examine the financial and non-financial costs of developing and implementing new policies, processes and actions
5. To uncover the enablers and barriers in improving board leadership
6. To advance theoretical understanding of effective healthcare boards
7. To analyse and synthesise the findings to inform a set of practical and evidence-based learning points for boards

Methods

This was a mixed methods study, theoretically rooted and informed by a range of conceptual frameworks. First there was a scoping phase, in which we obtained accounts through single depth interviews with 13 national stakeholder representatives, and updated a literature review on healthcare board governance. Second, we carried out a survey of members of all NHS acute and specialist hospital boards in England, and obtained 381 responses covering 90% of all trusts. Third, we undertook case study research in six hospital trusts, including interviews and focus group discussions with patient, staff and board representatives, a survey of ward and departmental managers and observations of board meetings. A final phase synthesised the findings from the different lines of investigation.

Patient and public involvement in the research

Advice was sought from a patient leader, active in seeking to improve the organisation of services in her local area, in developing the research proposal. A particular feature of subsequent patient and public involvement in this study was the recruitment process to the

chair and lay membership of the advisory group. Expectations of the lay member role were outlined, and a call was issued inviting applications. The result was 18 expressions of interest including five applications for the lay chair position. The final PPI membership (which was increased from four to five as a result of the higher than anticipated interest) was decided by two members of the research team, through matching expressions of interest and experience against expectations of the roles, and an interview for the chair position. An external summative assessment of the PPI arrangements was provided by National Voices. This concluded that the approach taken was well-motivated, authentic and broadly fit for purpose. It had some impact on the conduct of the research; a small number of ways in which the partnering approach could have been strengthened were suggested, as well as recommendations for the wider health services research community for future studies.

Equality and diversity

We were mindful of the NHS Equality Delivery System, including the goal for more inclusive leadership. The national survey questionnaire covered all NHS and foundation trusts in England. We ensured that the catchment populations of the trusts chosen for case study analysis reflected as far as possible the diversity of the population of England, and we took the advice of our lay-led advisory group in the case study selection process. Likewise, in identifying people to be interviewed in both the scoping phase and in the course of the case studies, we ensured an appropriate mix of ethnicity, age, gender and people with protected characteristics.

Key findings

The scoping phase, national survey and case study findings indicated that:

Board challenges

- The main self-reported challenges for trusts are patient safety, finances, dealing with regulator demands, workforce shortages and, for some, poor relationships in the local health economy

- Patient safety is generally reported as a very high priority for boards
- Long-term financial sustainability is also regarded as important, and the current access and finance targets environment can make it difficult to hold the line on maintaining quality and safety
- Managing the demands of multiple system regulators is sometimes experienced as distracting from the strategic and monitoring tasks of boards

Implementation of Francis policies

- Some trusts have developed or revised a raft of policies, including the handling of complaints and serious incidents, listening to patients and staff engagement
- Others reported that they already had policies in place
- The impacts of these policies vary according to the emphasis placed on robust governance systems and processes
- Policies and practices of listening to and acting on patient feedback are further advanced than partnering with patients to improve care
- Duty of Candour is reported to be well embedded and to have led to greater openness and patient confidence
- Perceived variable quality of middle management and of ward and department level teamworking can act as a barrier to implementation of policies associated with Francis

Board leadership and culture

- Board members are exercising leadership that is more visible to staff and patients
- The emphasis on quality following Francis may have provided an opportunity for the leadership role, sphere of influence and profile of the chief nurse to become more prominent on some boards
- A more stable board, with lower turnover, may help to facilitate acting in a more unitary way
- A culture of quality and service improvement in acute hospitals is emergent and variable

- Higher CQC ratings (Good and Outstanding) for hospital trusts are related to higher self-reported scores for emphasising all main board purposes including holding to account, supporting the executive team, building the reputation of the organisation, drawing upon the views of stakeholders and reconciling competing interests

Implications of results for policy

The Mid Staffs tragedy appears to have galvanised changes in the behaviours of NHS boards towards an increased focus on trying to improve patient safety, patient centred care, a culture of greater openness and staff engagement. The policy context since Francis has become more challenging, and this is affecting the ability of some boards to drive safe, compassionate and effective patient care. Overlapping, voluminous and sometimes contradictory policy and guidance from central NHS bodies can also be an obstacle for some executives.

Further encouragement is needed to build a culture of quality improvement which pervades throughout hospitals, which encompasses the involvement of patients and public as partners, and which supports the capability and capacity of middle and first line management.

We speculate that boards leading the more successful organisations may have a higher internal locus of control that is they operate on the basis that in addition to external commissioning, health system and regulatory pressures, they believe they can have a direct impact on patient safety and experience of care.

Conclusions and areas for future research

Francis has had an important impact on board priorities and on perceptions of culture change. Patient and staff engagement are a powerful lever for boards seeking to hold the quality and safety line. But growing financial, workforce and performance pressures may now threaten the pursuit of the quality agenda. Central direction can be experienced more as a ‘throttle’ and pressure than in support of quality and safety, and how to manage and maximise the value of multiple national edicts is a key challenge for boards and executive teams.

We have concluded that enablers for improving board level leadership in acute hospitals include:

- Having a strong and effective human resource and organisational development function
- In-house programmes to improve governance, quality, safety and complaints handling
- Sustainability and transformation plan-related work that improves local system relations
- A board that is able to sustain (in the eyes of staff) reliable, consistent and clear messaging
- A body of governors and patient representatives (or similar for non-foundation trusts) who are engaged closely in trust quality and safety work
- Using complaints and incidents as part of a wider programme of trust learning and review

This latest evidence points to the potential value of a ‘restless board’ that seeks constantly to find out more, benchmark itself, do better, and check on prior concerns and actions. It also needs to provide stability and consistency of purpose in a turbulent and pressured NHS. And boards may do well to embrace the full repertoire of board purposes and mechanisms identified in prior research.

We have conceived five main roles which are relevant for effective healthcare boards in the wake of Francis: board as conscience, sensor, diplomat, coach and shock absorber. These relate closely to the main board roles from the literature on board governance in relation to agency, stewardship, stakeholder, resource dependency and power, but are developed specifically to relate to the context and the pressures of the NHS in England since Francis.

Future research would benefit from exploring the utility of these roles across different healthcare contexts. Further, the question of how boards can exhibit a greater internal locus of control, as policy entrepreneurs and implementers as opposed to policy victims, should be explored. Finally, given some concerns about the lack of progress in service improvement strategies that work in collaboration with (rather than in consultation with) patients, the dominance of experts on boards, and the disappointing data about a continuing lack of diversity, a third area for future research includes understanding the impact of the

composition of the board, including backgrounds, experiences and perspectives of board members.

Dissemination

There were a number of disseminations during the course of the study. During 2016, early findings were published in the Health Service Journal (Chambers et al, 2016) and presented at the Health Services Research UK (HSRUK) conference. In the first half of 2017 there were also presentations by members of the research team at the European Health Management Association conference, and at the biennial NHS Providers Quality conference.

Finally, there were two presentations at the HSRUK conference immediately following submission of the report in July 2017. Plans are developing to formally launch the report, following approval of the final version. Articles for publication in leading international academic journals are also in preparation.

Wider dissemination is planned for boards, policy makers, regulators and interested patients and public. Two events have been scheduled which will be hosted by the Health Foundation: a breakfast seminar in December 2017 and an afternoon publication launch event in January 2018. Following recommendations by reviewers, there will also be a summary of the report coordinated by the lay members of the advisory group, highlighting findings of relevance and interest to patients and the public and this will be published and disseminated at the same time as the full report. The Health Service Journal has indicated keen interest in publishing headline findings ahead of the formal launch. Dissemination will include extracting messages for boards about how the proposed framework could support training and development of boards and new board members, and messages for regulators about focus and behaviours of national bodies that support and inhibit organisation improvement.

1 Introduction

1.1 The aim of this study

This research explores what organisations have done to respond to Francis and the lessons to be drawn. The overall purpose is to help policymakers and practitioners to understand how leadership and governance of NHS trusts and foundation trusts can be improved, how this might enable better management of organisations, better staff engagement, and hence safer and higher quality care.

In 2014, the Department of Health issued a strategic research initiative on policy responses to the second Francis Inquiry Report, calling for proposals for a suite of studies to assess the impacts of new policies following the publication of the report in 2013. The projects commissioned include: (1) building a culture of openness in healthcare, (2) implementation and costs of policies for safe staffing in acute hospitals, (3) evaluation of patient safety collaboratives, (4) the effects of the CQC inspection and rating system on provider performance and (5) this one on board level leadership changes in acute hospitals. In relation to this last one, the Department of Health stated the importance of understanding if the increased focus on board responsibility and capability in the NHS, and the introduction of the Fit and Proper Persons Requirement for board level appointments, have worked to drive improvements in NHS leadership and the quality of care.

In his public inquiry report, Robert Francis QC made it clear that the board of Stafford Hospital was primarily responsible for the failure of leadership that enabled poor standards of care to go unnoticed and unaddressed for so long. The Department of Health, in its response to the Francis Inquiry, emphasised the critical role of the board: ‘The leadership of an NHS provider organisation is the job of the board of that organisation’ (DH 2014a:76). The critical question faced by boards is how best to fulfil this role.

A grant was awarded to a team led by the University of Manchester, also involving the University of Birmingham and the Nuffield Trust, for research that examines how hospital boards in England, in varying circumstances, have responded to the Francis Inquiry, and what they have done to improve leadership, governance and culture. By identifying what boards have achieved in the pursuit of better management of their organisation, greater staff

engagement, safer and higher quality care, lessons will be drawn for use by policy makers, boards, patients, staff and the general public. A further aim is to contribute to theory about the characteristics of the effective healthcare board where there exist gaps in our knowledge, particularly in relation to board purposes and dynamics.

1.2 Research objectives

It was not within the scope of this research to shine a light overall on hospital quality and performance. Our general approach has been to explore the main themes on healthcare board-level leadership, which came out of Francis and the many overlapping reports that ensued, rather than to track and follow the impact of each separate report. The six research objectives and associated supporting questions are therefore:

- 1. To identify the different ways in which the boards of NHS hospital trusts and foundation trusts have sought to implement the recommendations on organisational leadership set out in reports following the publication of the Francis public inquiry.** What actions have been taken in areas such as the conduct and content of board meetings, staff engagement, board members' engagement with frontline care and staff, and organisational and board development?
- 2. To find out which mechanisms used by boards of NHS trusts and foundation trusts have led to reported improvements (or otherwise) in local organisational strategies, structures and culture, and the factors underpinning such progress.** How far do the mechanisms reported reflect NHS Healthy Board principles and practices? What do trusts report as being the impact of mechanisms put in place? How are trusts implementing the Fit and Proper Person's Requirements?
- 3. To explore the early intended and unintended effects of the different ways in which NHS hospital trusts and foundation trusts have sought to improve board and organisational leadership in response to Hard Truths and the Healthy NHS Board.** How are trusts monitoring the effects of mechanisms designed to improve organisational leadership? Do they have any evidence of change? How do they assure the quality of such data?

4. **To examine the financial and non-financial costs of developing and implementing new policies, processes and actions aimed at improving board and organisational leadership.** How are trusts keeping a record of the cost of board and organisational development activities? Are initiatives regarded as an investment or a cost? What are the plans to sustain such investments?
5. **To explore the enablers of and barriers to implementing different approaches to board and organisational leadership.** What are the local organisational inhibitors and enablers? How do they experience the external NHS culture of performance management and regulation?
6. **To analyse and synthesise the findings from this research to inform a set of practical and evidence-based learning points for boards.**

1.3 The scope of the study

In order to address the research questions, the study progressed through four linked stages. Chapter 3 provides more detail on the research methods employed. First, there was a scoping phase of interviews with opinion leaders from patient groups, national regulators and experts in board leadership. This was accompanied by an updated review of the literature about how boards of healthcare organisations, through effective leadership, can influence the safety, effectiveness and quality of patient care. A stakeholder workshop reviewed the outcome of this phase and informed the design of the second - an on-line survey questionnaire of all NHS hospital boards in England, to find out what they have done to respond to Francis Report recommendations about governance and leadership, and their views on impact.

This broad national picture was deepened in phase three through extensive field work in six case study hospitals. Interviews and focus group discussions were carried out with patient, staff and board representatives, and a survey undertaken of ward and departmental managers. A sample of board, governors and subcommittee meetings were observed and additional documentary analysis undertaken.

The final phase, outlined in chapter 7, is the synthesis of the main findings across the different areas of investigation.

1.4 The structure of this report

The study consists of four linked work packages, as described above, and the structure of this report mirrors these. Chapter 2 offers a resume of the background and the changing policy context for NHS leadership in acute hospitals, particularly in the years since 2013. Chapter 3 outlines the methods chosen for answering our research questions, including our assessment of the strengths and limitations of the approach that we took. Chapter 4 summarises findings from our updated literature review and accounts of opinion leaders and stakeholders solicited in 2015 and 2016 (work package 1). Chapter 5 describes the results of our national survey of NHS board members undertaken in the spring of 2016 (work package 2). Chapter 6 outlines the findings from our in depth six case studies, for which fieldwork took place over a period of 12 months starting in spring 2016 (work package 3). Chapter 7 moves to an exploration, synthesis and discussion of the main themes that have emerged from our different areas of investigation, including development of theory about the dynamics of the effective healthcare board (work package 4). Finally, chapter 8 discusses the implications for policy, practice and recommendations for further research.

2 Background and policy context

2.1 Introduction

This chapter sets out the background to the publication of the 2013 Francis Report, and the subsequent policy developments. It also maps out the current broad policy and financial context within which acute hospital trusts, and the wider health and care sector, are operating.

This chapter is divided into five sections as follows:

- 1) The 2010 Francis Report and other inquiries into Mid Staffordshire NHS Trust
- 2) The 2013 Francis Report, including the main themes
- 3) The government's response, including changes to CQC Inspection methods and legislative requirements
- 4) Changes since 2013 in the funding climate facing the NHS
- 5) Relevant policy developments since 2014

The overarching objective of this research project is to understand the impact of the 2013 report on the leadership of acute trusts in England. As will become immediately apparent in this chapter, the 2013 Inquiry Report was not a single or isolated event, but was situated in a web of linked policies, reports, initiatives and subsequent legislation (tables 1 and 2 below). To a lesser extent, the same is true of the report into the first independent inquiry into Mid Staffordshire NHS Foundation Trust, published in 2010, which was accompanied by related pieces of work that would have been influential on boards, for example the publication of 'The Healthy Board' by the National Leadership Council.

Just as the subject matter of this research cannot neatly be isolated, the context in which the trusts have been operating has been evolving rapidly between the publication of the Francis Report and the period in which the national survey and case study fieldwork for this research was conducted: between January 2016 and April 2017. This includes major changes in the regulatory landscape, with the implementation of the Health and Social Care Act (2012), but also the financial environment, as historically low increases in NHS funding (in the wake of

the 2008 financial crisis) have collided with growing demand and cost pressures that have accelerated since 2013.

2.2 The road to 2013: the first Francis Report and other inquiries into Mid Staffordshire NHS Trust

The failings in care between 2005 and 2009 at the Mid Staffordshire NHS Trust were subject to multiple reports and investigations. The first national report was conducted by the Healthcare Commission and published in 2009 (Healthcare-Commission 2009)(see table1), and the Secretary of State for Health also commissioned reviews by two senior clinicians into aspects of care at Mid Staffordshire, before ordering a full independent inquiry chaired by Robert Francis QC. This was formally known as the ‘Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust’ (Francis 2010) but is often referred to as the ‘first Francis Report.’ It was published in 2010, and in the same year other related reports were published by the Department of Health and other national bodies, including a review of Early Warning Systems (NQB 2010), also with recommendations, alongside other reports into the regulation of senior managers and the principles for good board leadership, known as ‘The Healthy Board’ (NHSLA 2013). This phenomenon of multiple, overlapping reports with recommendations and guidance that existed in 2010 is also characteristic of 2013.

Table 1: Reports and policies associated with the ‘first’ Francis Report

| Title | Body | Date | Content |
|--|-----------------------|-----------------|--|
| Investigation into Mid Staffordshire NHS Foundation Trust (Healthcare-Commission 2009) | Healthcare Commission | 17th March 2009 | 172 page investigation and recommendations for the trust |

| | | | |
|---|---|--------------------|--|
| | | | |
| Mid Staffordshire NHS Foundation Trust: a review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission Report (Albertini 2009) | Department of Health (Led by Professor George Alberti) commissioned by SoS and Monitor Based on three visits and interviews with staff | 29th April 2009 | 22 pages including 23 recommendations |
| Mid Staffordshire NHS Foundation Trust: a review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation (Thomé 2009) | Department of Health (Led by Dr Colin Thome) Investigation of the role of the local PCTs and SHA commissioned by SoS | April 2009 | 34 pages including recommendations |
| Independent Inquiry into care provided by Mid Staffordshire NHS Trust (First Francis Report) (Francis 2010) | Department of Health | 24th February 2010 | Two volumes: report and evidence (vol 2) 18 recommendations |
| Review of Early Warning Systems in | National Quality Board | February 2010 | |

| | | | |
|--|---|--|---|
| the NHS (NQB 2010) | | | |
| Advisory Group on Assuring the Quality of Senior NHS Managers (DH 2010) | DH commissioned, PwC research (led by Ian Dalton) | 23th February 2010 | 37 pages including 10 recommendations |
| The Healthy NHS Board (NHSLA 2013) | National Leadership Council (now NHS Improvement Academy) | First edition published in 2010, updated and republished in 2013 | 54 pages of guidance on board functions, effective working and behaviours |

The 2010 Francis Inquiry: the ‘first Francis Report’

The 2010 Francis Inquiry received verbal and written testimony from 966 patients and members of the public and 82 members of staff. The evidence, much of it harrowing, was published alongside the final report, which contained 18 recommendations. Although the remit of this inquiry was confined to understanding the causes behind the events that took place inside Mid Staffordshire itself, it was written with a wider NHS readership in mind, particularly members of boards. In his introduction to the 2010 report, Robert Francis wrote: *‘I suggest that the board of any trust could benefit from reflecting on their own work in the light of what is described in my report’* (Francis 2010: 3).

The inquiry report gave an account of what went wrong inside the trust between 2005 and 2009, and offered a diagnosis of the causes. The main findings are summarised below in box 1. A primary finding was that the culture of the hospital had been allowed to evolve in a negative way, allowing instances of poor care, stifling efforts by staff and patients to report failures and undermining (or preventing) the leadership of the trust from perceiving the problems or taking action to correct them.

Box 1: Main findings of 2010 Francis Inquiry on underlying causes of care failings

- Inadequate numbers of staff and limited or no board oversight of staffing levels
- Uncaring staff
- Poor record keeping e.g. serious incidents, complaints not properly handled
- ‘Forceful style of management’/bullying
- Overly strong board focus on meeting targets
- Disengaged consultant body
- Lack of openness at board level [business conducted in private]
- Overreliance on external assessment vs internal assurance
- Dominance of finance at board level
- Inexperienced NEDs
- Board too distant from operational detail
- Board overly focused on process not outcomes
- Lack of public engagement

2.3 The 2013 Francis Inquiry Report

The 2010 report flagged, but was not able to investigate, the failings beyond the trust itself, namely the role played by regulatory bodies, commissioners and the wider management system, locally and nationally. Four months after it was published, in June 2010, the incoming Coalition Government ordered a full public inquiry, under the remit of the Inquiries Act (2005), also chaired by Robert Francis QC. This second inquiry had a specific remit to examine this wider context, including:

the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner; and appropriate action taken. (Francis 2013a: 16)

The inquiry sat for just over a year, and took witness statements and evidence, both oral and written, which were put into the public domain. The ‘Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry’ was published on 5th February, 2013. The three-volume report set out an analysis of what went wrong across all these bodies, and contained 290 recommendations aimed at changing culture and practice at the Department of Health, the Care Quality Commission (CQC), Monitor, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), in addition to local patient and public scrutiny organisations.

Many of the recommendations also applied to boards of acute hospitals and to all those working in organisations providing services to patients. The executive summary of the report noted that the inquiry team received requests from ‘distressed members of the public’ about failings in other trusts, which were beyond the remit of the inquiry to investigate.

Main themes in the 2013 Francis Report for acute trusts

In his press statement at the release of the Francis Report, Robert Francis QC identified five main themes on which all NHS organisations needed to take action, namely:

- Fundamental standards
- Openness, transparency and candour
- Nursing standards
- Patient-centred leadership
- Information (Francis 2013b)

The next sections provide an overview of the recommendations that applied to the behaviour and action of those leading trusts.

Fundamental standards

The report found that quality standards that existed at the time of the Mid Staffordshire failure were confused, both in their objectives and their enforcement through regulation.

Many of the recommendations aimed to improve the quality of the standards themselves. Responsibility for developing and enforcing the recommended fundamental standards lay with national bodies rather than acute trusts; however, the report recommended that staff inside trusts should be willing to contribute to the development of such standards and comply with them (recommendation 11). Managers should insist that staff report failures and give feedback to staff in relation to any reports they make (recommendation 12).

The Francis Report recommended that trust boards should also publish comprehensive reports about their organisation's compliance with standards, including information about failures as well as successes (recommendation 37). In addition, foundation trusts should consider how to enable councils of governors to assist in the process of maintaining standards (recommendations 75 and 76).

Recommendations 109–122 related to better handling of, and response to, complaints. Trusts should ensure that they respond to and learn from all complaints (regardless of whether they are subject to formal investigations). External bodies, such as commissioners, should also have access to detailed and timely information about complaints. Patients and families should have clear and multiple channels to both comment and complain during and after treatment.

Openness, transparency and candour

The Francis Report concluded that many of the failings in care in Mid Staffordshire were the culmination of a leadership culture within the trust that 'lacked insight and awareness of the reality of the care being provided to patients. It was generally defensive in its reaction to criticism and lacked openness with patients, the public and external agencies' (Francis 2013c). This lack of openness also characterised the conduct of some of the national managerial and regulatory bodies.

Some of the recommendations under this theme required legislation or action at a national level (see below), notably the recommended statutory Duty of Candour on providers. Nevertheless, there was a general recommendation that every organisation, and everyone working in them, should be honest and open in their dealings with patients (recommendation 173). Where a serious incident occurred, patients and their families should be given full and truthful answers to questions, as should regulators and commissioners (recommendations 174–176).

Nursing standards

The Francis Report identified low standards of nursing in Mid Staffordshire, including poor leadership and inadequate recruitment and training (Francis 2013c: 45). Recommendations included:

- Employers assessing potential nursing staff values and attitudes towards patients
- Better performance management of nursing staff – including patients’ assessment of nurses’ caring values
- Ward managers being more hands-on and available to patients and staff, rather than office-bound
- The development and use of measurements of the cultural health of the nursing workforce
- A named ‘key nurse’ to coordinate care for patients

The inquiry findings also drew attention to the impact of cuts to nursing staff in Mid Staffordshire, but the recommendations in the report itself avoided the development of minimum patient-to-staff ratios, instead recommending that the National Institute for Health and Care Excellence (NICE) draw up evidence-based tools to establish minimum staffing levels for nursing and other clinicians (recommendation 23).

Patient-centred leadership

The Francis Report illuminated the role of poor-quality leadership, both within Mid Staffordshire NHS Foundation Trust and beyond. These leaders were focussed on the wrong objectives at the expense of patient care, isolated and inclined to ‘self-promotion rather than critical analysis and openness’ (Francis 2013c: 44). The report recommended the development of a code of practice and training for leaders, including those managing health care organisations. While the development of such codes, along with the recommended procedures for getting rid of those leaders who are not ‘fit’ for practise, lay outside the control of hospitals, many of the more general recommendations applied to values for all

those in leadership roles (executive and non-executive directors, and clinical directors and senior nurse managers) within hospital trusts. For example, all individuals working in the NHS should adhere to the values set out in the NHS Constitution, namely that ‘the overriding value should be that patients are put first’ (recommendation 4).

Information

The main recommendations that applied to provider organisations under this theme relate to having proper systems in place for the collection of real-time and accurate information about the performance of their services against the standards required, including at consultant and specialist team levels, and that this information should be made available to commissioners, regulators and the wider public, as appropriate.

2.4 The government response to the 2013 Francis Inquiry Report

In March 2013, the government published an initial response to the Francis Report, ‘Patients First and Foremost’ (DH 2013). It set out some immediate measures, for example adopting a rating scheme for health care providers (including hospitals) and setting up a chief inspector of hospitals and for other kinds of providers. At this point the government did not specify a list of actions that it expected hospital trusts to take, but the Secretary of State for Health wrote to the chairs of hospital boards asking them ‘to hold events where they listen to the views of their staff about how we safeguard the core values of compassion as the NHS gets ever busier’ (DH 2013: 6). The government also requested that trusts feed back on the outcomes of these listening events by the end of 2013 (Hunt 2013).

A more comprehensive response, entitled ‘Hard Truths: The journey to putting patients first’, was published in November 2013. This was a huge, two volume document. The first volume (which ran to 137 pages) contained a summary of multiple government existing and future initiatives and local case studies that related to the broad themes of the Francis Report. The second volume, 250 pages long, contained a detailed response to each of the 290 recommendations in the report, setting out the actions that the government would take in response to many (but not all) of the recommendations. These included:

- Requiring trusts to publish ward staffing levels monthly
- Requiring trusts to publish complaints data quarterly
- Legislation to create a Duty of Candour for providers and the development of a criminal charge of wilful neglect in the future (DH 2014a) (DH 2014b)

The foreword to ‘Hard Truths’, written by Jeremy Hunt, the Secretary of State, encapsulates the tensions at the heart of the government’s response to the Francis Report. On the one hand, Hunt pays tribute to the dedication of staff and the importance of an open, learning culture, but on the other lays out the reality of much tougher inspection and more vigilance on the part of ‘the system’: ‘(W)hen things really go wrong, or on the rare occasions when leaders and Boards fail to show the integrity we all expect, the response will be to enable failing hospitals to be turned around and puts in place proper accountability, and, when necessary, criminal sanctions’ (DH 2014a: 3).

The next sections set out the main contours of this ‘proper accountability,’ namely the tightened inspection regime, special measures, and the legislative outputs from Francis, namely the Duty of Candour and the Fit and Proper Person’s Test.

Impact of Francis on the CQC: Inspection and enforcement

In its own words, the CQC described the changes it had made to the inspection regime as ‘radical’ in the wake of the Francis Report and the government’s ‘Hard Truths’ Report (CQC 2015a). Central to these changes was the appointment of a chief inspector of hospitals, and a new inspection regime, which began in October 2013 and was completed for all acute hospital trusts by March 2016 (CQC 2016a). (All the case study trusts in our research had, therefore, experienced this new regulation regime). The new regime involved larger teams, with greater clinical and managerial expertise, as well as more extensive use of monitoring data. Trusts are now inspected across five domains: safety, effectiveness, caring, responsive and well led. The CQC now combines and publishes ratings with four performance levels: Outstanding, Good, Requires Improvement and Inadequate.

According to the CQC’s handbook for providers, an inspection will involve a team of up to fifty people visiting the trust for between two and four days, collecting detailed information

from patients, staff, local members of the public, trade unions, local commissioning groups and local authorities (CQC 2015b).

Well-Led

Since 2014, the leadership of trusts have been assessed by the CQC according to five ‘key lines of enquiry’ on how well they are led. The Well-Led domain is defined by the CQC as ‘(how well) the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture’ (CQC 2016b). At the time of writing, the CQC were revising the key lines of enquiry on the Well-Led (as well as the other domains) partly to bring themselves into alignment with the other regulatory bodies (formerly Monitor and the TDA, now NHS Improvement), which also assess the quality, financial performance and leadership of boards. The CQC’s current key lines of enquiry are summarized in box 2 below, each accompanied by between five and 11 detailed ‘prompt’ questions for the inspectors to ask of leaders, staff, patients and others.

Box 2: Key Lines of Enquiry for the Well-Led Domain CQC (CQC2017a)

- Is there a clear vision and a credible strategy to deliver good quality?
- Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are understood and managed?
- How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality care?
- How are people who use the service, the public and staff engaged and involved?
- How are services continuously improved and sustainability ensured?

Special measures

In 2017, the CQC published a summary of the inspections carried out under the new regime since 2013, 136 non-specialist trusts and 18 specialist trusts (CQC 2017a). The report gives details of the 28 trusts that were put into special measures since 2013/14, including the 11

identified by the Keogh Review in 2013 (table 2). According to the CQC, special measures are applied when a trust has been found to have serious failings in at least two of the five domains and ‘where there are concerns that existing management cannot make the necessary improvements without support’ (CQC 2017a: 97).

The CQC recommends to NHS Improvement that a trust should be placed in special measures, triggering a process which includes the appointment of an improvement director and partnering organisation, and a review of the capability of the trust’s leadership. This review might include ‘changes to the management of the organisation to make sure that the board and executive team can make the required improvements’ (Monitor 2015: 5).

Trusts have to report progress against the action plan every month, and are removed from special measures when re-inspection by the CQC of all, or targeted parts of the trusts’ activities have demonstrated improvement. According to the CQC, of the 28 trusts placed in special measures in the three years since 2014, 15 had exited, while 13 were still in special measures as of January 2017. The placing of a trust in special measures is done publicly, and covered by the local media. In 2017, in its review of acute trusts the CQC acknowledged that the imposition of special measures can affect the reputation of trusts, including its capacity to attract senior staff, but also states that existing staff were often ‘glad that the extent of the problems they face has now been recognised’ (CQC 2017a: 97).

Duty of Candour

Recommendation 181, for a statutory Duty of Candour for providers, became law on April 1st 2015. The requirements of the Duty of Candour are contained in Regulation 20 (under the Health and Social Care Act, (2008)). Regulation 20 sets out the procedure to be followed by health care providers where any ‘unintended or unexpected’ incident had occurred which did, or could, have resulted in death, or severe harm, moderate harm or prolonged psychological harm to the service user, in the ‘reasonable opinion of a healthcare professional’ (CQC 2017b). The Care Quality Commission, which assesses providers on the Duty of Candour, issued guidance in March 2015 which gave examples of the kind of incidents might require action (for example an unexpected death during surgery or injuries from treatment even when the patient recovers) and what sort of response would illustrate that the Duty of Candour had been complied with, including offering an apology and making sure everything was properly

documented (CQC 2015c). A core principle explained in this guidance was that hospitals (and other providers) needed to be open when things went wrong, and learn from mistakes, underpinned by a culture of openness and transparency at all levels and that there should be a ‘commitment to being open and transparent at board level (CQC 2015c: 8).

Fit and Proper Person Test

From April 1st 2015, all providers of care registered with the CQC were subject to a new regulation (5), which put a requirement on the chair of an NHS body to ensure that all directors are fit to hold their positions. The CQC’s guidance (CQC 2015d) explains that this goes beyond the standard requirements of ‘good character, health, qualifications, skills and experience’, but also means preventing individuals from holding office who: ‘have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or providing a service elsewhere which, if provided in England, would be a regulated activity’. The guidance goes on to explain that providers must ensure they have processes and policies in place to comply with the regulation, and ‘(m)ake every reasonable effort to assure itself about an individual by all means available’ (CQC 2015d: 10)

Parallel initiatives to improve quality and safety of care

The first government response to the Francis Inquiry Report, ‘Patients First and Foremost’ (DH 2013), contained a summary of the initiatives either underway or planned, illustrating just how numerous the initiatives relating to improving quality of care and the patient experience had become. The document referred to six new or concurrent reviews on: patient safety; quality and safety in 14 hospital trusts with persistently high mortality rates; health care assistants; the handling of complaints; the development of hospital ratings; and the burden of NHS bureaucracy, as summarised in table 2. These follow other initiatives that pre-date the Francis Report, including the creation of Quality Surveillance Groups, and Compassion in Practice – a review of caring and compassion for nurses and other care staff led by the chief nursing officer.

Table 2: Initiatives and reviews relating to the quality of hospital care 2012/13 and the second Francis Report

| Title | Date | Body | Content |
|---|-----------------------------|--|---|
| Patients First and Foremost: The Initial Government Response to the Report of Mid Staffordshire NHS Foundation Trust Public Inquiry | March 2013 | Department of Health | Statement of common purpose, and call to action for every part of the system to learn the lessons and act on them |
| Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh (Keogh 2013) | 16 th July 2013 | Department of Health/NHS England | 8 ‘Ambitions’ with 23 ‘Actions’ aimed at government and members of trust boards |
| The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings (Cavendish 2013) | July 2013 | Commissioned by the Department of Health | 18 Recommendations aimed at national bodies and Trusts (e.g. Nursing Directors) |
| A Promise to Learn- A Commitment to Act: Improving the Safety of Patients in England (NAG 2013) | 6 th August 2013 | Led by Professor Don Berwick, commissioned by the Department of Health | 10 Recommendations, aimed at government, NHS provider organisations and all healthcare professionals |
| A Review of the NHS | 28 th October | Led by Rt Hon | 40 Recommendations, 16 of |

| | | | |
|--|--------------------------------|--|--|
| Hospitals Complaints System: Putting Patients Back in the Picture (Clwyd and Hart 2013) | 2013 | Ann Clwyd MP and Professor Tricia Hart, commissioned by the Department of Health | which were aimed at Trusts specifically |
| Challenging Bureaucracy (NHS-Confederation 2013) | 15 th November 2013 | NHS Confederation, commissioned by the Department of Health | 30 Recommendations aimed at national bodies |
| More recent reports and inquiries | | | |
| Report of The Morecambe Bay Investigation (An independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013) (Kirkup 2015) | 3 rd March 2015 | Independent Inquiry set up by Secretary of State and chaired by Bill Kirkup CBE | 18 Recommendations aimed at the Trust Board, and a further 25 aimed at 'the wider NHS' |
| Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS | 11 th February 2015 | Sir Robert Francis QC, commissioned by the Secretary of State for Health | 20 'Actions' aimed at a range of bodies, including NHS Trusts |

| | | | |
|----------------|--|--|--|
| (Francis 2015) | | | |
|----------------|--|--|--|

The initiatives set out above are only a limited selection. A recent review of the policy developments relating to quality across the NHS as a whole identified 179 separate quality-related initiatives announced by government between June 2011 and December 2015, the equivalent of one a week (Molloy et al. 2016). As the table above shows, many of the post-Francis Report publications contained recommendations, some of which were aimed directly at boards. The Keogh review, for example, (Keogh 2013), contained many actions for board members, including putting early warning systems in place to identify patients at risk of deterioration, ensuring that they had staff in place to collect and analyse data on quality, and actively releasing staff across trusts to work on quality improvement. There were also differences in the tone of some of these reports, for example the independent Berwick review into patient safety, in contrast to the government’s language of vigilance and inspection, emphasised the importance of a blame-free culture: ‘culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime’ (NAG 2013: 11).

The Healthy NHS Board

Many of the issues touched on in the reports referred to above, namely how the leaders of hospitals should ensure quality and make sure that patients and staff are effectively engaged, were also summarized in The Healthy Board guidance, which was updated and republished in 2013 (NHSLA 2013), aimed at existing and aspiring board members of NHS provider trusts. The original guidance was published in 2010, accompanied by a literature review (Ramsay et al. 2010) that summarized evidence from both health and non-health theory and practice relating to board governance. The 2013 publication does not recommend any particular theoretical approach to board governance (see p 41 table 3), but instead identifies three key roles and three building blocks for effective boards. The three key roles are: formulating strategy, ensuring accountability, and shaping a health culture. In terms of the building blocks, effective boards will need to be cognizant of the external context, informed by intelligence and give priority to engagement within and beyond the organization. The Healthy

NHS Board contains detailed advice for boards in how to go about these functions, including what sort of committees might be appropriate, and the timing and content of board papers.

2.5 Changes in the financial context facing acute trusts since 2013

At the same time as the multiple reports and initiatives were being developed and announced in the wake of both Francis Inquiry Reports, there has been a substantial change to the financial environment facing the NHS, which has had a particularly profound impact on hospital trusts. Following the financial crisis of 2008/9, the UK government has pursued a policy of restricting public spending in order to reduce the public sector deficit. Although the funding made available for the NHS has been protected relative to other government departments since 2010 - rising at an average rate of 1% between 2009/2010 and 2015/2016 - demand for health care and the cost of providing it (particularly the cost of drugs and staff) has risen much faster than funding growth over the same period. In 2015/16, for example, the cost to trusts of providing hospital services rose by 3.2%, whereas their income grew by only 1.1% (Lafond et al. 2017).

This financial pressure on trust income has been a deliberate policy. About 60% of NHS hospital trusts' income is paid through the national tariff. Each year, the tariff is adjusted upwards for to take account of rising drug, staff and other input costs, but has then had an efficiency factor added in, which makes assumptions about the efficiencies that hospitals can make to bring their costs down. Between 2011/12 and 2014/15 the efficiency factor was set at 4%, higher than the uplift to the tariff. Although the efficiency factor was eased to 3.5% in 2015/16, it has meant that payments to hospitals for this part of their activity has fallen in cash terms for four consecutive years (Lafond et al. 2017). Non-tariff and block contracts have also been subject to the efficiency factor.

This gap between costs and income has been evident in the growing deficits of hospital providers since 2012/13.

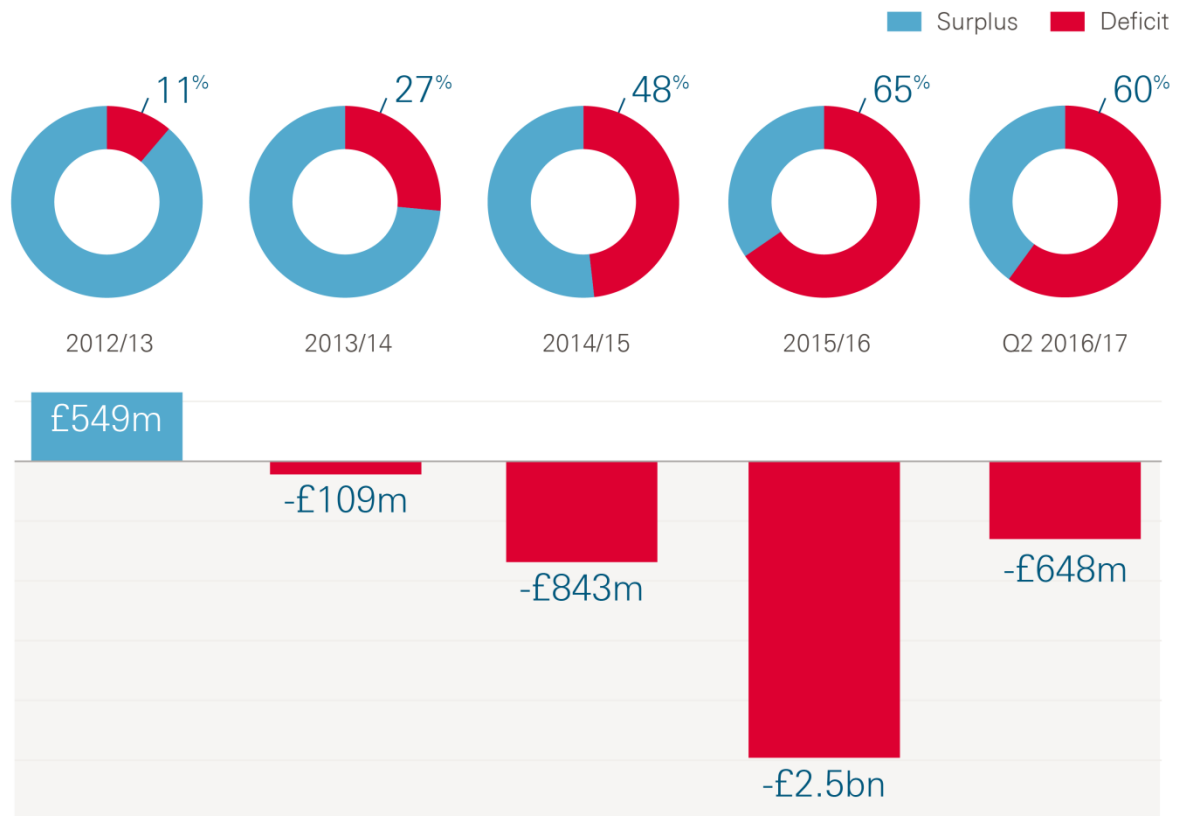
In 2013/14, trusts and foundation trusts reported a deficit of £91 million after delivering a surplus of £592m the year before. In 2014/15, the deficit increased to £859m, and in 2015/16, it more than doubled to £2.5 billion. In 2015/16 financial distress had spread across many different kinds of organisations, with 88% of acute trusts in deficit, and 50% of specialist

trusts also in the red (NAO 2016). Forecasts for this year (2016/17) are of a deficit of between £644 million and £873 million (Lafond et al. 2017) (figure 1).

Figure 1: NHS trusts in net surplus/deficit

NHS trusts in net surplus/deficit

Reported proportion and value of trusts in surplus/deficit, 2012/13–2015/16 and Q2 2016



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At the same time as financial performance deteriorated, so has performance against key access targets, notably the four hour A&E target, the 18 week target from referral to treatment for non-urgent treatment and ambulance response times. According to the National Audit Office, in 2012/13, 95.9% of trusts were meeting the four hour A&E standard, but by q1 in 2106/17, this had dropped to 90.3% of trusts. Similarly, in 2012/13, 94.1% of trusts were treating patients within 18 weeks, but by q1 2016/17, 91% were compliant (NAO 2016).

2.6 Changes in the policy landscape since 2013

When the Francis Report was published in February 2013, the NHS was making its final preparations to implement the structural changes contained in the Health and Social Care Act (2012). These included the creation of over 200 clinical commissioning groups, which formally began their duties in April 2013, overseen by a new arm's length body, NHS England. While the biggest organisational changes took place beyond the walls of NHS hospital trusts, the hospital sector was not insulated from change. A new body, the Trust Development Authority, was created to oversee the performance of non- Foundation Trusts, while Monitor kept oversight of foundation trusts, at the same time as having its own mandate expanded. Both bodies had oversight of financial performance of their respective trusts, but also saw their role in monitoring quality and performance alongside the CQC and the local clinical commissioning groups. They were merged in 2015 to become NHS Improvement.

2.7 The Five Year Forward View and STPs

In October 2014, NHS England, in collaboration with other arms-length bodies including NHS Improvement, published the Five Year Forward View (DH 2014b), which set out the challenges facing the NHS and plans to address these over the next five years. At the heart of the Five Year Forward View were new models of care, which were to receive funding and support to trial new ways of delivering care. These included 'acute care collaboratives' (groups of hospitals working together) and Primary and Acute Care Systems, where acute trusts built closer collaborations with community services, including GP services.

The Five Year Forward View, published on the cusp of the deteriorating financial situation in the NHS, also quantified the gap between available resources and future cost pressures, as equivalent to £30billion by 2020-21 (DH 2014b). Although the document speculated that efficiencies of up to 3% a year were theoretically possible (by holding down staff wages and forcing hospital trusts to cut costs using the national tariff), the implication was clear that the sort of transformation needed for the NHS would require additional funds.

In November 2015, the government committed £8 billion in extra funding to the NHS. In December 2015, NHS England and NHS Improvement broadened the scope of NHS reform

plans beyond new models of care by publishing planning guidance that required all NHS providers, commissioners and local authorities to collaborate across 44 local areas in drawing up ‘Sustainability and Transformation Plans’ (DH 2015). These plans had to include how local areas intended to return to ‘aggregate financial balance’ (DH 2015: 8). For hospital providers, this meant accelerating efficiency savings set out in the Carter Review (Carter 2016), but also being transparent about their costs with their local partners, and, in some areas, planning potentially radical changes to service provision.

Sustainability and Transformation Programme (STP) funding was available to help local areas, but further guidance released in September 2016 made this funding contingent on STPs and the organisations within them, meeting a financial ‘control total’(NHS-England 2016). This guidance made clear that individual organisations, including hospital trusts, would still be held to account for meeting their performance and financial targets, including caps on spending on agency staff, which NHS Improvement imposed on all acute trusts from April 1st 2016 (NHS-Improvement 2016).

The STP planning process has been criticized on several levels, including a lack of public transparency, overoptimistic assumptions about the scale of investment needed and the degree to which demand for services can be moderated (Walshe 2017). From a trust perspective, the STP process contains some contradictory messaging from government. On the one hand, there has been a strong emphasis on the importance of collaboration, as the NHS England guidance makes clear: ‘(w)hat makes most sense for patients, communities and the taxpayer should always trump the narrower interests of individual organisations’ (ref 17 below p 4). And yet the legal position for trust board members remained unaltered: ‘accountability for delivery will sit with individual organisations’ (Walshe 2017: 17).

2.8 Conclusion

The Francis Report identified serious dysfunctional deficiencies in the NHS and, at its heart, recommended fundamental culture change: ‘Aspects of a negative culture have emerged at all levels of the NHS system. These include: a lack of consideration of risks to patients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions of trust, acceptance of poor standards and, above all, a failure to put the patient first in everything done’ (Francis 2013a: 1357). Indeed, the Francis Inquiry, like the Kennedy Inquiry into

failings at Bristol Royal Infirmary a decade earlier, went to considerable trouble to understand the role of culture in a health care context. Some commentators noted that the subtlety of some of the supporting evidence to the inquiry was not matched by the same degree of nuance in the inquiry's recommendations, which could be viewed as somewhat aspirational and over optimistic about the feasibility of enacting purposeful culture change (Davies and Mannion 2013).

The multi-pronged response by government to the Inquiry Report and recommendations are likely to have further complicated this, from the perspective of trust boards. NHS boards are odd creatures of corporate governance – even Foundation Trusts are not autonomous – the government role of central control is very powerful and this has also arguably got tighter over recent years. Trusts were required to comply with new legislative duties, such as the Duty of Candour, at the same time as getting to grips with new, fledgling commissioning bodies, and a revamped care quality inspection process. The deteriorating finances of the NHS have also played into this turbulence, resulting in the majority of NHS acute hospital trusts boards being required to look for challenging efficiencies and savings each year since the Francis Report was published, at the same time as public expectations have increased and demand for services has grown.

3 Methodology

This chapter outlines the methods used to carry out this study. Given the intrinsic complexity of any relationships between board governance, organisational behaviour and care outcomes, we adopted a multi-method approach, integrating qualitative and quantitative elements to examine these relationships in both *breadth* and *depth*. We begin by outlining the chosen theoretical framework underpinning the study and then proceed to describe the research design and the content of the four work packages. Finally we refer to patient and public involvement in the study and research governance arrangements.

3.1 Theoretical overview

The theoretical framework for this research is based on a realist interpretation of the composition, focus and dynamics of effective healthcare boards. A realist angle builds on the

growing acknowledgement of the importance of contextual factors in board governance (see for example Bammens et al. (2011)). A realist approach emphasises the contingent nature of the evidence, and the notion that change is generated internally by stakeholders in conducive circumstances (Pawson and Tilley 1997). It addresses questions about what works in which settings, for whom, in what circumstances, how and why (Wong et al. 2014).

There exist conflicting and competing theories that explain the purpose and function of boards. In research which critiques the assumptions behind agency, stewardship and resource dependency theories, Nicholson and Kiel (2007) found that while each theory can explain a specific case, no single theory explains any general link with organisation performance.

Within empirical literature, boards have been characterised as having potential to influence strategy and performance that is highly contingent on contextual variables and the mobilising will and skill of board members (Ferlie et al. 1994, McNulty and Pettigrew 1999, Stiles 2001). Our proposed research seeks to identify the structure, functions and behaviours of boards in relation to effective organisational leadership and shaping organisational culture. Choosing appropriate mechanisms for this appears to be important according to the particular context faced by a board (Chambers et al. 2013). Accordingly, we propose using an adapted version of a realist interpretation framework for boards (ibid) to inform the research design. This examines five different combinations within boards of:

- Contextual assumptions (for example external environment conditions, levels of trust, appetite for risk)
- Mechanisms used by boards (for example instruments for monitoring and control, focus on partnership working)
- Intended outcomes (for example minimisation of risk, increasing rate of innovation, long-term added value)

The framework (table 3) acknowledges that alternative theoretical standpoints offer ways forward in particular circumstances, and depending upon what purpose and outcomes boards are most desirous of achieving.

We have focussed on the five main theories of boards relating to agency, stewardship, resource dependency, stakeholder and power. Other theories, for example public accountability theory, board legitimacy and dramaturgy of boards, all have merit and relevance, particularly in the health care context. The enactment of democratic accountability

and the performativity of boards post-Francis play an important part, as we shall see. Our view, nevertheless, is that these can be seen as derived, at least in part, from these five classic theories in understanding how boards lead change and improvement.

This is highlighted in the table below in relation to healthcare boards. This also now leads us to the proposition that boards do have real choices in relation to composition, processes, focus and behaviours.

Table 3: Guiding theoretical framework

Using a realist perspective for effective healthcare boards with the main board theoretical purpose driving the dynamics (from Chambers et al. (2013))

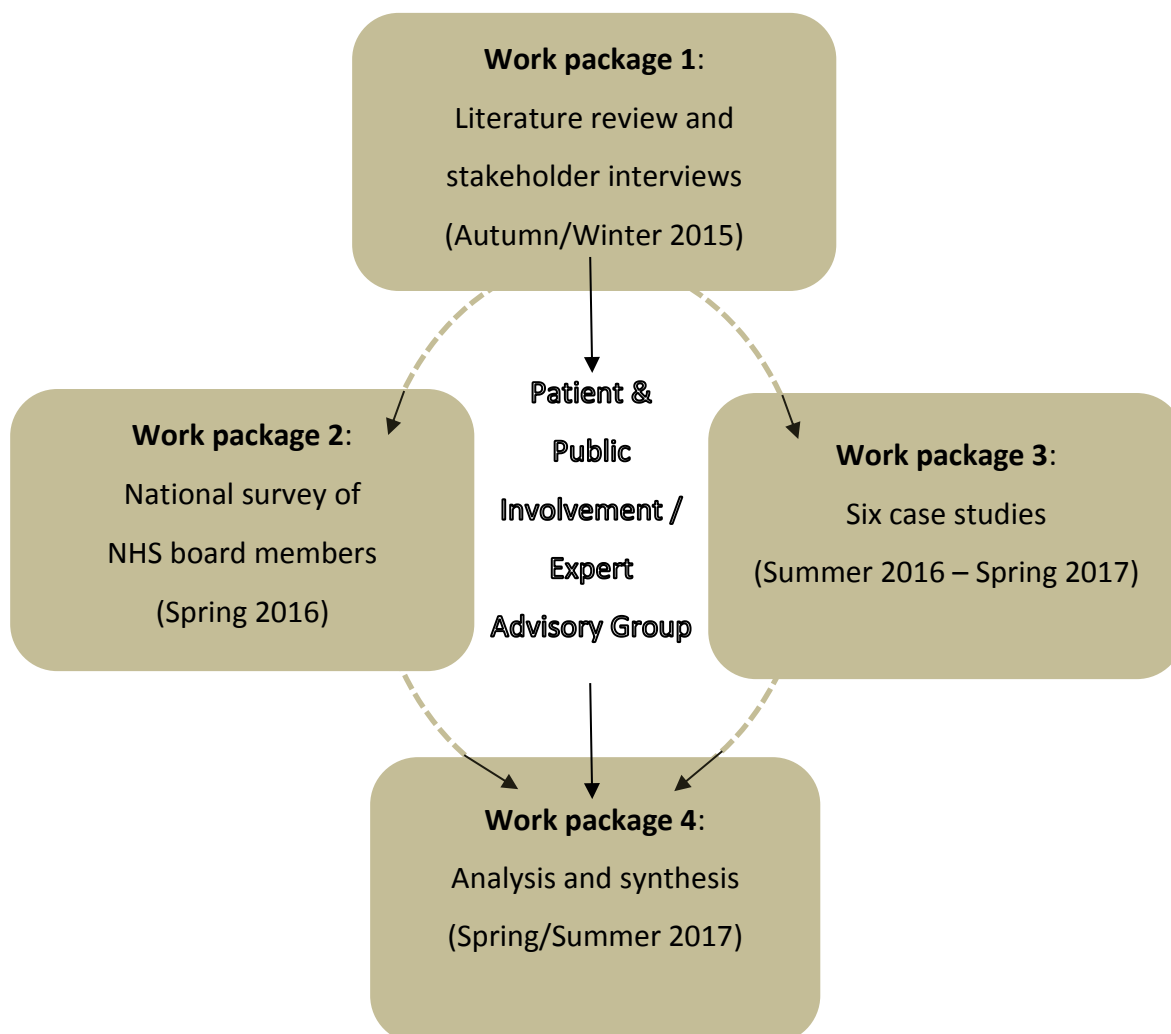
| Theory | Contextual Assumptions | Mechanism | Intended Outcome |
|---------------------|--|---|---|
| Agency | Low trust and high challenge and low appetite for risk | Control through intense internal and external regulatory performance monitoring | Minimisation of risk and good patient safety record |
| Stewardship | High trust and less challenge and greater appetite for risk | Broad support in a collective leadership endeavour | Service improvement and excellence in performance |
| Resource dependency | Importance of social capital of the organisation | Boundary spanning and close dialogue with healthcare partners | Improved reputation and relationships |
| Stakeholder | Importance of representation and collective effort; risk is shared by many | Collaboration | Sustainable organisation, high levels of staff engagement |
| Board power | Human desire for control | Use of power differentials | Equilibrium |

3.2 Research design

Given the intrinsic complexity of any relationships between board governance, organisational behaviour and care outcomes, and the importance of triangulation and completeness (see Robson 2011:167) we chose a mixed method approach, integrating qualitative and quantitative elements to examine these relationships in both *breadth* and *depth*. This is described briefly below and the linked work packages are described in more detail in following sections.

To ensure that the study is grounded in the latest empirical work and current policy developments, we undertook a scoping study (**work package 1**). To capture the *breadth* of any associations between board actions taken in response to the Francis Inquiry and care quality, we conducted a national survey exploring actions taken by hospitals in response to recommendations in reports following Francis and other policy guidance on board governance and organisational leadership (**work package 2**). To contribute *depth*, we used comparative case study methods and qualitative approaches to explore the detailed implementation and effects of boards' actions following the Francis Inquiry Report in six hospital trusts (**work package 3**). This included a survey of ward and department managers in the case study trusts. The findings of the three work packages were analysed separately and then synthesised into a set of practical and evidence-based learning points for boards, focussed on how improved leadership and governance can enable safer and higher quality care (**work package 4**) (see figure 2).

Figure 2: Research design - work packages 1 to 4



Our approach, and its connection to the research objectives, is set out in table 4:

Table 4: Research objectives and approaches used

| Research objective | Methods to be used |
|---|---|
| 1. To identify, describe and assess the different ways in which the boards of NHS hospital trusts and foundation trusts have sought to implement the recommendations on organisational leadership set out in Hard | Scoping interviews Update of literature review Scoping workshop National survey of NHS board members |

| | |
|--|--|
| <p>Truths and the Healthy NHS Board.</p> | |
| <p>2. To identify which mechanisms used by hospital boards have led to reported improvements (or otherwise) in local organisational strategies, structures and culture, and the factors underpinning such progress.</p> | <p>National survey of NHS board members Case study interviews and documentary evidence Board observations Survey of ward and department managers</p> |
| <p>3. To explore the intended and unintended effects of the different ways in which NHS hospital trusts and foundation trusts have sought to improve board and organisational leadership in response to Hard Truths and the Healthy NHS Board.</p> | <p>Case study interviews and documentary evidence Board observations Survey of ward and department managers</p> |
| <p>4. To examine the financial and non-financial costs of developing and implementing new policies, processes and actions aimed at improving board and organisational leadership.</p> | <p>Case study interviews Survey of ward and department managers</p> |
| <p>5. To explore the enablers of and barriers to implementing different approaches to board and organisational leadership.</p> | <p>National survey of NHS board members Case study interviews Survey of ward and department managers</p> |
| <p>6. To analyse and synthesise the findings from this research to inform a set of practical and evidence-based learning points for boards, focussed on how improved leadership and governance can enable safer and higher quality care.</p> | <p>Within- and across-case data analysis Testing of site-specific analysis Stakeholder workshop Synthesis of work packages 1, 2 and 3</p> |

3.3 Work package 1: Scoping phase

Scoping work involved 13 interviews (four by phone and nine face to face) with key individuals from national organisations representing patients, medical and nursing professions, healthcare regulators, policy think tanks and Department of Health leads on implementing the recommendations of the Francis Inquiry. Interviews focussed on research objectives 1 and 2, eliciting views on current concerns for boards, actions expected to have been taken as a result of the Francis Inquiry, the perceived and actual role of boards in overseeing and improving care quality and safety, the desirable characteristics of healthcare boards and the barriers to improving board-level leadership in the NHS (see appendix 1 for list of prompt questions that were used). The interviews were either recorded or extensive notes taken and thematically analysed and presented to the first stakeholder workshop held in November 2015.

We updated reviews of literature on patient safety and board governance, and board governance and organisational performance undertaken recently (Chambers et al. 2013, Millar et al. 2013). This update, which is outlined in chapter 4, is structured around research objectives 1-5, and presented alongside the key themes that emerged in the scoping interviews. At the end of this phase, the research team and advisory group ran a workshop together with healthcare professionals, lay representatives, policy makers, patient organisations, board development experts and governance specialists at which we summarised our findings and tested out and refined the research approach, criteria for selection of the six case study sites and questions for work packages 2 and 3.

3.4 Work package 2: National survey of NHS board members of general and specialist acute trusts in England

The purpose of the survey was to gather data about the composition of boards and leadership changes made since the publication of the Francis Report in February 2013 (see appendix 2 for Word version of the survey). The survey aimed to gather mainly quantifiable data about:

1. Specific actions to improve board and organisational leadership (e.g. new policies, processes)

2. Perceived impacts on intermediate outcomes (e.g. organisational strategies, structures, culture?) and on organisational performance
3. Understandings of the connections between actions and impacts, including underlying mechanisms, barriers faced, and contextual influences corresponding to categories in the research framework

The survey consisted mainly of multiple choice questions (with some scoring and Likert response format items), making it easy to complete and enabling statistical analysis of responses. We also included a small number of free text options for respondents to expand on key themes.

We purchased contact details from Binley's database and in spring 2016 conducted an online survey of chairs, CEOs, chief nurses, medical directors, directors of finance, non-executive directors and board secretaries (or corporate governance leads) of all the NHS hospital trusts and foundation trusts in England. We had intended originally to survey chairs, CEOs and board secretaries only, but widened participation to include other roles following advice from our advisory group.

Details of how we developed, tested and administered the survey questionnaire are provided in appendix 3. Multivariate analyses reported in chapter 5 (see also appendix 4) identify and compare differences in board activity and associations between actions and outcomes, informing the development of questions for the case studies.

3.5 Work package 3: Case studies of hospital trusts and foundation trusts

We used a comparative case-study design to generalise theoretically from within and between cases (Yin 1999). While each case has its own integrity in terms of theory building and generating policy implications, we developed common themes across sites using comparative case study methods and pattern matching (Eisenhardt 1989, Simons 2009).

We purposively selected six case studies using criteria for maximising the range that were agreed at the stakeholder workshop convened to refine our research approach. These included geographical variation, a mix of larger teaching hospital and smaller district hospital trusts, single and multi-site, greater or lesser stability of board membership, higher and lower performing organisations (as determined by the Care Quality Commission and Trust

Development Authority assessments), foundation and non-foundation trusts and at least one specialist acute trust. Obtaining support from trusts to participate was quite difficult: nine organisations turned us down; these included some high performing organisations and two specialist acute trusts. Reasons for declining the invitation to participate in the research included being distracted by an impending CQC inspection, turnover on the board and organisation turmoil. One did not respond to our request. By continuing to apply criteria for maximum variation, our final selection demonstrates reasonable spread, as follows:

- Foundation trusts and 1 non-foundation trust
- General acute hospitals and 1 specialist acute hospital
- Number of beds: 190 – 1300
- Single site: 3 Multi site: 3 CQC ratings at the time of selection: Requires Improvement (4) Good (1) Outstanding (1) (by the end of the case study period in May 2017, 2 of the trusts received a better rating: moving from Requires Improvement to Good)
- 2 in the North of England
- 2 in the Midlands
- 2 in the South of England

Data collection methods for case study work included semi-structured interviews with executive and non-executive board members of trusts, commissioners, staff representatives, patient groups and the trust board secretary. A minimum of 12 interviews took place in each case study site, supplemented by two governors, patient and staff focus group discussions or a series of single depth interviews per site. See appendices 5 and 6 for copies of the individual interview and focus group topic guides. We also observed one public board meeting and one meeting of governors in each site and a number of board committees, using these to inform our understanding of local board and organisational dynamics.

We undertook documentary analysis of board papers, trust annual plans and reports (including about staff engagement and development, patient and public involvement), materials related to board development activities, data on board and organisational development and quality accounts.

In interviews and focus group discussions, we explored knowledge and views of board initiatives taken in response to the Francis Inquiry. These included assessments of the

relevance, usefulness, and impact of such actions, costs in terms of staff and others' time, barriers encountered and thoughts about how best to improve further the governance and leadership of the board and trust. In addition, we were able to administer an online survey questionnaire to middle managers (ward and department managers) at three out of the six case study sites. Two of the others declined to participate, and in the remaining trust the response rate was too low for completed questionnaires to be considered for analysis. The survey was based on items in our national board-level survey. A particular aim was to elicit qualitative responses from a wider population to supplement the interviews and focus groups. Therefore we included many free-text-response items. A Word version copy of the questionnaire used is in appendix 7. It was piloted in the first of the trusts. There was a little tailoring to capture some differences between trusts (e.g. for multi-location trusts to capture at which location the respondents were based), and at each site our contact checked the questionnaire design. The three case-study sites themselves distributed a link to the questionnaire (hosted on a fileserver at the University of Manchester) by targeted internal email or by a notice in the staff newsletter. Follow-up reminders were also sent. Appropriate groups of staff were also alerted to it through the management chain. Responses were anonymous and overview summaries fed back to the sites.

Towards the end point of the research, we returned to the case studies to carry out up to three follow up interviews (by phone or face to face) with key informants (for example chair or CEO, board secretary, medical director, chief nurse) in each site exploring: accuracy and completeness of our emerging findings, perceived progress with actions taken, any initiatives that have been dropped or modified, costs incurred and seeking views about next steps.

Each case study was written up by its academic lead, focusing on the context of each board and organisation. In order to safeguard internal validity (Lincoln and Guba 1985), all board meetings were observed by two members of the research team except on one occasion. All interviews and focus group discussions or notes were fully transcribed and we used qualitative coding software (Dedoose) to facilitate data storage and retrieval in analysis. All members of the research team were involved in generating coding frames for themes from qualitative data, and we carried out an exercise to compare independent coding of a subset of data to identify and address coding differences and ensure consistency (see appendix 8).

As part of our testing of emerging themes and for checking external validity, we offered a case study summary for each trust with tailored feedback, thus ensuring that research

participants gained a local perspective on our analysis, and to support their board and organisational development plans. We also offered to present our findings on the study as a whole and on their trust at a board meeting at their convenience. Sites responded to our invitation to feed back to us on the insights shared, helping us refine our final report.

3.6 Work package 4: Synthesis of findings and production of recommendations

This package integrated the findings from earlier work packages. We conducted our synthesis by combining our multiple sources of data, and an iterative process of research team peer review. We started by summarising the key actions that have been taken by boards to implement the recommendations of the Francis Inquiry and the subsequent reports including those by Berwick (NAG 2013) , Clwyd (Clwyd and Hart 2013), Kirkup (Kirkup 2015), Francis 3 (Francis 2015) and Carter (Carter 2016). We then assessed the impact of those actions, the evidence for improvements in board leadership, the narrative around financial and non-financial costs of implementing Francis, the reported and observed barriers and enablers in implementing Francis and, finally, the implications for healthcare board governance theory. We concluded by making recommendations for policy, practice and further research.

3.7 Patient and public involvement, the role of the advisory group and the contributions made by the stakeholder workshops to the research

An advisory group, led by a lay member and consisting of three further patient representatives and five academic experts in healthcare board governance, met on two occasions with the research team in the course of the study. Members of the group were also invited to shape and participate in the two project scoping and review workshops, to give advice on how the research was carried out and on the selection of the six hospital case study sites, and comment on findings, draft reports and other materials. As well as the advisory group, the workshops included representatives from healthcare professional bodies, frontline clinical staff, and people involved in the administration of the Francis Inquiry. Changes were made to the questions in the national survey and its reach, additional lines of inquiry were

pursued in the case study sites, and interpretation of some findings was altered as a result of deliberations in the workshops.

Advice was sought from two patient representatives in the initial specification developed in response to the invitation to tender. A particular feature of patient and public involvement in this study subsequently was the recruitment process to the chair and lay membership of the advisory group. Rather than relying on personal contacts, we put out a call to invite expressions of interest, and outlined in more detail than usual the expectations that we had of the lay member role, for which we were able to offer a small honorarium according to INVOLVE guidelines. The result was 18 expressions of interest including five applications for the chair role. The final lay membership was decided by two members of the research team, by matching expressions of interest and experience against expectations of the roles and a telephone interview for the chair appointment. An external assessment of the arrangements for patient and public involvement in this study was provided by National Voices (see appendix 9 for more details). This assessment concluded that the approach taken was well-motivated, authentic and broadly fit for purpose. It had some impact on the conduct of the research. A small number of ways in which the approach could have been strengthened were suggested, and implications for the wider health research community.

3.8 Research governance arrangements

This research was subject to external academic peer review prior to funding. It then received ethics approval from the University of Manchester as the sponsoring body and research governance approval from the Health Research Authority via the IRAS process (IRAS No 196184). Research and Development (R&D) offices at all case study sites confirmed approval to proceed.

4 Characteristics of effective NHS boards: updated literature review and accounts of stakeholders

4.1 Introduction

The purpose of this chapter is threefold. First, it is to outline the findings from an updated literature review about the characteristics of effective healthcare boards, to further an understanding of what to look out for in our empirical work on the composition, structures, focus and behaviours of NHS board leadership post-Francis. Second, this account offers a theoretical lens for interpreting our findings in relation to effective healthcare board governance. Third, we report on interviews with key stakeholders in which we seek opinions about desirable changes in NHS board governance post-Francis, the extent to which, according to interviewees' experience and knowledge, recommendations have been acted upon, and their assessment of the enablers of and barriers to implementation. Underpinned by a theoretical understanding of effective healthcare board governance, the stakeholder interviews start the process of addressing our research objectives 1-5 as summarised below:

1. To chronicle how boards have sought to implement recommendations on organisational leadership since the publication of the Francis Inquiry Report
2. To determine which mechanisms used by boards have led to reported organisational/service changes, and the factors underpinning such change
3. To explore the intended and unintended effects
4. To examine the financial and non-financial costs of developing and implementing actions
5. To identify the enablers of and barriers to implementation

Findings from our interviews and the updated literature review were reported and discussed in our first stakeholder workshop and informed question setting in the national survey of board members (see Chapter 5) and lines of inquiry in our case study work (see Chapter 6).

4.2 Summaries of two recent reviews

Our aim here is to summarise two main recent reviews of literature on board governance, particularly in relation to (1) patient safety and (2) organisational performance, undertaken by

members of this research team (Chambers et al. 2013, Mannion et al. 2016) and then to provide an update from a search of relevant articles not captured by these two studies.

Using a narrative review approach, Mannion's team set out to identify the evidence and debates concerning board oversight of patient safety. 124 publications fell within the scope of their review. The findings were informed by an underlying programme theory that failures in care are conditioned by latent organisation factors rather than individual human error or malefaction. The researchers found that boards that place a high priority on quality and safety are more likely to be running higher performing organisations. They identified a wide range of operational governance practices linked to higher organisation performance, including the amount of time spent on quality issues and setting and reviewing quality goals, as well as benchmarking, constancy of feedback and monitoring. Strategic governance practices included having a separate quality committee with clinical membership, involving medical staff in developing the quality strategy and developing new services that enhance quality and safety. This review also identified that adoption of these approaches and activities remained highly variable. One significant barrier is the low level of technical competence and proficiency of board members in measuring and assuring quality and safety, and limited training opportunities. Nursing leadership was often low profile in board deliberations and decision-making.

In addition to the literature review, Mannion and his team conducted national quantitative surveys of hospital boards and in-depth case studies. Their empirical study (summarised in more detail in appendix 10) found:

- No statistically significant relationship between board attributes and process and any patient safety outcome measures
- A significant relationship between board attributes and process and staff 'feeling safe' to raise concerns and 'feeling confident' that their organisation would address those concerns
- A high proportion of desirable characteristics and processes that previous research studies indicate may be associated with high performance, including having quality sub-committees and proactive procedures in place to address patient safety and explicit objectives relating to improving patient safety

- Most boards do allocate considerable time to discussing patient safety and quality related issues. The survey found that hospital boards were using a wide range of hard performance metrics and soft intelligence to monitor their organisation with regard to patient safety, including a range of clinical outcome measures
- Development and implementation of a clear corporate strategy and operational plan is a key facilitator in enabling effective board governance
- Stability of board membership and strong, committed clinical leadership are important facilitators of patient safety governance
- Barriers included a corollary of the above i.e. lack of engagement among senior medical staff and problems and disputes over the validity and reliability of summary performance indicator data
- Boards of governors are generally perceived as well-meaning but they were also considered largely ineffective in helping to promote and deliver safer care for their organisations

Broadening the scope of board responsibilities, a literature synthesis of characteristics of effective healthcare board governance (Chambers et al. 2013) aimed to offer fresh insights into healthcare board composition, structures, processes and behaviours, and to further an understanding of how boards can affect organisational performance. Drawing from 670 texts selected for review, the study found that there was no one simple theory about how boards should operate. The review identified alternative courses of action for members of boards, using the learning from different theoretical standpoints on the purpose of boards and sources of evidence about effectiveness in the for-profit and public sectors, and relating it to the healthcare context.

Most academic papers on corporate governance were focussed on performance in financial terms. Hospitals need to maximise their use of limited resources, so the findings do offer enlightenment, but only in part, for the healthcare sector. The results from the general literature can be summarised as follows:

- Contradictory evidence: There was evidence of positive and negative associations or no effect in terms of overall impact of governance on performance and for specific

aspects of governance studied (e.g. board size, duality, gender and ethnic diversity) within statistical analyses.

- Contingent nature of relationships between key variables in relation to board composition. First, gender diversity has a positive impact on performance in firms that have otherwise weak governance, but in firms with strong governance, greater diversity may result in over-monitoring. Second, in relation to the length of tenure of outside directors, outside director tenure is positively related to performance, with the accumulated learning and power effects of long tenure enabling directors to be more effective in their various governance roles, but these benefits diminish as tenure further increases. In relation to board strategy, board independence (i.e. majority of outside directors) has a significantly more positive effect on performance for firms pursuing a strategy of cost efficiency than for those pursuing a strategy of innovation.
- Benefits accrued by larger boards, particularly in relation to increased monitoring, are outweighed by higher agency costs, informational asymmetry, communication and decision making problems.
- Improved monitoring can come at a cost of weaker strategic advising and greater managerial myopia. Firms with boards that monitor intensely exhibit worse acquisition performance and reduced corporate innovation.

In relation to the healthcare related literature, the review found the following:

- US studies comparing corporate and philanthropic models of governance suggest that corporate models are associated with increased operational efficiency. Hospitals with a corporate governance configuration, (i.e. smaller, narrow membership, greater management participation, strategic focus, scrutiny of CEO, competitive positioning) were more likely to respond to major change by diversification or merger and less likely to experience closure.
- Boards of high performing hospitals are more fully engaged in key governance processes and the prevailing governance culture is more interactive and proactive.

- High performing hospitals have: physicians involved on the main board; a quality subcommittee; greater expertise and formal training in quality; quality reported as a higher priority for board oversight and CEO performance evaluation; boards that are significantly more familiar with current performance and significantly more involved in reviewing quality data; and more time spent on clinical quality at board meetings (greater than the time spent on financial performance).
- Healthcare governance failings in UK and US are associated with boards having a comparative lack of focus on clinical performance and outcomes, and a preoccupation with financial matters, or, alternatively, not being sighted on the latter. There were also organisational culture issues including lack of grip by the board either on undesirable management behaviours or management performance.
- The importance of appropriate organisation-environment linkages, and of increasing embeddedness of healthcare governance as part of complex superordinate and subordinate governance networks within and across institutions
- There is some weak evidence that investment in board development affects organisation performance (for example improved board member confidence, greater board engagement and challenge, better financial results) but there is comparatively little to report definitively.

The authors derived some support from these findings for a triadic theoretical proposition of high trust - high challenge - high engagement for effective boards but with less empirical evidence to support the first of these three. This current study provides the opportunity to further test this proposition. Furthermore, given that governance theories suggest that boards face choices about their principal purpose, depending on the circumstances and situations that their organisation faces, a framework for effective healthcare boards was developed using a realist lens using the context, mechanism and outcome configuration to structure the model (see table 3 in Chapter 3 Methodology above). Along with the triadic proposition for all boards, this current study affords the chance to test this framework.

4.3 Themes from updated literature review

To inform this current study, we have drawn from the two literature reviews outlined above, and, in addition, we searched for additional material published since those reviews took place. The method for this selective review is described in more detail in chapter 3.

We found six articles for full review which are relevant to one or more of our research questions, and which not only confirm previous research, but also further our understanding of effective healthcare boards. These articles are listed in appendix 11.

We outline below the main themes from this update choosing the headings which relate to theories about the purpose of the board, and choices for boards in relation to their composition, the focus of their activities and dynamics in the boardroom.

Board purpose

The emergence of foundation trust NHS hospitals has resulted in governance structures that may provide new forms of board level scrutiny and oversight. All foundation trusts have a membership, a council of governors and a board of directors. The council of governors is made up of public governors, staff governors and patient, carer or service user governors. The governors are not directors but it is their duty to hold the non-executive directors, individually and collectively, to account for the performance of the board of directors (Monitor 2014). The rationale for foundation trusts is therefore rooted in stakeholder theory, which advocates the development of mutual and cooperative forms of organisation as a way of harnessing stakeholder ownership and influence.

The apparent higher performance of foundation trusts in terms of overall organisational performance, service quality and financial management scores and the behavioural measures of effectiveness, has been partially attributed to boards having a wider perspective in strategising, greater stakeholder involvement in decision making processes, being more open to internal and external feedback, and more willing to improve collegiality (Veronesi and Keasey 2012). Structures for stakeholder representation are not sufficient for effective accountability however; representatives need to be engaged and informed to have an impact. In some trusts where members of the public had a formal representative role, this allowed

patient representatives to pose questions that were well-informed, constructive and generated discussion amongst Board members (Endacott et al. 2013).

Board composition

A number of academic studies have sought to link board composition with patient outcomes and have found differences between high and low performing hospitals, with particular attention given to whether clinicians on the board can have a positive impact on performance. The line of thought here is that clinicians have acquired specialist knowledge through their training and direct interaction with patients that could lead to greater strategic leadership on the board, especially in relation to quality. Previous studies have identified links between the presence of physicians on the board and improved process of care and mortality (Jiang et al. 2009). Since the literature review conducted by Chambers et al. (2013), further studies have sought to establish a link between the presence of clinicians on the board and clinical outcomes. Veronesi et al ((2012), (2014)) analysed their own unique dataset made up of the qualifications of board members and performance scores incorporated in the ratings of hospital trusts published by the Healthcare Commission (now CQC) in their annual health check, and found significant and positive associations between a higher percentage of doctors on boards and quality ratings, i.e. waiting times, referrals to treatments, infection rates and their financial rating (ability to manage resources). A later study by Veronesi et al. (2015) also found a significant positive effect of the number of clinicians on the boards on overall patient experience scores, with five or more clinical board members instead of two having an even more significant positive impact on patient experience. Moreover, in a comparative study of the UK and US, it was found that 46% of board chairs from high performing hospitals reported that their board members had very substantial expertise in quality of care, compared to 26% of board chairs at low performing hospitals (Tsai et al. 2015).

A report into diversity of NHS boards in London (Kline 2014) found that only 8.6% of board members were from black or minority ethnic backgrounds. This figure is a reduction from 9.6% in 2006. Two-fifths of boards had no BME representation at all. Whilst there is no evidence to connect increased diversity on boards to improved performance in healthcare, West's work on high performing teams suggests that paying attention to issues of equality, diversity and inclusion matters (West et al. 2015).

Board focus on setting and tracking the strategic direction

Most studies confirm that the board has an important role to play in setting the strategic direction and in monitoring quality and safety within hospitals, and that the ability of boards to set clear measurable goals for improvement has an impact on performance (Mannion et al. 2016). Dixon-Woods et al. (2013) found that when boards did provide a strong focus in identifying system-level problems, they were powerful in supporting cultural change that delivered benefits for patients. However, they also identified some poor practice in which boards rarely stated clear objectives that were challenging and measurable. The case study analysis by Mannion et al. (2016) also found mixed practice within and amongst boards. For example, all case studies sought to provide strategic assurance by establishing organisational structures and processes for reporting safety information through the organisation and to the board. However, the study highlights that case study sites had localised ways of organising themselves and the way they used their time was variable. For example, only one of the sites sought to provide a strategic focus on quality improvement. It is therefore generally argued that boards have the ability to show leadership and to be influential in setting the direction for hospitals, especially in relation to quality, but have a variable track record in actualising this.

Board focus on monitoring of clinical quality of care

There is much discussion in the literature about the impact of devoting time and attention at board level to quality issues. The boards of English NHS trusts are found to devote a greater proportion of time to quality monitoring than their equivalents in the US and Scotland. In one study, 72% of English board chairs compared with 31% of US chairs chose clinical effectiveness as a top priority, and quality of care performance was on the agenda at every board meeting in 98% of English hospitals, but in just 68% of US hospitals (Jha and Epstein 2013). Scottish boards meet less frequently than those in England and focus on quality less, discuss it for a shorter time period, review data less often and set few local targets, despite having a greater number of NEDs and more with a clinical background (Bream et al. 2013). The national survey of NHS boards conducted by Mannion et al. (2016) also found that only a fifth of boards reported spending 30% or less of their time on quality and safety issues. The World Management Survey, which rates a hospital's overall management score from 1 to 5, with a score of 5 being the highest, across 20 questions, showed that management scores in

the UK and US were significantly higher in hospitals with boards that paid greater attention to quality, illustrating the importance of devoting attention to quality. These hospitals were also more likely to adopt effective practices related to the use of clinical quality metrics (Tsai et al. 2015).

There seems to be unanimous agreement about the importance of devoting time and having expertise in quality at board level. However, there is also debate about how quality information is best processed and understood by board members. Mannion et al. (2016) found that hospitals use a range of performance metrics and soft intelligence to monitor their organisation and that quantitative data were reportedly used at every board meeting in over 80% of hospital trusts. But both Mannion et al. (2016) and Dixon-Woods et al. (2013) are sceptical about simply using data to inform the board about quality performance. Mannion et al. (2016) found in their case study analysis of four NHS foundation trust boards that the use of performance data to alert the board to poor performance encourages under reporting and does not indicate how to address deficiencies, and the research by Dixon-Woods et al. (2013) argues for the importance of high quality intelligence (not just data) and making that intelligence actionable. The stakeholders interviewed by Mannion et al. (2016) also emphasised the need to ‘triangulate’ hard data with different information sources.

The importance of an emphasis on quality was illustrated in the previous literature review (Chambers et al. 2013). This updated review goes further in providing some international comparisons with English hospitals, suggesting that they spend more time on quality than their counterparts in other nations, as well as drawing the link between performance and time spent on quality. The recent literature also looks further into the use of quality data and challenges the extent to which boards effectively process and act on information about clinical quality of care.

Board dynamics

An observation of 24 board meetings at eight NHS Trusts and a content analysis of board minutes from 105 NHS trusts found that non-execs were variable in holding the exec team to account. Where NEDs were confident and tenacious, there was greater depth and discussion of all issues, including on clinical matters. On balance, they did find that NEDs’ behaviour was more indicative of an active strategic approach to governance than a passive rubber

stamp, as had been argued by previous literature. However, they did find that some NEDs said very little in board meetings and their ability to contribute and to hold the executive to account was very much down to individual personality and experience (Endacott et al. 2013, Sheaff et al. 2015).

Veronesi and Keasey (2011) found that a limiting factor for NEDs being involved in board decision making is the dominance of the individual expertise model, where individual expertise is given prominence at the expense of a holistic approach to problem solving. Analysis of stakeholder interviews conducted by Mannion et al. (2016) also found that limited knowledge of patient safety among board members, especially non-executives, restricted their ability to ask challenging questions about safety issues. The interviewees reported that this was exemplified by non-executives who do not have a clinical background.

These studies suggest that it is the perception of NEDs by the executive team and their own perception of themselves that is a significant barrier in their ability to have an influence over strategic decision making. Other studies have also suggested that the NEDs' ability to hold the executive to account is impacted by what other roles they occupy in the organisational structure, besides from board membership (Endacott et al. 2013, Sheaff et al. 2015).

Summary of new conceptions about the work of healthcare boards

There are five developing lines of inquiry from this review:

First, there is new evidence about the stakeholder model of governance that is embedded in NHS foundation trusts, which has the potential (not always realised) to provide the board with a wider perspective when strategising, decision-making, monitoring performance and receiving and acting on feedback. The developing role of the council of governors is worth scrutinising in this regard. Second, there is growing evidence about the positive effect that clinicians, particularly doctors, play as members of healthcare boards in terms of improving patient outcomes, although more evidence on how they enact their role as board-clinicians would be helpful. Third, there is a concern that ethnic diversity on NHS boards may actually be decreasing, with little understanding of the impact on staff engagement and patient experience. Fourth, there is a variation in the competence and diligence of boards in setting direction and monitoring quality of care in their organisations. Finally, recent studies also show variation in the level of board engagement, for example how firmly non executives hold

the executives to account, and, connected to this, the level of board confidence in relation to the use of quality metrics. A question that remains is what accounts for this variation in board practices, and how have these practices changed since the publication of the Francis Inquiry Report in 2013, which is the main focus of this study.

These lines of inquiry can now be compared with the results of interviews that we conducted with opinion leaders in 2015 and 2016, in which we asked for their views on how they expected that board leadership would have changed since 2013, and what their experiences and observations were about what had in practice happened so far.

4.4 Accounts of opinion leaders

Thirteen interviews took place between August 2015 – April 2016 with key stakeholders from national organisations representing patients, medical and nursing professions, healthcare regulators, policy think tanks and Department of Health leads on implementing the recommendations of the Francis Inquiry. Chapter 3 provides more detail about the methodology used. Interviews elicited views on current concerns for boards, desirable characteristics of effective board leadership, actions expected to have been taken as a result of the Francis Inquiry, the perceived and actual role of boards in overseeing and improving care quality and safety and the barriers to improving board-level leadership in the NHS and levers for change.

Main concerns of boards

The interviewees thought that boards shared three main concerns post-Francis. The first was how to maintain quality in a time of financial austerity. The financial pressure amounted to ‘a *different kind of worry*’ from patient safety worries, but one which was commanding much attention from the centre and which was also coupled with growing pressure on NHS Constitution access and other performance targets, especially with social care in crisis. The second concern was about the burden and anxiety around CQC visits and verdicts. The third was nurse staffing, agency costs, and wider workforce pressures. These themes are echoed in the findings of the national survey of board members conducted in spring 2016 (which we report on in chapter 5 and the case study investigations which took place from summer 2016

to spring 2017 (see chapter 6)). And the backcloth to these preoccupations was the need, according to these stakeholders, for boards to act simultaneously on so many reports and recommendations: Francis 2 (Francis 2013a), Berwick (NAG 2013), Keogh (Keogh 2013), Clwyd (Clwyd and Hart 2013), Francis 3 (Francis 2015) and Kirkup (Kirkup 2015).

Desired characteristics of healthcare board leadership

In the face of these challenges, we invited interviewees to comment on what they thought were the desirable characteristics of healthcare board leadership.

In terms of focus, there were four main areas that were considered to be crucial. First was a palpable concentration of effort towards ensuring patient-centred care. Second was the need to support staff, heed concerns and provide protection from negative pressures. A close alignment between what the board says and what staff say about what is going on in the organisation is a good sign. Third was the importance of promoting a certain culture which enabled a climate for compassionate care, insisting on certain behaviours and ensuring good governance. And running through all these was the perceived board priority that should be accorded to quality, safety and learning for improvement and, as one interviewee quoted, *'problem sensing than comfort seeking'* (Dixon-Woods et al. 2013), ensuring that the quest for assurance is balanced with a drive for improvement. Underpinning this effort, the board should be receiving detailed and timely data on patient and staff concerns, ensuring that quality improvement is hardwired through organisation, using good quality data and information as the basis for improvement. One respondent suggested that the national survey of board members should address the question about how much they know about what was of concern to patients, staff and regulators, and we acted on this suggestion (see appendix 2 for a copy of the survey questionnaire and chapter 5 for the results).

In terms of desirable behaviours, the need for boards to act as *'the guiding mind'* of the organisation and to live the organisation's espoused values was mentioned as important. Team spirit and good working relationships especially between the CEO, medical director and director of nursing, and between the chair and the CEO, with a balance of support and challenge from the non-executives and dissenting views shared and contained within the boardroom, was all called for. It was important to see collective leadership in evidence as well as a strong medical leadership voice. Finally, interviewees expected the appropriate full

deployment of subject matter expertise and executives who provided a broader view beyond their specific function.

Actions that boards were expected to take after Francis

Respondents felt that responsibility weighed heavily on boards after Francis. They would expect to see a programme of work to improve quality, staffing, safety, patient experience, complaints handling and raising concerns. Specifically, boards would need to understand and implement the Duty of Candour. They also expected boards to be attuned to concerns and to 'soft' data with regard to quality and safety, and that board papers would include impacts on patients, public and staff of proposals, as well as comments from these groups. They hoped that there would be closer relationships between the board, the executive and clinical directorates. Finally, they expected boards to be self-critical about board culture and behaviours.

Current realities for boards

The respondents were concerned that the current reality of board leadership was some way off from the desired focus, desirable characteristics and expected actions described above. They were aware of some high performing boards but elsewhere they considered that quality was not seen as a whole board issue and there was often a focus on financial pressures at the expense of quality and strategy. Compliance was driving out improvement: '*grip becomes throttle*' was how one respondent described the situation in some hospitals. This was compounded by variable access to and use of data.

In terms of behaviours, there was a worry about the cult of the CEO, cosiness of some board committees and that in some organisations boards were not listening to the concerns of middle managers or frontline staff and not inviting and acting on suggestions for improvement from the workforce. Other specific concerns included boards having little time and resource for board development, lack of diversity on boards, especially BAME, and also executive recruitment that fished from a very small pool, resulting in a self-perpetuating oligarchy ('the village'). This can result in it being easy for board leaders at random either to be either dropped or supported and a reluctance to look outside the system. This may be

connected to the low profile of the Fit and Proper Person's Requirement. Externally, poor relationships with others in the health economy were also often observed. Also externally, there was a warning about boards being focussed on reputation and image rather than substance and outwardly projecting an image of success whilst not having grip on operational performance.

Common board behaviours

Stakeholders were asked which behaviours were most commonly exhibited by boards, and in particular those behaviours connected with the various theoretical purposes of boards, that is agency, stewardship, stakeholder and resource dependency.

The three types of board behaviours that interviewees were most concerned about and had some experience of were the 'top-down', 'powerless' or 'cosy' boards. Beyond that, they reported a whole range, including observing board members expressing vulnerability and being sensitised to risks. Holding to account was the most common stance taken – which relates to board challenge connected with agency theory. There was a view that the stewardship and stakeholder theoretical models had most potential for staff engagement. The 'expert' board with a concentration of power was also common, and in this circumstance certain groups (for example patient representatives or certain professional groups) can feel marginalised.

In conclusion, the stakeholders judged that effective boards knew which mode of behaviour to use in which circumstances; despite confusing policy and governance guidance (and incongruent behaviours exhibited by national bodies).

Levers for change

Building on what respondents considered to be the barriers, current realities, post-Francis agenda and their knowledge of effective healthcare board leadership, they provided insights into levers for change. They indicated the importance of a broad leadership repertoire, balancing the range of board behaviours as appropriate, drawing from the alternative theories of board working. At the same time there was also a view that boards needed to think and work as a team (i.e. a dominance of stewardship theory). As indicated above in the section on

desirable characteristics of boards, there was considerable support for an approach to quality improvement that was agreed and backed by all the board and making use of soft as well as hard intelligence. Underpinning this was rigorous follow through of agreed actions from committees to the main board and across committees.

There was a strong emphasis on supporting and developing board leaders: the need for coaching of individuals and teams, replacement of poor performers where needed, providing tailored and sustained support for new CEOs and development in place before people take up executive roles. It was important for boards to look downwards and outwards to ensure cultural change. This included acknowledging the importance of middle managers (not always focusing on top tier and frontline) and commissioning bespoke internal leadership development programmes.

Externally, hospital chains and networks were seen as a way of drawing organisations together to learn, peer review and challenge. The incentives for board leaders to take on poorer performing organisations had to be right.

Concluding remarks

There are some recurring themes and questions arising from this literature review and accounts of stakeholders. The messages, which we shared at our first stakeholder workshop, helped to guide some of the questions in the national survey of board members and the lines of inquiry for data collection at our case study sites. These included: an exploration of the assuring versus improving dichotomy; unintended consequences, including the '*long shadow*' of Francis; initiatives started and stopped; reliance on action plans; and a seeming lack of focus on messages from the Berwick Report. One specific question, with broader organisation cultural significance, was whether the implementation of Duty of Candour was generally closer to the Alton Towers or the Thomas Cook model– which related to different organisation responses following tragic accidents.¹

¹ Alton Towers and Thomas Cook approaches to handling service failings resulting in harm to customers in their care:

Alton Towers

There is still considerable uncertainty about the most effective behaviours for boards to deploy. On the one hand there are many messages about the need for strong governance and boards which hold to account using a range of sources of credible data, drawing from agency theory, and on the other there are also views about supportive, collective leadership drawing from notions of stewardship theory and the unitary board. The accounts of stakeholders mentioned issues concerning sources of power in the organisation only a little, perhaps because the interviewees were themselves in positions of authority. Although references were made to the importance of staff engagement, structural frameworks for encouraging this (for example referring to stakeholder theory) were less to the fore. The ability to collaborate externally and manage the external environment (resource dependency theory) was also more in the background. The literature review and the stakeholder accounts do however lend further support, in particular around the quality and improvement agenda for the triadic proposition of effective healthcare boards that are high challenge – high support – high engagement.

On 2 June 2015, two of the trains on the Smile ride at the Alton Towers theme park collided leaving five riders seriously injured, including two young people who had partial leg amputations. The whole theme park was closed for five days as the company made an assessment of safety procedures covering all its attractions. An investigation by the Health and Safety Executive was initiated, and the ride was closed for the remainder of the season. The owner of Alton Towers admitted liability for the Smiler crash and was found guilty of neglecting to ensure safety standards and fined £5 million. In the days immediately after the accident the company took to the media to publicise messages directed at affected resort guests to make a claim for compensation which they said would be dealt with quickly and comprehensively.

Thomas Cook

Two children aged 6 and 7 from Yorkshire died of carbon monoxide poisoning while on holiday with family in Corfu in October 2006 arranged through the Thomas Cook travel company. The cause of death was found to be carbon monoxide poisoning from a faulty gas boiler. Three people, including the manager of the hotel where they were staying, were found guilty of manslaughter by negligence following a criminal trial in Greece in 2010 and were each sentenced to seven years in prison. At the inquest into the children's deaths, which was held at Wakefield Coroner's Court in 2015, the CEO at Thomas Cook said that he felt incredibly sorry for the family but there was no need to apologise because there was no wrongdoing by Thomas Cook. He said his company had a policy of avoiding gas-fired hot water appliances but that it had been lied to by the hotel, which had said that it had no gas supply. The jury at the inquest returned a verdict of unlawful killing and concluded that the travel company Thomas Cook had breached its duty of care.

5 National survey of board members and secretaries

This chapter details the findings of our national survey of members and secretaries of boards of NHS acute hospital trusts in England. First, we briefly outline the survey purpose and questions and assess the representativeness of the survey respondents. Then we present our findings regarding the following aspects of boards:

- The role of the board
- Challenges facing boards
- Board member knowledge of what is important to patients, staff and regulators
- Implementation and impact of the Francis Report recommendations
- Implementation and impact of the Fit and Proper Persons Requirement
- Implementation and impact of the Freedom to Speak Up Guardian
- Impact of the Duty of Candour
- Enablers and barriers to improving board leadership
- Board development
- CQC Well-Led Ratings and NSS scores

5.1 Purpose and scope

The purpose of the survey was to gather mainly quantifiable data about boards and how members see the board impacting on the organisation, including changes since the publication of the Francis Report in February 2013. We surveyed CEOs, chairs, chief nurses, directors of finance, medical directors, non-executive directors, and board secretaries between December 2015 and May 2016. For further details of the survey process, see chapter 3, section 3.4.

We asked questions about:

1. Specific actions to improve board and organisational leadership (e.g. new policies, processes)
2. Perceived impacts on intermediate outcomes (e.g. organisational strategies, structures, culture?) and on organisational performance

3. Perceptions of the connections between actions and impacts, including underlying mechanisms, barriers faced and contextual influences corresponding to categories in the research framework
4. Financial and non-financial costs incurred

All of the survey questions are detailed in appendix 2. Most of the questions were posed to all respondents, but to avoid duplication questions seeking factual information about the board as a whole (e.g. number of board members, number of board development days) were only put to board secretaries, who we considered would have the easiest access to the information sought.

5.2 Respondents

In this section we highlight key characteristics of the respondents to our survey, focusing on those most pertinent to the survey findings. Further details of respondent characteristics are given in appendix 12.

381 respondents completed the whole survey (response rate 20%), with an additional 57 respondents (3%) answering some of the survey questions. At least one full response was received from 139 (90%) of the 154 NHS hospital trusts and foundation trusts in England at that time. Our findings are based on statistical analyses of all 381 responses.

There were no statistically significant differences in response rates between different types of trust (acute, specialist, foundation, non-foundation), between trusts with different CQC Well-Led Ratings, or between female and male board members (Chi-square test, $p > 0.05$). Response rates did vary by role, with finance directors in particular being under-represented (11% response rate) (see box 3 below and further details in Table 17 in Appendix 12). Response rates also differed between regions of the country, ranging from 14% in London up to 26% in East of England.

Box 3: Completed survey responses by role

| | |
|------------------------|------------|
| Board secretary | 48 |
| Chair | 43 |
| CEO | 39 |
| Finance director | 19 |
| Medical director | 42 |
| Nursing director | 28 |
| Non-executive director | 162 |
| TOTAL | 381 |

184 out of 331 (56%) of all board member survey respondents joined their current board after February 2013. CEO respondents were more likely to be longer serving than board members in other roles. 74% of CEO respondents had joined the board before March 2013, whereas only 40% of board members in other roles had joined their board before March 2013.

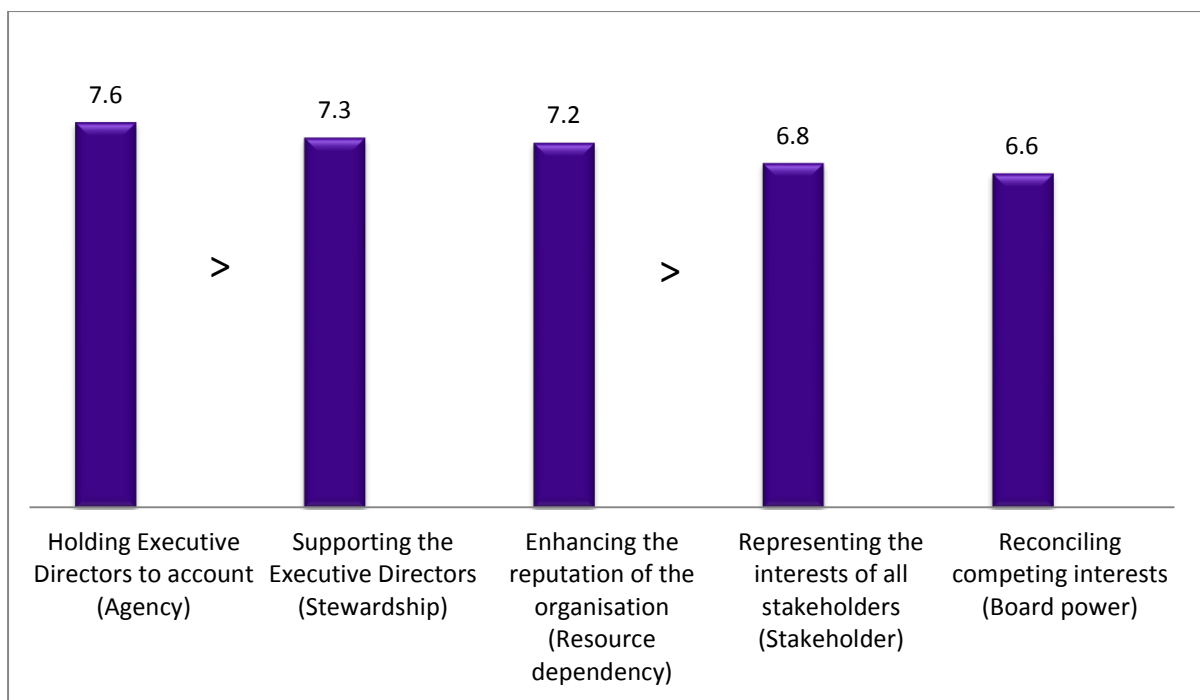
In terms of diversity, 37% respondents were female compared to 77% of the workforce, and 94% were white in comparison with 78% of the NHS workforce.

5.3 Findings

The role of the board: emphases placed on different purposes

When asked about how much their board emphasises purposes corresponding to those of the different theoretical models of boards, responses suggest that boards give most emphasis to holding the executive directors to account (figure 3). This was scored more highly than the other purposes. The scores for supporting the executive directors and for enhancing the reputation of the organisation were also higher than those for representing the interests of all stakeholders and reconciling competing interests.

Figure 3: How much boards emphasise different board purposes and associated theories of boards (average scores)



(1 = Hardly at all; 3 = A little; 5 = Moderately; 7 = Quite a lot; 9 = Massively)

($p < 0.01$, Wilcoxon signed rank test)

The differences are, however, relatively small; board members typically perceive that their board is giving ‘quite a lot’ of emphasis to all of the purposes. Exploratory factor analysis (promax with Kaiser normalisation) suggests that these variables may represent a single underlying latent factor, accounting for 59% of the variance, which we might perhaps call board diligence.²

The comments that respondents made in the survey about how the board of their trust viewed its purpose were varied, partly reflecting the range of possible purposes indicated by theories

² Exploratory factor analysis is a statistical technique that indicates whether quantitative data provided in answer to different questions might be similar, and whether potentially the different questions might be measuring aspects of a single underlying concept, or ‘latent factor’. For example, concepts such as personality type may impact on various visible behaviours, and personality types are usually assessed by asking a number of questions about such behaviours. Interpreting the results is an art as much as a science. The meaning attributed to the latent factor is provisional, and should be assessed through further research. Various techniques, such as promax rotation and Kaiser normalisation, may be used within factor analysis in order to aid such interpretation.

of boards, but also broader or higher purposes. Many respondents reported that the purpose of the board was to ensure that their trust provided safe and effective care to patients, whilst also keeping the organisation financially sustainable. There were also many references to the desirability of the board providing leadership for the organisation through having a clear purpose and vision to give strategic direction:

'1- Safety and quality 2- Money 3- Strategic direction.' [Medical Director]

Comments also suggested an emphasis on governance and accountability. This was frequently expressed in terms of the board seeking assurance, holding executives and managers to account, and having oversight of delivery.

Supporting the executives was also mentioned occasionally, usually as a complement to challenge. There were a number of references to the unitary board and NEDs and executives working together.

'In practice that means challenging and supporting the executive to develop the capability of the middle management of the Trust, whilst managing and synthesising the external forces brought to bear on the Trust.' [CEO]

'To challenge and support in equal measure the decisions the exec board make. To represent the values and patient interests. To encourage new ways of thinking and to ensure that there is a vision and strategy that all decisions can be measured against.'
[NED]

'I think the board of my trust has always been quite clear in its expectations of execs ... I certainly feel like I'm held to account, whilst at the same time being supported.'
[Medical Director]

In text comments in response to the question about purposes of the board, governance had 27 mentions in terms of the role of the board being accountable to external stakeholders such as governors, regulators, patients and the wider public. With regard to patients this was expressed as being patient centred, listening to patients and focussing on patient experience. There was also an emphasis on working in partnership with other local health and care organisations in order to produce coordinated, integrated systems of care. There were also reports of having the right core values embedded into the culture of the organisation with an engaged workforce that would deliver the organisations objectives.

'Our Board's focus is on the delivery of high quality care to patients and families, to provide this in a sustainable way within the financial envelope and to work in collaboration with the system to achieve that.' [Chief Nurse]

'The staff are very important and their wellbeing is a constant focus of discussion.'
[NED]

There was recognition of the multiple roles of boards and of the necessity of balancing competing demands or issues, and working within constraints. This could be difficult to achieve. Focussing on targets and key performance indicators (KPIs) was seen as part of the task, and special measures could provide a useful focus for Trusts in trouble, but there was a danger of focusing too much on performance detail and not enough on strategy or culture change and staff engagement.

'The Board considers its role to be more about day to day running of the Trust and holding to account than strategy. It has struggled to set a course between competing demands.' [CEO]

'The current board agenda is dominated by navigating the Trust through exceptionally difficult strategic, commissioning, regulatory and financial terrain whilst not losing sight of the core values of high quality patient care.' [NED]

'My Trust has been in special measures. Its purpose has been a simple one - Meet minimum regulatory requirements and in doing so provide safe services and exit special measures. In the longer terms the Board wants do this in a way which is financially sustainable.' [Board Secretary]

'Its sovereignty as a Board is significantly constrained by the NHS organisational structure and culture and, of course, its financial freedom to operate. Against that context, the board sees its role as ensuring operational grip (clinical quality, patient experience, and financial outcomes) is maintained; trying to engender a more strategic approach to the Trust's activities; nurturing organisational and cultural change; and being accountable for delivery / performance.' [Chair]

There were a few mentions of different board members having different perspectives. While it was thought by some respondents that this could be helpful in terms of getting a rounded view and division of responsibilities, it could also potentially be problematic.

‘The Board is complex and I think that different individuals view it in different ways. All would agree that we need to set the overall strategy and then monitor implementation. I also think there would be consensus on the need to gain assurance on how major strategic risks are being managed. I think we struggle at times to reconcile this with the necessity to undertake deep dives and get into some of the detail around quality and safety. ... Finally, our Board does struggle at times with the wide range of strategic priorities.’ [Finance Director]

Challenges reported by boards

We asked respondents to pick the top five challenges their board faced, drawn from a list of 15 common challenges identified by the research team. These challenges were selected to be (logically) related to the various board purposes, with a view to investigating whether such relationships would hold empirically. The most important challenge perceived by respondents was patient safety, which scored higher than finances, which in turn scored higher than patient experience (see table 5).

Table 5: Perceived challenges for boards in order of importance, showing statistically significant differences in importance between adjacent challenges

| Challenge | Average score | Our assessment of importance |
|--------------------|----------------------|-------------------------------------|
| Patient safety | 3.1 | Extremely high |
| > | | |
| Finances | 2.2 | Very high |
| > | | |
| Patient experience | 1.6 | High |
| A&E performance | 1.4 | |
| Workforce shortage | 1.3 | |

| | | |
|--|-----|--------|
| Service reorganisation across the local health and social care economy | 1.3 | |
| Clinical effectiveness of care | 1.2 | |
| > | | |
| Staff engagement | 0.8 | Medium |
| > | | |
| Organisation viability | 0.6 | Low |
| Responding to regulators | 0.5 | |
| Referral to treatment (RTT) times | 0.4 | |
| Workforce capability | 0.3 | |
| Relationship with commissioners | 0.2 | |
| Infection control | 0.2 | |
| Organisation reputation | 0.1 | |

(Rank 1 scores 5, Rank 2 scores 4, Rank 3 scores 3, Rank 4 scores 2, Rank 5 scores 1, otherwise scores 0)

(Wilcoxon signed rank test, $p < 0.01$)

A factor analysis (promax, Kaiser normalisation) indicated one latent factor, which we have characterised as a quality outcomes orientation, as opposed to a focus on organisational processes and inputs or national targets. This orientation places importance on clinical effectiveness, patient experience, patient safety and to some extent staff engagement, rather than on finances, A&E performance, workforce shortage and to some extent responding to regulators. This factor only accounted for 15% of the variance however, so does not on its own explain a large part of the data.

Respondent comments on the challenges faced by the organisation, as perceived by the board, echoed and amplified comments made earlier in the survey about the purposes of the board (see above), reaffirming the centrality of quality and safety but highlighting the perceived difficulty of balancing these against financial pressures.

'If the safety of patients and the quality of services are a priority together with effective staff engagement then many of the other challenges will follow e.g.

financial viability, organisational reputation. It's getting those basics right that is imperative. [NED]

'The board takes patient safety and experience as the key priorities but recognises that these are the outputs of resources and especially staff. Therefore these latter issues are seen as primary in terms of operational focus. We are undertaking a lot of work around patient defined value in the knowledge from other industries that if this drives change, most other matters will come right as an output of this central focus.' [Finance Director]

'We have a number of competing challenges but the board will not compromise patient safety for targets or finance. Future sustainability across the whole health economy is a key issue, along with recruitment issues and increasing demand.' [Board Secretary]

For some boards, achieving safe staffing levels was regarded as being more important than financial sustainability, at least in the short term, whereas for others finances were regarded as a hard constraint. Some boards highlighted staff shortages in A&E and other service areas, particularly with regard to skilled clinical professionals, which threatened patient safety, or exacerbated financial problems because of the high cost of agency staff. In the medium term insufficient capital investment might also become an issue.

'We know we cannot function without great people. We have some very loyal staff, with over 40% with us for 10 years+. But we also have niche vacancies and high turnover in some areas, compounded by our own investments to expand, for instance, night time qualified nursing. This dwarfs all other issues, but demands good management, which we looking to develop greater capability in, as the gulf between our best teams and the weakest is a large gap.' [CEO]

Difficulties in achieving A&E targets were mentioned several times. While A&E performance was an important issue in its own right, and could produce unhelpful stakeholder attention – ‘naming and shaming’ – it was more often perceived as emblematic of a key underlying issue of lack of smooth/sufficient patient flow through the hospital, which produced inefficiencies and other undesirable effects. While some boards were focussed on internal actions to improve flow, 22 respondents indicated in their comments that they believed that this problem was primarily a wider system issue that lay beyond the control of

the trust, emanating from increased demand from a frailer, more elderly population. Many boards perceived that this required a system level perspective and radical change, so were seeking to work in collaboration with other stakeholders such as commissioners and local authorities. STPs were mentioned several times as the vehicle through which such collaboration was being sought. Some reconfiguration of services to improve patient pathways was being pursued.

'A&E performance as it is reputationally challenging and creates financial issues due to fines for non-performance. Ironic as the main reasons for failure are the delayed transfer of fit patients to external care which is an issue largely outside the immediate influence of the trust.' [NED]

A number of respondents saw value in a positive, proactive approach from boards, seeking to reshape the health system. There was an acknowledgement however that trying to lead system change, while also seeking to be collaborative with other organisations in the local health community, was difficult. Many respondents expressed frustration that other local stakeholders did not appear to share the same priorities, or lacked strategic leadership capacity, skills and experience. There was also concern about the many and various demands of the Department of Health, NHS England and regulators. There was perceived to be a lack of joined up thinking, with such demands sometimes being a distraction, or getting in the way of local system partnership working, rather than being supportive. Furthermore, the difficult financial situation made change even harder to achieve because of the additional costs of change.

'It's interesting how much the regulator influences the board's focus. So in breach of licence for finances and failing A&E target consumes the time.' [Board Secretary]

'The financial difficulties prevalent across the sector are hugely distracting and frustrating and make it difficult to move forward the type of organisational and facilities changes which we know are required to prepare us for the demographic changes which will increase the pressures on our service areas.' [NED]

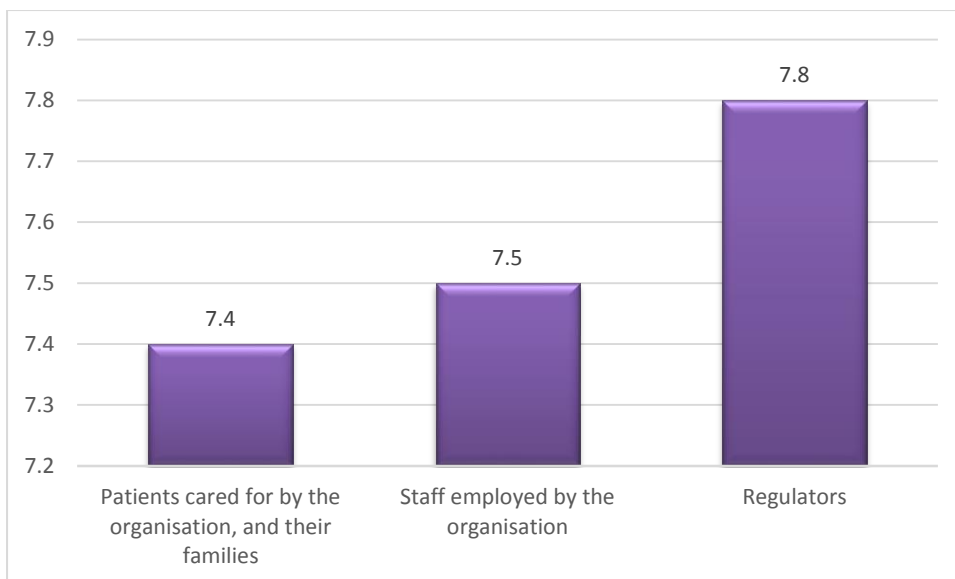
Board member knowledge of what is important to patients, staff and regulators

We asked board members to say how much they knew about what is important to the following groups:

- Patients cared for by the organisation and their families
- Staff employed by the organisation
- Regulators

The average scores indicated that board members felt they knew quite a lot about what was important to these stakeholder groups (figure 4). This was particularly the case for regulators, about whom knowledge scores were higher than the other two ($p < 0.01$, Wilcoxon signed rank test).

Figure 4: Board member self-assessed knowledge of what is important to different stakeholder groups (average score based on ranks)



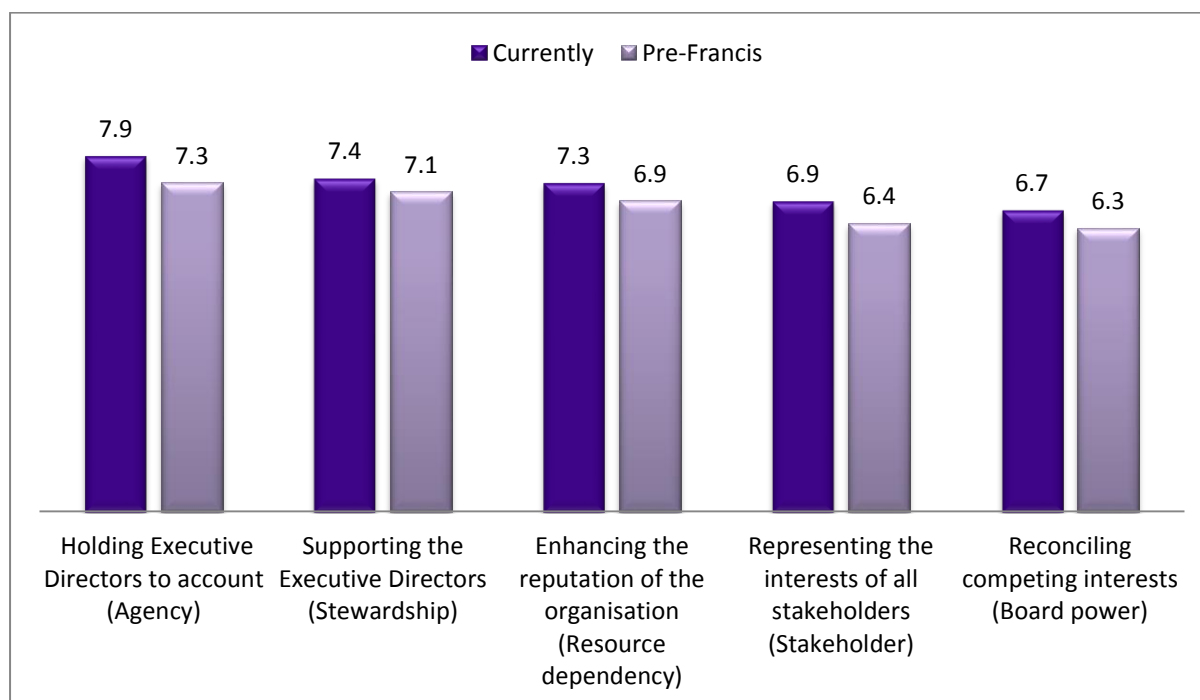
(1 = Hardly anything; 3 = A little; 5 = A moderate amount; 7 = Quite a lot; 9 = A massive amount)

Implementation and impact of the Francis Report recommendations

Impact on the role of the board: emphases on different purposes

We asked the 147 board member respondents who had been associated with their current board since before March 2013 how much they thought their board emphasised the various board purposes prior to the publication of the Francis Report in February 2013. The scores given to the different purposes followed a similar pattern to the scores given to current purposes, but were somewhat lower (see figure 5). All of the differences were statistically significant.

Figure 5: Emphasis on different board purposes and associated theories of boards: comparison of current and pre-Francis average scores (long-standing members only)



(1 = Hardly at all; 3 = A little; 5 = Moderately; 7 = Quite a lot; 9 = Massively)

($p < 0.01$, Wilcoxon signed rank test)

We asked longstanding board members to comment on what influence they thought the Francis Report had on how their board views its purpose and priorities, either directly or indirectly.

Many respondents said that the report had prompted self-examination by the board to check that it was actually and consistently focussed on patient safety and quality as aims, and a re-examination of governance processes and structures to ensure that they were contributing effectively to this.

Developing new policies and implementing new actions

Board secretaries responding to our survey question about how various policies had been developed since the publication of the Francis Report in February 2013, typically indicated that policies were already in place, but had been formally reviewed and reissued (table 7). For most policies, 15-20% had been newly established by trusts since the publication of the Francis Report.

Table 6: How organisation-wide policies have developed since the publication of the Francis Report

| | Newly established since Francis | | Pre-Francis policy has been formally reviewed and reissued | | Pre-Francis policy is still in place; not formally reviewed since | | No organisation-wide policy | |
|---|---------------------------------|---------|--|---------|---|---------|-----------------------------|---------|
| | Count | Row N % | Count | Row N % | Count | Row N % | Count | Row N % |
| Statement of common purpose, guiding principles, values and behaviours for the board and the organisation | 12 | 23.1% | 33 | 63.5% | 5 | 9.6% | 2 | 3.8% |

| | | | | | | | | |
|---|----|-------|----|-------|---|------|---|------|
| Policy on learning and improvement | 9 | 20.5% | 30 | 68.2% | 4 | 9.1% | 1 | 2.3% |
| Policy on listening and responding to patients | 10 | 21.3% | 34 | 72.3% | 1 | 2.1% | 2 | 4.3% |
| Policy on how to raise concerns | 11 | 20.8% | 41 | 77.4% | 1 | 1.9% | 0 | 0.0% |
| Policy on complaints handling | 5 | 10.0% | 44 | 88.0% | 1 | 2.0% | 0 | 0.0% |
| Policy on openness about patient safety incidents | 10 | 20.4% | 39 | 79.6% | 0 | 0.0% | 0 | 0.0% |
| Policy on improving staff wellbeing | 8 | 17.4% | 34 | 73.9% | 3 | 6.5% | 1 | 2.2% |

Over half of responding trusts had not newly established any of these policies since Francis, while 10% had established 5 or more new policies. This suggests some polarisation, with a lot of new policies formulated in some trusts, but few in the majority. Establishing at least one new policy was associated with having a lower CQC Well-Led Rating at the time of the survey (table 8).

Table 7: Relationship between establishing at least one new policy since the publication of the Francis Report and the trust's most recent CQC Well-Led Rating prior to the survey

Count

| | | Previous CQC Well-Led Rating | | | | Total |
|---|-----|------------------------------|----------------------|------|-------------|-------|
| | | Inadequate | Requires Improvement | Good | Outstanding | |
| At least one new policy established since the publication of the Francis Report | No | 0 | 13 | 12 | 1 | 26 |
| | Yes | 5 | 12 | 4 | 2 | 23 |
| Total | | 5 | 25 | 16 | 3 | 49 |

(Chi Square = 9.2, df=3, p=0.03)

Board secretary respondents indicated many actions post-Francis (table 9). Over 70% of respondents said that regular reports to the board on ward-by-ward staffing levels had been newly established since Francis. A substantial minority of boards had also newly initiated patient stories in board meetings and various staff engagement activities. About a third of boards had also instigated external reviews of the organisational climate, to include board leadership and values. Board and executive development was reported to have been reviewed by a majority of trusts. Board walkabouts, or quality walks, were most often mentioned under ‘other activities’.

Table 8: Actions taken since the publication of the Francis Report

| | Newly established since Francis | | Done pre-Francis; formally reviewed since | | Done pre-Francis; not formally reviewed since | | Not done | |
|---|---------------------------------|---------|---|---------|---|---------|----------|---------|
| | Count | Row N % | Count | Row N % | Count | Row N % | Count | Row N % |
| Hearing and discussing patient stories at board meetings | 22 | 43.1% | 7 | 13.7% | 20 | 39.2% | 2 | 3.9% |
| Listening Into Action surgeries or events for staff led by board members | 18 | 36.0% | 17 | 34.0% | 12 | 24.0% | 3 | 6.0% |
| Other engagement activities with frontline staff, led by board members | 20 | 44.4% | 5 | 11.1% | 17 | 37.8% | 3 | 6.7% |
| Regular reports to the board on ward-by-ward staffing levels | 37 | 72.5% | 3 | 5.9% | 10 | 19.6% | 1 | 2.0% |
| Collective board development days or half days | 6 | 11.8% | 7 | 13.7% | 32 | 62.7% | 6 | 11.8% |
| Individual executive leadership development | 7 | 16.7% | 3 | 7.1% | 24 | 57.1% | 8 | 19.0% |
| External review of the climate in the organisation, including board-level leadership and values | 15 | 31.9% | 11 | 23.4% | 15 | 31.9% | 6 | 12.8% |
| Other actions | 5 | 33.3% | 7 | 46.7% | 3 | 20.0% | 0 | 0.0% |

The distribution of total numbers of actions again suggested some polarisation, like the promulgation of new policies described above. Implementing at least three new actions was associated with having a lower CQC Well-Led Rating at the time of the survey (table 10).

Table 9: Relationship between implementing at least three new actions since the publication of the Francis Report and the trust’s most recent CQC Well-Led Rating prior to the survey

Count

| | | Previous_CQC_Well_Led_Rating | | | | Total |
|--|-----|------------------------------|----------------------|------|-------------|-------|
| | | Inadequate | Requires Improvement | Good | Outstanding | |
| At least three new actions implemented since the publication of the Francis Report | No | 1 | 12 | 14 | 3 | 30 |
| | Yes | 4 | 12 | 1 | 0 | 17 |
| Total | | 5 | 24 | 15 | 3 | 47 |

(Chi Square = 13.5, df=3, p<0.01)

Board member respondent views were rather mixed with regard to the actions arising from the Francis Report. Some respondents felt that there had been a change of mindset and a valuable refocusing on patients rather than on finance. They pointed to concrete examples of changes that they believed were positive. Greater emphasis was now given to board level engagement with staff, and generally collecting patient and staff feedback and other qualitative data and on getting to the bottom of issues rather than just looking at statistics and indicators. There were some mentions of candour and increased openness.

‘It became ‘ok’ to talk about the patients and their care much more, the old adage of strategy as being the ‘in’ thing was actually eaten by the understanding that the right culture is what is really important. 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.’ [Chief Nurse]

‘The Francis Report has made the Trust Board focus more on the safety of care, the quality of care and the outcomes of care provided by the Trust. An example of this is the creation of a Trust Board sub-committee entitled Quality & Patient Experience Committee.’ [NED]

'It was a Stop moment for us.' [NED]

'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.' [NED]

Many respondents believed that Francis had led to a much greater focus on staffing levels in order to ensure safe, high quality care. For some, this was thought to be at the expense of financial sustainability, creating new tensions with government bodies; for others it was about recognising and taking account of the links between funding, staffing and outcomes.

'More focus on safer nursing. However this has contributed to financial stresses. There is a huge supply and demand dilemma here. Not enough nurses nationally especially in certain specialities and agency caps should lead to bed closures to maintain safety ratios but demand for services and the number of very sick patients makes this a difficult call.' [NED]

Some board members said that while Francis had not changed the board's direction, it had strengthened their resolve, provided them with an additional lever to help persuade other board members or staff and bring about change, and made them think through what needed to be done.

'The Francis Report did not cause us to change our values or objectives, or change the accountability we already felt for the conduct of the organisation in providing best care quality, but it did cause us to think hard about whether we really knew everything that we had to know, whether our staffing levels were what they should be, whether we cared properly for our patients.' [NED]

'The Francis Report reminded the Board about the importance of good leadership and the priorities of the organisation. The Trust has moved on from the Francis Report, but a lot of its actions are the basis of some of how the Trust now looks at issues.' [Board Secretary]

Others felt however that the Francis Report had achieved little, had been a waste of time, and had increased costs. There was some cynicism about whether it had really produced a change of approach.

'(The board) requested a thorough review of the report's recommendations but did not consider changes to its role or responsibilities were required.' [Medical Director]

'It raised costs both by making far too many recommendations which turned into a massive additional paper chase across the NHS and by encouraging a general increase in nursing numbers which in turn led to a rapid rise in agency costs.' [NED]

'Setting of 'safe staffing' levels without an agreed phasing meant Trusts were all fishing in the same limited pool at the same time. Almost overnight this made working as an agency nurse a very attractive career move. Following this we have had to spend huge amounts on Agency and on international recruitment. This expense is repeated across the entire NHS and could have been largely mitigated with a sensible phasing plan.' [NED]

'The post Francis focus is not genuinely about whether patient experience is better or outcomes are enhanced it is just about having added quality metrics to the dashboard and wanting them to be green.' [CEO]

There were some concerns that Francis had led to an increased bureaucratic burden of regulation and reporting which was time consuming and costly; although others saw positives in how regulation had changed.

'None - we still prioritise quality & safety. However, the difference is we spend more time having to prove it and watch each other's backs.' [CEO]

'The regulatory regime post Francis has impacted on putting quality first. There is more challenge and deep dives into quality.' [Board Secretary]

Some notes of caution for the future were sounded. In particular that there was a renewed emphasis on financial and performance targets:

'We focused to a far greater extent on listening and engaging staff and over the last three years that has really made an impact on our focus as an organisation. The real

test will be now we have been told the two priorities are money and A&E targets.'
 [Finance Director]

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

In summary:

'It has reinforced our focus on quality and safety. It has made us more aware of the risks of boards not understanding what is going on. Both of these were achieved by the initial report. It has also made life harder by producing an unnecessarily long list of recommendations which we have had to monitor, by prompting a competition for extra nurses which has exacerbated shortages, and by making the inspection regime more aggressive and costly.' [NED]

Impact on board views about which challenges are important

We also asked the 147 longstanding board members to rank the top five challenges that their boards faced pre-Francis, choosing from a list of challenges that we supplied. Comparing these rankings with current rankings, the most important challenges are perceived to be the same ones (table 11). Workforce shortage and service reorganisation across the local health and social care economy have however become markedly more important issues for board members. On the other hand, board members regard infection control, relationships with commissioners, responding to regulators, referral to treatment times and organisation reputation as being less important challenges now. None of these were regarded as particularly important previously, but they are still less important now.

Table 10: Perceived challenges for boards, showing statistically significant differences in importance between pre-Francis and the time of the survey

| Challenge | Average score currently | | Average score pre-Francis |
|----------------|-------------------------|--|---------------------------|
| Patient safety | 3.1 | | 3.1 |
| | | | |

| | | | |
|--|-----|---|-----|
| Finances | 2.2 | | 2.0 |
| | | | |
| Patient experience | 1.6 | | 1.7 |
| A&E performance | 1.4 | | 1.5 |
| Workforce shortage | 1.3 | > | 0.6 |
| Service reorganisation across the local health and social care economy | 1.3 | > | 0.6 |
| Clinical effectiveness of care | 1.2 | | 1.3 |
| | | | |
| Staff engagement | 0.8 | | 0.6 |
| | | | |
| Organisation viability | 0.6 | | 0.5 |
| Responding to regulators | 0.5 | < | 0.8 |
| Referral to treatment (RTT) times | 0.4 | < | 0.7 |
| Workforce capability | 0.3 | | 0.2 |
| Relationship with commissioners | 0.2 | < | 0.6 |
| Infection control | 0.2 | < | 0.7 |
| Organisation reputation | 0.1 | < | 0.3 |

(Rank 1 scores 5, Rank 2 scores 4, rank 3 scores 3, rank 4 scores 2, rank 5 scores 1, otherwise scores 0)

(Wilcoxon signed rank test, $p < 0.01$)

Most respondents did not provide comments about the role of the Francis Report in influencing the importance of challenges. The overall impression is of important challenges being associated with more proximal and direct causes than the Francis Report. Of the two challenges that had increased significantly in importance, board member comments have connected workforce shortages with Francis, but service reorganisation would appear to be largely due to other factors, such as the advent of STPs, and only indirectly to Francis, which had contributed to financial issues becoming prominent and hence the need for service reconfiguration to reduce costs.

There were a number of comments about the difficulty of balancing different priorities. Finances were typically mentioned in regard to this, despite the importance of financial challenge apparently not having risen significantly. Francis was also sometimes referred to as contributing to this difficulty, because it had ruled out reducing staffing to save money, although some other comments suggested that this was no longer the case.

'The differences in the two responses above (current and pre-Francis challenges) are about timing, not about Francis. Our whole landscape has changed in 3 years: we had good finances and full compliance on all targets in 2013- now we don't so there are now our big challenges. Patient safety was and is the highest priority, but it's not the biggest challenge.' [NED]

'It is extremely challenging trying to keep the three points of the triangle in balance - Safe services, target delivery and financial balance. When the numbers don't add up any more and there a limited places to look (after many years of Cost Improvements and the option to reduce ward based staff is no-longer there (post Francis) then there is a high risk that target delivery will be compromised.' [NED]

'We've been 'riding' the quality and safety horse since Francis but others are making the finance and performance horse their bet.' [Chief Nurse]

Impact on board member knowledge about what is important to patients, staff and regulators

We also asked the 147 longstanding board members about their knowledge of what was important to patients, staff, and regulators, respectively, pre-Francis. All of the groups rated their knowledge levels as being higher now than they were pre-Francis (see figure 6).

Figure 6: How much board members know about what is important to patients, staff and regulators: Comparison of current and pre-Francis average scores (long-standing members only)



(1 = Hardly anything; 3 = A little; 5 = A moderate amount; 7 = Quite a lot; 9 = A massive amount)

($p < 0.01$, Wilcoxon Signed Rank test)

We asked respondents what influence they thought the Francis Report had had on their board knowing about what is important to patients, staff and regulators. 47 out of 144 who provided additional comments in answer to this question said that the impact had been minimal, and some of these indicated that they already had mechanisms in place to provide good knowledge in these areas. In some instances where there had been changes, these were thought to be more due to the initiative of new board members rather than to the Francis Report.

'Little, we did that before Francis II.' [Medical Director]

'I don't know - staff survey and friends and family test certainly inform the Board. Patients' stories, Board walkabouts, staff forums, Quality report were all in place from 2010.' [Medical Director]

Some respondents highlighted greater engagement with staff or patients. A few respondents said that new mechanisms for obtaining feedback had been established, such as staff with responsibility for patient experience, or patients' councils.

'We were always strong on listening to patients, but since Francis we have also paid much more attention in listening to our staff.' [Chair]

'Execs have established an 'in your shoes' programme and spend time doing other people's jobs on the shop floor.' [CEO]

'Prompted us to ask more questions of patients and staff. Much more co-design with both groups.' [Chair]

'It prompted a much stronger focus on the patient experience, their views and the views of their relatives or carers. We now have a patient experience coordinator, who marshals patient stories for Trust Board.' [NED]

However, a small number of respondents said that engagement strategies were developed through consultation with and involvement of local stakeholders, with local views being a greater influence on the strategy than the recommendations from Francis.

'The (patient experience) strategy was lead locally by staff, patients and service users but clearly took into account national initiatives and recommendations.' [Chief Nurse]

There was a sense that knowledge of what was important to regulators hadn't needed to be increased, because regulators had good communication channels to trust leadership anyway.

'Not a lot. We knew what patients wanted and were told in no uncertain terms what regulators wanted.' [Chair]

Impact on the leadership style and behaviours of the board

We asked longstanding board members how they thought the leadership style and behaviours of their board had changed since February 2013, and what the influence of the Francis Report had been, either directly or indirectly. Some said there had been little change. Others referred to new board members having produced positive change. It was thought that some new

executive directors lacked depth and breadth of experience however, and a degree of stability of board membership might be helpful.

'We have had fundamental changes but this is down to a change in all of our NEDs (including the chair), a new CEO and a new COO. All of which has made a huge difference for the better.' [Board Secretary]

'We have experienced significant change to the board structure and membership at Executive Director level which combined with the maturity and experience of 3 of the NEDs has led to a very open and honest environment which is very healthy and productive. I am not sure that the time limit on the service of NEDs is in the best interests of the NHS. With churn at board level of Execs the stability of the NED contribution is extremely important.' [NED]

Boards could also develop without changes in personnel.

'Our board is a very stable board, with a very stable executive team. We haven't changed - but we have grown and developed and have brought to life a very engaging style with our workforce.' [CEO]

A number of respondents thought that their board had become more open, transparent and visible, engaging more with staff, patients and the public, governors and external stakeholders, with a view to learning and collaboration and an emphasis on values. This was sometimes linked with non-executive directors being more challenging. There were also references to boards being more unitary with members working well as a team and supporting each other. Challenge and support could complement each other, but in some instances greater NED challenge was seen to have impeded board cohesion.

'Greater openness and transparency. More focus on acting on feedback and improving patient experience, and on creating a learning organisation. More emphasis on the board holding the executives to account but with some detriment to the board functioning in (a) unitary way.' [Board Secretary]

'In spite of our personality style I think we are made to feel we should be much more vocal in Boards. I resent this to a degree since I spend a lot of time in the hospital working with senior management and sitting on committees which feed into Clinical Governance. What is the point of making a set piece statement about an issue that you

know is declining in target achievement but you know the plan, you know what is being done and you are trying to be part of the solution!’ [NED]

There were few mentions of boards having changed for the worse. Some may have become more directive.

‘The Leadership style has become more direct and not necessarily supportive or facilitative.’ [CEO]

Views were mixed about the extent to which these changes had been influenced by the Francis Report. Some perceived little or no influence on their board, whereas others perceived massive influence (typically positive) on their board’s approach. Where there had been impactful changes in board membership however, these were typically regarded as not being a consequence of the Francis Report, and of being more important than any changes due to Francis. Some respondents connected Francis with increased regulation, reporting requirements and central direction, which they regarded as unhelpful distractions.

‘Just another set of action plans to add to all the others e.g. Mid-Staffs, Keogh. We and many other trusts suffer from ‘response to reports fatigue’ ... whilst we struggle to afford basic maintenance never mind new initiatives.’ [NED]

‘The Francis Reports had a significant impact on changing the focus on the Board and resulted in it feeling more accountable, and indeed more vulnerable, to external regulation.’ [CEO]

‘Heightened accountability and ownership of the patient safety agenda and a greater challenge on issues beyond the national must dos.’ [Chair]

‘It did raise the profile of patient safety, make us think much harder about the Duty of Candour and result in an increase in ward staff but I don't think it materially altered the Boards leadership style.’ [NED]

‘Reconfirmed the need for openness and accountability ... Francis has also provided a real impact to the need for whole systems leadership.’ [NED]

For some, Francis was receding into the background, but for others it was still emblematic.

‘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.’ [NED]

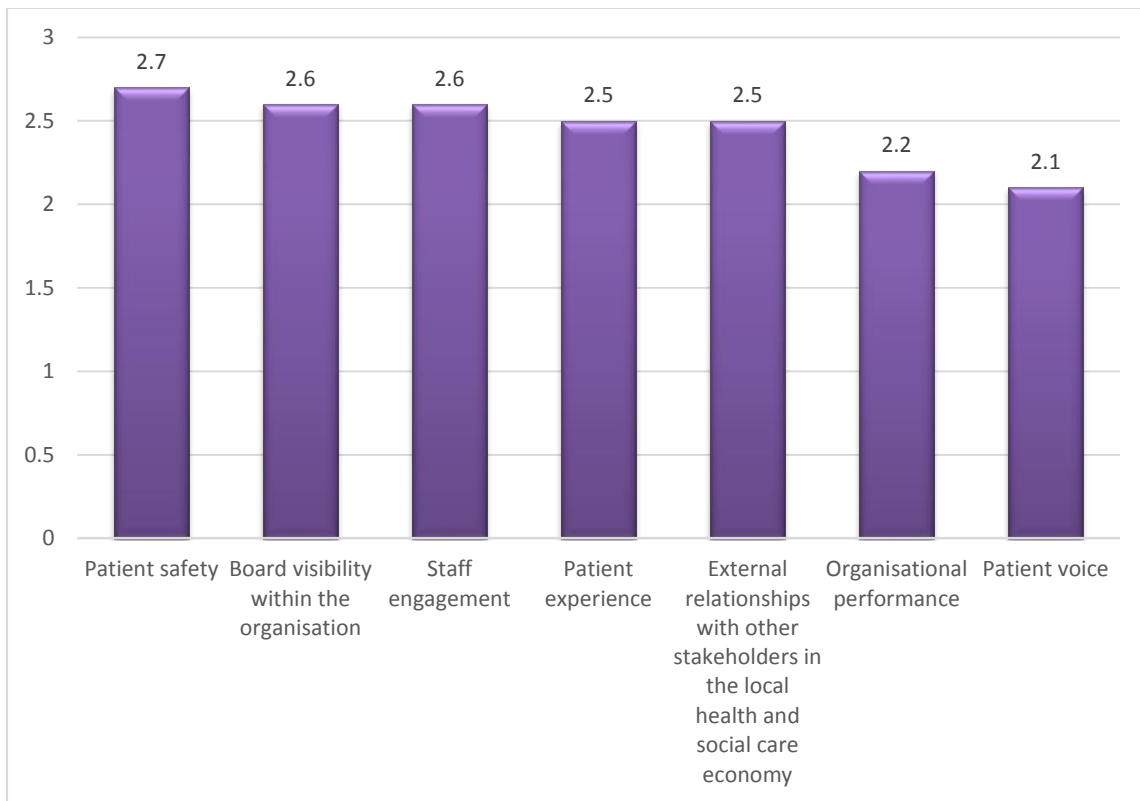
Board Impact

We asked the 147 longstanding board members about their assessments of board impact since February 2013 with regard to the following:

- Organisational performance
- Patient safety
- Patient experience
- Patient voice
- Board visibility within the organisation
- Staff engagement
- External relationships with other stakeholders in the local health and social care economy

Overall, respondents believed that their boards had made all of these outputs or outcomes quite a lot better (figure 7). The greatest perceived impact was on patient safety. Patient voice and organisational performance were not perceived to have improved by as much as the others. All of the impacts were highly correlated with each other. Very few responses indicated negative impacts, but there were a small number for external stakeholder relations, organisational performance and board visibility.

Figure 7: Perceptions of board impact since February 2013



(-5/-4 = Made it massively worse; -3/-2 = Made it quite a lot worse; -2/-1 = Made it a little worse; 0 = Made no difference; 1/2 = Made it a little better; 2/3 = Made it quite a lot better; 4/5 = Made it massively better)

5.4 Implementation and impact of the Fit and Proper Persons Requirement

We asked board secretaries to indicate the various potential actions their organisation had taken to implement the Fit and Proper Persons Requirement. The majority of respondents said that their organisation had carried out background checks on existing board directors and on new appointments (see table 12). A small proportion had responded to CQC concerns about directors. The other actions reported were largely concerned with requirements for directors to make an annual declaration, sometimes as part of an annual review which involved checks with relevant external agencies such as Companies House.

Table 11: Actions taken to implement the Fit and Proper Persons Requirement

| | Yes | | No | |
|--|-------|---------|-------|----------|
| | Count | Row N % | Count | Row N % |
| Carried out background checks on existing board directors | 38 | (80.9%) | 9 | (19.1%) |
| Carried out background checks on new appointments (since the requirement came into force in November 2014) | 44 | (93.6%) | 3 | (6.4%) |
| Responded to CQC concerns about directors | 4 | (8.5%) | 43 | (91.5%) |
| Other actions to implement Fit and Proper Persons Requirement | 13 | (27.7%) | 34 | (72.3%) |
| No actions to implement Fit and Proper Persons Requirement | 0 | (0.0%) | 47 | (100.0%) |

All respondents were asked to comment on the impacts of implementing the Fit and Proper Persons Requirement. Many said that there had been little impact, as no issues had been identified with regard to current or past directors, and the self-declaration element could be regarded as a tick box exercise. A small number of respondents suggested that the requirement had reputational benefits for the organisation and provided some reassurance to the public. It was thought that the requirement could contribute towards a culture of transparency and cause individual directors to reflect on moral and ethical values, and was not suggested to be a deterrent to recruitment.

‘It went well and an Internal Audit of this subject highlighted quite a few areas where we needed to improve our record keeping for those concerned with this aspect of regulation. We are now fully up to speed on this one.’ [NED]

‘Internally, the annual performance review process has been beefed up and standardised to ensure expectations of individuals are met.’ [NED]

Many board members reported that their trust already had similar processes in place, but typically the Fit and Proper Persons Requirement had codified and extended these. In a few trusts the requirement had prompted perceived improvements in recruitment policies, procedures and practices to provide due diligence. Views differed about the resources taken

up by administering the requirement, but the overall balance was that it was not overly onerous and was consistent with good governance, albeit that the impact might be marginal. Individual respondents suggested that increasing the diversity of board members and reducing central regulation and ‘bashing’ of managers were of greater importance with regard to recruitment to the board.

‘The checks required prior to implementing the FPP requirement were already fairly rigorous and the additional checks (insolvency, disqualified directors) were minimal in terms of the burden they represented.’ [Board Secretary]

‘The rationale behind Fit and Proper Persons recruitment is sound and the impacts are positive. The approach is highly relevant to ensuring rigour in the recruitment of appropriate persons to roles within the NHS.’ [Chair]

‘The centrally defined requirement is not that fit for purpose. It has not shown up any ‘bad apples’ or ‘undesirables’ in our Trust. Looks to be another box ticking type activity.’ [NED]

Where the requirement had revealed potential issues, then it was reported that the impact could be large. For example, the subsequent investigation could be disruptive, time consuming and expensive. A small number of concerns were expressed about the rules emphasising problematic issues.

‘One of the concerns is the retrospective nature of the requirement: actions from years ago may be picked up and gone over, as happened to a CEO in a nearby trust. She was vindicated, but it opens up all sorts of possible needs to carry out expensive reviews (the internal review in that case was held not to be independent enough) which could cause uncertainty and instability within a trust until the repost has been provided. I don't think the definitions are clear enough and nor are the actions that a trust should take if it is alleged that due to some past action a board member's fitness and properness is called into question.’ [NED]

5.5 Implementation and impact of the Freedom to Speak Up Guardian

We asked respondents how their board had implemented the Freedom to Speak Up Guardian role. Trusts are at various stages of the implementation process, from reviewing pre-existing

arrangements, such as raising concerns and whistleblowing policies and procedures, to developing a new model and roles, to implementing the new model through staff recruitment, etc. A significant proportion of respondents were however either not aware of the guardian role, or not aware of how it was being implemented.

A number of trusts had pre-existing arrangements including a lead NED for whistleblowing, and facilitating opportunities to access governors and senior managers. Some trusts determined that these arrangements already met the requirements, and appeared to have simply rebadged and re-publicised these. Some trusts were awaiting the outcome of consultation on a national whistleblowing policy, so that their arrangements could dovetail with this.

'Nominated a NED - that's about it.' [Finance Director]

'Existing policies have been reviewed and a nominated non-executive director now has responsibility as part of their portfolio. This is being widely publicised and will supplement existing processes and practices that exist and are robust within the Trust.' [Board Secretary]

'One has been appointed - me - but it has not been embraced by the Trust and I do not yet feel that I am in role and can make a difference.' [NED]

Arrangements appeared typically to consist of employing a guardian, sometimes part-time, together with a network of staff acting as champions in different parts of the organisation, plus confidential email addresses and phone numbers and various forms of publicity (e.g., incorporation into induction). The guardian would have access to a nominated lead NED and lead ED for support, typically the CEO.

Some concerns were expressed that the Guardian needed to be external if there was to be confidence in the role. One trust was planning to work with another trust to provide external support, while others saw governors as an appropriate channel.

Where the role had been implemented, comments suggested that this was having a positive impact, while also acknowledging that much would need to be done to embed a culture of speaking up across and around professional hierarchies.

'We have implemented multiple channels to encourage freedom to speak up - through the unions, through staff governors, through specialist designated staff. Feedback has

improved substantially. Role play sessions at our clinical governance half days have proved very effective at getting all staff to understand how their behaviours might stifle important warnings or contributions from staff team members.' [Finance Director]

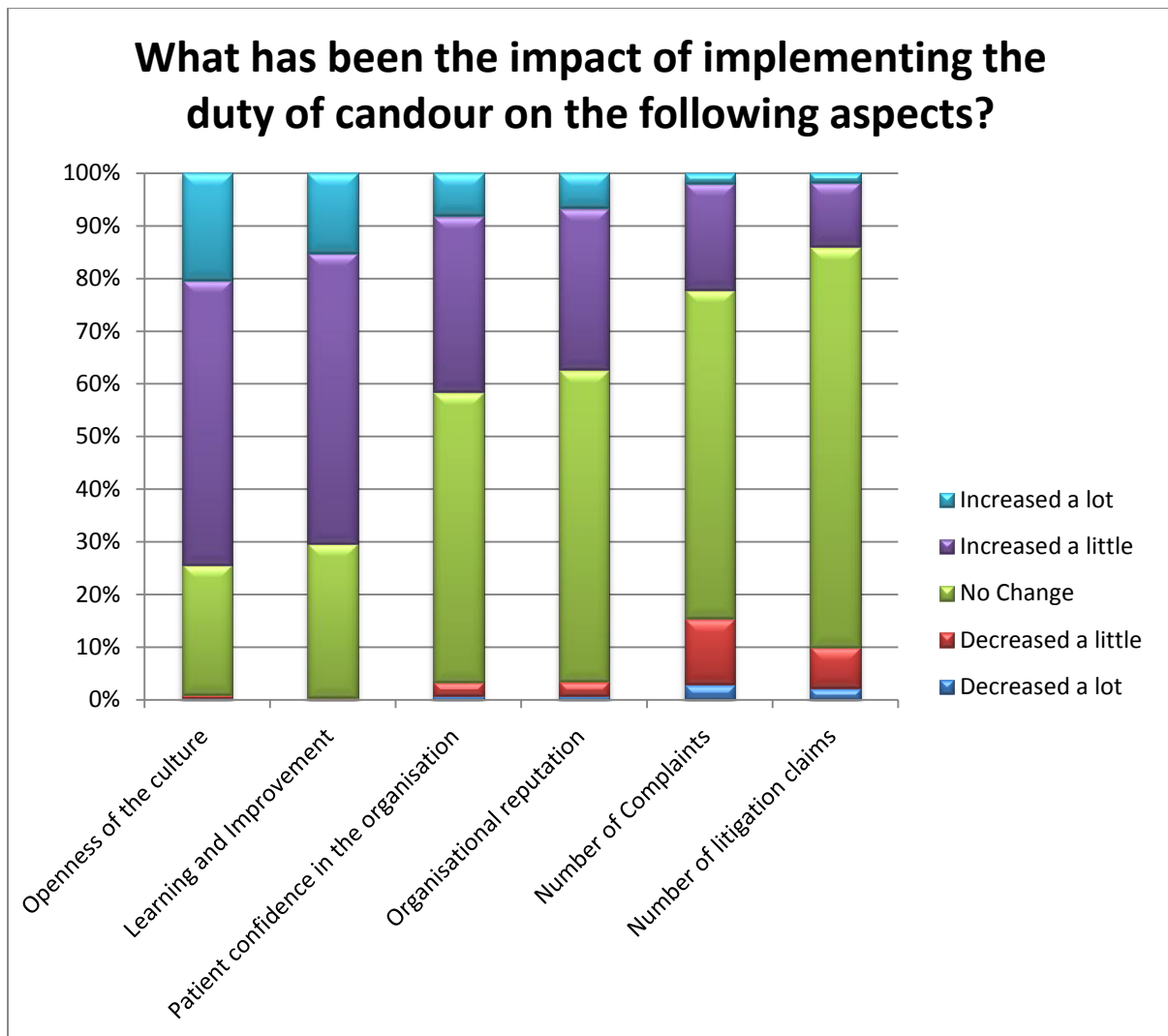
One respondent however suggested that the model was already outdated in a social media age.

'This is now already irrelevant and old fashioned. Transparency is through social media for which there is no filter or censorship and from which there is no hiding place. The public are and will become more their own 'speak up' guardians and we already see this.' [Chair]

5.6 Impact of the Duty of Candour

We asked respondents for their assessments of the impact of implementing the Duty of Candour on various aspects of the organisation and its functioning. The overall picture is of marked increases in the openness of the culture and in learning and improvement (see figure 8), albeit this is based on subjective judgements of a complex situation. There would also appear to have been some net reputational benefits and increases in patient confidence and in whistleblowing, but little change in numbers of complaints and litigation claims.

Figure 8: Impact of implementing the Duty of Candour



Comments indicated that the policy had required substantial resources to implement, particularly with regard to staff training. The amount of documentation required was seen by some as potentially burdensome to frontline clinicians, with a danger of tick box compliance and routine issuing of letters rather than keeping to the spirit of the policy and communicating sensitively with patients and families following an error.

‘We have spent a great deal of time and money on comprehensive training across the trust. It is probably too soon to judge if that is now engrained in the culture.’ [Chair]

‘It is quite onerous as the process is very prescriptive e.g. need to follow up conversation with a formal letter and to keep an audit trail. There is a danger of it becoming a tick box exercise. It has involved a lot of training which is a positive thing

and our trust has tried to focus on the quality of the conversation and learning.'

[Board Secretary]

In common with other aspects of Francis, some respondents felt that their trust had already been practising the values and behaviours of the Duty of Candour. These respondents typically perceived little value, although some saw benefits in the greater formalisation and an opportunity to reinforce the existing approach.

'I believe we were already very open but this has reinforced the message. Duty of Candour is mentioned very regularly in board meetings.' [NED]

'It is a natural extension of what we did, with more formality and more conscious expectation.' [NED]

Other respondents identified better handling of complaints and incidents by clinicians, which was appreciated by patients and relatives.

'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.' [NED]

'Whilst ethically all professionals would feel a Duty of Candour (since this is the basis of honesty and integrity and respect to our patients and their families), the formalisation of this has helped many staff reflect upon its importance and thus embed such integrity into their practice.' [Medical Director]

A number of respondents stressed that it takes time and perseverance to change the organisational culture and make openness and candour a norm for all staff. A couple of respondents pointed out that the word 'candour' was not readily understood by all staff, and suggested a change in terminology.

'It is the correct way forward but trust in staff needs to be nurtured to remove the 'blame culture'. Staff and patients need to be encouraged to talk to one another and resolve issues in a professional and transparent way. Time is needed to achieve this change in culture.' [NED]

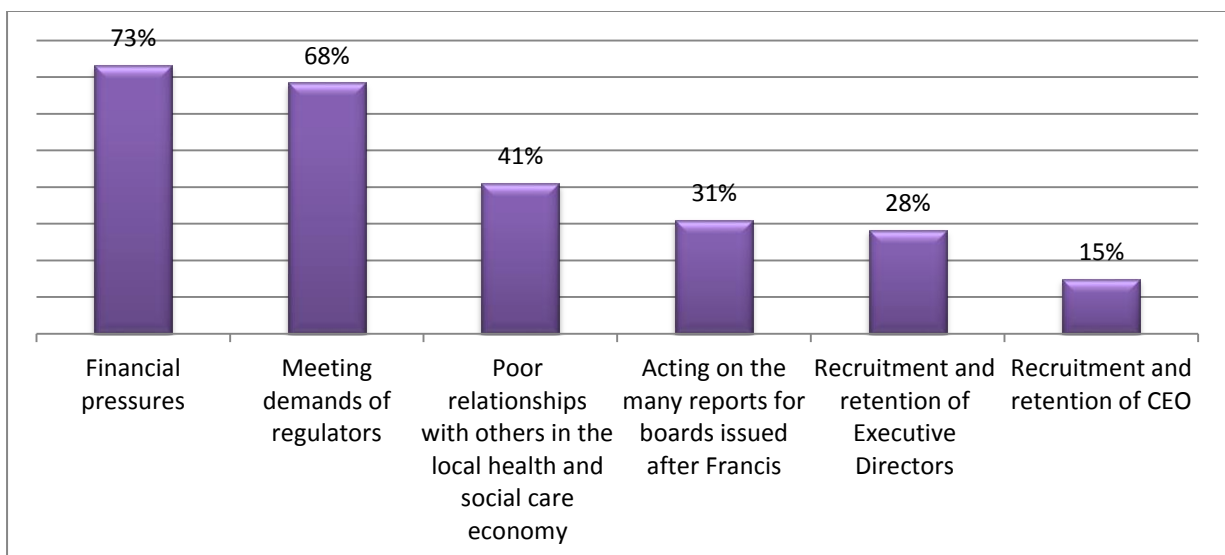
'When you ask (staff) about Duty of Candour they look vacant. If you ask the about openness etc they know what you mean. The term needs to change!' [NED]

'We, as a Trust Board have to think very carefully each time something appropriate arises where Duty of Candour might have an impact. We are now moving quite clearly to a position where we routinely consider this in our various actions on a day to day basis.' [NED]

5.7 Barriers to improving board leadership

We asked respondents to indicate significant barriers to improving its leadership that their board had experienced, by choosing from a list of common barriers drawn up by the research team. Financial pressures and meeting the demands of regulators were selected by a majority of respondents (figure 9). Substantial minorities of respondents also experienced barriers arising from poor relationships with others in the local health and social care economy, acting on the many reports for boards issued after Francis, and recruitment and retention of executive directors.

Figure 9: Respondents reporting barriers to improving board leadership



The recruitment and retention variables were correlated – in 70% of the instances in which recruitment and retention of the CEO was perceived to have been a barrier, recruitment and retention of other executive directors had also been a barrier. Financial pressures and meeting regulator demands were also related – in 83% of the instances where meeting demands of regulators was perceived to have been a barrier, financial pressures had also been a barrier.

Both of these variables were also related to action on reports issued after Francis, although the correlation was lower. The results of a factor analysis were suggestive of three factors: recruitment and retention issues; external/national agency demands and pressures; and local health and social care economy issues.

A number of comments highlighted the quality of current leadership as a barrier. The board itself could be problematic, either due to poor leadership from individuals in key roles (Chair, CEO), or the culture or experience of the board as a whole. Some respondents indicated that recruitment and retention of NEDs could also be a barrier, together with associated issues of not having appropriate skills and experience, or lack of diversity or being sufficiently representative of the local community. A small number of respondents said that insufficient remuneration of board members was a problem, particularly in non-foundation trusts.

Respondents also highlighted that good leadership at board level needed to be backed up by good leadership throughout the organisation. There were two themes within this: the need to recruit high quality managers below board level, and the need to improve the quality of clinical leadership, all within the context that these roles might not always be sufficiently attractive.

Many comments indicated that a lack of system leadership nationally and locally were problematic. A lack of coherent long term strategy and consistency among politicians, government agencies and commissioners made it difficult for boards to plan. Respondents also said that strategic thinking could be squeezed out because of demands caused by system shortcomings: a lack of coordination, with too many initiatives and reporting requirements from government agencies and regulators; and having to address pressing operational issues arising from insufficient capacity in other parts of the local health and care system.

'Lack of a clear vision for the local health economy with local CCG overspent and its own Board in a state of flux. Local health & social care organisations being forced to reduce costs unilaterally putting pressure on others rather than a whole system approach.' [NED]

'Although the relationships with others in the local economy could not be said to be 'poor', they are not necessarily helpful. What is lacking is system leadership to try to overcome individual agendas and encourage collective thinking and action for the benefit of patients. There appears to be too much sitting on the sidelines by

commissioners, regulators and key players and an aversion to any level of risk taking.’ [Board Secretary]

‘Our Executives spend too much time reacting to external audits and reports and not sufficient on developing the strategic direction of the individual clinical specialties with the clinicians. It is hard to develop a culture of empowerment with accountability in this hospital when the NHS itself suffers from a culture of command and control and management by committee with little individual accountability. Both are completely outdated in the year 2016!’ [NED]

‘Reactive focus on regulators’ demands and insufficient time set aside for forward thinking. Lack of investment in understanding in detail the needs of our health economy and the views of our stakeholder. We limp from crisis to crisis.’ [NED]

5.8 Board development

We asked board members to estimate how many days of individual leadership development they had participated in during the last 12 months. We also asked board secretaries to estimate how many collective board development full and half days there had been. Seminars and briefing sessions were excluded.

20% of respondents said they had not participated in any individual leadership development during the last 12 months. The median was participating in three days of leadership development.

Executive directors generally participated in more days of leadership development (median 4 days) than did NEDs and chairs (median 2 days) ($p < 0.01$, independent samples median test). This is in line with expectations, as most executive directors work full time, while NEDs are part time. To allow for this, in subsequent analyses we have applied a simple global correction factor of two to the development days indicated by NEDs and Chairs.

5.9 Associations with indicators of leadership effectiveness

We investigated the relationships between variables, including with indicators of leadership effectiveness, in the form of Care Quality Commission (CQC) Well-Led Ratings (CQC

2015b) at trust level and selected NHS staff survey (NSS) scores (NSS 2016). The dataset is complex to analyse fully on two counts. First, it includes data at two different levels: board/organisation (e.g. NSS scores) and individual board member (e.g. days of leadership development). Rigorous analysis of such data typically requires the use of multi-level modelling techniques that take account of the likelihood that members of the same board/organisation will provide more similar responses than will members of different boards. Second, response rates varied greatly between different boards/organisations, with the number of respondents from each board varying between zero and seven. Such ‘unbalanced’ data makes multi-level modelling more challenging and reduces its power.

Contrary to expectations, initial analyses indicated that while there was some variation in the data which could be attributed to factors at the organisational/board level, levels of agreement between respondents from the same board were not particularly high, despite being asked questions directly about their board. We calculated Intra-class Correlation Coefficients (ICC’s) for each variable as per Lüdtke et al. (2009). ICC1 was typically of the order of 0.1 and ICC2 of the order of 0.25, much lower than the suggested 0.8 cut off if aggregating individual board member responses is to provide a reliable average figure for each board.

In view of these complications and the complexity of the dataset, we have conducted exploratory bivariate and multivariate regression analyses which do not involve multi-level modelling in order to get a sense of the relationships between variables. In order to reduce the risk of spurious results, we have focused only on highly statistically significant relationships which are robust to exclusion of outliers and high leverage points. The following findings should however be regarded as indicative.

In this section we consider the following indicators of impact:

1. Board member assessments of board impact since February 2013 on patient experience, patient voice etc.
2. CQC Well-Led Ratings for the trust at the inspection closest in time to the survey
3. NSS scores on four indicators of leadership up until 2016

CQC ratings and NSS scores are correlated with each other, but not with board member assessments of board impact since February 2013. These assessments could only be provided by relatively longstanding board members however, restricting the size of the dataset.

Board member assessments of board impact since February 2013 were correlated with the amount of leadership development they had participated in during the past 12 months. The highest correlations were with impact on patient experience, staff engagement and patient voice ($p < 0.01$). Correlations were low for impact on organisational performance and external relationships with other stakeholders locally.

Board impact self-assessments were also correlated with emphases on the different board purposes. Some correlations concurred with expectations from theories of board performance. For example: greater emphasis on representing all stakeholders is particularly strongly correlated with impact on patient voice relative to correlations with other impacts, and greater emphasis on holding the executive to account is more strongly correlated with impact on organisational performance than with other impacts. There are various significant correlations however, and more sophisticated analysis would be required to more confidently determine the key relationships.

Board impact self-assessments are most highly correlated with assessments of impacts of implementing the Duty of Candour, particularly the impact on patient confidence in the organisation. CQC ratings and NSS scores are correlated with emphases on the different board purposes, being a foundation trust, and being a specialist trust. They are negatively correlated with various barriers to leadership improvement: particularly recruitment and retention of CEO and executive directors, but also financial pressures, meeting demands of regulators and poor relationships with other stakeholders locally. They are negatively correlated with the total number of beds and with the impact of the Duty of Candour on the openness of the organisation's culture, and respondents joining the board more recently tend to be from trusts with lower CQC ratings (see above).

To develop this analysis further we conducted a multivariate statistical analysis in the form of binary logistic regressions and ordinal regressions. The dependent variable for each regression was a variant of the CQC Well-Led Rating for the trust that was closest in time to the survey data collection period, based on CQC inspection dates. The independent variables were drawn from the list in the previous paragraph, and various stepwise procedures were used to identify a set of variables which contributed significantly to the model fit. The binary logistic regressions focused on distinguishing CQC ratings of Good and above from lower ratings; one set of ordinal regressions focused on unadjusted CQC ratings, the remainder

combined Inadequate and Requires Improvement ratings into a single category because previous modelling suggested that independent variables did not distinguish these categories.

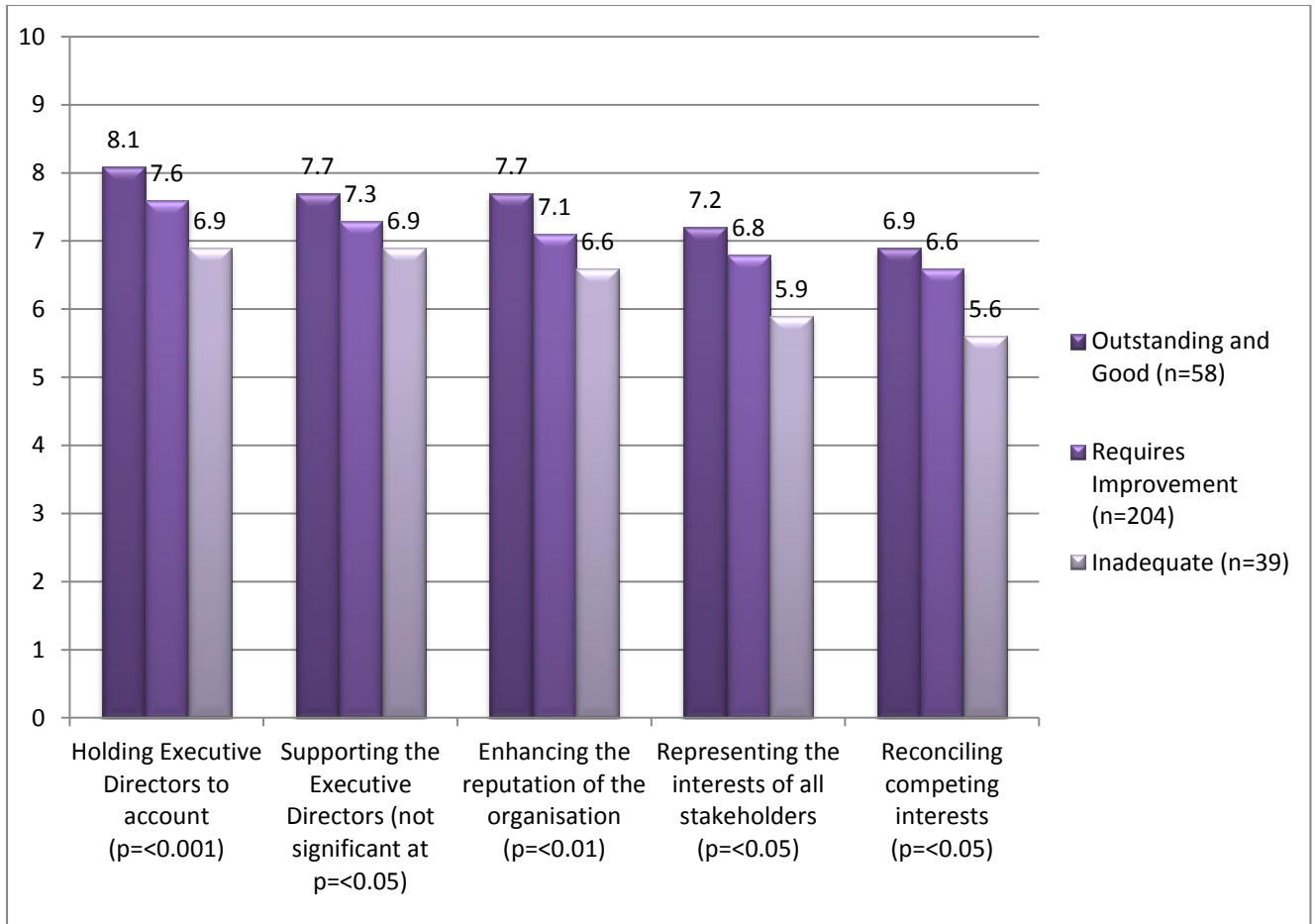
The various regressions produced similar results. The independent variables that were consistently statistically significant in the models ($p < 0.01$) are listed in table 13. The confidence intervals for the coefficients in the model were quite wide, so we cannot be confident in the relative strengths of the associations with different variables.

Table 12: Variables associated with CQC Well-Led Ratings

| Higher CQC rating | Lower CQC rating |
|---|---|
| Emphasis perceived across the five board purposes | Recruitment and retention of EDs perceived as a barrier |
| Is a foundation trust | Meeting demands of regulators perceived as a barrier |
| | Is an acute trust |

A higher CQC rating was positively associated with a stronger self-reported emphasis on all board purposes, with the biggest difference on holding executives to account (see figure 10 below).

Figure 10: Association between CQC Well-Led Ratings and board emphasis on different purposes



Correlations with other variables may provide some pointers to what underlies the lower ratings of acute trusts and the higher ratings of foundation trusts. Being a respondent from an acute trust is also associated with clinical effectiveness of care not being perceived as an important challenge, RTT times not being perceived as an important challenge, A&E performance being perceived as an important challenge, number of beds, recruitment and retention of EDs being a barrier, poor relationships with others locally being a barrier and financial pressures being a barrier.

Being a respondent from a foundation trust is associated with an emphasis on holding directors to account, an emphasis on enhancing the reputation of the organisation, an emphasis on representing the interests of all stakeholders, having joined the board more recently, a higher proportion of female board members, fewer beds, knowing more about

what is important to staff, recruitment and retention of EDs and CEO not being a barrier and poor relationships with others locally not being a barrier.

We conducted further multivariate analyses with CQC rating as the independent variable, but including the variables listed in the previous two paragraphs rather than those indicating whether trusts are acute or foundation trusts. The results were less clear cut than for the previous regressions. In addition to the ones in the previous model, the strongest consistent relationships were positive associations with the proportion of women on the board. There were less consistent and generally weaker associations with being a relatively longstanding board member (positive), poor relationships with others locally being a barrier (negative) and with the number of beds (negative).

5.10 Summary of main findings from the national survey

As reported above, the main self-reported challenges for trusts are patient safety, finances, dealing with regulator demands, workforce shortages and, for some, poor relationships in the local health economy. Patient safety is generally reported as a very high priority for boards. Long-term financial sustainability is also regarded as important, and numerous respondents said that the current access and finance targets environment can make it difficult to hold the line on maintaining quality and safety. Managing the demands of multiple system regulators is sometimes experienced as distracting from the strategic and monitoring tasks of boards.

We now summarise the main findings against the three research objectives as set out in table 4 in our methodology chapter that this survey addresses:

- 1. To identify, describe and assess the different ways in which the boards of NHS hospital trusts and foundation trusts have sought to implement the recommendations on organisational leadership set out in Hard Truths and the Healthy NHS Board.**

The survey results show that board members see it as their role to provide a high level of challenge to the executive team. This suggests a concern for performance, addressed by ensuring that the executive directors are held to account and scrutinised effectively at board meetings. However, the relatively small difference between board purpose scores and, particularly, the high score given to supporting the executive directors, suggests that board

members recognise the importance of high levels of support, combined with high challenge within a board environment. The emphasis placed on holding the executive to account can be seen to reflect one of the three key roles for boards within The Healthy Board guidance, that of ensuring accountability. The relatively high scores for representing the interests of all stakeholders and for reconciling competing interests, albeit the bottom two board purpose scores, might suggest that boards are also beginning to commit to one of the key building blocks also contained within the report, that of giving priority to engagement within and beyond the organization. Boards that embody the range of NHS Healthy Board principles and practices may be correlated with higher performance, with statistical evidence showing a positive association between higher CQC ratings and a stronger self-reported emphasis on board purposes that stress both challenge and support at board level, as well as stakeholder engagement.

The majority of boards had not newly established their organization-wide policies, choosing instead to formally review and reissue existing policies. This might suggest that the changes required post-Francis involved alteration or reinforcement of existing policies, as opposed to wholesale revision. Those boards with lower CQC ratings within the Well-Led domain were correlated with establishing at least one new policy, post-Francis. This indicates that the greatest level of learning has taken place within those trusts with the most need of improvement. The number of board level actions, however, has increased substantially post-Francis, with the introduction of reports on ward-by-ward staffing levels, patient stories at board meetings and board walkabouts, reflecting the implementation of recommendations within the Hard Truths Report.

Greater emphasis is now widely given to board level engagement with staff, gaining feedback, and considering a broad range of information, which also reflects a further building block contained with the Healthy NHS Board Report, which is to arrive at sound judgments about organization performance informed by multiple sources of data. The extent to which board members feel they are having an impact on patient experience, staff engagement and patient voice is correlated with a higher number of board development days, suggesting that increased training enhances the self-assessed ability of the board to act on requested varied intelligence and stakeholder engagement. The fact that board members reported that they knew slightly more what was important to regulators than to staff or patients is telling with regard to the ways in which boards call for, discuss and process information about performance and their *de facto* sense of accountabilities.

Overall, many boards have taken actions to improve the conduct and content of board meetings by introducing reports on staffing levels, patient stories and board walkabouts. A much greater emphasis on making decisions based on qualitative feedback from a range of sources, as well as analyzing quantitative data, has been implemented. Boards are also reporting that they see their purpose as encapsulating a range of different roles, from holding the executive to account to representing the interests of all stakeholders.

2. To identify which mechanisms used by hospital boards have led to reported improvements (or otherwise) in local organisational strategies, structures and culture, and the factors underpinning such progress.

Mechanisms for obtaining the views of patients, staff and regulators included designating staff with specific responsibility for patient experience, or implementing patient councils. However, many respondents said that listening mechanisms were already in place before Francis, or that newly developed feedback processes were developed through engagement with local stakeholders, as distinct from being generated by the Francis Report. Trusts were at various stages of implementing the Freedom to Speak Up Guardian role, with positive impacts, such as improved feedback, found when the function had been more fully developed. However, it was also highlighted that much more needed to be done to achieve culture change, with some suggesting that the traditional guardian role may be outdated, given the rise in the influence of social media.

The Healthy NHS Board Report placed emphasis on the importance of having highly qualified directors who are capable of setting strategy, monitoring and managing performance, and emphasising quality improvement. The report also stresses that there should be a balance between continuity and renewal in appointments. Respondents found the arrival of new non-executive directors to have led to major improvements in the working of the board, including increased openness and transparency, and greater level of engagement with staff, patients and external stakeholders. These impacts were specifically linked with the introduction of non-executive directors who were challenging, mature and experienced.

The Hard Truths Report introduced the Fit and Proper Persons Test to ensure that board members are compliant with a prescribed standard of conduct in public life, and signalled the implementation of a statutory Duty of Candour, which requires providers to inform people if they believe treatment or care has caused harm. The majority of boards said that their organisation had carried out background checks on existing board directors and on new

appointments. However, many reported that the checks had little impact and the self-declaration element could be regarded as a tick box exercise. Nevertheless, some did say that they that the requirement contributed towards a culture of transparency and that it was consistent with good governance. Duty of candour was found to have had a considerable positive impact, with increases in the openness of organisational culture and in learning and improvement, as well as better handling of complaints by clinicians. However, some also felt that implementation was resource intensive, and overly prescriptive. As with most of recommendations generated from Francis, many also believed that they were already doing what was being suggested.

Overall, many trusts have implemented mechanisms that have led to greater engagement with staff and patients, improved culture and greater organisational openness. However, it is not always easy to determine the exact contribution of Francis, as some mechanisms predate the publication of the report, or have developed through different means.

3. To explore the enablers of and barriers to implementing different approaches to board and organisational leadership

The majority of respondents found that the greatest challenge their board faced was patient safety, with many reporting that Francis, specifically, had prompted them to ensure that this remained their main focus. Francis was seen, in some instances, to be an enabler to boards making improvements, by focussing board aims, and acting as a reminder to place quality of care and patient safety at the top of the agenda. However, financial pressures were still seen as a barrier to making these ambitions a reality. Some respondents highlighted staff shortages in A&E and other service areas as exacerbating financial difficulties and creating a threat to patient safety. Financial pressures were reported as the top barrier to improving board leadership, suggesting that boards see financial difficulties as permeating all aspects of their work. A prominent issue was ensuring safe staffing levels, and rising agency costs. Many respondents reported that the setting of safe staffing levels without phasing meant that all trusts were fishing in the same pool of agency staff. Some felt this was part of a wider problem with Francis in that it had created far too many recommendations that led to additional bureaucracy and higher costs.

The second and third barriers to improving board leadership felt by respondents were meeting demands of regulators, and poor relationships with others in the local health economy. Many boards felt that trying to lead system change should be a central aim of the board, but this was difficult due to local stakeholders not sharing the same priorities, or lacking strategic leadership. Contradictory demands from Department of Health, NHS England and regulators were also seen as obstructing system working.

Overall, Francis has enabled boards to refocus their attention on patient safety and care. However, external factors, such as limited finances, variable system relationships, and regulators that are sometimes perceived to be overbearing, are still acting as barriers to boards achieving their strategic and organisational aims.

The next chapter provides an opportunity to look at these themes in more depth and to begin to understand the circumstances and mechanisms that are associated with improvements in board leadership.

6 Case study findings

This chapter outlines the findings from our six case studies. Mirroring our research objectives, we look at local contextual factors, what actions were taken by boards of these trusts to respond to Francis recommendations, progress made on quality and safety and changes to the composition, role and behaviours of boards. We describe board efforts to put patients first, engage staff and support quality improvement. Finally, we assess changes that have taken place in these sites with regard to organisation culture. In order to assure anonymity of the case study sites and because of the sensitivity of some of the information shared with us, we have chosen to analyse the findings thematically, rather than to summarise them case by case. We provide a brief summary of the main themes at the start of each of the sections.

6.1 Characteristics of the six case study sites

Box 4: Features of the six case study sites

5 Foundation Trusts and 1 non Foundation Trust

5 General acute hospital and 1 specialist acute hospital

Number of beds: 190 - 1300

Single site: 3; Multi site: 3

CQC ratings [May 2016]: Requires Improvement [4] Good [1] Outstanding [1]

CQC ratings [May 2017]: Requires Improvement [1] Good [3] Outstanding [1]

NHS Staff Survey 2016 overall engagement score:

1 = < 3.80

3 = 3.81 – 3.84

2 = > 4.02

2 in the North 2 in the Midlands 2 in the South

Fieldwork and data collection took place from April 2016 – May 2017

Box 5: Aggregated information about interviews, focus group participants and meeting observations across the six case studies

Stage one - 1:1 Interviews n = 69

Chair 6

CEO 6

Non-executive directors 7

Executive directors 18

Other staff 22

Patient and public representatives including governors 7

Commissioner 3

Focus groups n = 8

4 x Patient experience - number of participants = 31

4 x Staff experience or staff side or staff meeting – number of participants = 53

Meeting Observations n = 16

Public board meeting - 6

Private board or committee meeting – 6

Council of governors meeting - 4

Stage 2 follow up 1:1 interviews and/or email contact n = 12

Chair = 5

CEO = 3

6.2 Main local contextual issues

All six case study sites had more in common than divided them. All were facing growing financial difficulties and increasing demand, and all the boards named similar priorities around quality and safety. Differences included the challenges brought by the local external environment and in particular tensions, or opportunities, that the STPs presented, problems with staffing and most of all the scale of the operational leadership challenges facing the four trusts on an improvement trajectory. More detail on local issues is provided below.

At the time the Francis Report was published, four out of the six case study sites had been experiencing difficulties in the quality and safety of their services, as well as financial management. This resulted in two of them being placed in special measures, and a third being made a 'Keogh' trust, which meant implementing an action plan to improve quality.

It is noteworthy that within the time period from 2013 to 2016/7, when the fieldwork was conducted, even the two remaining case study sites, which had been judged by regulators to be high performing organisations and financially secure for some years, had begun to experience pressure from the combination of rising demand and restricted budgets referred to in chapter 2. This has clearly been a shock for some: *'Posting a deficit, this organization, posting a deficit, never happened. I never thought I'd see the day.'* [ED, Trust 3]

The pressure to meet the demands of performance targets and financial balance was a strong theme common to nearly all of the interviews. Two of the six trusts are currently managing to meet A&E performance targets well and the others are struggling to meet the four hour target: *'Our acute services, particularly our ED is inundated - I'm just thinking whether that's the right word, but it probably is- is inundated with patients who shouldn't be anywhere near a hospital.'* [NED, Trust 6]

The other main contextual factor is the influence of the potential changes in the local health economy that are resulting (or might result from) new models of care launched in the Five Year Forward View (see chapter 2) and the sustainability and transformation plans that are being implemented across the country. In some areas, the plans are interacting with long standing problems with the financial and clinical sustainability of standalone trusts. The spectre of mergers hung over two of our case study sites, and all case study trusts are actively

involved in discussions in their local STP about closer collaboration with other providers and with commissioners.

In terms of the stated priorities of the trust boards, the public-facing documents emphasised very similar objectives, for example: the improvement of clinical quality, governance and organisation viability, overarching priorities for safe, timely, patient-focussed and clinically effective service delivery, education and training, and research and development. Releasing the talent of staff, working in partnership and accelerating improvement also featured prominently in some of the trusts' objectives.

But the interviews revealed different emphases, reflecting the different circumstances faced by individual case study trusts.

Some were starting from an organisation baseline that quite recently was poor on staff capability and patient safety: *'(w)e've had an organisation that over a period of ten years was bereft of what I would call competent staff and the capacity to deliver what was expected of it... I was quite shocked....that I could walk into a ward and find that the drug cupboard would not be locked.'* [Chair, Trust 6]

Other trusts had priorities that were particular to them, for example getting out of special measures, or the perceived threat of new models of care e.g. Multi-Specialty Community Provider Vanguard, and organisation sustainability:

Obviously the sustainability of the organisation, given the turbulence that is being experienced at the moment, and obviously I mean it goes without saying that to enable that sustainability you need to deliver on your key performance areas as well as your financials to support the service anyway. So, yeah, that said, you can't stop thinking about improvement and innovation because that of itself is something that enables sustainability too.' [Chair, Trust 1]

This combination of pressures driven by the national financial environment, and the opportunities and threats resulting from sustainability and transformation plans, affected the ability of several trusts to protect headroom for adequate strategic thinking. The chief executive of one of the trusts, which had worked its way out of special measures, described the effort needed to work on developing a future strategy simultaneously as *'trying to fix what's in front of you today'* [CEO Trust 5].

In one trust, the CEO reported that his priorities were more clinically focussed, e.g. receiving and acting on results from clinical benchmarking rather than digesting national policy documents: *‘...I don’t read any of the stuff that comes out from NHS England.....it’s a source of immense frustration.... I haven’t got the time and most of the time I’m uninterested. So I am lucky that..... I’m an NHS lifer, so a lot of my social contacts are NHS, so I’m completely immersed in it anyway...so I walk round the thicket...’* [CEO, Trust 2]

6.3 How the trusts responded to recommendations from the Francis Inquiry in 2013, and other reports

There was evidence in all case study sites of a flurry of activity immediately following the Francis Report in 2013, especially focussing on staff. Longer term, we discerned the spirit of Francis continuing in ongoing work programmes to improve patient experience and staff engagement, as well as the continuation of specific actions such as the implementation of the Duty of Candour. The efficacy of immediate and longer term responses by the six trusts varied. More detail is provided below.

Immediate actions

As required, trusts responded formally to the Francis Report and published action plans. As we have already indicated, for four of the trusts, the publication of the Francis Report coincided with a very difficult time when there had been some high profile patient failures or external regulatory interventions that required urgent review of systems and culture anyway. These four trusts reported that Francis was a useful backdrop in guiding and supporting them in the urgent implementation of measures and organisational cultural changes required by the findings of the CQC and other external reviews.

One of our case study sites was local to Staffordshire and the issues were keenly felt by the organisation. The trust chief executive there took the recommendations of Francis 1 (the initial independent report) in 2010 and developed an action plan for the trust. This plan included changing the way in which complaints were handled and having Listening Into Action events with complainants.

When Francis 2 came out in 2013, the trust built on this work, although the major impact for them of the public inquiry report was subsequent regulatory intervention. In response to

questions about Francis, this intervention was nearly always mentioned. In another of the case studies, the fact that the organisation went into special measures in 2013 dominated, rather than implementing the recommendations of the Francis Inquiry.

At one case study site (where there were no concurrent regulatory interventions), board interviewees described an immediate response involving briefings for all managers on recommendations and content of the report. Focus groups were used to explore the issues in Francis, reaching 12% of the workforce over a period of ten days. A report was fed back to the board. Board members described the Francis Report as a catalyst for greater self-reflection, re-stating of values, a reminder of the importance of communicating between leadership and front line and it legitimized what they were doing. It also came out at the time that the trust had launched a big initiative, led by the chief nurse, to train the whole workforce in better patient centred care for vulnerable people. This trust has the highest staff engagement score of our six sites, as reported in the NHS Staff Survey carried out in 2016.

A wide range of initiatives following Francis were reported to us across the six sites. These included actions which were compulsory (either legally required or subject to central performance management) for example the implementation of the Duty of Candour policy, overhaul of the complaints policy with an emphasis - where possible - on swift resolution, establishment of champions for speaking up/whistleblowing, improvement in the reporting of serious incidents and investment in nurse and medical staffing. But common to all the trusts were other initiatives which were central to Francis, but not mandated in any concrete form, for example, efforts to improve staff engagement, opportunities for staff and patients to communicate with the CEO directly, safety huddles, 15 steps, improved governance of quality and safety, patient stories at board meetings and new ways of involving and working with governors.

The quality and safety strategy from one case study frames the trust's priorities in the context of the Francis Report and also explicitly refers to the recommendations of Hard Truths, Keogh, Berwick and Cavendish. The overarching thrust here is striving for excellence, and the strategy is also framed round the five domains identified by the CQC.

Impacts of actions post-Francis

Some of the reported impacts included that mistakes are now more likely to be seen as an opportunity to improve, and trusts are more likely to commission an external review in more serious cases. There was a sense that at least in some places, the spirit of Francis has lived on even though the details of the report are no longer current in the minds of staff. The survey of managers indicated that, although not all staff are closely familiar with the precise recommendations of the Francis Inquiry, working practices have been significantly influenced by Francis and the board has exercised clear leadership in this regard: *‘Within our team, the results of the Francis Report are central to work streams and decision-making. Francis has been the foundation of work streams including Schwartz Rounds....’* [Senior Manager, Trust 4]

For one of the trusts (and this was echoed in responses to the national survey) the Francis Inquiry confirmed and energised a direction of travel that they had already taken:

‘I would say that the publication of the Francis Report and the follow up action around speaking up, raising concerns, about transparency and candour, were very positive reinforcements for a culture which I think people hoped they had here, and has led to, I think, further developments in clinical governance, which continue to go on.’ [Chair, Trust 3]

One chief executive assessed that his organisation still had a way to go, saying that the board has now arrived at a position *‘...which is to have them [Francis recommendations] as part of core business..... I think one of the big issues that we’ve got by having this sort of stuff as core business is you’ve got to be totally confident about what you do as core business and how you assess that. I think there’s a real challenge about how we assess our core business internally and at board level and down to ward level.’* [CEO, Trust 2]

Duty of Candour has been embraced enthusiastically, as reported to us by board members and managers, and from documents obtained from case study sites, although we weren’t able to corroborate this, within the scope of this study, with much evidence from the patient perspective. We were told that the legislative underpinning of this policy does sometimes make staff wary and for clinicians it can be difficult and frightening. There was a perception amongst some board members that the Duty of Candour was more useful than the speaking

up initiatives, which have tended to turn up more HR issues that genuine safety/quality issues, although at the same time the speaking up campaign has facilitated the spread of good practice across the whole organisation.

In relation to the Berwick Report, which emphasised the importance of learning for improvement, the application of quality improvement science is a work-in-progress and was not systematic across all areas in any of the six case study sites. Intention to apply a systematic focus was detected and programmes of work, and training and development of managers and staff was taking place during the time of our fieldwork.

We found that the Fit and Proper Persons Requirement for vetting board members has been implemented, but rarely discussed and not particularly embedded in the culture, for example in the medical workforce. There is a sense in which it is rather literally implemented which, it was observed by one respondent, might be due to the fact that the policy is not well constructed (nationally) or understood.

At one of the observed board meetings, and in relation to the patient story, the medical director mentioned Francis when commenting that compassion had got better in emergency care and less so in elective care. Patients actively involved in the trust, and governors, reported to us that the patient story at the start of board meetings was an important symbolic gesture. Some of these patients also wanted to report, in general, greater confidence in more recent years about the quality of care: *'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, Trust 2]

But there was a concern about lack of consistency in the level of patient centredness of care. One carer's story in one of the case study trusts echoed some of the very same problems that the Francis Inquiry uncovered:

'Some of the wards are much different from others and it does rely very much on particular individuals and particular shifts, how things are. I mean we have had two elderly neighbours..... and one of them had dementia and she had a nephew who lived in London and only us. And because we were not next of kin, nobody would talk to us

about her.....I looked at her notes quite often and they would tick that she'd taken her medicine. On her bedside table were these little cups with the tablets still in them..... It wasn't enough to pop them in a pot and put them on her table; nothing would happen. You know, if she was thirsty, she was hungry, she wouldn't ring her bell because she was so confused.....So my husband and I used to come in just about every night just to make sure that the basics were being dealt with because she would talk to us because she knew who we were. But we, as far as the hospital were concerned, we were nothing..... Some of the staff would say to us, 'We'll lose our jobs if we talk to you.' It seems counterproductive...' [Patient and governor focus group participant, Trust 2]

6.4 Progress on quality and safety

Despite examples of variability as shown above in patient experience of care, there was a strong emphasis reported in all our sites and in most of the interviews on initiatives to measure and improve patient safety. We found evidence to demonstrate there had been a step change since 2013 in the seriousness with which trust boards took matters of quality and safety. More detail is provided below.

One trust moved from being one of the worst for hospital mortality to being now in the top 10%. In another of the case studies, the clinical effectiveness and services group has a clear remit to prioritise clinical audit activities and improve clinical outcomes. Around 2015, its remit was broadened to encompass service evaluations and improvement.

Handling and reporting of serious incidents has had a marked focus. In one trust it was reported that the medical director and chief nurse now get a daily report with incidents from all divisions and a complaints summary. *'It comes into my inbox between four and six, and I can see every single incident that's occurred in the organization the day before'* [Medical Director, Trust 6]. Staff are able to flag potential solutions alongside reporting the problem. The trust also holds a patient safety summit every week. It lasts for an hour, looks at a recent incident (not always serious), presented by the clinical team in question, and attended by representatives from all the divisions, and other doctors, nurses and students. Between 30 and 70 people attend. *'The narrative starts off by saying this is not about who. This is about*

what happened, where it happened, how it happened, to extract learning to help with root cause analysis' [Medical Director, Trust 6].

Board members across all sites reported varying progress with improving the quality of data to measure quality and safety, for example clearer presentation of trends over time, benchmarking against national standards and processes for validation.

Although there was perceived good intention in relation to patient safety in all cases, the trusts varied in the attention paid to structures and formal processes to see initiatives through.

6.5 Composition, role and behaviours of the board (including individual members of the board)

There was much evidence of board renewal since 2013 in all trust sites in terms of membership, committees and ways of working. There are significant issues with regard to ethnic diversity and the strategic sightedness of boards. All were focussed on staff and patient experience but with varying impact. More detail is given below.

Composition and structures

Four out of six of our case study sites had had significant turnover on the board since 2013, including new chairs and CEOs. The most stable board also had the highest proportion of non-executive directors (four) with clinical or social care backgrounds; others had one, two or three. Two trusts had an all-white board; others did better but not much in terms of Black and Asian Minority Ethnic (BAME) representation. NEDs with BAME backgrounds were, in general, scarce. Gender balance was good.

New appointments were generally welcomed by a number of respondents from across the organisations. The contribution of new CEOs with their refreshing leadership styles was particularly singled out generally for positive comment. During our fieldwork phase in 2016, the CEO in one of the case studies departed for another CEO position in a larger trust and their loss was commented on as keenly felt by some of the interviewees. For many of the directors, especially in the smaller trusts, it is their first executive role.

Board committees, especially quality committees, have received greater attention in recent years, and been enhanced in size and seniority of membership and length of meetings. One trust had combined quality and performance, to ensure that there were joined up assurance processes around access targets and clinical quality. For one trust who had been the subject of regulatory intervention, there was a strong emphasis on the safety/governance axis to ensure follow-through of intentions.

Non-executive directors in the most challenged trust, which had just come out of special measures, were concerned about their workload. This included their contribution to the many new appointments that had to be made and the hard graft in getting stronger governance and assurance processes embedded. Two of the trusts (both rated as Requiring Improvement at the start of the case study field work) reported they had difficulty in recruiting non-executive directors.

Role of board

It was observed that part of the job of the board is *'to filter all the nonsense that comes from outside'* [Director of Organisation Development, Trust 3]. This interviewee, and others in the same trust, felt that the board was effective in conveying to staff of the trust the importance of carrying on with caring for patients, and putting to one side some of the policy ambiguity that might be reigning in the wider NHS. This 'shock absorber' role of the board is developed further in our concluding chapter. At the same time, there was evidence in a couple of the trusts with more stable membership, that as well as a steady internal focus on quality, attention was paid to developing productive relationships with commissioners and other local health care providers, and having one or more of their executive directors take a lead on aspects of the local Sustainability and Transformation Plans (STPs).

For one of the trusts that had recently come out of a regime of special measures imposed by the regulators, the board role was described as getting the basics right, a good line of sight from board to ward and then beginning to focus on organization strategy. Sometimes getting the basics right involved board meetings getting into quite a lot of operational detail, including rehearsing some of the conversations that had taken place in the quality committee.

Space for strategic conversations at the public board meetings appeared to be limited and sometimes comments on strategic agenda items had an operational bent. Private board meetings were more likely to get into the detail on risk.

We observed that in four of the case studies, in order to gain assurance and promulgate core values around patient centred care and the importance of staff engagement, the boards carried out a lot of direct communication with the organisation: core briefs, meet the CEO sessions, contact the CEO, freedom to tweet, walking the wards, mock CQC inspections, and what the chair in Trust 6 called '*dawn raids*' to find out what's not been fixed. These efforts were generally appreciated: '*Some but not all of the Board are very adept at reflecting and modelling the values of the Trust in their leadership style and behaviours*' [First Line Manager, Trust 4]. '*Highly committed, very supportive and focussed in quality improvement, responding to risks and development of services...*' [Consultant, Trust 4].

Board behaviours

It was reported and observed that the longer serving and more stable boards exhibited greater unity and collective effort in terms of their behaviours. This was described by board members as being on the same side, not trying to catch executives out, and building close relationships with the senior clinical leadership of the trust, as well as being challenging, in an interrogative rather than in a confrontational way. This was the subject of probing at a CQC visit, which was not well received: '*Maybe I'm over sensitive- there was a slightly veiled positioning about you're daft to trust people, we shouldn't use trust as a currency, whereas I always thought exactly the opposite*' [Medical Director, Trust 3].

Challenge by non-executive directors was expected, especially from the more recent appointments, and generally welcomed by executive directors. A view was expressed that they could be even more testing. Chairs were keen to coach NEDs to be appropriately challenging and, in one example, played devil's advocate to provoke the expression of alternative perspectives.

One of the public board meetings observed was very stage managed, with no questions from the public and little cross-questioning, but it was directly followed by a governors' meeting in which executives fielded a wide range of questions. A board meeting at another trust was quite low energy and formal with little challenge from NEDS, and the meeting at a third also

demonstrated fairly low challenge from NEDs. The discussions at the board meetings of the other three organisations were more spontaneous and spirited but challenge was nearly always congenial and supportive.

Box 6: Summary of observations of board meeting at Trust 2 in July 2016

At the board meeting we observed a predominant focus on monitoring of performance data, calling for more information and holding the executives to account. Much time was spent on reporting on and gaining assurance about workforce, mortality rates in particular specialties and patient safety issues (e.g. management of deteriorating patients). Finance and performance came later in the agenda. There was not much attention paid to strategy and no monitoring against strategic objectives. There was a debate about the tactical (to meet RTT) vs strategic approach to outsourcing work to the private sector. There was little reference to the local health and care landscape except in relation to the STP. There wasn't a pervading sense of representing the public or stakeholders and the trust values weren't invoked in the course of discussions. However in relation to the patient story (about lack of compassion in relation to a minor planned operation), the medical director mentioned Francis when commenting that compassion had got better in emergency care and less so in elective care. The response from the chief nurse was notably un-defensive and robust in calling for the surgical team to 'step up'.

There was a clear division between executive directors and NEDs with regard to board roles and contributions ('you' rather than 'us') and not a strong sense of collaboration amongst the NEDs. The DOF stepped out of her functional role to comment on the role of porters in compassion in relation to the patient story. The NEDs questioning style varied from strongly interrogative ('*I want assurance*' as one NED put it) to much quieter approaches. We witnessed examples of EDs supporting each other to manage NED challenges and close working relationship between CN and MD. The chair was not particularly interventionist or involved in the substance of agenda items but closely sighted on inviting contributions from all. When they did put a question it was framed in a supportive (c.f. stewardship) way but was responded to within an agency framing by the ED.

We observed strong nurse leadership in four out of six cases, both internally and, to some degree, externally focussed. It was suggested that the re-ordering of priorities (and board agenda items) since Francis, with a greater emphasis now on quality of care, had provided the opportunity for the chief nurse to take up a more visible and prominent role as a trust leader. As the chief nurse in Trust 3 put it, her role is '*pricking the conscience of the board continuously*'.

We also observed variable contribution of executive directors beyond their functional role (for example finance directors commenting on issues arising from the patient story). These contributions had a marked impact and other board members listened carefully. Otherwise, contribution at board meetings by executive directors was generally dependent on the board agenda item. Actively supportive relationships between medical directors and chief nurses was noted – when examples of this occurred, it enhanced messages to the board about quality and safety.

The chair and CEO in all case study sites set a tone that was calm, inclusive and thoughtful. In most cases the chair was also careful to draw in contributions from all board members and encourage executive director challenge as well as asking questions of their own. In one case the chair tended to summarise the agenda topic rather than to invite contributions.

Relationships between the board of directors and the council of governors at all five foundation trusts appeared to be, on the whole, close, mutually respectful and supportive and, in one, vibrant and highly engaged. We witnessed differing degrees of challenge by governors towards the board of directors. There had been different histories of relationships in the trusts, including a legacy of distrust in more than one that executive teams appeared to have worked hard to overcome.

Board development

Three of the boards described extensive board development activities.

Trust 2 commissioned a nine month board development programme in 2016 in order to build a closer bond between board members (especially between executives and NEDs) and to ensure rigorous scrutiny from a platform of strong and respectful relationships. The main

reported impact of this so far has been that members have gotten to know each other better and behaviours have become more cohesive across the non-executive director and executive director constituencies - still appropriately challenging but *'less of us and them'* [Executive Director, Trust 2]. There has not yet been an agreement on actions about what the board might do differently in future.

Trust 4 has undergone a board development programme over two years using an internal OD team for facilitation and sometimes an external person. The board benefitted from choosing, *'rather than having it done to us'* [Non-executive Director], to have one of the early Well-Led reviews; the exercise proved to be a timely reminder that self-assessment can often be more generous than external assessment.

Trust 6 had also commissioned board development from an external provider, focussed closely on the CQC Well-Led domains. A different external provider was providing leadership coaching for the executive team.

6.6 Board efforts in relation to putting patients first (including Duty of Candour)

Structures for hearing about and responding to patient experience were in place in all sites. Initiatives were further advanced and more embedded in some organisations than others; sometimes this reflected the different starting points for each of the organisations in 2013. More detail is provided below.

Leads for patient experience were identified in all our case study sites. Processes for listening and responding to patient experiences were more advanced in some sites than in others, where the top priority had been to ensure patient safety because of a recent history of failures in care. Box 7 gives an example of the remit of a patient experience group at one of the trusts.

We heard many examples of where the trust tried hard to put patients first, really listening to their concerns. Non-executive directors and governors were enthused by this agenda. These efforts had, with some exceptions noted elsewhere, a tangible impact on patient experience: *'from a patient's perspective, I mean I've been a regular visitor to the hospital over the past ten years..... and I must say I've seen an enormous improvement in the service provision,*

and I mean across the board. I don't mean just from one particular ward or one particular nurse and so forth. I mean portering, I mean in the cleaning, I mean in everything. And I think it's incredible the way that we mustn't forget that this hospital is improving at quite a rapid rate. And, you know, the last CQC is evidence of that' [Patient and Governor Focus Group Participant, Trust 2]. And this was also attributed to good leadership: *'.... I believe that leadership is working here because I've seen leadership happen at ground level. And to me what that is is when I'm a patient in a bed in a ward, it's that person who comes round to me and says to me, 'We haven't got this today, we can't do this right now, but what I'm going to do about it is—and that's a great illustration. I've seen that happen so many times in the last year. I've seen people take responsibility for what is there within their reach and people be open about these things'* [Patient and Governor Participant, Trust 2].

Box 7: Summary of remit and impact of the patient experience group (Trust 1)

- Chaired by the chief executive since 2012
- Feeds into quality committee
- Examines patient survey data and patient experience feedback
- Contributes to service reviews
- Considers actions on issues identified
- Examples of programmes of work include: outpatient care organisation; patient food; day case care organisation and planning; and arrangements for patient discharge from hospital

The approach taken by medical consultants was important – culture change in terms of putting patients first was seen as difficult when some consultants did not see patient views as having clinical benefit. This was addressed in a couple of trusts by having a medical lead for patient experience. Conversely, when consultants went the extra mile in their care for patients, this had a big positive impact on other staff.

It was reported that the Duty of Candour has been embraced enthusiastically across all sites, either formalising a process that was already in practice or adopted by those trusts who had been the subject of failures of care to win back patient confidence and embed new values. Box 8 describes the approach taken by one of the trusts. We were told that the policy can

make staff feel nervous and for clinicians; being honest with patients in this newly systematic way when things have gone wrong can be a difficult experience for them. The unit and department manager survey findings indicated staff saw the board as strongly committed to the Duty of Candour and that the policy was seen as having a positive impact on learning and development, openness, organisation reputation and patient confidence in the organisation. There remains a residual anxiety about patients and their families, on very rare occasions, having an appetite to refer doctors to the General Medical Council, and armed with more information than they would previously have had. There was also a minor worry expressed that some minor clinical issues could grow out of proportion as a result of the bureaucracy surrounding this policy.

Box 8: Implementation of Duty of Candour policy (Trust 5)

'The Duty of Candour has been supported by the Board. For this Trust there was a need to demonstrate a more open and transparent approach to patient care and responding to concerns. The duty has been helpful in achieving this.' [Board Secretary]

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

The Duty of Candour itself means that there has to be formal monitoring, but the trust has sought to go much further than simply writing apology letters to change the organisation's culture so that there is reflection and learning from what has gone wrong. The trust's view is that acknowledging wrongs to patients and families enables them to work with you to improve things and this can be very powerful – invite them in to work with you and have a stake – see what is wrong and help you to improve it. Generally, patients and the public do want to help and do recognise the pressure staff are under. The latest CQC inspection reviewed root cause analysis reports from serious incident investigations and found that the Duty of Candour was addressed, with specific details of when the patient and/or family were communicated with and an apology was given. Well thought through actions had been implemented to reduce the risk of recurrence.

6.7 Board efforts in relation to staff engagement

Structures for engaging staff were in place in all case study sites. The sophistication and the impact of these varied, and were more related to stability than to size of the organisation. More detail is provided below.

Engaging staff is seen as central to patient safety and quality improvement by all the trusts. Two trusts started from a low baseline in 2013: *'Nobody told them they were good at anything'* [Medical Director, Trust 6]. Efforts were being repaid through better NHS staff survey scores and other positive feedback: *'Nothing [is a barrier to the Trust Board improving leadership]. They seem to listen and make changes. No matter who suggests the*

change. If it is believed it will take the Trust forward, it is acted upon' [Ward and Department Manager Survey Respondent, Trust 5].

Initiatives have included staff listening weeks led by board members, briefings, Listening Into Action, Speaking Up campaign, Schwartz Rounds, staff stories at board meetings, staff awards, a behavioural standards framework and, in three out of six sites, ambitious staff health and wellbeing strategies. The approach taken at one trust in terms of staff engagement strategy is outlined in box 9.

Box 9: Characteristics of staff engagement (Trust 4)

Staff wellbeing, including both physical and mental health, is a high priority. Health and wellbeing services include chiropody, counselling, physiotherapy, complementary therapy, weight loss class, Pilates and trust sports team sponsorships. The organisational commitment to staff health and wellbeing was also acknowledged in the high scores in the NHS Staff Survey.

There are open invitations for staff to take part in Schwartz rounds and sessions that focus on the Berwick principles of quality and safety. The latter are attended by a range of clinical and support staff and focus on excellent practice and also practice which ‘keeps you awake at night’. There are also quarterly staff listening weeks. Relationships with staff side trade union representatives are respectful, trusting, open and robust.

There are staff stories presented at board meetings. There are also a range of staff and team awards which are deeply appreciated by staff: ‘...one of my team won it quite recently and he doesn’t shut up about it...’ [Staff Focus Group Participant]. The employees in the private sector company providing support services are also eligible for staff awards, involved in multi-disciplinary service quality groups and represented in the hospital trade union staff partnership structure.

The survey of managers indicated that generally the board was highly visible to them. This philosophy has found its way through the organisation: ‘from my perspective, you know, if we ever had a problem we could go to our manager, discuss the concerns and they would do their best to support you in that’ [Staff Focus Group Participant]. Despite being very busy, the approachability and helpfulness of ward managers was also praised by other staff.

Communications between senior managers and staff was also highly scored in the NHS Staff Survey (2016) as was, amongst other things, effective team working, opportunities for flexible working, support from immediate managers, and staff satisfaction with the quality of the work and care they were able to deliver. Flexibility of working patterns was also very much appreciated by staff and it was noted that this also meant staff offered flexibility back about finish times if there was a particular problem. Overall, there was a strong sense that staff were ‘lucky’ to be working at this particular trust in comparison with others that some had experience of. There was some minor concern about turnover of managers at divisional level which inhibited the building of relationships.

CQC reports and our research interviews have indicated variable visibility of executive directors in the case studies to front line staff with some indication that this might be improving: *'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'* [Staff Focus Group Participant, Trust 2]. More 'back-to-the-floor' exercises were recommended not just for board members but other senior and middle managers, too. One trust had had a big push on greater board and management visibility following weaker scores on this in the NHS Staff Survey.

Other evidence indicates that, in three of the trusts, the CEO personally had a high visibility. Invitations to make direct personal contact with the CEO are taken up and dealt with diligently but there was a perception that controversial issues are unlikely to be raised.

It was reported by some staff in some of the trusts that the quality of leadership varied across the organisation from *'pockets of real excellence'* [Staff Focus Group Participant, Trust 2] to poor, in particular in some support service departments, described in one case as *'over managed and under manned'* [Staff Focus Group Participant, Trust 2]. Front line staff were not always given the opportunity to engage with progressing the good ideas that had been generated at the top of the organisation and the quality of communication could be patchy: *'with the Trust, you hear things are going to happen and then you don't hear anything else, the communication seems to stay up the top, at the ceiling if you like..... this is why it starts a lot of the rumours off, because the staff don't know what's happening, so you hear all these Chinese whispers, and if they communicated a lot more, I know they're better now, but if it was even better still, there wouldn't be such apathy'* [Staff Focus Group Participant, Trust 1].

In addition to communication weaknesses, other obstacles to greater staff engagement were reported as lack of execution on diversity and inclusion policies, workforce shortages, pressure on staff, redundancies of non-clinical staff (which impacted on the work of others) and the fact that champions in safeguarding type roles were seen as part of the organisation rather than independent from it.

6.8 Patient and staff involvement in quality and service improvement

All six trusts aspired to have quality improvement embedded across their entire organisations; in practice each had some exemplar areas, while other departments and wards lagged behind. Quality improvement efforts were hampered by unclear lines of accountability and facilitated where there was clear board leadership in this area. More detail is provided below.

See box 10 below for an example in one trust, which was mirrored in one other, of staff engagement in quality improvement. Patients were most likely to be involved in the design of new facilities. At least one trust viewed patient and staff involvement in quality and service improvement as a key driver for organisation success. This trust has combined Listening Into Action with improvement tools and techniques using the IHI model for improvement (PDSA cycles), supported by staff training, with and through Gold, Silver and Bronze Improvement Champions. Cross-organisational/STP-wide improvement events are planned. They also have plans for six listening events per annum to ask patients and the public for their ideas for improving services. Users have been involved in interview panels, reviewing quality of services and in the design of new facilities. In another trust, there were huddle boards on the wards for staff and patient panels which were involved in specific service areas, and in a third trust there was mention of patients being called upon to test proposed service changes and to contribute to specification of new service contracts. At this trust there was staff training available at all levels on quality improvement.

Box 10: Staff engagement in quality improvement (Trust 5)

The trust engages staff in continual review and supportive challenge through corporate quality reviews, which provide a balance of positive feedback and ideas for improvement. These reviews began initially as CQC mock visits in preparation for CQC inspections, but have been continued because they were found helpful. The reviews are conducted by teams that involve a range of internal and external stakeholders including staff from neighbouring wards or departments. This provides opportunities for staff to learn both by reviewing and being reviewed. Staff are also encouraged to learn from elsewhere by visiting other

organisations, and recruiting staff externally bringing with them new ideas into the organisation.

Staff are now more empowered so that change and innovation can happen organically without needing to be directed. Staff are also supported by having policies in place and slick administrative systems, automated where possible, to enable rapid response (e.g. complaints). Project management and business cases have been strengthened through training and access to specialist staff support, so that things are done in a more business like way and are delivered. There are also structures and processes for learning and sharing learning.

Improvements were described in one public and patient focus group discussion at another trust as rather *'piecemeal'* [Staff Focus Group Participant, Trust 2]. There were views expressed by staff that where service improvement initiatives do take place that some consider the drivers are as much financial as they were about quality or as a result of a national policy priority, and led either by managers that all too quickly move on, or by external management consultants.

It was reported that some trusts and representatives of some healthcare professions still have a habit of talking to patients rather than involving them in improvement work.

It was reported that managers were not always good at listening to frontline staff views about how to improve services or reduce waste. Support for staff and teamwork in some departments is excellent and reported in others to be non-existent. This also varied between trusts, with some seeing staff engagement in improvement activities as core to the trust's strategy.

Initiatives can be hampered by a lack of a clear line of responsibility and accountability: *'there was no-one really identified as being accountable and responsible for carrying it [a particular project] forwards, and that can be really frustrating. There might be people with good ideas, but it's harnessing it and getting someone to lead and go with it....So I still don't know who – how that's going to go forward and how that's going to happen. There's some good ideas and a lot of the things are out there and can be done, good intentions'* [Staff Focus Group Participant, Trust 2].

6.9 Costs of implementing leadership changes since Francis

Increasing leadership costs (as distinct from staffing costs) since 2013 did not feature prominently in views expressed in our interviews. We had some difficulty in obtaining the specific financial costs of implementing leadership and governance changes following Francis from the case study sites as these hadn't been recorded in this way and were often seen as necessary improvements. We were however able to gather some information, as described below.

In five out of the six trusts, there was a deliberate policy by the board, led by the CEO, to put quality first: – *'in that first three months (in 2013) we set down a trajectory to basically break the bank. in the last three and a half years we've gone from 106 consultants to 155 in a time when everybody in the Health Service is saying there's no money....we've increased nurses by 20%. I mean yes, it's showed on the quality metrics side massively and yes, it's showed on the financial side massively'* [CEO, Trust 2]. Three trusts reported that staffing costs went out of control.

Five of the trusts have commissioned a series of leadership development programmes – for boards, clinical leads, newly appointed consultants, deputy heads of service and for the board.

Incident reporting has increased and this is a burden in terms of investigating and supporting staff during the investigations but is also considered to be a symbol of an open and learning organisation culture. Similarly complaints handling is a large amount of work.

In addition to the decision to invest in additional frontline staff, the following were noted as additional management costs (not necessarily perceived in a negative way) in the interviews and in the managers' survey:

- Increased training and development of staff
- Health and wellbeing services
- Increased governance arrangements, including the costs of implementing Duty of Candour
- Extra committees: *'ever increasing burden of meetings...'* (Senior Manager)
- Increased scrutiny (the positive impact being improved quality structures across the divisions and an Outstanding CQC rating)

- New job descriptions to reflect importance of Duty of Candour and patient experience
- Volunteer support

Most respondents highlighted that these additional management costs were desirable investments, rather than being unnecessary or particularly financially burdensome.

One of the stakeholder interviewees alerted us to the possibility that damages paid out for failures of care was likely to increase following the implementation of the policy of Duty of Candour. We therefore looked at payments made by the NHS Litigation Authority over recent years. Payments have increased (see table 14 below) but it is difficult to ascribe any particular reason, as processing of claims has recently been speeded up. There was no pattern or trend in our six case study sites that could be linked to actions taken by senior leadership at the trust in the years following 2013.

Table 13: Total CNST payments in £million made by NHS Litigation Authority = Damages + defence & claimant costs in £millions

(Source: (NHSLA 2016))

NB 45% is for maternity / birth harms

| Trust | 2013/14 | 2014/15 | 2015/16 |
|--|----------------|----------------|----------------|
| Trust 1 | 5.9 | 8.0 | 5.6 |
| Trust 2 | 2.5 | 3.4 | 6.7 |
| Trust 3 | 7.1 | 11.1 | 9.5 |
| Trust 4 | 0.53 | 1.3 | 3.4 |
| Trust 5 | 4.5 | 9.6 | 11.0 |
| Trust 6 | 13.3 | 15.7 | 13.2 |
| S/H interviewee* trust | 4.8 | 5.3 | 6.3 |
| TOTAL across all NHS trusts in England | 1.051 billion | 1.169 billion | 1.488 billion |

NB TOTAL for 2010/11 = 1.095

For 2011/12 = 1.117

*The stakeholder interviewee (trust medical director) who alerted us to the possibility that payments would be going up as a result of implementation of Duty of Candour and had in his trust

6.10 Organisation culture (including degree of openness)

Board members in all the trusts emphasised the importance of an open culture. This was acknowledged as being hard work to achieve and more likely where communications, systems and processes were reliable and with consistent role modelling by board members. More detail is provided below.

There was much evidence in all our case study sites that a vision for the organisation, including the values and strategy, were developed through consultation with staff and patients. PRIDE (Passion, Responsibility, Innovation, Drive and Empowerment) as a set of values was important in two of the organisations. In other trusts, there was evidence that the promulgation of organisation values had somewhat lost momentum recently, particularly in the light of current service pressures.

In all the trusts, we identified overall a culture of greater openness, exemplified by a change in attitude over time towards CQC inspections in the case of one trust which had been in special measures:

'The best way to describe the culture might be the example of CQC inspections ... The first one, everyone was worried. The second one, people were less worried and were thinking, I wouldn't mind if they came in and I could tell them about what we're doing. In October they were like, so where are those inspectors? I'm going to find them and tell them about the great stuff that we're doing. So it was quite ballsy actually, the culture, ballsy and on its uppers, really positive about what it was trying to do differently and showcase the really, really good things. Over time, it's about saying, we've learnt from that, we're respectful of what happened, but we're not ashamed of it because we've learnt from it. And now, actually, we are prepared to tell

you everything that's good about the organisation.' [OD and Workforce Director, Trust 5]

Although as we referred to above, significant importance is attached to staff morale and staff engagement, interviews in some of the trusts suggested there was a fine line between supporting staff and driving much needed transformation in performance and quality. In trusts on an improving patient safety trajectory, it was reported that at times an autocratic style was needed to correct unacceptable levels of performance, together with an acknowledgement that it had to be used sparingly. The legacy of having been in special measures, with staff reportedly too frightened to report incidents, was that there was a level of anxiety in this organisation.

There was a strong sense at another trust, which also had patient safety problems, that the staff were bound together as comrades in adversity, especially when being criticised by external parties. This trust and one other also had a strong family feel; a drawback was that this meant that the culture came across to some as quite old fashioned in modern hospital facilities.

Board members in nearly all the trusts report a strong emphasis, energy and enthusiasm on being a learning organisation. Patient representatives in one trust made a plea for this to be more visible as they weren't aware how lessons were learnt after mistakes were acknowledged. There was also a plea for greater visibility of and delegation to middle management: *'I do think that there's also scope within the leadership team for more emphasis to be placed upon heads of departments and more involvement – for those people to be more visible because they are quite hidden at this moment in time'* [Patient and Governor Focus Group Participant, Trust 2].

Some patients in our focus groups reported that staff were being more open, whilst others reported a perception that clinical staff weren't always being upfront with them about problems or details about their current clinical conditions on the basis that they wouldn't understand.

Patients reported a greater openness over recent years on the part of nursing and medical staff to explain and share clinical problems that patients and those caring for them were facing. Equally it was clear that one of the boards in particular aimed to conduct as much business in public as possible, to be open and to avoid a paternalistic culture. Respondents indicated that

some board members can be nervous especially in relation to papers reporting on serious incidents and independent investigations. There are perceived limits to the board's commitment to transparency and openness.

As reported above in the section on staff engagement, communications, systems and processes were reported to be unreliable or slow at times and the quality of documents underpinning trust governance was observed as variable. One trust had put a deliberate emphasis on having strong processes to ensure follow-through.

As reported above, the CEOs at five of the six trusts were instrumental in setting the tone. At one of these, they '*...set the heartbeat for the organisation*' [Finance Director, Trust 1] and there was a concern about how that might endure after this person had left.

Box 11: The role of the board in shaping organization culture (Trust 3)

The response to Francis was presented under a set of values, which already existed, in order not to confuse staff: '*because the NHS is full of initiatives, and then, and actually in the end you go from one to another, and your poor nurse, student doctor, porter, housekeeper haven't got a clue what's going on and doesn't understand the language*' [Chief Nurse].

The trust values had been around since 2006, but '*sat on posters and cups and haven't meant anything to anybody really*', but a patient centred care campaign brought them alive.

The notion of culture was spoken about frequently in interviews, and, from a leadership perspective, the importance of role modelling of senior leaders. The chair described the central role for the board in relation to culture: '*there's an ambassadorial function for the board in relation to the cultural values of the organization.... so living out the values of the organisation.*'

6.11 Reflections on the legacy of the Francis Report

There was a strong message from two of the trusts that Francis was a wake-up call, and it could have indeed been them in the news. Two others described Francis as fitting well with

the direction of travel they were already going in. The final two were subject to external regulatory interventions in 2013, which were both a shock and a spur. Berwick was seen as a positive driver to stimulate thinking and take action on engaging staff in service improvement. More detail is provided below about case study respondents' views on the prospects for and threats to the legacy of Francis.

For one trust, the relative proximity to Stafford was considered to be an enabler for implementing Francis recommendations, as the issues felt close by and very real. For three of the trusts, external regulatory intervention, although a shock and difficult, was also reported to have been a key enabler, supported by the work of CQC. Interviewees at one of these trusts described how the external scrutiny had galvanized them: *'actually we're not as bad as the papers make us out... And there's been a push to start proving that'* [CEO, Trust 1].

Local enablers included having good working partnerships and commissioners who listen. There was also a view that involvement in STPs was having a beneficial impact on external relationships in the local health economies.

Across five of the trusts, the leadership of the CEO was also seen as strongly helpful in setting the tone for the implementation of the Francis recommendations.

The interviews and survey of managers (more about which is in section 6.12 below) reported the following internal enablers to improving leadership:

- Training and development at every level
- Having an effective and cohesive team
- Collective leadership programme and PRIDE (both mentioned many times)
- Personal rather than email communication
- Highly organised and structured way of doing things
- Action plans that are followed through

On the other hand, all the trusts described an external environment that had the potential to undermine the progress made in the wake of the Francis Report. This included the sheer volume of multiple policy initiatives, seen as impeding progress on improving patient centred care: *'I think certainly in this trust there seems to be far too much effort put into pilots and projects that are never really seen through rather than actually focusing that time and energy*

onto genuine improvements in customer care' [Staff Focus Group Participant, Trust 2]. It was also reported to us that leaders and staff were under strain to address criticism (e.g. from the media) and the bureaucracy of regulatory oversight was also constraining because of the need to provide '*endless external assurance*' [Staff Focus Group Participant, Trust 5] as people came and went in regulatory organisations, commissioners and NHS England. The pressure from external agencies was described as sometimes overwhelming, with a confusion between support for improvement and punitive grip: '*It's a weird mix of more bureaucracy, more governance, more grip, more you must do versus complete chaos actually, and ambiguity and guidelines coming out left right and centre*' [Dir OD, Trust 3].

Other issues mentioned include the lack of consistency between NHSE and NHSI, which is '*unhelpful and damaging*' [CEO, Trust 6], with NHSE encouraging collaboration via the STP, and NHSI insisting on hitting the financial control total, regardless of the money available in the CCGs.

Although elsewhere the intervention of the CQC had been seen as an enabler for improvement, the regulator came in for criticism from one trust, especially the continual focus on a narrow number of indicators and micro-detail. The impact of the CQC inspection in this organization was not positive, despite the Good rating overall: '*we had staff in tears about how they were spoken to, because they were basically accused of lying because they were saying positive things*' [OD Director, Trust 3]. The observation was made that this sort of inspection was not in the spirit of the Francis Report recommendations. At another trust, CQC and other external regulatory interventions were seen as producing a 'fear factor'.

Whilst delayed transfers of care and the shortage of social care funding came up often, the weakness of local primary care and other community health services was cited as a barrier at only two of the trusts. But more generally, staff pressures and financial challenges for boards felt, to some, that the NHS is at a watershed: '*I do worry that we're about to lose every bit of the legacy that Robert Francis could leave*' [Chief Nurse, Trust 3].

Both staff and board members indicated that stable board leadership was critical, and there had been, at the time of Francis, a lack of leadership capability in two of the trusts. This was not cited as an issue currently on the executive side, but two of the trusts commented that it was hard to recruit non-executive directors of high calibre. The quality and visibility of the middle management tier varied and this had a significant impact on the delivery of the Francis agenda.

6.12 Trust middle-management surveys

Three of the six case-study sites (Trusts 1, 4 and 5) agreed to distribute a link to a questionnaire aiming to gather opinions from middle managers (for example the leaders of departments and wards). In Trust 6, the survey link was distributed to a small number of middle managers late in the project. The questionnaire included some items from our national, board-level survey, and also many free-text items to capture some richer responses to supplement data gathered in the interviews and focus groups.

Respondents

A total of 91 middle managers largely completed the survey. The modes of distribution make determining response rates difficult; see table 14 below for details of numbers of respondents. The sampling frame was very small in Trust 6; the handful of text responses were fed into the information for the case, but no further analysis was done. For the other three case studies, we estimate the response rate to be very roughly 50%, with nearly 50% of these providing mostly-complete responses (the others supplying only demographics, or little beyond that). Therefore we estimate the completed response rate to be around 20-30%.

Table 14: Middle-manager survey: respondent numbers and percentages

| Trust | Sent to approx number | Demographics | | Mostly complete | | |
|-------|-----------------------------|--------------|-------------------------|-----------------|-------------------------|-----------------------------|
| | | number | approx % of total | number | approx % of total | approx % of responses |
| 1 | 200 | 85 | 43% | 39 | 20% | 46% |
| 4 | 60 | 37 | 62% | 18 | 30% | 49% |
| 5 | - | 70 | - | 30 | - | 43% |
| 6 | - | 20 | - | 4 | - | 20% |

We asked respondents to give their job role (free text) and self-identify as a *first-line* or *senior manager* or *other*. Typical titles for ‘*first-line managers*’ included titles like lead

nurse, head/manager of department/service, team leader and clinical consultant. ‘*Senior managers*’ included matron, deputy director/deputy chief, director, head of function (nursing, estates, service improvement, communications etc) and directorate manager. ‘*Others*’ included clinical consultants, educators and district nurses. There was, of course, overlap, in particular there were clinical consultants who self-identified in each category. Roughly a third were senior nurses or nurse managers.

Findings

The primary aim was this supplementary information-gathering rather than statistical testing or model building.

Amongst the quantified items, of particular relevance to the discussion in this report are the middle managers’ perceptions of:

- Training opportunities
- Their board’s commitment to the Duty of Candour, openness and transparency
- Encouragement to innovate

There were very few responses from Trust 6 on these items (four or fewer), so only the data for Trusts 1, 4 and 5 have been included.

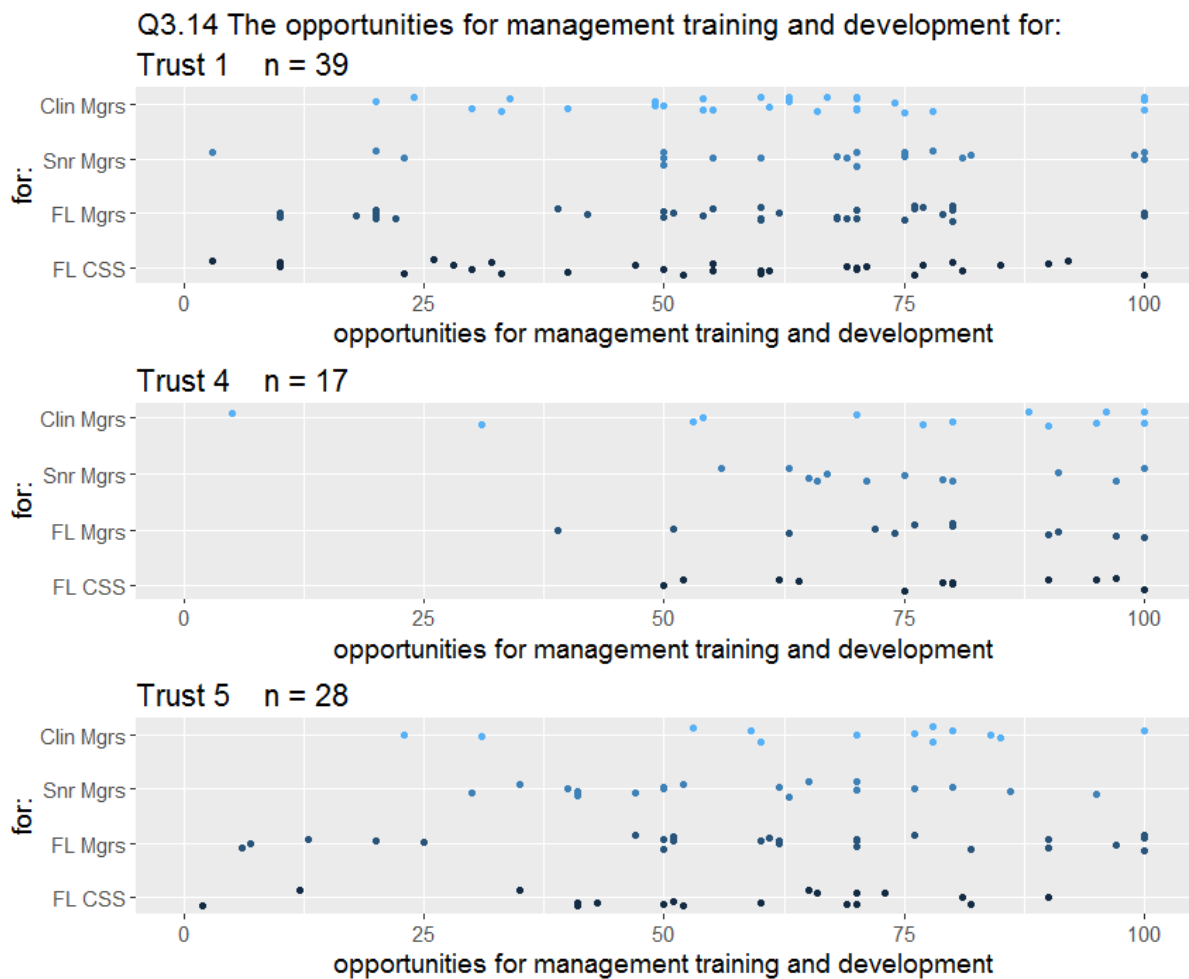
On training opportunities, Question 3.14: was

‘How do you rate the opportunities for management training and development for staff (of four types) in this Trust? (0 = Not good at all, to 100 = Extremely good)’

In Trusts 1 and 5 it is remarkable how dispersed the responses are, from poor to excellent, (see

Figure **11** below).

Figure 11: Middle managers’ perceptions of the opportunities for management training and development in their trust



Clin Mgrs = clinical managers Snr Mgrs = senior managers FL Mgrs = front line managers
FL CSS = front-line clinical, scientific and support staff

On Board commitment, Question 3.18: was

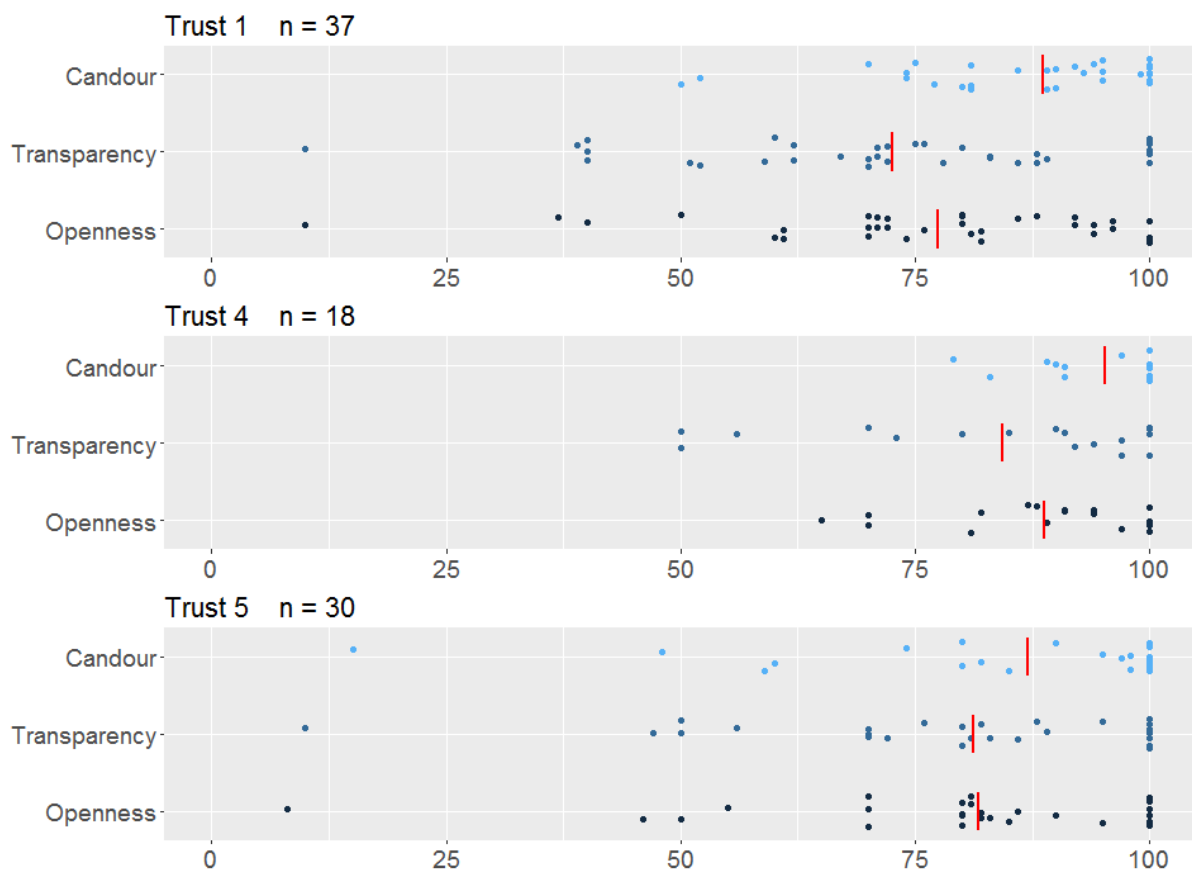
‘In your experience how strongly is the Board and senior management committed to the following:

- Openness (allowing concerns to be raised and aired)
- Transparency (sharing of information)
- Candour (ensuring that patients who have been harmed are informed of the fact)

(0 = Not at all committed, to 100 = Extremely committed)’

The responses are shown in Figure 12. The vertical lines indicate the means. For Trusts 1 and 4, board commitment to candour is perceived as materially higher than transparency and openness. For Trust 1 this is robustly statistically significant (using the Kruskal-Wallis test with Conover-Iman post-hoc comparison with Bonferroni adjustment). For the other two trusts, though candour is higher, the difference fails to reach the threshold for statistical significance with samples of these sizes (though note the small sample size for Trust 4).

Figure 12: Middle managers’ perceptions of their board’s commitment to Duty of Candour, openness and transparency

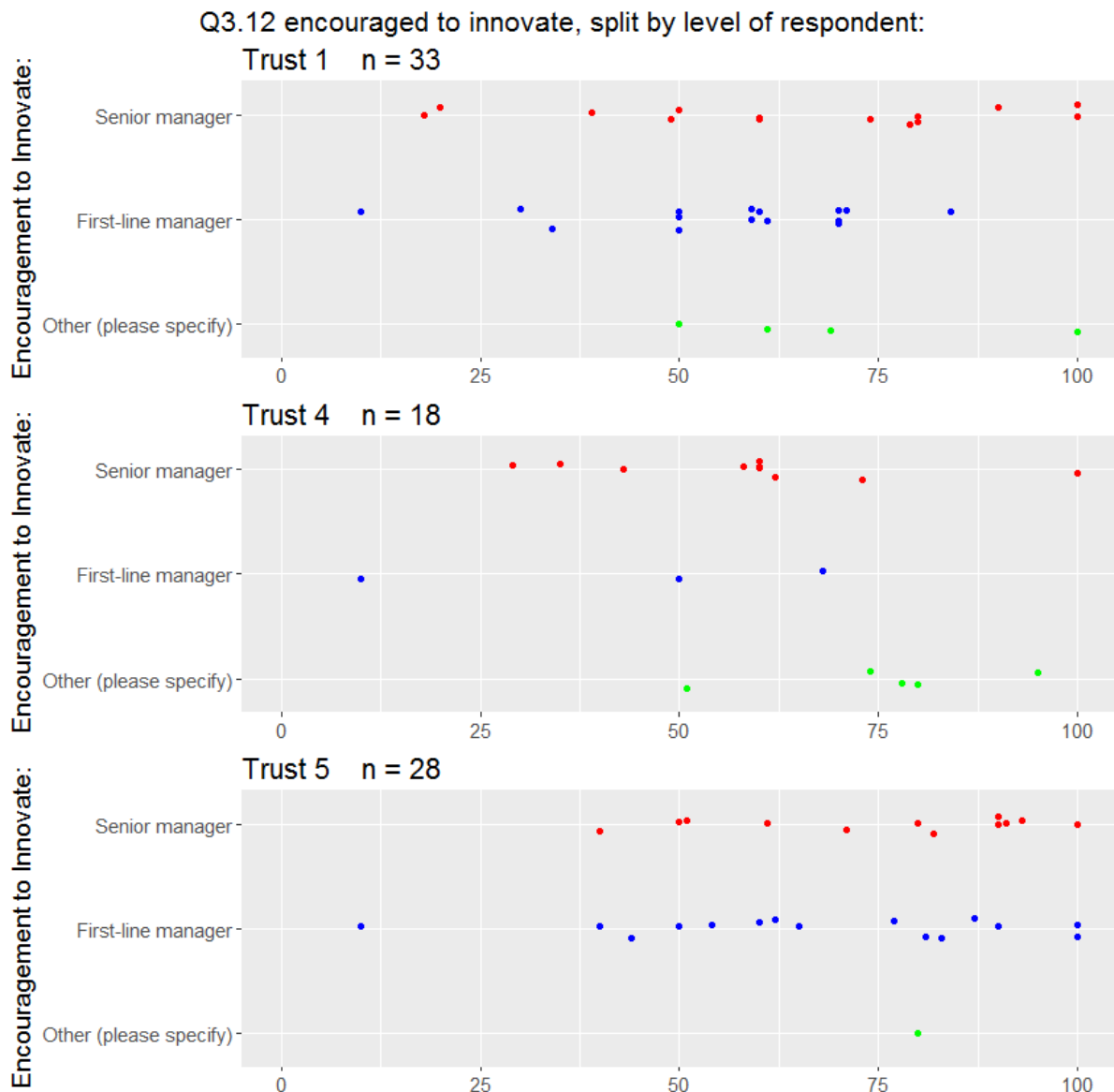


On encouragement to innovate, Question 3.12 was:

‘To what extent are frontline staff and managers encouraged to innovate to do things differently, by allowing them to make decisions and take reasonable risks? (0 = no encouragement at all, to 100 = very strong encouragement)’

The survey indicated there is great variety in the middle managers' perception of this (see Figure 13), and there is little difference between the views of the (self-identified) 'first-line' and 'senior' managers.

Figure 13: Middle managers' perception of the extent of encouragement to innovate in their trust



With regard to additional text comments volunteered by the survey respondents, there is very little specifically about board improvement initiatives. On the other hand there were many comments more broadly on organisational leadership. These are summarised below under the

themes of leadership strategies, structures, styles and culture, financial and non-financial costs of improving board and organisational leadership, and strengths and weaknesses in board and organisational leadership.

Leadership strategies, structures, styles and culture

Middle managers at Trust 1 reported a generally good and open relationship with board level leaders, with increased transparency through reports and feedback to staff, and respect for the clinical staff. It was felt that a lot of effort had been put into direct communication from the CEO (talks, newsletters, Listening Into Action, away days for consultants). The leadership style of the recently-departed CEO was felt to have left a lasting legacy. There were mixed reports on visibility. There was praise for how visible, open and approachable the CEO had been and some reports of visibility and a visit by the chair (much appreciated) and staff awareness of names and faces, however many reports of there not having been any visits to departments and community sites. Whilst many members of the board acted as good role models, there were some suggestions that this was deteriorating and when under pressure some of the board exhibit negative behaviours (for example, belittling, disempowering). Several staff talked about a cohesive and ‘can do’ culture with engaged and empowered staff and an upbeat patient focus, with staff embedded in ‘old style’ culture leaving. However, others talked of deterioration recently, with strong leadership and board visibility in nursing deteriorating, and some suggested the trust’s focus appeared to be increasingly about money and capacity.

At Trust 4 the board were felt to be visible; seen around the hospital, they chatted with staff, and could be found when needed. (It was noted that it is a small trust). Changes at board level since Francis included: restructuring of board, clearer terms of reference, annual audit of compliance for all board and sub board committees; changes to job descriptions to include clearer Fit and Proper Person and Duty of Candour elements; introduction of new roles such as Freedom to Speak Up Guardian and restructured committees to ensure that all information is passed up to the board. Members got involved in staff and patient survey data collection. The majority of the board were felt to reflect and model the values of the trust in their leadership style and behaviours. Recent changes had overcome deficiencies of some board members who had ‘development needs’; things have improved, including moving away from a ‘slightly catastrophizing’ style of medical management. Leadership was now very

professional, receptive to innovation or concerns. The trust board always listened to the clinical staff, and now there is further increasing staff engagement with regular clinical senates. At Trust 4, staff credited the following as having helped to improve leadership from the board: changes to the executive team, board development sessions, collective leadership approach to quality and leadership and an open culture (open to ideas and opinions from staff at all levels) as foundations for the quality and patient safety strategy.

At Trust 5 (as at others), middle managers reported that governance was felt to have improved greatly and to have increased performance of the trust.

At Trust 6, respondents reported that the current chief executive had engaged first line managers and tried to engage clinical and other staff. There was a greatly improved culture of transparency and openness, honesty and freedom of speech, empowerment, drive, staff recognition and innovation. However, there were views that engagement may be focused on certain groups and not sustained, and that leadership visibility was more in the form of social media, with the previous monthly executive rounds are now less frequent.

Respondents had suggestions for improvements to board level leadership. At Trust 1 there were ideas for better communications between the board and the frontline: for example, a quarterly forum with members of board for staff to access and discuss any issues, and confidential focus groups for shop floor staff with board members to discover what is really going on. Similarly, at Trust 4 it was proposed that there was more interaction with service frontline staff. Trust 6 respondents indicated that engagement needed to be wider, deeper and more sustained.

Financial and non-financial costs of improving board and organisational leadership

At Trust 1, it was reported that there was generally no additional budget specifically allocated for improving leadership. There was, on the other hand, indication of investment in training, time outs, wellbeing services, Schwartz rounds, staff awards, management time on governance and patient safety summits.

Trust 4 respondents similarly reported that improving leadership was contained mainly within current resources, including requirements to attend study sessions, investment in an E-portfolio, more committees and scrutiny.

At Trust 5, as at others, it was noted that there was more staff to ensure safer staffing levels and more trained night staff. There was one suggestion that this was cost neutral as it brought down absence rates due to stress and bullying. Respondents at this trust reported pressure for short-term cuts (including to safe staffing) starting to reappear.

Respondents also noted a large growth in their corporate governance departments, costs for internal and external engagement events and significant spend to improve services and equipment to respond to regulators.

Strengths and weaknesses in board and organisational leadership

At Trust 1, middle managers commented positively on the creation of a trust slogan and vision and values, new senior team briefings and support from the board for leadership courses. There was a widespread perception that governance structures had greatly improved. At Trusts 1 and 4, staff noted that allied health professionals (AHPs) were not represented or visible at board level.

At Trust 5, many reported no barriers to the process of improving leadership. A few, on the other hand, mentioned the risk of the dilution of messages from the board due to middle-management filtering, and often still being target driven rather than quality driven. Executing a change of trust culture from 'heavy touch' management required to bring the trust out of special measures to the light touch management style required to encourage innovation and development was considered to be a work in progress.. There was a sense of being pulled in different directions by middle managers and by board level leaders.

The few respondents in Trust 6 considered it a strength that the organisation culture allowed for discussions in a non-critical way, so as to explore innovative ways of working towards improvement and the provision of safety summits to discuss incidents. Weaknesses included lack of stability, particularly too many management staff not remaining in post for longer than two years, too much top down leadership and too many decisions made without engaging those who work on the floor and who have the clinical expertise.

In conclusion, there are some clear messages emanating from the 91 middle managers in our survey about their perceptions of desirable leadership. These included prioritising training and development at every level, building effective and cohesive teams, preferencing personal over email communications, insisting on organised and structured ways of doing things and having action plans that are followed through. These are also amongst the themes that have emerged from the fieldwork as a whole that we conducted across our six case study sites which we recap below.

6.13 Summary of findings from the case study sites

We now summarise the main findings against the five research objectives as set out in table 4 in our methodology chapter.

1. To identify, describe and assess how boards have sought to implement recommendations on organisational leadership since the publication of the Francis Inquiry Report

There was evidence in all case study sites of a broad range of actions instigated by boards immediately following the Francis Report in 2013, especially focussing on patient experience and staff, which we have been able to chronicle in some detail. Longer term, we discerned the spirit of Francis living on in ongoing work programmes to improve patient experience and staff engagement, as well as the continuation of specific actions such as the implementation of the Duty of Candour.

2. To determine which mechanisms used by boards have led to reported organisational/service changes, and the factors underpinning such change

We found evidence to demonstrate there had been a step change since 2013 in the seriousness with which trust boards took matters of quality and safety. The efficacy of immediate and longer term responses by the six trusts varied. The robustness of governance, communications and administrative systems and processes, the credibility and drive of the CEO, medical director and chief nurse and the quality of middle management had a bearing on the ability of senior leadership to execute desired improvements. Stability of board leadership was also associated with these organisational attributes. Respondents to our survey of middle managers felt particularly strongly about the importance of consistency of

messaging by board level leaders and about the impact of poor middle management, a cadre which they are, simultaneously, both part of and immediately affected by.

3. To explore the intended and unintended effects

There was a strong message from two of the trusts that Francis was a wake-up call. Two others described Francis as fitting well with the direction of travel they were already going in. The final two were subject to external regulatory interventions in 2013, which were both a shock and a spur. Generally speaking the actions taken by boards in the wake of Francis were viewed as resulting in a more open organisation culture. Implementation of the Duty of Candour has been part of that journey. Middle managers of the three trusts where we were able to administer a ward and department managers survey reported that the commitment of their boards with regard to candour (ensuring that patients who were harmed were informed of the fact) was generally higher than their commitment to openness (allowing concerns to be raised and aired) and transparency (sharing of information).

Berwick was seen as a positive driver to stimulate thinking and take action on engaging staff in service improvement, although none of the case study trusts had, by the time of the close of the fieldwork, been able to implement a culture of quality improvement comprehensively.

4. To examine the financial and non-financial costs of developing and implementing actions

Increasing leadership costs (as distinct from staffing costs) since 2013 did not feature prominently in our interviews. There was some concern about the time costs in preparing for CQC visits but others welcomed the challenge that inspections brought to the organisation to raise their game. There were also mentions of increased bureaucracy around implementing the Duty of Candour. Other costs, for example on board leadership development, staff training, and improved governance arrangements were considered to be justified.

5. To identify the enablers of and barriers to implementation

The main enablers were seen to be organisations with a stable board, visible senior leadership who consistently modelled behaviours that were congruent with trust values, good governance, communications and administrative processes, and an empowered, capable cadre of middle managers. Barriers were the absence of these things and, additionally, unhelpful and sometimes conflicting interventions by the different national bodies. On the horizon, too,

and more to the fore towards the end of our fieldwork, were issues connected with workforce shortages, social care funding and primary care capacity to deal with increasing demand. In conclusion, all the trusts had a number of strategic priorities including patient safety, finances, dealing with regulator demands, workforce shortages, long-term organisation sustainability and working productively with their STP. All boards had developed or revised a raft of policies since Francis, including in the handling of complaints and serious incidents, listening to patients and staff engagement. Policies and practices of listening to and acting on patient feedback were further advanced than partnering with patients to improve care. Duty of Candour was reported to be well embedded and to have led to greater openness and patient confidence. Board members in all trusts were exercising leadership that was more visible to staff and patients. There were notable differences between the case study sites. Only one board demonstrated excellence in equality and diversity. It was noteworthy that this trust served a predominantly poor white population, although it had a diverse workforce.

More stable boards, with lower turnover of members, were able to act in a more unitary way. The space created on boards for strategic thinking varied. A culture of quality and service improvement was emergent and variable. Managing the demands of national bodies was challenging. Some trusts had experienced the intervention of CQC as supportive and others had less positive experiences. Perceived variable quality of middle management and of ward and department level teamworking acted as a barrier to implementation of policies associated with Francis. The emphasis on quality following Francis may have provided an opportunity for the leadership role, sphere of influence and profile of the chief nurse to become more prominent on some boards. There was considerable variation within trusts too. For example the middle managers in the ward and department managers' survey that we were able to conduct at three of the sites reported significant variation in training and development opportunities and in encouragement they were given for innovation.

What contextual influences accounted for some of these differences? Variations in the perceived quality of middle management, quality of teamworking, the embeddedness of quality improvement, the stability of board membership and the self-assessed strategic competence of the board were associated, in three of the four cases, with those organisations which were on an improving trajectory. And in two of these four cases there were also reported concerns about the robustness of governance systems and processes. This indicates the sustained hard work, over an extended period of time, that is involved in the leadership

effort to take organisations out of trouble. It also suggests a context that national bodies need to be aware of as they performance manage and support these fragile organisations.

7 Analysis, synthesis and discussion of findings

7.1 Summary

This chapter draws together the findings from work packages 1, 2 and 3 of this research study. We start by summarising the key actions that have been taken by boards to implement the recommendations of the Francis Inquiry and the subsequent reports including those by Berwick (NAG 2013) , Clwyd (Clwyd and Hart 2013), Kirkup (Kirkup 2015), Francis 3 (Francis 2015) and Carter (Carter 2016). We then assess the impact of those actions, the evidence for improvements in board leadership, the narrative around financial and non-financial costs of implementing Francis, the reported and observed barriers and enablers in implementing Francis and, finally, the implications for healthcare board governance theory. The following four sections in this chapter correspond to four of our five research objectives outlined in chapter one. The final chapter addresses the fifth research objective which is to assess the implications of this study for policy and practice and further research.

7.2 Actions taken by boards

(Research objective 1: To identify the different ways in which the boards of NHS hospital trusts and foundation trusts have sought to implement the recommendations on organisational leadership set out in reports following the publication of the Francis public inquiry)

In our scoping phase, national opinion leaders and formers told us that responsibility weighed heavily on boards after Francis. These interviewees said they would expect to see a full programme of work to improve quality, staffing, safety, patient experience, complaints handling and staff able to raise concerns. From the national survey and case studies, boards asserted to us that they had risen to that challenge, providing energetic and comprehensive responses. Over half of board secretaries responding to our national survey said that their trusts had not newly established any of these policies since Francis, while a much smaller number had established five or more new policies and the numbers of actions also varied. This suggests some polarisation, with a raft of new policies formulated in some trusts, and few in the majority. Establishing at least one new policy was associated with having a lower

CQC Well-Led Rating at the time of the survey. This suggests that post 2013 the boards of organisations with a legacy of lower performance may have been making conscientious attempts to narrow the gap by adopting policies and practices that others already had in place and implementing recommendations of the above named reports. And it suggests the benefits of regulatory intervention for struggling trusts. We also observed this levelling up in three of the six case studies that had had regulatory intervention or failures of care that had come to light between 2012-2014. The following sections will consider the extent to which these efforts have been sustained and what impact they have had.

7.3 Impact of Francis and of actions taken

(Research objective 2: To find out which mechanisms used by boards of NHS trusts and foundation trusts have led to reported improvements (or otherwise) in local organisational strategies, structures and culture, and the factors underpinning such progress)

This study has identified a number of impacts of the actions taken by boards following Francis and the suite of reports that ensued. We have grouped these into five areas: patient experience, staff engagement, openness (including Duty of Candour), improving the quality of care and improving governance. We would like to add a cautionary note – some of our findings relate to self-reported impacts and we are aware from upper echelons theory (Hambrick 2007) that executives' experiences, values, and personalities colour their interpretations of the situations they face, their influence and their contributions. We also know that board members in the healthcare sector can also overestimate the quality of care in hospitals that they oversee (Jha and Epstein 2013). We have sought corroborative evidence from other sources to mitigate this problem and highlighted this where this has been possible.

Patient experience

The structures for improving patient experience were widely evident in the case study sites, including patient experience leads or coordinators, job descriptions emphasising Duty of Candour and patient experience, the establishment of patient councils or patient experience committees (in one case chaired by the CEO), welcoming HealthWatch representatives at

board meetings and encouraging governors to take an active role in this area. Patient experience came third as a board challenge after patient safety and finances in the national survey, indicating insight that this was still very much work in progress. In recognition of this, two of our case studies had medical patient experience leads to support change in mindsets in the medical workforce.

Leads for patient experience were identified in all our case study sites. Processes for listening and responding to patient experiences were more advanced in some sites than in others, where the top priority had been to ensure patient safety because of a recent history of failures in care.

We heard many examples of where the trust tried hard to put patients first, really listening to their concerns. Non-executive directors and governors were energised by this agenda, although it might seem odd to outside observers that boards felt liberated to be able to do this:

'It became 'ok' to talk about the patients and their care much more, the old adage of strategy as being the 'in' thing was actually eaten by the understanding that the right culture is what is really important. 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.' [National Survey Respondent]

From what we could glean, and in the absence of large scale patient surveys which were beyond the scope of this study, these efforts had a tangible positive impact on patient experience: *'from a patient's perspective, I mean I've been a regular visitor to the hospital over the past ten years..... and I must say I've seen an enormous improvement in the service provision'* [Patient and Governor Focus Group Participant, Trust 2]. But there were exceptions, sometimes within the same trust. And there were stories depressingly similar to those reported to the Francis Inquiry:

'Some of the wards are much different from others and it does rely very much on particular individuals and particular shifts...we have had two elderly neighbours... one of them had dementia... And because we were not next of kin, nobody would talk to us about her...I looked at her notes quite often and they would tick that she'd taken her medicine. On her bedside table were these little cups with the tablets still in them...You know, if she was thirsty, she was hungry, she wouldn't ring her bell

because she was so confused...So my husband and I used to come in just about every night just to make sure that the basics were being dealt with because she would talk to us because she knew who we were. But we, as far as the hospital were concerned, we were nothing. It seems counterproductive... [Patient and Governor Focus Group Participant, Trust 2]

We also found that consulting on new facilities, and listening and feeding back to patients on their care, was more strongly embedded than involving patients in the co-design of new services or on service improvement ideas. Arnstein's ladder of citizen participation, which is a classic reference on patient and public involvement (Arnstein 1969) and still widely referenced in the healthcare context (see for example Ocloo and Matthews (2016)), suggests that management attempts at involving the public, in their direct care and in organisation and service design, can range along a continuum from tokenism through to ceding control. An appropriate level of engagement does clearly vary according to circumstances, but our view is that, where rung one is nonparticipation and rung eight is citizen leadership and control, most trusts are on rung four or five (consultation and involvement through eliciting feedback through surveys, and including patient representatives on committees).

The finding from the national survey (see section 5.3 above) that board members themselves knew somewhat more about what was important to regulators than what was important to patients is an indication of the limits to patient-centredness of boards in today's NHS. The growing financial pressures and continued perceived dominance of a target culture were strongly emphasised in the stakeholder interviews and in the extensive text comments in the national survey. This provides additional evidence of the extent to which a nascent culture of truly patient centred care is under threat unless, as one respondent put it, boards can... *'...keep all of the plates spinning'* [Chair].

Staff engagement

As with patient experience, we found much effort had been invested in improving staff engagement. These included huddles, Schwartz rounds, CEO with an open door, walk-about by directors and so on.

The reported impact of these efforts varied across our case study sites. One of the inhibiting factors was the quality of and investment in the middle management cadre. In some of our

case study sites, the onus lay too heavily on the executive tier. A further issue commented on by staff in one case study site was a lack of discipline and consistency in internal governance arrangements, accompanied by erratic internal communications.

Two particular characteristics constituted excellent staff engagement, as evidenced by good NHS Staff Survey results and feedback from managers and staff at three of our case study sites: a comprehensive staff health and wellbeing strategy, and opportunities for listening and training events that successfully included the whole workforce. Boards that emphasised one of their purposes as reconciling different interests in their organisation were also more likely to have staff engagement as a top challenge, which we have interpreted as also a top priority.

Guidance in the Healthy NHS Board (NHSLA 2013), about which more is included below, emphasised the importance of a people strategy that supports comprehensive management training and development for all categories and grades of staff. The evidence from the ward and department managers survey (see figure 11, section 6.12 in chapter 6 above) conducted at three of our case study sites indicates that a comprehensive people strategy remains somewhat of an aspiration. In two of the trusts it is remarkable how dispersed the responses are, from poor to excellent, to the question about how they rate the opportunities for management training and development.

Openness (including Duty of Candour)

We asked respondents in the national survey for their assessments of the impact of implementing the Duty of Candour on various aspects of the organisation and its functioning. The overall picture is of marked increases in the openness of the culture and in learning and improvement, albeit that these are based on subjective judgements of a complex situation. There would also appear to have been some net reputational benefits and increases in patient confidence and in whistleblowing.

In common with other aspects of Francis, some respondents felt that their trust had already been practising the values and behaviours of the Duty of Candour. These respondents typically perceived little value, although some saw benefits in the greater formalisation and an opportunity to reinforce the existing approach.

The findings in the case study sites mirrored those in the national survey, and managers and staff also confirmed what board directors were saying about efforts to implement the Duty of Candour (see figure 12, section 6.12 in chapter 6 above). Training for clinicians in Duty of Candour had generally been well organised and support was available. Of all the recommendations coming out of the Francis Report, the Duty of Candour is the one which appears to have been the most solidly implemented. According to the results in the ward and department managers survey in two of the trusts, the board is seen to be materially more committed to Duty of Candour (admitting when mistakes happen to patients) than openness (allowing concerns to be raised and aired) and transparency (sharing of information). For Trust 1 this is robustly and statistically significant

Our advisory group observed that the Duty of Candour is commonly understood in the NHS to be directed at patients but that it was also important for staff, and it was this aspect that was still somewhat under-developed. As well as it being a policy which fits the zeitgeist, a further reason for the wholesale implementation of the Duty of Candour to patients could be that it is explicit, mandated and measurable, and accords with the mantra that what gets measured gets done (Peters and Waterman 1984).

In relation to a culture of openness, our findings are corroborated by the latest NHS Staff Survey findings (NSS 2016). Eighty-five percent agreed that their organisation encourages staff to report incidents. When incidents are reported, 63% of staff felt that action is taken to prevent the incident happening again, and only 6% disagreed that this is the case. Findings on unsafe clinical practice were similar, with 70% of staff feeling secure in raising any concerns they may have regarding clinical practice. Fifty-eight percent of staff had confidence that their organisation would address their concerns if they were raised. Reflecting back on a question that arose from the stakeholder interviews, the evidence suggests an approach which is generally closer to Alton Towers than to Thomas Cook (as evidenced by two high profile recent incidents), in how the NHS handles failures of care. The caveat from the NHS Staff Surveys, and corroborated by findings from our case studies, is that some organisations, although committed to openness, are not always as adept at acting to address concerns and prevent recurrence.

Improving the quality of care

Accounts from the case study sites and from the national boards survey suggest that patient safety and patient experience have taken a higher priority than enhancing clinical effectiveness. We found from our interviews, board observations and survey of managers that a quality improvement culture was not yet comprehensively embedded in any of the trusts, although there were a number of examples of good practice and a strong sense in three of the case study trusts that there was about to be a big push. Related to service improvement, the ward and department managers survey findings at three of our case study sites provides salutary confirmation of this variability in their answers to the question about how much front-line staff and managers are encouraged to innovate (see figure 13, section 6.12 in chapter 6 above).

From observations of board and committee meetings and interviews, we gleaned that particularly the medical director and other clinical members of the board demonstrated a potentially significant, but not always realised, role in raising the sights of the organisation in terms of national and international benchmarking. The space for this conversation at board meetings was limited, although we did observe and note rigorous debate and data presented for assurance at quality committees.

Improving governance

As described above, boards had established or invigorated committees particularly to obtain assurance on matters of patient safety and clinical quality of care. Board governance is about setting strategic direction, making investment choices, and accounting to stakeholders as well as monitoring performance (Garratt (1997) and see figure 14 below). We noted engagement by boards in strategic matters, but the monitoring of progress against agreed strategic objectives was not as explicit or as regular as might be expected. Those boards which exhibited a stronger internal locus of control (Hodgkinson and Sparrow 2002) also maintained a focus on strategy and had a stronger quality outcomes orientation. This orientation, based on an exploratory factor analysis explaining 15% of the variation, places importance on clinical effectiveness, patient experience, patient safety and to some extent staff engagement. Others, who experienced a more external locus of control, (and therefore were seemingly more powerless in the face of regulator demands), paid more attention to

monitoring national performance targets, finances, A&E performance, workforce shortage and to some extent responding to regulators.

We found that the Fit and Proper Persons Requirement policy has been implemented but was a low profile policy in comparison with other initiatives. Not all trusts are checking on continuing fitness of directors, according to board secretaries responding to our national survey in 2016. The requirement has been interpreted rather literally. We know from events during the period of our study that there have been cases (for example at St George's University Hospital Foundation Trust) where the policy has failed to prevent inappropriate appointments of individuals.

7.4 Improvements in board leadership

(Research objective 3: To explore the early intended and unintended effects of the different ways in which NHS hospital trusts and foundation trusts have sought to improve board and organisational leadership)

In this section we examine improvements in board leadership since Francis, using the framework offered by the Healthy NHS Board (NHSLA 2013). This is not because we judge that this is necessarily the sole source of wisdom on healthcare board governance but because this is government guidance that NHS boards have been expected to use. The guidance outlines three roles for boards (strategy, accountability and culture) and three building blocks (context, intelligence and engagement). To complement this practical examination, in section 7.7 below we discuss and offer refinements to the theoretical framework for effective healthcare boards, discussed in chapter four, in the light of our findings.

Three roles of boards (from NHSLA (2013))

Strategy: We have already noted that the strategy space for NHS boards is not very large and this has been pointed out previously in research on healthcare boards (NHS-Confederation (2005), Chambers et al. (2013)). There are patterns in the data from the national survey of board members that suggest that those boards with a stronger quality outcome orientation (instead of concentrating on monitoring performance against targets) are also those who have carved out time for strategy and have a stronger sense of an internal locus of control

(Hodgkinson and Sparrow 2002). Sustainability and Transformation Programmes (STPs) were unfolding during the time we were collecting data from our case study sites and we noted that boards in all our sites were playing an active system leadership role and contributing to improvements in health and care system relationships.

Accountability: We have already noted that boards in our case study were not always focussed on monitoring progress against the delivery of strategic objectives, being often pre-occupied with tracking performance against mandatory targets for example for waiting times in A&E, Referral to Treatment Targets (RTT), cancer waits and responding to CQC verdicts. This is notwithstanding the view that national targets are useful and reflect legitimate issues of patient and staff concern and experiences.

The NHS Healthy Board and our stakeholders referred to the importance of seeking out different sources of evidence to obtain assurance around safety and quality. The work of Dixon-Woods and colleagues (2013) emphasises the importance of problem sensing rather than comfort seeking. One of our respondents in the national survey talked of the importance of '*the restless board*'. Observations from our case study sites indicated variation in both the rigour and the maturity of their boards' approach to sourcing and using relevant data. The most diligent boards were using national and international benchmarks, tracking performance over time, had CEOs who were focussed on monitoring clinical outcomes, and chief nurses and medical directors who were vocal at public board meetings and board committees.

Culture: The NHS Healthy Board notes that the extent to which culture can be defined, identified and then deliberately changed is contested within the academic literature (see, for example, Davies and Mannion (2013)). There is, however, some agreement on the value of encouraging the exploration of culture at every level and modelling desired values and behaviours. Boards have a key role in prioritising and supporting this work within the organisation. The findings from this study indicate that boards almost universally espoused the importance of setting the tone for the organisation. There is some evidence that first-line and senior managers also recognise the importance of culture. As one respondent put it: '*the culture in my area of work has changed, this is a slow process but definitely improving...*'. [First-line Manager, Trust 5]. There remains a challenge in ensuring consistency of desired

behaviours in every corner of hospital trusts whilst acknowledging that ward and department subcultures as well as hospitals as a whole may, for good reasons, vary because of different histories and the nature of the work undertaken.

Three building blocks (from NHSLA (2013))

Context: The NHS Healthy Board mentions the importance of boards taking into account the full range of key elements of the external environment in shaping strategy and considering risks. Our public board and board committee observations, consideration of minutes and interviews at our case study sites indicated close familiarity with some areas (the regulatory environment, for example). Our national boards survey also found that board members had a greater knowledge of what concerned regulators than what was important to their patients. From what we could gather, the case study sites were very well sighted on the local and national social and economic picture, legislation, political turbulence and all the latest government policies (and generally had workable mechanisms for dealing with the plethora of guidance which came their way). There was more limited exposure to trends in changing public expectations and less discussion of the wider determinants of health which would impact on the way in which the public would be using the services of their hospital.

Intelligence: We have already noted above that boards in our case study sites did not always succeed in monitoring progress towards meeting their organisation's strategic objectives. They also did not always make extended use of trends, forecasts and systematic benchmarking against similar hospitals in England and internationally. There was much more detailed data, and more focus, on monitoring operational performance. Good practices in exception reporting and triangulation of different sources of data (for example quantitative data and patient feedback) were also widely apparent.. Metrics on workforce received considerable attention, although here the adage that what gets measured gets done did not always ring true, for example more attention was sometimes paid to a scrutiny of sickness absence and vacancy rates than to efforts to tackling the causes of these.

Engagement: Workforce issues bring us to the third of the building blocks for effective boards outlined in the NHS Healthy Board. This guidance emphasises the importance of a people strategy that hears, supports and nurtures all staff, and enables and rewards a culture of innovation and improvement. Staff engagement is increasingly emphasised and high levels are associated with better organisation performance (West and Dawson 2012). Although there was considerable reported activity in each, the six trusts varied in their overall staff engagement score according to the latest national NHS Staff Survey results. We have also discussed patient engagement in section 7.3 above and made an assessment of the level of maturity in acute hospitals in this area. We noted that in terms of wider stakeholder engagement, there were some encouraging findings about how boards in our case study sites were collaborating with their council of governors. Meetings included cordial and robust challenges to the board of directors, and there was evidence of inviting governors to contribute proactively (i.e. beyond scrutiny) to the work of the trust. This has to be set in the context of earlier studies indicating some ambiguity about the role of governors in NHS Foundation Trusts (Chambers et al. 2013). Relationships with others in the local health and care community varied, with 41% of respondents in our national boards survey indicating that poor local relationships was a barrier.

Improving board effectiveness

The NHS Healthy Board guidance defines the scope of improving board effectiveness as board capacity (including composition), capability, disciplines and behaviours. Our view is that the reality is more nuanced and that the focus for improving board effectiveness will depend to some degree on history, legacy, local circumstances and desired organisational strategic priorities. We examine this in more detail in section 7.7 below on the implications of this study for theories of healthcare board governance.

In relation to board composition, the characteristics of improving board leadership from the stakeholder comments, national survey and case studies included stability on the board and particularly the CEO. Our stakeholders were concerned about a possible cult round the CEO and whilst we saw no striking evidence of this in any of our case studies, there was no doubt that in five of the trusts this individual was high profile, influential in driving culture change and the board, and the organisations were quite dependent on these individuals. We also noted the growing influence and contribution made by the chief nurse in five out of six of our

case study sites and it may be that the post Francis culture and re-ordering of priorities (patient experience, safe staffing and workforce) has given the opportunity for the board nurse to have a far greater voice.

Despite considerable investment, there has been little evidence so far of the impact of board development activities beyond increased reported confidence of individual board members (Chambers et al. 2013). This current study suggests that there are links between the investment in individual board director development (measured in terms of number of days per year) and certain organisation characteristics. In particular, from our national boards survey findings (see section 5.9 above), higher numbers of days of individual board member development is correlated positively with greater reported board impacts on staff engagement and patient experience, knowing the concerns of patients and staff, and recruitment and retention of CEO and executive directors not being barriers to leadership development. There may be a virtuous circle at play here: investing to a greater degree in board leadership development is associated with board confidence in a quality outcomes orientation rather than a regulatory driven performance and access outcomes orientation, a greater sense of internal locus of control and an increased ability to recruit and retain board executive leaders.

We would, however, be wary of positing simple cause and effect. Case study research can help to explain patterns but the data is often messy and contradictory and can point in all directions. Facing some common challenges (financial, meeting targets, patient safety) and some very different ones (coming out of special measures, legacy of failures of care, geographical isolation), it was striking how the board leadership of our six case study sites exhibited very different corporate personalities. Summing them up each individually in one word, in alphabetical order, they were: classy, courageous, defiant, shiny, ramshackle and recovering, with the caveat that these are to give an impression of certain characteristics of the cases, and to illustrate diversity, rather than to pass judgement.

The ‘classy’ trust has pride, self-confidence, a fantastic brand, a non-executive cadre with their own distinguished careers, and is extremely focussed on clinical excellence and improving staff engagement and loyalty. The ‘courageous’ trust has had opprobrium piled upon it by media, been seen as professionally isolated, and is now seen as an exemplar in several areas of patient and staff engagement and has built a reputation for living by its values. The ‘defiant’ trust is a district general hospital that used to consider itself successful, was shocked by external regulatory intervention, has a strong family feel and is somewhat

defensive about external criticism. The ‘shiny’ trust has superb administrative systems and processes and an excellent reputation for its staff engagement strategy and for patient-centred care. The ‘ramshackle’ trust demonstrates strong commitment to values of staff engagement and improving patient experience, but consistent attention to execution and to follow-through is lacking. The ‘recovering’ trust is picking itself up after a long period of churn on the board, poor staff morale and buffeting by regulators and the media. We therefore believe that the findings provide a rich picture of the acute hospital sector in the NHS which is wrestling (more or less successfully) with trying to deliver cultural change for well organised and compassionate care for patients.

We therefore suggest that it would be both unwise and also impossible to guide or reduce hospitals to a common style or approach for the implementation of policies. This also lends weight to our view that a realist approach to understanding the characteristics of effective healthcare boards that takes into account different contexts and different priorities is the preferred way forward. This is dealt with in more detail in our discussion on implications for healthcare board governance in section 7.7 below.

7.5 Financial and non-financial costs

(Research objective 4: To examine the financial and non-financial costs of developing and implementing new policies, processes and actions aimed at improving board and organisational leadership)

A common but not uncontested view from the national survey of board members, and the interviews and surveys of ward and department managers at our case study sites was that although there were complaints about the bureaucracy involved, the costs of policies and of improving leadership and governance (as distinct from staffing) following Francis, they were not generally considered excessively burdensome. And the investments were considered by most to be worthwhile; in many cases they had been initiated by the trust leadership and there was a strong conviction that they were necessary for improved patient experiences and staff engagement. There was very little complaint about the drain on resources to enable improved leadership and stronger governance. The main costs after 2013 were to ensure safe staffing, which is the topic of another research study (Ball et al. forthcoming). These costs were large and were experienced as a significant cost pressure for trusts: three of the case study site

trusts reported that they prioritised safe staffing over balancing the books which we did consider was a deliberate choice made by the board leadership and there were numerous references to the resource implications of safe staffing in the national survey responses.

7.6 Barriers and enablers

(Research objective 5: To explore the enablers of and barriers to implementing different approaches to board and organisational leadership)

The detail of the barriers to and enablers for improving leadership uncovered in the case study sites are rehearsed in some detail in section 6.12 above. The main barriers bear a close resemblance to those that emerged from our national survey of board members, and to the concerns mooted by the stakeholders whom we interviewed in the initial scoping phase of this study. In a tough financial environment with high levels of demand on services, the iron triangle trade-offs of quality, cost and access dominate (Kissick 1994). As one respondent in our national survey put it: *'There are no weekends or Christmas breaks in our world and the pressure to perform miracles with less funding are unabated'* [NED].

The preoccupation with CQC visits and verdicts is also evident. There is additionally a frustration with the differing messages and positions taken by the different national agencies, especially NHS England and NHS Improvement.

Finally, it is striking how often the contribution of middle management comes up, either as a barrier when under-developed or as a facilitator of change when empowered: *'.....I don't feel I can comment very well on this but appearances are that behaviours are more professional and representative of the culture and values of the trust. 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, especially so when there is a lack of experience within the service that they represent'* [comment offered about leadership styles and behaviours, in ward and department managers survey response from First-Line Manager, Trust 5].

7.7 Implications for healthcare board governance theory

The outcome of our selected literature review and interviews with key opinion formers led us to pursue the following specific lines of inquiry, in relation to composition, focus and dynamics of boards, in our analysis of the empirical data in this study:

- i) The particular contribution of clinicians as board members
- ii) The relevance of stakeholder theory in the healthcare context particularly for broader strategizing purposes
- iii) The assuring/improving dichotomy
- iv) Appropriate behaviours for boards
- v) The capability and the effort taken by boards

These themes are woven into the triadic proposition of high trust – high challenge – high engagement for effective boards, which we outlined in chapter 3, and into a realist framework that indicated that boards may do well to focus on different purposes and mechanisms depending on variations in circumstances and desired outcomes. The study has provided an opportunity to test both the proposition and the framework and thus contribute to a refreshed conceptualisation of effective healthcare boards.

In relation to board composition, we had identified from a number of earlier studies that the presence of clinicians (and particularly medical clinicians) on boards was associated with higher organisation performance especially in relation to clinical quality and levels of hospital mortality. We found in this study (something we had not particularly sought), that the strengthened focus and priority in the post-Francis era on safe staffing, patient experience, and patient safety may have provided a platform for the board nurse to have a stronger voice and influence on the board. As one described it herself, her job is ‘*to prick the conscience of the board*’ (Chief Nurse, Trust 3). We also noted that an observably close working relationship between the medical director and the chief nurse in some of our case studies was conducive to board attention on how to improve patient safety and clinical outcomes.

We found that a broadly similar proportion of respondents in our national survey of board members (and we have no reason to suppose that the respondents were atypical of the total NHS acute board member population) were of white ethnic origin as the levels reported in

the Kline Report of 2014 (Kline 2014). It was therefore also disappointing that only one of our six case study sites demonstrated excellence in the formulation and execution of their equality and diversity strategy. West et al. (2015) pointed out the importance of diversity and inclusion for staff engagement, wellbeing and positive patient experience.

The Green Paper on corporate governance issued by the last government (BEIS 2016) mooted the controversial idea of worker directors on company boards. This would address, strategically, issues of diversity of thought and stakeholder representation. It would bring the UK closer to the German model that includes the trade unions on boards and holds to the principle of co-determination of decision-making. If adopted in the NHS (leading for once rather than copying private sector governance innovations), the worker board director might also pave the way to achieving the higher levels of staff engagement required.

Section 172 of the Companies Act (2006) requires directors to promote the success of the company for the benefit of shareholders, and in so doing to have regard for the interests of workers, consumers and other stakeholders. In the NHS in England, the question of the relevance of a stakeholder model for healthcare board governance has increased with the advent of hospital foundation trusts and their two tier model of board level governance including a council of governors as well as a management board. We found examples in our case studies of respectful and productive relationships between the board and the governors. The national survey of board members made numerous mentions of governors as external stakeholders with whom it was important to build close relations and to whom they were accountable. This equation of governors with other external stakeholders, which we also saw in the case studies, combined with earlier studies indicating a degree of ineffectiveness and ambiguity about the role of governors (Chambers et al. 2013, Mannion et al. 2016), suggests that, in practice, acute hospitals may not yet have embraced the stakeholder model. The impact of this may be to take an insufficiently broad, place-based and system leadership perspective when formulating strategy, thereby passing up the opportunity to build long term organisation value and sustainability.

The interviews with key opinion formers identified concerns that boards may be pre-occupied by seeking assurance around hospital performance against a suite of standards to the detriment of enabling improvements and innovations. This relates to the (Garratt 1997) conformance/performance dichotomy in the balance of board tasks model that he proposed (see figure 14 below).

Figure 14: Balance of board tasks

| | Short term focus on 'conformance' | Long term focus on 'performance' |
|---------------------------|--|--|
| External Focus | <p><i>Accountability</i></p> <ul style="list-style-type: none"> • Ensuring external accountabilities are met, e.g. to stakeholders, funders, regulators. • Meeting audit, inspection and reporting requirements | <p><i>Policy formulation</i></p> <ul style="list-style-type: none"> • Setting and safeguarding the organisation's mission and values • Deciding long-term goals • Ensuring appropriate policies and systems in place |
| Internal Focus | <p><i>Supervision</i></p> <ul style="list-style-type: none"> • Appointing and rewarding senior management • Overseeing management performance • Monitoring key performance indicators • Monitoring key financial and budgetary controls • Managing risks | <p><i>Strategic thinking</i></p> <ul style="list-style-type: none"> • Agreeing strategic direction • Shaping and agree long-term plans • Reviewing and deciding major resource decisions and investments. |

The main functions of boards (adapted from Garratt (1997: 45-47))

Hodgkinson and Sparrow (2002) argue for balance and organisation ambidexterity to achieve strategic competence. Our case study findings suggest, at the same time, the importance of excellence in administrative processes and governance structures. Chait et al. (2005) suggest that there are three levels (fiduciary, strategic and generative) in institutional public governance and boards need to know when to operate in which mode. We would argue that

these modes are also building blocks: patients' and staff trust and confidence is built through excellence in basic management practices and this then enables improvement and innovation via strategic vision and careful consideration of strategic choices.

This balancing act around a twin-track focus on strategy and on operational performance brings us to appropriate behaviours for boards. Roberts et al. (2005) argue for theoretical pluralism, given that evidence about board behaviour suggests that traditional theoretical divisions between agency and stewardship theory, and control versus collaboration models of the board do not adequately reflect the lived experience of non-executive directors and other directors on the board. The evidence from this study would support this. Holding to account (agency theory) and support for (stewardship theory) executive directors are both important. And so, is the fulfilment of the other purposes of the board. This is also consistent with Storey et al's (2010) research findings about an association between the level of non-executive directors' involvement and organisation performance in the NHS. The findings from the national survey suggest that what we call 'the diligent board' goes beyond the high-trust high-challenge high-engagement proposition, to a fuller board repertoire including emphases on enhancing the reputation of the organisation (resource dependency theory), representing the interests of stakeholders (stakeholder theory) and reconciling competing interests (power theory). The boards of organisations with higher care quality ratings had statistically significant higher scores for all these purposes as reported by board members. The highest scores were for holding to account suggesting that there are dangers in taking the foot off the pedal on this board purpose, and the importance of the 'restless' board.

Our findings indicate that our provisional realist framework for effective healthcare boards has promise. The knack for board members is to know when and how to be keepers of all board purposes and to be able to switch from one mode of behaviour to another in order to meet the range of desired outcomes for a successful healthcare organisation. Chapter 8 goes into more detail about the roles of the board as conscience of the organisation, shock absorber, diplomat, sensor and coach, respectively, according to circumstances and situations.

We would suggest, however, that our framework, as it stands, needs some modification and elaboration (see table 15 below for a proposed revised framework). Our observations of board meetings and comments from the national survey of board members indicate that an additional column for behaviour mode would be helpful, and also that more than one mode is

relevant to each theoretical board purpose. We have provisionally suggested one dominant and one secondary mode but we would not rule out additional modes.

Table 15: Revised theoretical framework for effective healthcare boards

| Theory | Contextual Assumptions | Dominant modes of behaviour | Mechanism | Intended Outcome |
|---|--|------------------------------------|--|---|
| Agency (holding management to account) | Low trust and high challenge and low appetite for risk | Challenging, supportive | Holding to account and control through intense internal and external regulatory performance monitoring | Minimisation of risk and good patient safety record |
| Stewardship (supporting management) | High trust and less challenge and greater appetite for risk | Collaborative, inquiring | Broad support in a collective leadership endeavour | Service improvement and excellence in performance |
| Resource dependency (enhancing the reputation of the organisation) | Importance of social capital of the organisation | Ambassadorial, curious | Boundary spanning and close dialogue with healthcare partners | Improved reputation and relationships |
| Stakeholder (representing interests of all stakeholders) | Importance of representation and collective effort; risk is shared by many | Listening, questioning | Collaboration | Sustainable organisation, high levels of staff engagement |

| | | | | |
|--|--------------------------|---------------------|----------------------------|-------------|
| Board power (reconciling competing interests) | Human desire for control | Courageous, probing | Use of power differentials | Equilibrium |
|--|--------------------------|---------------------|----------------------------|-------------|

Some explanation of the choice of different behaviours for each board theoretical purpose is necessary here. First, for the purpose of holding executives to account, it is usual to suggest that board challenge is important. We have observed that, particularly on a unitary board such as is the case in NHS hospital trust, supporting executives to achieve the highest possible levels of patient safety is equally productive and indeed most effective when combined with grasp that comes from a close understanding of the data and the issues (our triadic proposition). Second, supporting executives to take considered risks, to encourage their staff to innovate, and to embed a service improvement culture would suggest behaviours which are collaborative and also inquiring (for example to understand risk appetite and what innovation and excellence looks like). Third, for the purpose of enhancing the reputation of the organisation, an ambassadorial bent is helpful, that is an ability to represent the organisation externally, with authority and credibility at the same time as having curiosity about the priorities, strengths, interests and challenges of other players in the local and national health and care landscape. Fourth, representing the interests of stakeholders requires listening and questioning behaviours; the study has found that, although there is a way to go, efforts to listen to patients and staff have been strengthened in the post-Francis era. Finally, reconciling the conflicting interests of different powerful stakeholders is hard. Internally, there is the power of the healthcare professions to deal with, but this study found that it was the influence of the national regulatory bodies that boards found hardest to handle. Board members in the national survey commented on the difficulties and the distraction of meeting demands of regulators. Two of the case study trusts, with very high proportional financial deficits, had found a way to negotiate with these bodies to secure protection from external opprobrium and to prioritise safe staffing over financial balance.

7.8 Synthesis of findings: concluding remarks

We have already referred to the fact that the Francis Inquiry team received requests from distressed members of the public about failings in other trusts, which were beyond the remit of the inquiry to investigate. The findings from this research, drawn from our national boards survey and the six case studies, confirm that many NHS board members themselves recognised that their own organisation needed at the time of the Francis publication report in 2013 to do significantly better in providing safe, compassionate care, and that some still do. We also found that there was huge reported commitment, effort and drive from many boards to either set or confirm a new direction for their organisation.

This study indicates that execution may lag behind commitment in achieving safe, high quality, timely and well organised services in some hospitals. Given the paradoxes inherent in board work, Cornforth argues for the importance of reflexivity to get a better understanding of behaviours, roles and impact (Cornforth 2003). Our approach is also not to argue prescriptively but, in line with a realist approach, to offer a framework for boards to draw upon to develop a broad leadership repertoire, aiming towards what we would call a *'full board service'* for patients, staff and the public.

We suggest that boards with a sense of an internal locus of control, who believe that they can influence events and situations with their efforts and skill (Hodgkinson and Sparrow 2002: 198) are likely to have a greater quality and innovation outcomes orientation than those with an external locus of control who attribute the fortunes of their organisation more to external agencies and forces (ibid) and are likely to have a greater targets and performance outcomes orientation. These authors caution, however, against excessive internality which can lead to an illusion of control. This takes us back to the importance of balance of board tasks and spread of board purposes.

8 Implications for policy practice and future research

8.1 Introduction

In this chapter we reflect on the findings and conclusions of our research, setting out the implications for health policy and practice – in the UK and beyond - of this analysis of the leadership changes made by NHS hospital boards in response to the Francis Inquiry. Although this research is based on hospital trusts (as per the commission from the Department of Health for this study), we suggest that the findings are for the main part also relevant to the boards of mental health, community health and ambulance services trusts. This relevance is borne of the fact that the corporate board model used for the governance of hospital trusts and foundation trusts in England is also used by mental health, community health and ambulance service providers. Thus the governance model is common, as is the wider context of NHS healthcare organisations, albeit we acknowledge that some hospital-focused aspects of the learning from our research may present some limitations in respect of other NHS trusts and foundation trusts.

The main lessons from this research about how boards are composed and work, their role in leading change with the aim of improving quality and safety, and their role in shaping organisational culture and behaviours are, we suggest, relevant to all NHS and other health care and public sector boards in the UK and overseas that operate with this particular model of governance, and to the bodies that regulate them. We know from our wider research and policy analysis work that the Francis Inquiry Report has been read and heeded in many jurisdictions beyond England, and its lessons considered by many health care systems in relation to the governance of care quality and safety within organisations. This research report on the leadership role of boards is therefore of relevance in the international as well as English NHS context.

8.2 The impact of the Francis Report on NHS organisations and boards

Our research has revealed that the Francis Report represented something of a landmark event for NHS organisations in England and their boards. For some this landmark is described as having come as a shock, a stark warning of what might happen if they were to fail similarly

in relation to quality and safety of patient care. For others the report serves as a point of reference in respect of a welcome increase in focus by the NHS on quality, safety and in particular regulation of standards of care. For yet others it is regarded as the cause of increased '*regulatory throttle*' and administrative burden, an influential example of a series of external reviews considered to have missed the point by calling for too many disparate changes.

It is, however, important to note that it is difficult to disentangle the reported effects of the Francis Inquiry Report from other policy initiatives and changes made to health care regulation, quality and safety in recent years. Indeed, respondents in our research often linked the Francis Report to the other Francis Reports (initial independent investigation into the events at Stafford Hospital, and the review of whistle-blowing in the NHS) and to related reviews such as those of Sir Bruce Keogh and Don Berwick (see chapter 2 and table 2 for more details). This research is based on six case study hospitals and a national survey of board members, so is necessarily represents a snapshot of how board members and others viewed the Francis Report as they looked back from 2016.

This research has shown that in 2016-17 NHS boards are placing more emphasis – in board meetings, sub-committees and other activities – on quality and safety. Whether boards ascribe this to the Francis Inquiry Report in full, part, or at all, is a moot point, although all six of our case study hospitals acknowledged the important role of the report in validating and adding urgency to such work.

The most significant impact of the Francis Report on hospital trusts appears to have been the investment made in increasing nurse staffing levels, paying more heed to these on an ongoing basis, and reaching a corporate conclusion that quality and safety trump financial performance. This echoes the findings of work undertaken in the first year after the publication of the Francis Inquiry Report (Thorlby et al. 2014) where it was noted that the balance of an NHS hospital board's core priorities appeared to have shifted in favour the quality and safety of care, even when under extreme pressure in relation to perceived poor financial performance.

The additional major (and increasing) pressure now being experienced by NHS hospital boards, and hence requiring significant attention, is that of a very scarce workforce at a time of effectively flat funding for the NHS and hence rising deficits (see chapter 2 of this report). This runs directly counter to the post-Francis requirement to invest in higher levels of nurse

and other staffing (for example medical staff in accident and emergency departments) as a way of ensuring a properly patient-focused culture of compassion and fundamental standards of care, and our research revealed that boards are very worried about the impact that workforce pressures are having on the safety and quality of patients services, and of course the need to try and achieve financial balance. Thus there is a sense of Francis Report-related progress being halted to some extent – not as a deliberate act, but as a result of a wider context of shortages in the supply of staff, and a resulting reliance on costly agency staff known to be likely to compromise continuity and safety of care.

On a more positive note, our research has revealed the many other ways in which the Francis Report has led to NHS hospitals reporting that they were concentrating more of their management time and resource on matters of quality and safety, and ensuring a broader culture of service improvement in response to patient and carer feedback and concerns. One example of this is a greater focus on trying to handle patient complaints in more responsive and open ways, such as committing to meet with patients and families in person to discuss concerns, and doing so as the default position, prior to entering into paper-based communication. Likewise, our case study hospitals had adopted new ways of investigating and responding to serious incidents, seeking always to demonstrate a Duty of Candour in being open with patients and their families, and using different forms of learning events to try and ensure that each incident (or group of incidents) can lead to lessons being shared across teams, departments or the whole organisation as appropriate.

8.3 The roles of an NHS board post-Francis

Our analysis of the leadership changes made by NHS hospital boards following the publication of the Francis Inquiry Report highlights five areas within which we conclude that policy and practice of board governance and working require attention:

- The board as conscience
- The board as shock absorber
- The board as diplomat
- The board as sensor
- The board as coach

These suggested roles are used as a framework for setting out ways in which NHS boards might take action to ensure that they are able to continue to try and meet the challenges set out by the Francis Inquiry Report, in particular those in relation to assuring, developing and accounting for safe and high quality care within an organisational culture that is supportive, compassionate and open to challenge and change.

8.4 The board as conscience

The findings of this research underline the need for NHS boards to own and honour the legacy of the Francis Report in respect of upholding fundamental standards of care, especially when the wider context makes this difficult to do, acting in effect as the conscience of the organisation. The need for this is seen in the way in which boards have increasingly had to resolve a profound tension between sustaining standards of care quality and safety on the one hand, and meeting ever more difficult financial targets on the other. This tension was woven throughout our survey and case study work, and often felt much more like an impossible and demoralising challenge of gargantuan proportions.

The starting point for a board in being the conscience of the organisation is to be the guardian of its values, and the custodian and monitor of its culture. These are fiendishly difficult areas to codify and assess, but this research revealed boards that were very aware of the need for them to be part of shaping and upholding core values for the organisation, and using these in areas such as recruitment, decision-making about investment priorities, response to (and learning from) incidents and ensuring approaches such as the effective operation of the Duty of Candour.

For boards, there is therefore a need to be clear about the standards of care quality and safety that are sacrosanct for their organisation, and beyond the achievement of nationally-defined access and financial targets. Our research revealed that it typically feels that all that matters to national bodies is meeting the financial control and the 4-hour A&E waiting time targets. Organisations look to their board – and its quality committee - to give a more nuanced and bolder set of required standards, and to send out consistent messages about this, within the organisation to staff, and more widely to patients, the public and commissioners. For foundation trusts, this calls for a sophisticated and mature relationship with trust governors, ensuring that there is mutual respect for the setting and upholding of standards for patient

care quality and safety. For all trusts, this role of conscience requires attention to a range of internal and external relationships, and exhibiting a strong stakeholder orientation in respect of board working, something that we explore below in relation to the board as diplomat.

In this research, financial pressure was cited as the most frequently experienced barrier to boards seeking to improve their leadership, and there is no sign that this is going to ease in the coming years (Lafond et al. 2017). Thus NHS boards will increasingly find themselves confronting priority setting or rationing decisions – something more typically associated with commissioners and funders – for they will have to plan and enact major programmes of efficiencies, prioritise cases for investment within the trust, and likely decide on contentious issues such as pay restraint, staff cuts and the curtailing of previously planned developments. To do this, they will need evidence-based frameworks to guide their decision-making, and the adoption of deliberative and inclusive approaches to how they will take and account for such actions.

Box 12: Focus of the board as conscience of the organisation

Boards must lead the development, upholding and review of a core set of values for the organisation, ensuring that leadership behaviours at all levels of the trust reflect these values.

Boards must clarify the core care standards of the organisation, including and beyond national requirements, and how these will be monitored and acted upon at board and within care groups.

Boards should work in partnership with its governors (where a foundation trust) or other community and patient partners to debate, review and seek constantly to improve care standards.

Boards need to have evidence-based frameworks in place for use when planning, prioritising and enacting funding decisions and efficiency programmes, to aid transparency in making difficult and contested decisions.

Boards may wish to use deliberative and inclusive approaches to making priority-setting decisions, drawing on the research evidence available in this area.

It is vital that regulators support boards in their conscience role, being attuned to the difficult dilemmas faced in respect of balancing financial and quality/safety pressures, and focusing on ensuring that boards have sound local decision-making processes in place, and not creating ‘regulatory throttle’ that could skew the decisions made by boards.

8.5 The board as shock absorber

A theme running through our research, from the initial senior scoping interviews, through the board members’ survey and to the case study work, was that of the burden of external regulation experienced by NHS organisations, in particular from NHS England, NHS Improvement, the Care Quality Commission and local commissioners (clinical commissioning groups). It was striking that board members responding to our survey felt that they were more aware of the requirements of national regulators than those of staff and patients, suggesting that boards find themselves looking upwards to central bodies more than inwards to staff, or outwards to patients.

Boards need therefore to act as a ‘shock absorber’ for the organisation, receiving the attention and challenge of multiple national regulators and arm’s length bodies, and interpreting such feedback and determining what priority different elements of this should be given – a further dimension to the board conscience role described above. This shock absorber role is not about dismissing or diminishing important external feedback and challenge, rather it is concerned with distilling what is often a huge amount of data and opinion into a clear set of organisational messages that can be used by the board and wider trust leadership to guide and support needed changes. In this, the board can play a critical role in ensuring that the ‘regulatory throttle’ described in our research can instead be experienced as helpful regulatory appraisal and challenge, used to guide rather than crush.

We know from the body of research evidence on boards of healthcare organisations that a ‘triadic approach’ of support, challenge and engagement is desirable, something that one would hope to also be the culture and way of working of healthcare regulators. In a centrally managed health system such as the English NHS, regulation always risks being experienced as over-bearing and burdensome, and hence the board of a trust has the potential and responsibility to act as the absorber of external shock and challenge, and to interpret this into

messages and objectives that feel possible, achievable and capable of motivating teams to improved performance.

It is not just in relation to regulators that our research found boards to be acting as shock absorber. Other external shocks included the plans of new Sustainability and Transformation Partnerships (district planning areas for the NHS in England) which at times appears to be at odds with the aspirations of individual hospital trusts, for example by requiring significant scaling back of hospital bed provision to enable more community-based care. In addition, cuts made by local government to social care funding and provision were adding to the pressures experienced by trusts, as were ‘new care models’ being developed such as extended forms of primary care including ‘multi-specialty community providers’.

In a busy – and for our case studies often frenetic – policy environment where new initiatives can appear to shower down on local hospital (and other) trusts, the board is looked to as a source of stability that can withstand some of this policy onslaught, sort out what matters more for the organisation, and what can be ignored or deferred for the time being. Again, the need for board to carry out priority setting comes into play, along with helping to protect the organisation, keep it on course, and avoid unnecessary distraction from core priorities of ensuring safe, high quality and well-run services.

Box 13: Focus of the board as shock absorber

Boards can play a critical role in guiding and supporting the executive team in determining which aspects of external regulatory feedback is most significant and relevant to the wider mission and priorities of the organisation.

The board can support the organisation in difficult times when subject to sustained regulatory scrutiny and criticism, bringing perspective, providing resources, offering motivation and encouragement and helping prioritise areas for more immediate – as well as longer term – action.

The board in its stakeholder role can provide vital support to an organisation in helping it to think through, negotiate and communicate its position and plans in respect of wider developments such as the new care models advocated by the NHS Five Year Forward View, and district plans as designed by sustainability and transformation partnerships.

The board has a key role to play in setting organisational priorities in relation to which aspects of national and local health and social care policy are of most relevance to the core mission, sustainability and needs of the organisation and the people it serves.

Regulators must ensure that as well as expecting that Well-Led boards demonstrate that they use the triadic approach that research tells us is vital for boards – to support, challenge and engage – they also as regulators adopt this way of working in the way in which they interact with health care organisations and boards.

8.6 The board as diplomat

A theme running through this research was the importance of the board – and its non-executive and executive members in equal measure – being curious about and attending to the diverse range of stakeholder interests and perspectives that have a bearing on the organisation. Some of these perspectives are internal to the organisation, for example staff members and their representatives, professional groups, patients, carers, foundation trust governors, and patient organisations. Others are external, and include: commissioners, other health care provider organisations, social care providers, local government, members of parliament, the local and national voluntary sector, the media at local and national level, health care regulators, the Department of Health and many others.

For the board of the trust, there is a vital role to play as diplomat, identifying these stakeholders, understanding the nature of the existing (or lack of) relationship with the trust, prioritising which of these needs particular attention (thus acting again as conscience) and planning how best to nurture these. As a diplomat would skilfully build and extend trusted networks of influence and information, so must the healthcare board, and in so doing must do this in a way that means that the links forged by individual board members are brought together into a coherent, board-focused whole. This will likely necessitate careful attention by the chair and chief executive in particular, as overseers of the stakeholder relationships of the trust, ensuring that different board members are asked to focus on certain organisations and key individuals, and to bring back insights, concerns and issues to the wider board and organisation.

Professional communications and public affairs support will be required for some elements of this ‘diplomacy’ work by the trust, and other elements will be of necessity informal, but nevertheless important. The chair and chief executive will need to ensure that there is sufficient board development and reflection time to capture and thematise insights from the myriad stakeholder interactions that the board will undertake, also identifying where a critical relationship is missing or struggling, and working out how this should be addressed.

This role of the board as diplomat, working out for example how to relate to and operate within new sustainability and transformation partnerships (STPs) in the NHS, has connections to the next role to be explored of the board as sensor. This role of diplomat is about the stakeholder relationships of the board and organisations, sensed by its members, and acted upon in a manner similar to that of a country’s diplomat whose role it is to represent the country overseas (here organisation in the wider local and national context), build and strengthen relationships, spot and address emerging tensions, and translate cultural, linguistic and other features that may risk the wider relationship and hence future working between the organisation and its partners.

For an NHS board, its governors as well as board members are critical to this diplomacy role, as are its staff, patients and carers. The staff, patient and community engagement work that featured so strongly in the fieldwork for this research is a core part of the diplomatic effort of NHS trusts and foundation trusts. The knitting together of insights from this work, and taking action to develop it further in the context of the organisation’s priorities, is a core function of the board.

Box 14: Focus of the board as diplomat

Boards need to be curious about and attend to the diverse range of stakeholder interests and perspectives that bear on their organisation.

Some of these stakeholder interests will be internal (e.g. staff, patients) and others external and at a local, regional and national level.

The board has a vital role to play as diplomat, identifying, understanding and attending to these relationships, setting priorities as to which matter most and when.

The chair and chief executive have a key role to play in overseeing the myriad stakeholder relationships and helping the board and organisation to read, interpret and decide which ones should be acted upon, individually or collectively.

Professional communications and affairs expertise will likely be needed as part of an overall trust approach to its diplomatic work, as will organisational development time and support to ensure sufficient sharing of and reflecting on these many stakeholder relationships.

Regulators should hold boards to account for the extent to which they have diversity of membership, engage with and reflect an appropriate range of stakeholder interests, and the nature and quality of relationships between the board and its patients, community, staff and other stakeholders.

8.7 The board as sensor

Mary Dixon-Woods and colleagues (2013) point to the vital role of health care boards in being able to sense problems, rather than seek comfort from internal and external data. One of the new lines of enquiry that we pursued in this research (based on our updated literature review and stakeholder interviews) was that of a board assuming a stronger stakeholder role, engaging with others to find out about problems, determine solutions, and seek constantly to improve care. As we have noted, we found boards to be marginally more focused on the priorities of national and central bodies than those of local staff and patients, albeit our case study work revealed many different ways in which hospital boards and wider management were seeking to engage staff more actively and work in new and different ways with patients, carers and local community groups.

Indeed, patient and staff engagement were found to be used by some boards as a powerful way of shaping priorities for service improvement and change, for example when responding to the requirements of national regulators and external reviews and needing to undertake major programmes of quality improvement work. The boards of NHS trusts are comprised ideally of people of a diverse range of expertise and backgrounds, intended to be able to connect with different professions, experience, communities and perspectives. Where they do not themselves have such a diversity of connections, they are expected to be able to build these through other routes, looking constantly outwards to the community and wider public,

inwards to the body of staff and experiences of patients and carers, and sideways to other organisations against which the trust can be benchmarked and challenged. This presents a major challenge to many boards however, which fail adequately to be representative of their local community, particularly in relation to ethnicity and indeed age (Kline 2014); in difficult times where tough decisions need to be made about services and funding, this lack of diversity and representativeness makes the board's role as a sensor of need and priority very vulnerable.

A board therefore needs to be attuned to its role as sensor, and assuring itself of an appropriate range of sources of information about its current services, the needs of patients and the public for improved or other services, and the ways in which it compares with other similar health care organisations locally, nationally, and where appropriate internationally. This calls for skill and wisdom in relation to the use of data (both hard and soft sources) and ensuring that there is sufficient clinical and statistical expertise available to the board and its committees to seek out, interpret, and act on complex and diverse information. The presence of trusted and yet appropriately distant patient and community representatives is vital here, as with a high-performing body of foundation trust governors who can inform, challenge and sense-check a board's progress in identifying and responding to problems and priorities for care. In this way, the board needs to be challenged to be 'restless', as was suggested in this research as being a vital characteristic of a high performing board.

Box 15: Focus of the board as sensor

The board has a central role to play in discerning issues and problems, both externally to the organisation, and internally through staff and patient engagement.

The composition of the board should be sufficiently diverse to ensure that it can adequately reflect and connect with the perspectives, priorities and experience of the people served by the trust, and the staff within the organisation.

The board needs to have a process by which it can assure itself of having appropriately effective means of sensing local problems and issues (within and outside the trust) and doing so in a manner that reflects the diversity of the local population and staff.

Board members need to have regular and tailored training to ensure that they know what data sources to use to notice and evaluate problems and issues related to care quality and safety, and also those concerned with other aspects of performance such as finance, workforce and activity.

In identifying and using such data sources, boards need to be sure that they have access to a mix of soft and hard data, that such data are quality-assured, and that there is an opportunity for regional, national, and where appropriate international benchmarking of indicators.

The board may wish to undertake regular 360 degree appraisal of its performance – as a collective in addition to the individual appraisal that takes place for board members – to ensure that it is sensing its own performance and impact, and is able to take steps to change and improve as necessary.

Regulators have a key role to play in sharing good practice across boards and organisations, for example in relation to: the format, content and data contained within board papers; approaches to undertaking quality improvement work; extent of use of evidence-based frameworks for priority setting; and taking transparent and ethical decisions about health care funding and delivery in a context of financial constraint.

8.8 The board as coach

In the troubled and turbulent times observed in our survey and case study research with the boards of NHS hospitals in England, it was clear that in relation to the core themes of the Francis Report, boards saw their role as one of acting as a coach to the wider organisation. In this, we mean as a sports coach, setting ambition and direction, assessing performance, agreeing areas for development and improvement, and instilling a restless urge for the achievement of higher ambitions. Indeed, the ‘confident and tenacious’ non-executive directors cited by Endacott et al. (2013) are part of what is inferred by this metaphor of coaching.

A vital aspect of a board being able to operate effectively in this coaching mode is for it to have stability and continuity of membership, something that is typically elusive in the NHS where executive directors in particular are subject to regular churn. The wider research literature underlines the importance of stability for a board (although not so much that it

becomes complacent or fails to be restless) and the work of Jones et al. (forthcoming) regards this continuity as an aspect of the ‘quality improvement maturity’ deemed important for effective board working. This calls for boards to be attentive to their membership, and ensuring an appropriate blend of skills and experience, along with time devoted to team and board development.

In this research, we found evidence of an increasingly important and visible role for the chief nurse on NHS boards, thus broadening the interpretation of ‘clinical involvement’ as typically considered significant for board performance, and usually meaning medical representation. The increased focus on quality and safety, and in particular nurse staffing, fundamental care standards, organisational culture and speaking up, all seemed to have encouraged boards to focus attention, support and higher status to the role of chief nurse.

Significant efforts are expected of boards (to set priorities, absorb shock, build and sustain networks of stakeholder relationships, sense the environment, and coach for improved performance) and this can only occur if the board itself models effective development. We know from the research literature that training is required for board members to ensure that the right data can be sought, interpreted and acted on, and appropriate approaches to quality improvement adopted and followed through. This research revealed significant variation in boards’ attention to and investment in training and development for their executive and non-executive members. Whilst such activity might be regarded as a luxury in difficult financial times, we conclude that it is indeed even more important that support and training are given to those charged with steering and coaching major public service organisations to sustained and improved performance.

As part of this development and training, boards need to be encouraged and challenged to ensure that they are aware of and are using the full repertoire of board purposes and mechanisms available to them. Thus they need to be sure that they are able to be the conscience, shock absorber, sensor and coach for the organisation, and able to demonstrate a mix of stewardship (service improvement), agency (holding to account), stakeholder (staff and patient engagement) and resource dependency (building and nurturing external relationships). A vital part of being confident and competent in using this wider repertoire is having regular and protected time for board development that is both topic and behaviour focused. Similarly, providing support and time for board members to be present and visible in the wider organisation is important, for our research underlined the value that this is given by

staff, governors, patients and others, instilling a sense of ‘we are all in this together’ and of the board being connected to its many stakeholders and interests.

Box 16: Focus of the board as coach

Stability and continuity of board membership should be sought by an organisation, in order that it can establish the necessary ‘quality improvement maturity’ needed for higher performance and avoid the costs and disruption of too much ‘churn’.

Whilst stability of the board is important, there is a parallel need to attend to the need for ‘confident and tenacious’ challenge, and to find ways of ensuring that the board remains restless, and focused on benchmarking, questioning and ambitions to develop to the next stage.

The role of the chief nurse is critical to ensuring high organisational performance in relation to quality and safety. Support should be given to the operation and development of this role, seeking to enable clinical involvement and leadership of quality and safety that are broader than ‘medical’ and include nursing and other healthcare professions.

Board training and development – for both executive and non-executive members – is critically important in enabling a restless and high functioning board, and requires sustained attention and investment, even in a tough financial climate.

The board and its members need to be skilled in employing a wide repertoire of board behaviours and attributes, and their training and development should focus on this at both an individual and collective level.

The board and its members need to seek constantly to find ways of maximising their visibility, both within and beyond the organisation. The use of 360 degree board appraisal is one way of assessing whether such visibility is happening or not.

Regulators must ensure that Well-Led board frameworks underpin and inform the activity and approach of a board, and are never allowed to become a mere ‘tick-box’ exercise. A key element of a Well-Led approach must be to explore the extent to which a board is able to both act as coach to its organisation and also be coaching itself, and constantly seeking external review, challenge and support.

8.9 Limitations of the study

We consider that there are three main strengths of this study. First, we have deployed mixed methods, and sourced evidence from a range of sources within and across the work packages. Within the scoping phase, we conducted interviews with key opinion formers *and* updated our literature reviews on healthcare board governance. In work package two, our national survey of board members yielded rich data from comments from respondents as well as quantitative findings from closed questions. In work package three, we carried out surveys of ward and department managers to triangulate findings from interviews, focus groups and board meeting observations at our case study sites. Second, with regards to the case studies, we were involved over a period (our time at each site lasted between 5-12 months) which enabled us to get below the surface, pursue possible lines of enquiry and investigate initiatives as they developed and matured, rather than seeing only a snapshot. Third, the advisory group contributed extensively to the conduct of the research and the lay membership of this group were involved throughout the course of the study from the start.

Limitations include a response rate from the national survey of only 20%. This is mitigated by achieving 90% coverage of all acute and specialist acute trusts in England, but it still means that we have to be cautious about drawing conclusions from the results.

Equally, it is important to acknowledge that although we selected for maximum variety, six trusts agreed to open their doors to us for our case study work, but nine others declined, so this former group may be (literally) more open to external scrutiny and learning than others. In other ways, the six case studies are a small group and they may not be entirely representative: it is interesting, for example, that all six have introduced Schwartz rounds, a reflective and supportive space for staff to share difficult caring experiences. We estimate from data available online on the Point of Care Foundation website (PoCF 2017), that about 70% acute trusts have so far signed up.

The other major limitation is that the research focused on board level leadership changes at a point in time (between March 2016 and May 2017) and it was not possible (nor was it the intention) to arrive at an absolute judgement about changes in quality of patient care, patient experience and clinical effectiveness since Francis in acute hospitals.

There was limited engagement with patients and relatives at case study sites. Recruitment of participants for the patient experience focus groups was organised by the trusts and not by the

researchers. There is potential here for selection bias, and our learning for future studies would be to contact local voluntary organisations to assist with recruitment to avoid this. Reported improvements in Duty of Candour, openness, and patient safety are not generally derived from the patient perspective, and although a degree of corroboration was gained from focus groups, these were limited in number.

Our meeting observations were generally undertaken by either one or two researchers. In retrospect it would have been valuable to invite a lay member of our advisory group to join this activity to embed the public perspective more deeply in this study. In addition, although extensive fieldnotes were taken, a greater observational component would have been beneficial including a structured way of noting teamworking, and information sharing and tracking the actions committed to and their impact on frontline staff.

Furthermore, the national survey data and much (although not all) of the case study material is concerned with self-report and therefore there are potential issues with accurate recall and social desirability bias.

We did not manage to obtain much data on the financial costs of the leadership and governance aspects of implementing the Francis recommendations. The principal reported investment was in increased staffing levels, which is not the main focus of this study.

A member of our advisory group has suggested that we could have scrutinised more carefully the roles and contributions of individuals on boards. The point is well made, given that healthcare boards are composed of individuals as well as being collective entities, and the importance of board dynamics. We therefore intend to carry out further analyses of the data to examine further the roles and contributions of individuals on boards.

8.10 Areas for further research

Given some concerns about, first, the lack of progress in service improvement strategies which work in collaboration with (rather than in consultation with) patients, second, the dominance of experts on boards, and, third, the disappointing data about a continuing lack of diversity, an area for future research includes understanding the impact of the composition of the board, including backgrounds, experiences and perspectives of board members, and how the council of governors can add value and complementarity. Boards would benefit also

from exploring the roll-out and utility of the classification of roles in the healthcare context as conscience, sensor, coach, diplomat and shock absorber. Further research to develop and test the revised framework for effective healthcare boards is required. The question of how boards can exhibit a greater internal locus of control, as policy entrepreneurs and implementers, as opposed to policy victims, should be explored.

The role of middle managers is touched on, and is known to be a longstanding issue in hospitals. Further work is needed to understand how to build capacity and capability of this cadre.

The impact of the work and behaviours of national bodies, and in particular regulators, on senior leaders in hospitals is a theme that runs through the report. An important question to be addressed is what impact external regulation has on the effectiveness of the NHS in achieving the triple goal of improved health outcomes, better patient experience and greater value for money and how external regulation can work hand in hand with improved organisation level leadership.

We intend to use the opportunity of the publication of this report in early 2018 to explore with stakeholders additional avenues for future research.

8.11 Conclusion

This research has explored what organisations in the English NHS have done to respond to Francis and the lessons to be drawn. The overall purpose was to help policymakers and practitioners to understand how leadership and governance of NHS trusts and foundation trusts can be improved, how this might enable better management of organisations, better staff engagement, and hence safer and higher quality care. In undertaking and reporting this research, we have also drawn out the wider lessons for health care organisations more generally, in particular in relation to the governance, leadership and development of the workforce, services and culture that combine to create appropriately compassionate and safe care.

The research has also established a revised repertoire of desirable roles and associated behaviours for boards, drawing from both the theoretical literature and the empirical evidence. Building on the components of the revised theoretical framework for effective

healthcare boards outlined in chapter 7, we can now propose links between the five roles for NHS boards described above (conscience of the organisation, shock absorber, diplomat, sensor and coach) with the behaviours associated with the different theoretical purposes. We have therefore amended our revised framework to include these board roles in table 16 below.

Table 16: Revised framework for effective healthcare board roles

| Theory about purpose of board | Contextual Assumptions | Modes of behaviour | Mechanism | Intended Outcome |
|---|---|--|---|---|
| Agency (holding management to account) | Low trust and high challenge and low appetite for risk | Challenging, supportive Board as sensor | Holding to account and control through intense internal and external performance monitoring | Minimisation of risk and good patient safety record |
| Stewardship (supporting management) | High trust and less challenge and greater appetite for risk | Collaborative, inquiring Board as coach | Broad support in a collective leadership endeavour | Service improvement and excellence in performance |

| | | | | |
|---|--|--|---|---|
| Resource dependency (enhancing the reputation of the organisation) | Importance of social capital of the organisation | Ambassadorial, curious Board as diplomat | Boundary spanning and close dialogue with healthcare partners | Improved reputation and relationships |
| Stakeholder (representing interests of all stakeholders) | Importance of representation and collective effort; risk is shared by many | Listening, questioning Board as conscience | Collaboration | Sustainable organisation, high levels of staff engagement |
| Board power (reconciling competing interests) | Human desire for control | Courageous, probing Board as shock absorber | Use of power differentials | Equilibrium |

When acting as the conscience of the organisation, also described by one stakeholder interviewee in the scoping phase of our study as *'the guiding mind'*, the board needs to embrace both challenging and supportive behaviours. This connects with the agency theoretical perspective (keeper of values and problem sensing not comfort seeking, at the same time as knowing that change comes from being supportive as well as challenging management), and also the wider stakeholder perspective, indicative of listening and questioning behaviours. Acting as shock absorber, the board needs to demonstrate courageous and probing behaviours. This is associated with the board theoretical purpose as reconciling competing interests and balancing demands arising from different sources of power and influence, both internally (particularly from the different healthcare professions)

and externally (from regulators and national bodies). Acting as sensor, the board needs to combine agency type behaviours of seeking assurance, with curious and ambassadorial behaviours to improve the patient experience and staff engagement. The role of the board as diplomat, with accompanying ambassadorial behaviours, relates particularly to the resource dependency theoretical purpose of boards. Finally, the board as coach indicates collaborative and inquiring behaviours. This connects to the stewardship model for boards. This adds up to a framing for individual and collective leadership development for board members to ensure they can be the confident, tenacious, competent and rounded individuals that they need to be.

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Appendices

Appendix 1: List of prompt questions for scoping interviews

List of prompt questions for scoping interviews

Thanks for taking part; assurance of confidentiality; themes only will be reported; recording – do we have permission? Ask for signed consent if F2F or audio record consent if phone interview (see consent form for guidance)

1. What do you think boards are most concerned about at the moment? What are they most focused on?
2. What do you think are the desirable characteristics of board level leadership in our acute hospitals following Francis?
3. What actions would you expect boards of acute hospitals to have taken following the publication of the Francis Inquiry report?
4. What leadership behaviours do you observe / hear about in practice?
5. If there is a difference between 2 and 3, why is there a gap?
6. How does this relate to the behaviours you observe/experience/hear reported most often and least often? Is it one of these? Or a combination? Relate this to the various theories about boards:
 - agency – holding to account - observe low trust/high challenge behaviours
 - stewardship – spirit of collaboration on the board – observe high trust/ comrades together behaviours
 - resource dependency – observe discussion mainly about external environment, relationships and networks
 - stakeholder – observe focus on reaching consensus with all interested parties
 - power – observe dynamics which are all about who is ‘in’ and who is ‘out’
7. What tools/mechanisms/levers do boards use to achieve their desired outcomes?
8. What’s the role of the board in improving safety and quality of care to patients?
9. What difficulties do boards face?
10. What do you think about the idea of introducing a new role of Chief Quality Officer on NHS boards?
11. What questions should we be asking in our national survey?

12. What should be the focus of our inquiry in our 6 case study sites?
13. Healthy Board 2013 guidance – how has this been used or how would you expect it to be used?
14. Fit and Proper Persons requirement – how has this been used or how would you expect it to be used?
15. Anything else you would like to say about changes in board level leadership in acute hospitals after Francis?

Thanks for your time; we would like to invite you to a stakeholder workshop on 24 November where we will be presenting findings from these stakeholder interviews and the latest evidence on effective healthcare boards

NC 070915

Appendix 2: Survey of NHS board members and board secretaries 2016

Survey on leadership changes made by boards following the Francis report (Word version of an online tool)

Dear colleague

Thank you for responding to this confidential survey, which should take no longer than 25 minutes to complete. The survey has 4 sections:

1. About you
2. About the board and its leadership
3. Policy, leadership development and impact
4. Implementing specific requirements arising from the Francis report (E.g., duty of candour, Fit and Proper Persons test)

If you have any queries, email alan.boyd@manchester.ac.uk

Best wishes

Naomi Chambers Professor of Healthcare Management, Alliance Manchester Business School, University of Manchester

1. About you

In approximately what year did you become Board Secretary for your current trust?

What is your gender?

- Female
- Male
- Transgender
- Prefer not to say

What is your ethnicity? Please select one option

| | | | | |
|-------------------------|---|---|--|--|
| White: | <input type="radio"/> White British | <input type="radio"/> Irish | <input type="radio"/> Any other White background | |
| Mixed: | <input type="radio"/> White and Black Caribbean | <input type="radio"/> White and Black African | <input type="radio"/> White and Asian | <input type="radio"/> Any other mixed background |
| Asian or Asian British: | <input type="radio"/> Indian | <input type="radio"/> Pakistani | <input type="radio"/> Bangladeshi | <input type="radio"/> Any other Asian background |
| Black or Black British: | <input type="radio"/> Caribbean | <input type="radio"/> African | <input type="radio"/> Any other Black background | |
| Any Other Ethnic Group: | <input type="radio"/> Chinese | <input type="radio"/> Any other ethnic group | | |
| Prefer not to say: | <input type="radio"/> Prefer not to say | | | |

Were you Board secretary for a different acute or specialist hospital trust when the Francis report was published in February 2013?

- Yes
- No

2. About the board and its leadership

What is the gender and ethnic make-up of the board of your current trust? Please indicate the total number of members in each category, including both executive and non-executive directors. Give your personal assessment if you do not have official figures to hand

_____ members

_____ men

_____ white (white British, Irish, or any other white background)

In practice, how much do you think the board of your current trust emphasises the following purposes?

Give a figure between 0 and 10 for each. (1 = Hardly at all; 3 = A little; 5 = Moderately; 7 = Quite a lot; 9 = Massively)

_____ Holding Executive Directors to account

_____ Supporting the Executive Directors

_____ Enhancing the reputation of the organisation

_____ Representing the interests of all stakeholders

_____ Reconciling competing interests

If you were Board Secretary prior to February 2013, how much do you think the board emphasised the following purposes prior to the publication of the Francis report?

Give a figure between 0 and 10 for each. (1 = Hardly at all; 3 = A little; 5 = Moderately; 7 = Quite a lot; 9 = Massively)

Please respond only if you were board secretary prior to February 2013.

- _____ Holding Executive Directors to account
- _____ Supporting the Executive Directors
- _____ Enhancing the reputation of the organisation
- _____ Representing the interests of all stakeholders
- _____ Reconciling competing interests

Please comment on how you think the board of your current trust views its purpose.

What influence do you think the Francis report has had on this, either directly or indirectly?

the most important challenge.

Please respond only if you were board secretary prior to February 2013.

Top 5 challenges

_____ Patient experience

_____ Patient safety

_____ Clinical effectiveness of care

_____ Staff engagement

_____ Referral-to-treatment (RTT) times

_____ A&E performance

_____ Infection control

_____ Workforce shortage

| |
|--|
| _____ Workforce capability |
| _____ Finances |
| _____ Organisation reputation |
| _____ Organisation viability |
| _____ Relationship with commissioners |
| _____ Service reorganisation across the local health and social care economy |
| _____ Responding to regulators |

If you were Board Secretary prior to February 2013, of the challenges below, which do you think the board regarded as most important for the organisation prior to the publication of the Francis report in February 2013?

Select the top 5 challenges from the list below, and number them from 1 to 5, with 1 being the most important challenge.

Please respond only if you were board secretary prior to February 2013.

| Top 5 challenges |
|---|
| _____ Patient experience |
| _____ Patient safety |
| _____ Clinical effectiveness of care |
| _____ Staff engagement |
| _____ Referral-to-treatment (RTT) times |

_____ A&E performance

_____ Infection control

_____ Workforce shortage

_____ Workforce capability

_____ Finances

_____ Organisation reputation

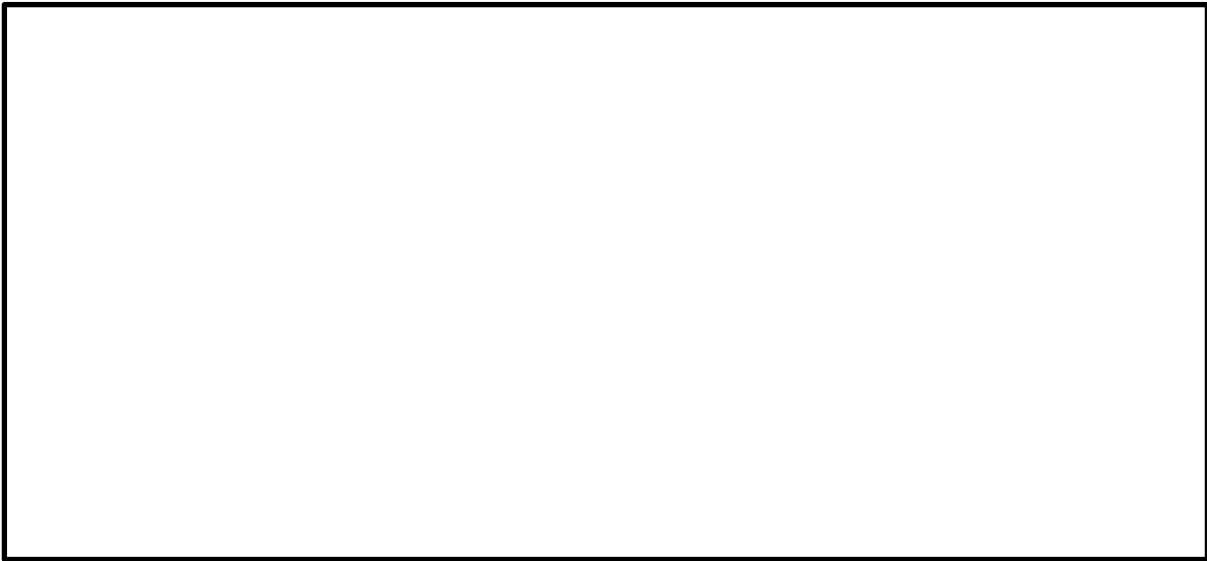
_____ Organisation viability

_____ Relationship with commissioners

_____ Service reorganisation across the local health and social care economy

_____ Responding to regulators

Please comment on how your current board views the most important challenges for the organisation.



What influence do you think the Francis report has had on the priorities of your current board, either directly or indirectly?

How much do you know about what is important to each of the following groups?

Give a figure between 0 and 10. (1 = Hardly anything; 3 = A little; 5 = A moderate amount; 7 = Quite a lot; 9 = A massive amount)

_____ Patients cared for by the organisation, and their families

_____ Staff employed by the organisation

_____ Regulators

If you were a board member prior to February 2013, Prior to the publication of the Francis report in February 2013, how much did you know about what was important to each of the following groups?

Give a figure between 0 and 10. (1 = Hardly anything; 3 = A little; 5 = A moderate amount; 7 = Quite a lot; 9 = A massive amount)

Please respond only if you were on the board prior to February 2013.

_____ Patients cared for by the organisation, and their families

_____ Staff employed by the organisation

_____ Regulators

What influence do you think the Francis report has had on your current board knowing about what is important to patients, staff and regulators?

How have the following organisation-wide policies or statements developed in your current trust since the publication of the Francis Report in February 2013?

Tick one option in each row

| | Newly established since Francis | Pre-Francis policy has been formally reviewed and reissued | Pre-Francis policy is still in place; not formally reviewed since | No organisation-wide policy | Don't know |
|---|---------------------------------|--|---|-----------------------------|-----------------------|
| Statement of common purpose, guiding principles, values and behaviours for the board and the organization | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Policy on learning and improvement | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Policy on listening and responding to patients | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Policy on how to raise concerns | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Policy on complaints handling | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Policy on openness about patient safety incidents | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Policy on improving staff wellbeing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Which of the following actions to improve board-level leadership has your organisation instituted since the publication of the Francis report in 2013?

| | Newly established since Francis | Done pre-Francis; formally reviewed since | Done pre-Francis; not formally reviewed since | Not done | Don't know |
|---|---------------------------------|---|---|-----------------------|-----------------------|
| Hearing and discussing patient stories at board meetings | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Listening Into Action surgeries or events for staff led by board members | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other engagement activities with frontline staff, led by board members (please state) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Regular reports to the board on ward-by-ward staffing levels | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Collective board development days or half days (not board seminars or briefing sessions) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Individual executive leadership development | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| External review of the climate in the organisation, including board-level leadership and values | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other actions (please state) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

In total, approximately how many days of individual leadership development have you participated in during the last 12 months?

Exclude collective board leadership development sessions, seminars and briefing sessions

If you were Board Secretary prior to February 2013, how much impact do you think the board of your current organisation has made on each of the following since February 2013?

Give a figure between -5 and +5 for each. (-5/-4 = Made it massively worse; -3/-2 = Made it quite a lot worse; -2/-1 = Made it a little worse; 0 = Made no difference; 1/2 = Made it a little better; 2/3 = Made it quite a lot better; 4/5 = Made it massively better)

If you don't know, leave your answer blank

Please respond only if you were board secretary prior to February 2013.

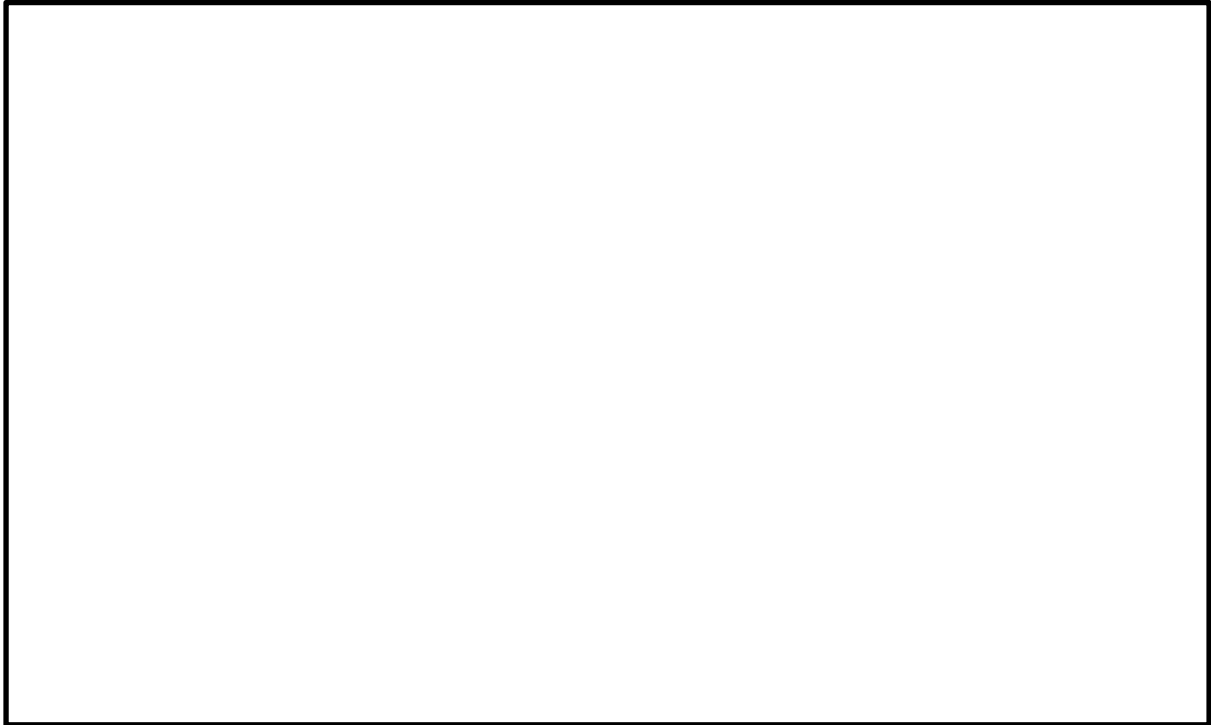
- _____ Organisational performance
- _____ Patient safety
- _____ Patient experience
- _____ Patient voice
- _____ Board visibility within the organisation
- _____ Staff engagement
- _____ External relationships with other stakeholders in the local health and social care economy

Which of the following has your current board experienced as significant barriers to improving its leadership? Tick all that apply

- Recruitment and retention of Executive Directors
- Recruitment and retention of CEO
- Financial pressures
- Meeting demands of regulators
- Poor relationships with others in the local health and social care economy
- Acting on the many reports for boards issued after Francis
- Other barriers (please state) _____

If you were Board Secretary prior to February 2013, please comment on how you think the leadership style and behaviours of the board of your current trust have changed since February 2013.

Please respond only if you were board secretary prior to February 2013.

A large, empty rectangular box with a black border, intended for the respondent to provide their comments on the leadership style and behaviours of the board of their current trust.

If you were Board Secretary prior to February 2013, what influence do you think the Francis report has had on the board's leadership style and behaviours, either directly or indirectly?

Please respond only if you were board secretary prior to February 2013.

A large, empty rectangular box with a black border, intended for the respondent to provide their answer to the question above. The box is currently blank.

4. Implementing specific requirements

What actions has your current organisation taken to implement the Fit and Proper Persons Requirement for positions on your board? Tick all that apply

- Carried out background checks on existing board directors
- Carried out background checks on new appointments (since the requirement came into force in November 2014)
- Responded to CQC concerns about directors
- Other actions (please state)

-
- No actions have been taken

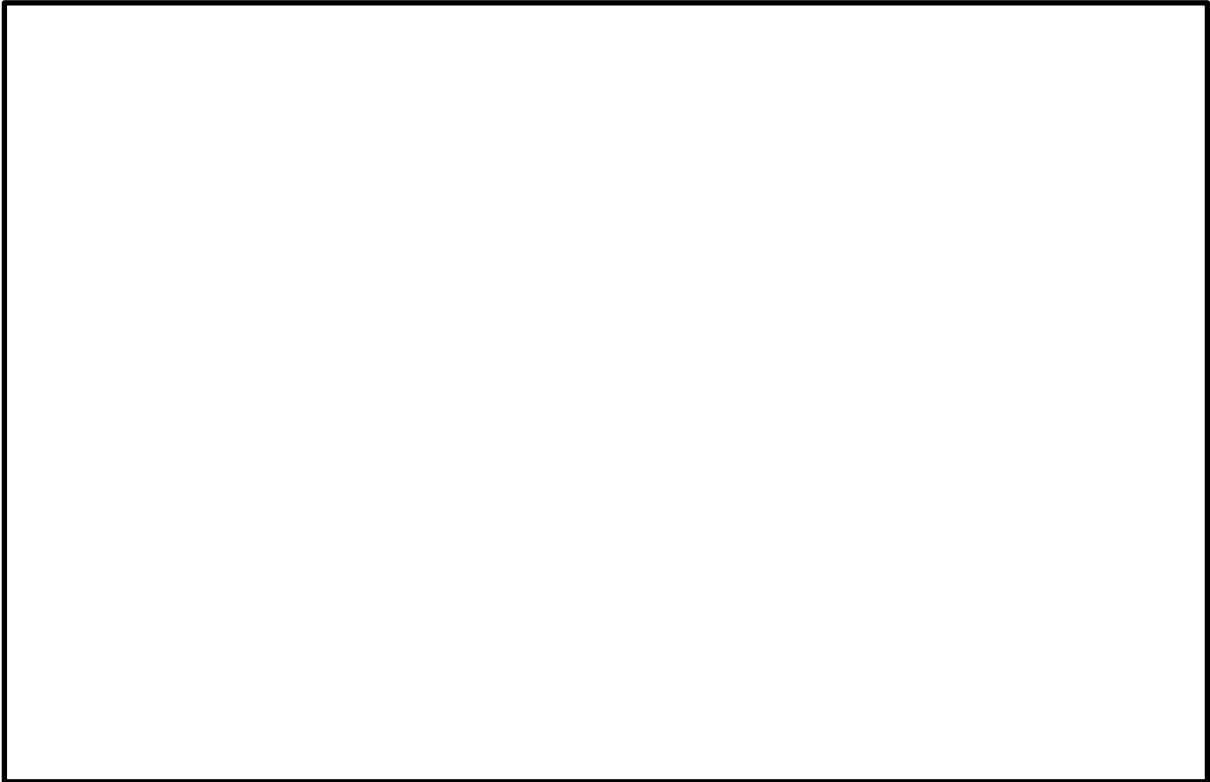
Please comment on the impacts of implementing the Fit and Proper Persons Requirement.

What has been the impact of implementing the duty of candour on the following aspects of your current organisation? Tick all that apply

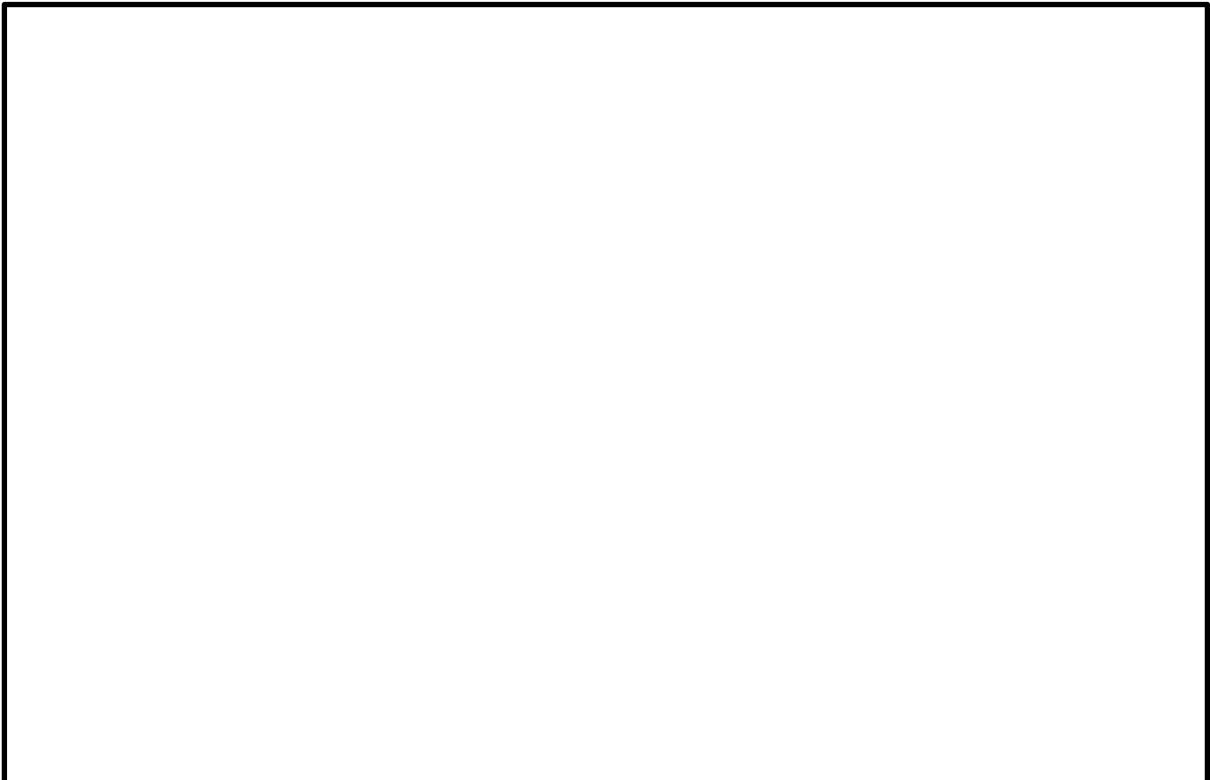
| | Increased a lot | Increased a little | No change | Decreased a little | Decreased a lot | Don't know |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Learning and improvement | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Openness of the culture | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Organisational reputation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Patient confidence in the organisation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Number of complaints | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Number of litigation claims | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Whistleblowing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other (please state below) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Please comment on the impacts of implementing the duty of candour.

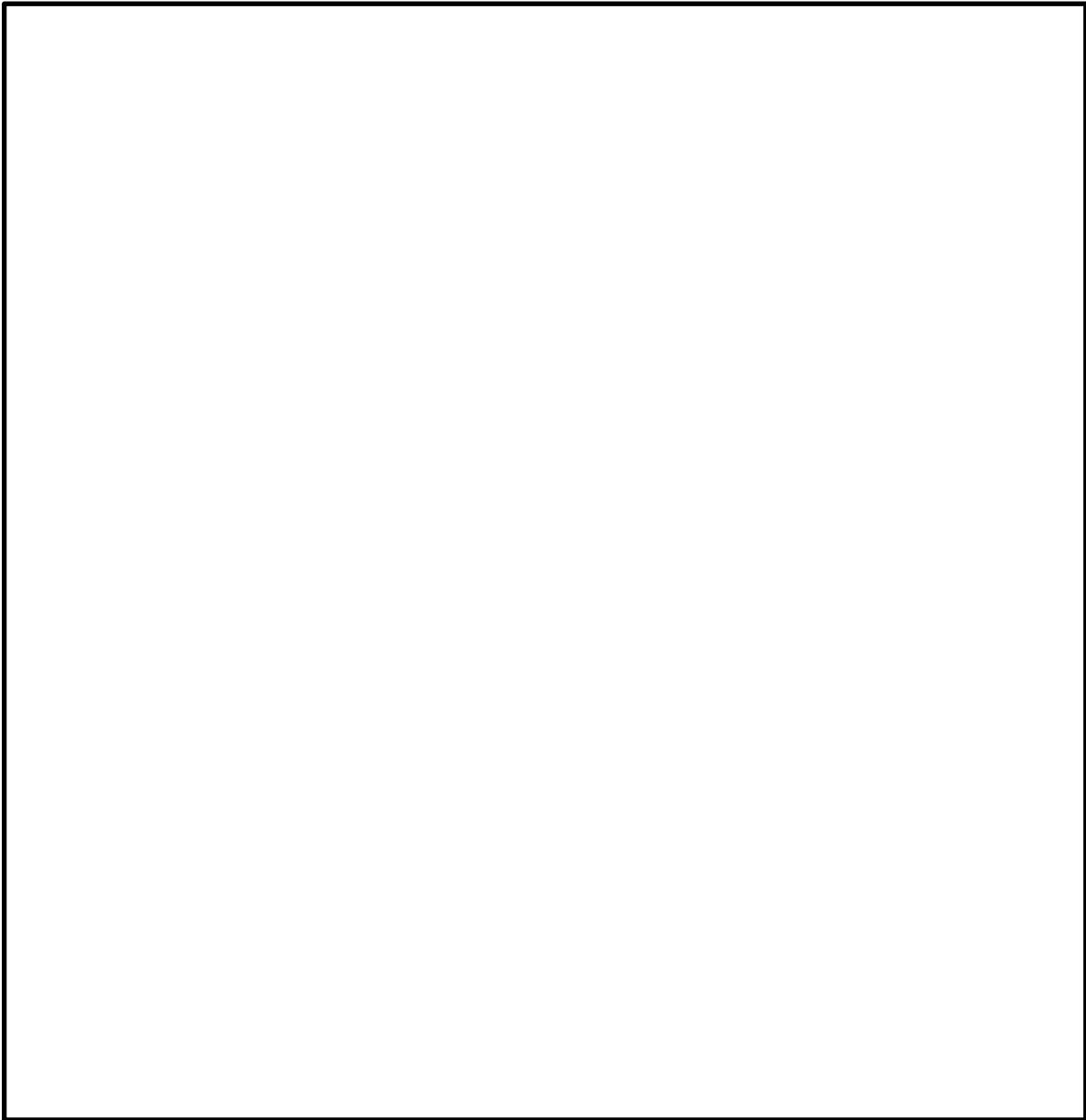
How has your current board implemented the Freedom to Speak Up Guardian role?

A large, empty rectangular box with a black border, intended for the user to provide their response to the question above.

What plans does the board of your current organisation have for improving its leadership over the next 12 months?

A large, empty rectangular box with a black border, intended for the user to provide their response to the question above.

Are there any other comments you would like to make about the board level leadership in your current organisation?

A large, empty rectangular box with a black border, intended for the respondent to provide their comments on board level leadership in their current organisation.

Appendix 3: Development and administration of NHS board members survey questionnaire

The survey questions were devised in order to answer relevant research questions from our proposal, bearing in mind findings from the initial stakeholder interviews, existing theories about boards and recommendations and guidance from policy documents. A mix of tick box and free text responses were sought in order to facilitate both comparative statistical analyses and an understanding of underlying issues and the influence of contextual factors. We were aware of needing to keep the questionnaire short because board members have many demands on their time and because of evidence of association between length of survey questionnaires and diminishing response rates (Galesic and Bosnjak 2009).

Comments on the survey questionnaire were sought from Advisory Group members. Members were sent a link so that they could view/complete a draft of the survey online. The survey questionnaire was then discussed at a meeting of the Advisory Group, with email comments also being received from some group members who were unable to attend. Later, Advisory Group members were also given an opportunity to comment on a final draft of the survey and on draft invitation letters.

Cognitive interviews were conducted in order to make the survey easier to complete and to improve the quality of the information collected. Through the interviews we gained insights into how respondents might understand the survey questions, and practical problems they might encounter in trying to complete the survey. Interviewees were personal contacts of members of the research team. 5 people were interviewed during between November 2015 and January 2016:

1. Medical Director of an acute trust
2. Former Finance Director of an acute trust
3. Chair of an acute trust
4. Board secretary of an acute trust
5. Non-Executive Director of an acute trust

The general format of the interviews was that the interviewee was asked to answer some of the survey questions. After each answer, the interviewer asked some follow up questions

about the thought processes of the interviewee. Notes were taken and subsequently discussed by the research team. The exact format and conduct of each interview varied, depending on the circumstances and preferences of the interviewee, their time availability, which survey questions had been covered in previous interviews, and the instincts of the interviewer.

If a computer with internet access was available, then the interviewee accessed the online survey directly. This was preferable, being closer to the experience of actual respondents. If no suitable computer was available then printed copies of the survey questions were used. One interviewee completed the survey online prior to the interview and was asked to recall her experiences.

A set of generic probes were prepared for use by the interviewer as appropriate (table 17):

Table 17: Interview probes

| Probe | Example |
|------------------------------|---|
| Comprehension/Interpretation | What does the term 'X' mean to you? |
| Paraphrasing | Can you repeat the question I just asked in your own words? |
| Confidence judgement | How sure are you that your answer is accurate? |
| Recall | How do you remember that information (you provided in your answer)? |
| Specific | Why do you think that (view expressed in your answer)? |
| General | How did you arrive at that answer? Was that easy or hard to answer? I noticed that you hesitated - tell me what you were thinking |

Particular probes were also identified that might be asked in relation to particular survey questions. For example:

- After reading the introduction - How does this make you feel about the survey?
- After being asked if they would be willing to provide the name of a previous trust they worked for and to answer questions about it – What were you thinking?

- After viewing answer options containing words or phrases that we suspected might be interpreted in different ways:
 - What does the term ‘management’ in question 1 mean to you?
 - What does the term ‘competing interests’ in question 5 mean to you?
 - What does the term ‘organisation viability’ mean to you?
 - What does the term ‘management challenge for clinical leaders’ mean to you?

Various changes were made to the wording of the survey introduction and questions as a result of the cognitive interviews. A few questions were removed because it emerged that they might be difficult for some interviewees to answer. A few additional questions were inserted. There were numerous rewordings of phrases to improve clarity.

Survey administration

Names, job titles and email addresses of relevant board members and secretaries were identified using Binley’s database. The database had almost full coverage of Chairs, Medical Directors, Nursing Directors and Finance Directors, including email addresses for over 90% of people in these roles. There was almost full coverage of Chief Executives, but only 68% of entries specified an email address. Board Secretaries were harder to identify, as many of their job titles did not actually contain the word ‘Secretary’, but we were able to identify about 90% of Board Secretaries in the database, and about 90% of these had email addresses specified, giving 80-85% coverage by email. Coverage of Non-Executive Directors appeared good, but only about 33% of those listed in the database had email addresses specified.

In view of these gaps in the database, and the suggestion of one cognitive interviewee that phoning the board secretary might be a good way to engage them and to access other board members, particularly CEOs and NEDs, we piloted phoning the board secretary. We did this for 9 Trusts, chosen at random, in late December 2015 and early January 2016. First we checked the Trust website to identify the names and roles of any board members who might potentially not have been included in our database. Then we phoned the board secretary to inform them about the research and to ask them if they would check and update our list of board members and their email addresses. In some instances this did bring our contact database more up to date and produced a commitment from the board secretary to encourage board members to respond to the survey. It was time consuming however. The Board

Secretary was not typically immediately available to speak on the phone, and there was not always a person in post. When contact was made, there was usually a request for further information to be emailed through. Some Board Secretaries did not want to act as intermediaries between ourselves and board members, and there was a reluctance to provide us with the email addresses when NEDs used their own personal email addresses.

We decided to continue with this initial phone call approach for 50% of the Trusts, picking those where we either had no email address for the Board Secretary, or where the number of missing email addresses across all board members was the greatest, in order to maximise the benefits for updating our database. Following contact with the Board Secretary we updated our database as appropriate and emailed out survey invitations either directly, or via the Board Secretary, as they preferred. Where we had not been able to make satisfactory contact with the Board secretary after at least three phone calls we emailed out survey invitations to those people for whom we had email addresses.

For the remaining 50% of Trusts we proceeded as follows:

1. An initial invitation email was sent to the board secretary, containing a link for them to take the survey, and informing them that in a week's time we would email them survey invitations to forward on to board members for whom we have no email address.
2. In the meantime, we checked the Trust website to identify the names and roles of any board members who might potentially not have been included in our database.
3. 7-10 days after the initial invitation email to the board secretary, we emailed survey invitations direct to all board members for whom we had email addresses. For those board members for whom we had no email address, or whose invitation email 'bounced', we emailed their invitations to the board secretary, with a request for them to forward on the invitation.

If people we had emailed directly had not responded to the survey within about 3 weeks, a reminder was emailed. Email invitations and reminders were issued between 24th January 2016 and 28th April 2016. A final postal invitation was sent out to people for whom we did not have an email address, or who had not responded since their email reminder. The postal invitation contained a link to take the survey online plus a hard copy version of the survey and a pre-paid reply envelope in case the person preferred to respond on paper. Postal

invitations were posted between early April and early May and resulted in over 60 additional responses. The survey was closed on 21 May 2016.

Appendix 4: Details of multivariate statistical analyses

Regression summaries – Board emphasis on purposes- current

| Dependent variable | Statistically significant independent variables | | |
|---|---|---|---|
| | Positive | Negative | Doubtful (isn't robust enough once Cook is applied) |
| Total score across all purposes (using CQC) | <ol style="list-style-type: none"> Is Good or Outstanding Is NED plus Chair | <ol style="list-style-type: none"> RTT Responding to regulators Finances | |
| Total score across all purposes (using NSS) | <ol style="list-style-type: none"> NSS scores Is NED plus chair | <ol style="list-style-type: none"> Responding to regulators Finances | <ol style="list-style-type: none"> Is nursing director Is RTT Is female Is exec |
| Holding to account score (using CQC) | <ol style="list-style-type: none"> Is Good or Outstanding Clinical effectiveness | | |
| Holding to account scores (using NSS) | <ol style="list-style-type: none"> Clinical effectiveness NSS score | <ol style="list-style-type: none"> Is recent board member | |
| Supportiveness score (using CQC) | <ol style="list-style-type: none"> Is NED plus Chair Is Good or Outstanding Workforce shortage | <ol style="list-style-type: none"> RTT Finances | |
| Supportiveness scores (using NSS) | <ol style="list-style-type: none"> is NED plus Chair NSS score | <ol style="list-style-type: none"> Finances Organisation reputation RTT | <ol style="list-style-type: none"> Workforce shortage |
| Reputation score (using | <ol style="list-style-type: none"> Is Good or | <ol style="list-style-type: none"> Finances | <ol style="list-style-type: none"> RTT |

| | | | |
|---------------------------------------|---|---|---------------------------------------|
| CQC) | <p>Outstanding</p> <p>2. Is non-exec</p> <p>3. Is nursing director</p> <p>4. Infection control</p> | 2. Is female | |
| Reputation score (using NSS score) | <p>1. NSS score</p> <p>2. Is non-exec</p> <p>3. Is nursing director</p> | <p>1. Finances</p> <p>2. Is female</p> <p>4. Clinical effectiveness of care</p> | 1. Org viability |
| Representing stakeholders score (CQC) | <p>1. Is Good or Outstanding</p> <p>2. Is NED plus chair</p> <p>3. Service reorganisation</p> <p>4. Org viability</p> | <p>1. Finances</p> <p>2. Responding to regulators</p> | |
| Representing stakeholders score (NSS) | <p>1. NSS score</p> <p>2. Is NED plus chair</p> <p>3. Is nursing director</p> | <p>1. Responding to regulators</p> <p>2. Finances</p> | 3. Is female |
| Reconciling interests score (CQC) | 1. Is Good or Outstanding | <p>1. Responding to regulators</p> <p>2. Finances</p> | <p>3. Is female</p> <p>4. Is exec</p> |
| Reconciling interests score (NSS) | <p>1. NSS score</p> <p>2. Is NED plus Chair</p> | <p>1. Responding to regulators</p> <p>2. Finances</p> | <p>1. Is female</p> <p>2. Is exec</p> |

Regression summaries: Emphases on purposes - pre Francis, and current-pre Francis

| Dependent variable | Statistically significant independent variables | | | |
|---|---|--|---|---|
| | Positive | Positive doubtful | Negative | Negative Doubtful |
| Pre-Francis score across all purposes (using 2015 NSS scores) | 1) Is Good or Outstanding (not significant for NSS scores) 2) Organisation viability | | 1) Responding to regulators 2) Is Nursing Director | |
| Pre-Francis score across all purposes (using 2013 NSS scores and pre Francis challenge scores) | 1) Is Good or Outstanding | 1) Is NED plus Chair 2) Workforce shortage | 1) Finances 2) infection control 3) Is Nursing Director | 1) A&E performance 2) is CEO (added post Cook) |
| Pre-Francis score across all purposes (using 2013 & 2012 NSS scores and pre Francis challenge scores) | 1) Is Good or Outstanding | 1) Is NED plus Chair 2) 2) Workforce shortage | 1) finances 2) infection control 3) is Nursing Director | 1) Is CEO (added post Cook) 2) A&E performance |
| Difference post minus pre-Francis scores across all purposes | | 1) Organisation reputation 2) Patient experience (became significant once Cook was applied) | | |
| Difference post minus pre-Francis scores across all purposes (using 2013 NSS scores and pre Francis challenge scores) | 1) Finances | 1) Organisation reputation | | 1) Workforce shortage |

| | | | | |
|--|---|--|---|------------------------|
| | | | | |
| Difference post minus pre-Francis scores across all purposes (using 2013 & 2012 NSS scores and pre francis challenge scores) | 1. Finances | 1. A&E performance 2. Is Female (added post Cook) 2. Organisation reputation | 1. Workforce shortage | |
| Difference - accountability | 1) Is Board secretary 2) Service reorganisation across the local health econ | | | |
| Difference - supportive | 1) Is CEO 2) Patient safety challenge | 1) Patient experience | | |
| Difference - reputation | | | 1) Patient experience 2) NSS scores (not significant for CQC rating) | |
| Difference - stakeholder | | | 1) Is Medical Director | 1) Is Finance Director |
| Difference – reconciling interests | 1) Organisation reputation 2) Staff | 1) Workforce shortage (became significant once | | |

| | | | | |
|--|------------|-------------------|--|--|
| | engagement | Cook was applied) | | |
|--|------------|-------------------|--|--|

Further analyses

Report

| GENDER | | Holding Executive Directors to account | Supporting the Executive Directors | Enhancing the reputation of the organisation | Representing the interests of all stakeholders | Reconciling competing interests |
|--------|----------------|--|------------------------------------|--|--|---------------------------------|
| Female | Mean | 7.4318 | 7.1364 | 6.9771 | 6.5086 | 6.3771 |
| | N | 176 | 176 | 175 | 175 | 175 |
| | Std. Deviation | 1.68892 | 1.71169 | 2.02273 | 2.00536 | 2.20645 |
| Male | Mean | 7.7012 | 7.4315 | 7.4066 | 7.0083 | 6.8257 |
| | N | 241 | 241 | 241 | 241 | 241 |
| | Std. Deviation | 1.36701 | 1.55070 | 1.57076 | 1.65326 | 1.89811 |
| Total | Mean | 7.5875 | 7.3070 | 7.2260 | 6.7981 | 6.6370 |
| | N | 417 | 417 | 416 | 416 | 416 |
| | Std. Deviation | 1.51519 | 1.62516 | 1.78532 | 1.82423 | 2.04303 |

ANOVA

| | | Sum of Squares | df | Mean Square | F | Sig. |
|--|----------------|----------------|-----|-------------|-------|------|
| Holding Executive Directors to account | Between Groups | 7.384 | 1 | 7.384 | 3.233 | .073 |
| | Within Groups | 947.671 | 415 | 2.284 | | |
| | Total | 955.055 | 416 | | | |
| Supporting the Executive Directors | Between Groups | 8.862 | 1 | 8.862 | 3.375 | .067 |
| | Within Groups | 1089.848 | 415 | 2.626 | | |

| | | | | | | |
|--|----------------|----------|-----|--------|-------|------|
| | Total | 1098.710 | 416 | | | |
| Enhancing the reputation of the organisation | Between Groups | 18.702 | 1 | 18.702 | 5.937 | .015 |
| | Within Groups | 1304.058 | 414 | 3.150 | | |
| | Total | 1322.760 | 415 | | | |
| Representing the interests of all stakeholders | Between Groups | 25.318 | 1 | 25.318 | 7.731 | .006 |
| | Within Groups | 1355.721 | 414 | 3.275 | | |
| | Total | 1381.038 | 415 | | | |
| Reconciling competing interests | Between Groups | 20.401 | 1 | 20.401 | 4.934 | .027 |
| | Within Groups | 1711.789 | 414 | 4.135 | | |
| | Total | 1732.190 | 415 | | | |

Appendix 5: Interview topic guide for case study sites

Semi-structured interviews in 6 x case study sites

(n= 12; board members, commissioners, staff and patient representatives, Healthwatch, trust advisers)

Interview topic guide – please note this is a guide and the precise choice and sequencing of questions will vary depending on the role and background of the participant

1. What is your role in this organisation; how long have you been involved here?
2. As far as you know, what are the priorities of the board of this organisation? How does the board handle 'policy thickets' i.e. all the various policies and guidance that they are required to respond to?
3. What in the external environment is constraining or influencing the board at the moment?
4. What mechanisms do the board use to hear the voices of all the different stakeholders with an interest in this hospital?
5. As far as you know, what board-level actions have been taken and what board processes have been put in place to implement the recommendations from the Francis Inquiry?
6. What do you think are the barriers to implementing Francis?
7. How has the Francis report impacted on frontline staff in wards and departments?
8. How well do you think frontline staff are aware what the Francis Report was about?
9. What are the costs of implementing Francis have been in terms of investment in leadership and culture change?
10. Can you give an example of a recent patient safety or patient experience issue that the organisation has been tackling? What is the story here?
11. What part do patients play in service redesign and service improvement? Can you give an example?
12. What part do frontline staff play in service redesign and service improvement? Can you give an example?
13. How does the board decide what goes in the private and public section of the agenda?

14. Can you describe how the board and the top management team communicates with the rest of the organisation?
15. What structural changes have been made to improve communication flows through the organisation for staff and for patients?
16. How embedded is the approach to quality improvement – systematic service improvement - use of service improvement tools and technologies?
17. Can you describe how complaints are handled at the trust? Have changes been made to the complaints policy recently?
18. Can you describe the policy for hearing about staff concerns? (Freedom to Speak Up)
19. As far as you know, how has the Duty of Candour requirement changed things? What has been the financial cost to the organisation?
20. As far as you know, how has the Fit and Proper Persons Requirement been implemented? What has been the financial cost to the organisation?
21. How has the culture - the way things are done round here changed over the past three years?

Appendix 6: Focus group discussion topic guide for case study sites

- What do you think are the main leadership challenges facing this hospital?
- What is your opinion of the commitment of this organisation to the principles of openness, transparency and candour as recommended in the Francis Report?
- What is the culture of this organisation? i.e. the way things are done round here
- What changes have taken place in the last three years in relation to the patient experience of care here?
- How does the board of the hospital take into account the views of patients receiving care?
- How do the clinical teams make use of the views of patients?

Appendix 7: Ward and department managers' survey

Q1.1 FRANCIS REPORT RESEARCH PROJECT

This survey seeks to gather information about how your Trust has responded to the Francis Report, for example by putting patients first, developing a culture of care, encouraging openness and transparency, having effective leadership and accountability, empowering staff and working in partnership, and improving quality and innovation.

This survey is being undertaken as part of national research by an independent team of researchers funded by the Department of Health, and with the support of (person), (role).

We have sent this questionnaire to all ward, department and unit managers in your organisation.

Your responses to the survey will be confidential. They will be seen only by the academic research team members, and neither you nor your Trust will be named in any of our reports.

The questionnaire goes up to Q3.23; please press the purple >> button at the bottom of pages to continue.

Thank you for your time.

Professor Naomi Chambers

Alliance Manchester Business School,

University of Manchester,

Booth Street East,

Manchester.

M13 9SS

naomi.chambers@manchester.ac.uk

Q2.1 What is your job title?

Q2.2 How would you describe your position?

- First-line manager
- Senior manager
- Other (please specify) _____

Q2.3 Which Directorate do you work in?

Q2.4 In what year did you start working at this Trust?

1966 1971 1976 1981 1986 1991 1996 2001 2006 2011 2016



Q3.1 What do you see as the most important 5 challenges for the Trust?

Please drag 5 items from the list to the box.

Put the most important challenge at the top - you can reorder items within the box by dragging them:

| Items | Top 5 challenges |
|-----------------------------------|-------------------------|
| Relationship with commissioners | |
| Patient safety | |
| Cancer waiting times | |
| Staff engagement | |
| Finances | |
| Referral-to-treatment (RTT) times | |
| Workforce shortage | |
| Clinical effectiveness of care | |
| Workforce capability | |
| Reputation of the Trust | |
| Viability of the Trust | |
| Patient experience | |

Q3.2 How familiar would you say that staff in your ward/department/unit are with the recommendations of the Francis Report published in 2013 on:

putting patients first, developing a culture of care, encouraging openness and transparency, having effective leadership and accountability, empowering staff and working in partnership, and improving quality and innovation?

| | Not at all familiar | Somewhat familiar | Mostly familiar | Completely familiar | Don't know |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Q3.3 Comments about staff familiarity with the recommendations of the Francis report:

Q3.4 What changes have taken place in the last three years in your ward/department/unit?

Tick all that apply:

| | Got worse | Stayed the same | Improved |
|---|-----------------------|-----------------------|-----------------------|
| Quality of patient experience has: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Staff morale has: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Investigation of serious incidents has: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Relationships with other local health and care organisations has: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Involving patients in planning and decision making has: | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other change (please specify) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other change (please specify) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other change (please specify) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Q3.5 Comments about changes in your ward/dept/unit:

Q3.6 Over the last 2 or 3 years, how much action you have taken as a manager to implement the following recommendations arising from the Francis Inquiry.

None A very great deal

0 10 20 30 40 50 60 70 80 90 100

Duty of candour Not relevant to my role or period of employment

Safe staffing levels Not relevant to my role or period of employment

Enabling patients to feed back comments and concerns about their care Not relevant to my role or period of employment

Leadership training for yourself and your staff Not relevant to my role or period of employment

Other actions (please state) Not relevant to my role or period of employment

Q3.7 Comments on the actions you have taken:

Q3.8 What have been the additional staff costs and other financial costs of your actions?

Q3.9 What other resource implications have there been from actions taken by the Trust to implement the Francis Inquiry recommendations? (For example have there been new committees, working groups, new governance processes, other calls on management time?)

Q3.10 What do you think are the barriers to improving leadership in this Trust at the level of:

your ward/department/unit:

your Division/Directorate:

your Trust's Board:

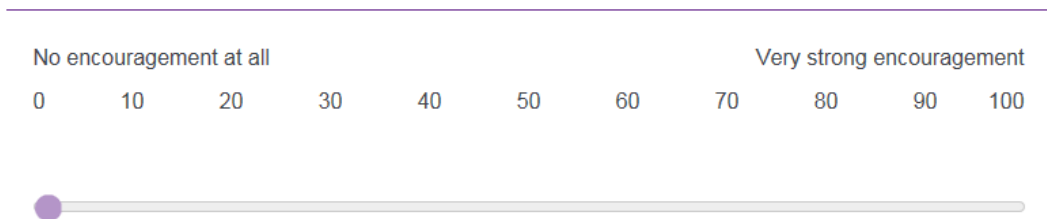
Q3.11 What do you think has helped to improve leadership in this Trust at the level of:

your ward/department/unit:

your Division/Directorate:

your Trust's Board:

Q3.12 To what extent are front-line staff and managers encouraged to innovate to do things differently, by allowing them freedom to make decisions and to take reasonable risks



Q3.13 Comments about encouragement to innovate:

Q3.14 How do you rate the opportunities for management training and development for staff in this Trust?



Q3.15 Comments about opportunities for management training and development:

Q3.16 In your experience, how visible are the Board members (the executive directors e.g. Medical Director, Chief Nurse, Finance Director and non-executive directors, the Chair and the Chief Executive) to staff in your ward/department/unit?

Not at all visible Extremely visible
0 10 20 30 40 50 60 70 80 90 100



Q3.17 Comments about visibility of Board members:

Q3.18 In your experience how strongly is the Board and senior management committed to the following:

Not at all committed Extremely committed
0 10 20 30 40 50 60 70 80 90 100

Openness (allowing concerns to be raised and aired) I'm not able to comment on this

A horizontal slider scale from 0 to 100. The slider is currently positioned at 0.

Transparency (sharing of information) I'm not able to comment on this

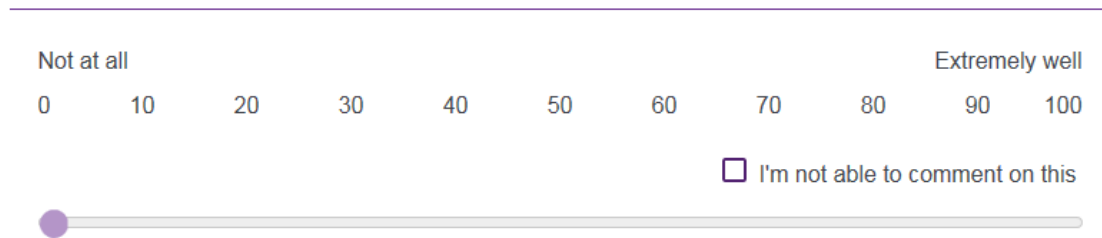
A horizontal slider scale from 0 to 100. The slider is currently positioned at 0.

Candour (ensuring that patients who have been harmed are informed of the fact) I'm not able to comment on this

A horizontal slider scale from 0 to 100. The slider is currently positioned at 0.

Q3.19 Comments about Board and senior management commitment:

Q3.20 In your experience, to what extent do the Board and senior management team reflect and model the values of the Trust in their leadership style and behaviours?



Q3.21 Comments about leadership style and behaviours:

Q3.22 In your own words, please describe the change in culture ('the way things are done around here') at your Trust over the last 3 years

Q3.23 Please add any other comments you would like to make about changes made at this Trust over the last 3 years

Appendix 8: Coding framework for case study transcripts

(high level Francis themes in underlined italics as the main codes)

NB 5 research objectives (ROs):

1. To identify the different ways in which hospital boards have sought to implement the recommendations on leadership in response to Francis
2. To identify which mechanisms used by boards of NHS trusts and Foundation Trusts have led to improvements
3. To explore the early intended and unintended effects
4. To examine the financial and non-financial costs of developing and implementing new policies, processes and actions for improving board and organisational leadership
5. To explore the enablers and barriers in improving board level leadership

| Code | Relates to ROs | Headings for chapter on case study findings |
|--|----------------|---|
| <u>Francis Report</u> | | |
| | 1 | How the trusts responded |
| Impact of the inquiry report | 3 | ' |
| Actions taken as a consequence of the inquiry report | 1 | ' |
| Unintended effect (s) | 3 | ' |
| Costs of Francis | 4 | Costs of implementing changes |
| <u>Putting patients first</u> | | |
| | 1 | Board efforts in relation to putting patients first |
| Patient complaints | 1 and 2 | ' |
| Patient safety | 1 and 2 | ' |
| Patient experience | 1 and 2 | ' |
| Role of HealthWatch | 3 | ' |
| | | |

| | | |
|------------------------------------|---------------|--|
| <u>Culture and values</u> | 1 | Organisation culture (including degree of openness) |
| <u>Openness</u> | 1 | ' |
| Duty of candour | 1 and 2 and 3 | Board efforts in relation to putting patients first |
| Freedom to Speak Up | 1 and 2 and 3 | Board efforts in relation to staff engagement |
| Media interest and relations | 3 | Main local contextual issues |
| | | |
| <u>Accountability</u> | 1 | How the trust responded |
| Fit and Proper Persons Requirement | 1 and 3 | ' |
| | | |
| <u>Improving leadership</u> | 1 and 5 | Composition, role and behaviours of the board |
| Composition of the board | 2 | ' |
| Effectiveness of the board | 2 | ' |
| Board dynamics/tone | 2 | ' |
| Role of the CEO | 2 | ' |
| Role of the board | 2 | ' |
| Role of subcommittees | 2 | ' |
| Role of the chair | 2 | ' |
| Non executive challenge | 2 | ' |
| Non executive support | 2 | ' |
| Role of governors | 2 | ' |
| Workforce | 1 and 2 | ' |
| Enablers | 5 | Enablers and barriers to implementing Francis recommendations |
| Barriers | 5 | ' |
| Quality/finance tension | 4 and 5 | Progress on quality and safety/ Organisation culture/Enablers and barriers |

| | | |
|-------------------------------------|---------------|--|
| <u>Empowering staff</u> | 1 and 3 | Board efforts in relation to staff engagement |
| Listening to staff | 1 and 2 and 3 | ' |
| Schwartz rounds | 2 | ' |
| <i>Staff engagement</i> | 2 | ' |
| <u>Improving quality</u> | 1 | Involvement of staff and patients in quality and service improvement / Culture |
| Service improvement | 2 and 3 | ' |
| Measuring quality | 2 and 3 | ' |
| | | |
| | | |
| <u>Innovation</u> | 1 | Culture/ Trust priorities |
| Change programme | 2 | ' |
| Involvement in research | 3 | ' |
| | | |
| <u>Policy context</u> | 5 | Enablers and barriers |
| STPs/new models of care | 5 | ' |
| Regulators | 5 | ' |
| Control of system service pressures | 5 | ' |
| Government policies | 5 | ' |
| Commissioners | 5 | ' |

Naomi Chambers 160317

Appendix 9: National voices assessment of patient and public involvement in research study

RESEARCH PROJECT ON NHS BOARD LEADERSHIP CHANGES FOLLOWING THE FRANCIS REPORT:

AN ASSESSMENT OF PATIENT AND PUBLIC INVOLVEMENT IN THE PROJECT

Summary

National Voices was asked to review the patient and public involvement in a research project investigating changes in NHS board leadership in the wake of the Francis Inquiry. This paper sets out a framework against which the involvement was assessed.

We found that the approach taken was well-motivated, authentic and broadly fit for purpose. It has had some impact on the conduct of the research.

We suggest a small number of ways in which it could have been strengthened (and still could) and we draw a few implications for the wider health research community.

Introduction

National Voices was commissioned in early 2017 to carry out a short assessment of the arrangements for patient and public involvement in this project. The exercise fulfilled a commitment in the research team's original application to the funder, the National Institute for Health Research (NIHR) to 'make arrangements for an organisation such as National Voices to assess how closely we are operating against principles of best practice in involving patients and the public'.

National Voices³ is the national coalition of health and care charities in England, with expertise and experience in patient and public involvement.

How National Voices' assessment was carried out.

This was a short piece of work conducted by me, Jeremy Taylor, the CEO of National Voices in the spring of 2017. My activities included attending a project workshop, exchanges with project leader Professor Naomi Chambers, semi-structured telephone interviews with a sample of members of the research team and advisory group, including the lay chair of the advisory group, reading relevant documents and then drafting an assessment based on this evidence and drawing on National Voices' knowledge and understanding of good practice in involving citizens in health matters.

This report was shared with the interviewees in draft. Their reactions were reflected in the final document. Most of the work was done in April and May 2017.

Interviewees shared their views with me in confidence and this report accordingly does not attribute any comments to individuals, with the exception of comments made by Professor Chambers who commissioned this work.

What does good involvement look like?

There is a large and diverse range of activities in the spheres of health services and research that constitute 'involvement', 'engagement' or 'participation'. (These terms, for all practical purposes, are synonymous). There is a correspondingly large body of literature and guidance on the involvement of patients and citizens in health

³ <http://www.nationalvoices.org.uk/>

matters, and more broadly on matters of citizen participation in decisions taken in the public and private sectors.

'What good looks like' is determined by a combination of principle, evidence and context. It can be difficult to distil. For one thing, the literature reflects a number of distinct if overlapping strands, including:

- **Citizenship and democracy:** a concern with participation as an aspect of citizenship rights and responsibilities (including in relation to the publicly funded and collectively-owned NHS)
- **Consumerism:** a concern with voice as an aspect of consumer rights
- **Equality and fairness:** a moral drive to hear and incorporate the voices of the disadvantaged and excluded
- **Impact on outcomes:** a practical and empirical interest in the impact of patient and citizen involvement on the nature and quality of decision making and the resulting health outcomes (ranging from the narrowly clinical to the more broadly experiential)
- **Social value:** a concern with growing the capacities of individuals and communities to take part, take charge and make their own decisions

For this exercise, I have approached 'what good looks like' from three angles which together distil much of the wisdom contained in the literature.

- **Purpose and impact:** was there clarity about the purpose of involving people; was it a reasonable purpose; did the activities undertaken fulfil the purpose and have a meaningful impact?
- **People:** who got involved? Were they the 'right' people?
- **Power:** how much influence did the people involved have? Where did it lie on a spectrum from mere tokenism to complete control? Was there genuine partnership working or co-production?

How did the research team involve patients and the public?

NIHR imposes a requirement on applicants that they must demonstrate how patients and the public are involved in research projects. It is for applicants to decide how to do this.

Planning

The intentions of the research team are summarised below, based on extracts from their application to NIHR.

‘We have selected the model of a patient-led advisory group to ensure that the research is shaped around the ultimate concerns of patients and their families, which is that the organisation treating them is well-managed, well led and is able to create a climate for providing compassionate and clinically competent care. In this we are mindful of Arnstein’s ladder of participation (Arnstein, 1969) and are desirous of moving the level of patient and public involvement up the rung from ‘consultative’ to ‘in control’.

‘Chaired by a patient, the group will inform the development of research tools and site selection, specifically how we assess boards’ approaches to incorporating and listening to the voice of patients and their carers’

‘The application has been tested with a patient representative.’

‘We have set aside a budget to ensure that patient members of the advisory group are remunerated in accordance with INVOLVE principles’

‘We will ensure that there is appropriate training and we will also make arrangements for an organisation such as National Voices to assess how closely we are operating against principles of best practice in involving patients and the public.’

‘This approach will benefit the research by ensuring that lay wisdom is at the heart of the process. The findings will also be sense-checked by the patient-led advisory group addressing the all-important ‘so what’ question.’

‘Patient representatives will contribute to project scoping (WP1), and survey design (WP2 and WP3). In WP3 (case studies), patient representatives will be interviewed in each site. PPI colleagues will participate in both project workshops.’

Execution

Broadly, the arrangements for patient and public involvement followed the original plans, with the patient-led advisory group as the key mechanism for involvement. A public call for advisory group members was issued in June 2015, including one patient chair and three lay members. Expressions of interest were invited, there was a sifting and interviewing process, and the advisory group was constituted by autumn 2015. In the end four lay members were appointed in addition to the chair, though one was subsequently unable to contribute for personal reasons.

Since then there have been two meetings of the advisory group and two larger stakeholder meetings, including the advisory group members. There have also been several exchanges outside the formal meetings, for example commenting on draft questionnaires by email.

At the time of writing this report, a further engagement with the advisory group, to shape the final outputs of the project, is still awaited.

Compared with original stated intentions, there was less patient and public involvement in the project scoping stage and in the case studies.

Purpose and impact

What was good

There was general agreement that a patient-led advisory group, bringing ‘lay wisdom’ to bear on the project, was an appropriate mechanism, serving an appropriate purpose and that it had made an impact.

Interviewees in their own words mirrored the intentions set out in the original application:

- To keep the project grounded
- To widen the perspectives brought to bear
- To keep the project focussed on what really matters to patients and avoid getting too preoccupied with issues of structure and governance.
- To provide a touchstone

Interviewees were able to cite several specific ways in which the presence of a patient chair and lay members had made an impact. Examples cited were:

- Influenced the detailed conduct of the research, including the survey and the methodology for investigating the case study sites.
- Influenced the stance of the project on specific themes such as 'patient stories' at board meetings, the role of Foundation Trust governors, and Healthwatch.
- Provided challenge to academic viewpoints, ensuring that there was a healthy tension – or 'positive discomfort' – between more academic and more 'lay' concerns
- Helped avoid 'capture' by the case study sites, ensuring sufficient independence
- Encouraged engagement with healthcare professionals, ensuring a sufficient staff voice alongside the lay voices.

Overall, the involvement of lay people has made a modest but significant impact on the conduct of the research so far. The impact had been 'in line with expectations'. It had not 'fundamentally changed the project' but had kept it grounded, 'kept pulling it back' to the concerns of patients. This had been done as well as possible, given the limitations.

One interviewee noted that the leadership of Professor Chambers had been important in ensuring that the arrangements were authentic, added value and avoided tokenism. Professor Chambers herself affirmed that, not least because of the subject matter of the research, she had been determined that the project should 'model good practice'.

What can be questioned?

The patient and public involvement in the research did not fully live up to the original intentions. There was little involvement in the project scoping and in the stages prior to establishing the advisory group. Nor was there much PPI in the case studies. The research team relied on the trusts in question to nominate patients and lay people to be involved. The advisory group itself had little say in this process.

While patients and lay people had a strong voice on the advisory group, an advisory group itself is not the most powerful of mechanisms for involvement. It is not necessarily party to all decisions. And its advice does not have to be followed. (That said, there was general agreement that this advisory group did have a meaningful role. One respondent thought that it behaved more like a steering group).

It was noted that the resources for involvement, including honoraria for the lay participants, were modest. While the chair received £900, the other lay members received £300 for their time in travelling to and attending four meetings and engaging in email contact between times. In that context: 'Not much money for patient voice!' (to quote one participant) seems fair comment.

Some of the interviewees expressed a sense that the vision for patient and public involvement might have been too narrow (partly a consequence of limited patient and public involvement at the stage of putting the bid together).

- 'There could have been a more ambitious plan in the original bid'.
- 'Is there a more meaningful way of involving people?'
- 'Do we have enough knowledge of other forms of involvement? More creative, imaginative?'

And there were one or two specific proposals:

- 'Would an IPSOS Mori poll or focus group have been more valuable than getting people to sit through a load of meetings?'
- 'Should there have been a lay person on the research team itself?'

People

What was good?

There was unanimous approval of the open and criteria-based recruitment process resulting in the appointment of four lay members, including one patient chair. Open recruitment is good practice. Some of the interviewees contrasted this favourably with other research projects in which the patient or lay participants had been chosen in an opaque and incontestable manner as a result of prior association with the researchers.

One of the lay participants commented that they had not experienced an open recruitment process before and would not have found out about the opportunity otherwise.

The lay participants were thought to be good – having the skills and qualities necessary to perform their roles.

What can be questioned?

The interviewees raised three areas of relative weakness.

- Whether there should have been more diversity among the lay participants, in particular to better represent more 'ordinary' patient and lay perspectives. 'Look outside, look wider – we could have had a more diverse and livelier bunch'.
- Whether there were enough lay participants. Four were appointed but only three were able to contribute, and of these just two played the most active and continuing roles.
- Whether patients from the case study sites could have been more meaningfully involved.

Power

What was good

Respondents were unanimous that lay involvement in the advisory group had been an appropriate mechanism for bringing patient voice to bear on the project. There was praise for the decision to have a lay chair, which was seen as a creative and relatively unusual arrangement in health services research. Most agreed that the lay participants had had an equal voice in the proceedings.

- 'Having a lay chair sends an important message'.
- 'It was a relationship of equals - not 'them and us'.
- 'There was equality of voice – we felt listened to and looked after'.
- 'Comments were warmly welcomed and taken on board.'
- '(The research team) put a lot of effort into it.'
- 'There was effective challenge especially from the [Chair] and (one other lay participant)'
- 'As good as I've seen in a research project'.

What can be questioned

Respondents noted that key aspects of the application process and project design significantly limited the scope for patient and public involvement.

- 'Time constraints in the bidding process meant that time for thought and coproduction was lacking.'
- 'There should have been more thought and consultation (eg with chair) on designing patient voice input through whole project at the outset and allocating sufficient budget to it'
- 'There was not much lay involvement in study design or application. By the time the lay people arrived, the key decisions had been set in stone'.

Some limited concern was expressed about whether the lay participants had been equipped to play a sufficiently strong role. Had they had enough training and briefing? Would more clarity on the rules of engagement might have helped? Did

they find it daunting being on the group with bunch of professors? It is not clear that these worries were borne out in practice.

One participant said they 'felt in limbo' in the period following the formal meetings but before the final outputs of the study. Were they still needed? Would they be involved in the final stages? There was a felt need for more communication and to know what impact the lay members had made and that it had been valued.

Conclusions

A lay-chaired advisory group, with chair and other lay members recruited through open competition, has been an appropriate channel for bringing patient voice to bear on this research project, and has had some impact on the project.

The lay members are felt to be equal members of the group and have been responsible for demonstrable changes to the conduct of the research which interviewees were able to articulate clearly.

The impact achieved by the lay participants is a reflection of the people involved and the mechanism chosen. It has also been a consequence of the attitudes and behaviours of the research team. With Professor Chambers leading by example, they set a positive tone for patient and public involvement in the project, ensuring that the advisory group had a meaningful role and that the lay people had equal voice within the group. In other hands, similar arrangements could have been formulaic or tokenistic.

The jury is still out on how effective the patient and public involvement has been overall, since the project is not yet complete.

Could there have been stronger patient and public involvement?

In principle, definitely. This was not co-production. Patients and the public did not get a say in setting the research priorities, they did not co-design the project or the application. They did not get a say in determining how patients and the public should be involved! They had little involvement in the case studies.

The contribution of the lay people was channelled along lines set before they arrived and it made change at the margin, rather than in fundamentals. A lay-chaired advisory group is not a particularly radical arrangement. The fact that it can be seen as cutting edge in the health research world perhaps says more about the conservatism of that world than about the innovativeness of this project.

A small number of competent lay people were recruited to the advisory group who are well suited to expert partnership work. That takes a special kind of person. There was not a diversity of voices representing lived experience of illness and disability and the diversity of England's communities.

In practice, given the constraints of time, process and resource faced by the researchers, and given the intended purpose of the patient and public involvement, aiming for the highest possible levels of co-production, diversity and inclusion would have been disproportionate and probably not achievable.

In fact, the chosen arrangements seem broadly fit for purpose. Nevertheless, the research team could have:

- Done more to integrate patient and public perspectives into the design of the study and the application to NIHR
- Recruited a larger number of lay people to the advisory group, in particular to hedge against attrition
- Found supplementary ways of bringing insight from a wider cross section of the public and from people with lived experience of ill health and disability, especially given the desire to keep the project 'grounded' and able to ask the 'so what' questions
- Exerted more say over the patient and public involvement in the case studies, rather than leaving that to the relevant NHS trusts.

Given that the project is not over, there is still time for the research team – together with the advisory group – to strengthen the impact of patient and public voices on the final outputs of the study.

Wider implications

Much of this assessment applies to the particular research project in question and is not necessarily generalizable. Nevertheless, a few issues arose that might have wider relevance for researchers wishing to involve patients and the public in their work, and for organisations funding research.

Implications for research teams

- **Leadership for patient and public involvement** – the willingness to take it seriously, do it properly and embed it in research – is important at all stages of the project from conception to completion. It is probably just as important as the particular methodologies chosen.
- **Think carefully how patients and the public can be involved at the start:** in the scoping, design and application processes.
- **The particular methodologies will be determined by purpose, context and practicalities**, including resources.
- **Researchers should always challenge themselves** in the following ways: ‘What impact do we want to see from involving people? Are we being inclusive enough? Are we working in partnership? Are we involving people early enough?’
- **Patients and citizens can contribute in a variety of ways.** Researchers need to be clear about their purposes and approaches. The people whose experiences of healthcare you want to understand may not be the same as the people you want to engage as expert partners. Defaulting to inviting people to meetings might not elicit all the contributions you need.
- **Evaluating the quality and impact of your patient and public involvement is good practice.** It is a hedge against researchers defaulting to tokenistic mechanisms and it is a way of helping the research community as a whole learn from its successes (and failures). (As author of this assessment I have an obvious interest to declare, though this point was also made in the interviews).

Implications for research funders

A clear theme of this assessment was that there was limited scope for patient and public involvement at the stage when the application was being developed (with the consequence that various features of the project were not readily amenable to change later on).

Three aspects of NIHR's application process could be seen to serve as constraints in this regard:

- Their timescales
- Their willingness (or assumed willingness) to cover the costs of co-design with patients and the public in the application phase
- The specificity they require about approach and methods in the application (which limits the scope for co-designed changes later).

One worthwhile outcome of this assessment would be some engagement with NIHR and the wider research funding community on the scope for increasing the degree of patient and public involvement at the scoping, design and application phases of research, taking account of the factors listed above, and any others.

Jeremy Taylor

National Voices

23 May 2017

**Appendix 10: Summary of findings from publications arising from research study on ‘Effective Board Governance of Safe Care’
(Mannion et al, 2016)**

| Author/date | Aim of study/paper | Type of study/method | Type of organisation | Impact of board | Factors affecting board performance | Board processes |
|---|---|--|--|---|--|--|
| (2016) Mannion, Freeman, Millar and Davies ‘Effective Board Governance of Safe Care: A theoretically underpinned) cross-sectioned examination of the breadth and depth of relationships through local case studies and national surveys’ | Aim of the study is to generate theoretically-grounded empirical evidence on the associations between board practices, patient safety processes and patient centred outcomes. | Three stands to the research: 1. Narrative systematic review in order to describe, interpret and synthesise key findings and debates concerning board oversight of patient safety-124 publications were deemed relevant for detailed review. Conducted between Dec 2011 & Dec 2014. 2. In-depth mixed methods case studies in four organisations used to assess the impact of hospital board governance and external incentives on patient safety processes and outcomes- observations of board meetings and interviews were used. Conducted between Sept 2012 and Sept 2014. 3. Two national surveys | Survey in NHS acute and specialist hospital trusts in England. Case studies took place in four NHS FTs | 1. Boards of governors are generally perceived as well meaning. They were also considered largely ineffective in helping to promote and deliver safer care for their organisations. Meetings frequently resembled seminars for information sharing, rather than a formal board meeting 2. Board of governors seemed to serve a useful educative role and community linkage role, but with limited challenge or holding of executive to account. 3. Did not find any statistically significant relationship between board attributes and | 1. Results from the national survey show a high proportion of desirable characteristics and board related process that research says may be associated with high performance- all having quality sub-committees and proactive procedures in place to address patient safety and explicit objectives relating to improving patient safety. 2. Development and implementation of a clear corporate strategy and operational plan is a key facilitator in enabling effective board governance 3. Stability of board | 1. Most boards allocate considerable time to discussing patient safety and quality related issues. The survey found that hospital boards were using a wide range of hard performance metrics and soft intelligence to monitor their organisation with regard to patient safety, including a range of |

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| | | <p>undertaken about board management in NHS acute and specialist hospital trusts in England- first was issued to 150 trusts in the financial year 2011/12- received 145 replies- second survey data gathered between May 2012 and April 2013- 334 received responses.</p> | | <p>process and any patient safety outcome measures.</p> <p>4. There was a significant relationship between staff 'feeling safe' to raise concerns and 'feeling confident' that their organisation would address those concerns</p> | <p>membership and strong committed clinical leadership are important facilitators of patient safety governance.</p> <p>4. Other barriers included perceived lack of engagement among senior medical staff, and problems and disputes over the validity and reliability of summary performance indicator data.</p> | <p>clinical outcome measures.</p> |
|--|--|---|--|--|---|-----------------------------------|

Studies that use research from above study

| Author/date | Aim of study/paper | Type of study/method | Type of organisation | Impact of board | Factors affecting board performance | Board processes |
|--|---|---|---|---|---|---|
| (2015a) Mannion, Davies, Freeman, Millar, Jacobs, Kasteridis 'Overseeing oversight: governance of quality and safety by hospital boards in the English NHS' | Aims to contribute to an understanding of hospital board composition and to explore board oversight of patient safety and health care quality in the English NHS. | Two national surveys about board management in NHS acute and specialist hospital trusts in England- 334 responses across both surveys (66% response rate). First survey in 2011/12. Second online survey undertaken in 2012/13. | NHS acute and specialist hospitals trusts | 1. English NHS boards largely hold a wide range of attitudes and behaviours that might be expected to benefit patient safety and quality. | 1. There is scope for improvement as regards to formal training for board members on quality and safety, routine morbidity, reporting at boards and attention to the interpersonal dynamics within boards. | 1. 90% of boards have 10-15 members. 2. No significant difference in board size between trusts of different types. 3. Clinical representation on boards was limited (for about two-thirds of trusts, board members with a clinical background made-up less than 30% of members. |
| (2015) Freeman, Millar, Mannion and Davies 'Enacting corporate governance of healthcare safety and quality: a dramaturgy of hospital boards in England' | Applies a dramaturgical framework to explore scripting, setting, staging and performance, in the four case studies | Article draws on qualitative data from overt non-participant observation of four NHS hospital foundation trust boards in England. Hayer's analytical framework to qualitative data collected through overt non-participant observation at four case | 4 NHS Foundation Trusts | | 1. Operationalising the governance of patient safety largely in terms of assurance through retrospective use of performance data to alert the board of poor performance encourages under reporting and does not indicate how to address deficiencies. Specific responses noted at the sites | 1. All of the case study sites sought to provide strategic assurance by establishing organisational structures and processes for reporting safety-related information throughout the organisation and to the board. 2. Case study sites exhibited governance behaviours |

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| | | study sites. Cases were selected on the basis of their performance trajectory over the last three years on a range of safety and quality indicators selected from Dr Foster database for 2011. | | | <p>included: challenge and blame by NEDs at Skye; interpretive work by the CEO to forestall at Arran; and framing targets as unrealistic and requiring challenge of regulators.</p> <p>2. Findings highlighted the challenges board members face in terms of scripting and staging, especially when decisions pass unchallenged, unremarked or even unnoticed. A better understanding of these issues may feed into revised training and induction processes for board members.</p> <p>3. While summary reporting of quality indicators is important, local processes of organising that make it possible for non-executive board members to use such information to hold executives to account sensitively are required.</p> | <p>variously related to agency and stewardship theory.</p> <p>3. While the amount of time devoted to discussing patient safety has been identified as potentially important, the article draws attention to the fact that boards used their time differently.</p> <p>4. While similar levels of performance indicator data relating to infection control were available at each site, differences in use were significant and related to the practices legitimated within each setting.</p> |
| (2013) Ross Millar, Russell Mannion, Tim Freeman and Huw Davies 'Hospital Board | A narrative review of empirical research to inform the debate about hospital boards' oversight of quality and patient safety. | Lit review, search identified 122 papers for detailed review published after 1990 | Hospitals | 1. Empirical studies linking board composition and processes with patient outcomes have found clear differences between high and low performing | <p>1. Effective board oversight is associated with well informed and skilled board members</p> <p>2. External factors, such as</p> | |

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|---|--|--|---|-------------------|--|--|
| <p>Oversight of Quality and Patient Safety: A Narrative Review and Synthesis of Recent Empirical Research'</p> | | | | <p>hospitals.</p> | <p>regulatory regimes and the publication of performance data, might also have a role influencing boards.</p> <p>3. Strong and committed leadership that prioritises quality and safety and sets clear and measurable goals for improvement has an impact on performance.</p> | |
| <p>(2015) Ross Millar, Tom Freeman and Russell Mannion (Birmingham search)</p> <p>'Hospital board oversight of quality and safety: a stakeholder analysis exploring the role of trust and intelligence'</p> | <p>Paper aims to offer critical reflection on the relationship between hospital board oversight and patient safety. The paper analyses the potential dangers and limitations of approaches to hospital board oversight that is too narrowly focussed on a risk-based view of organisational performance.</p> | <p>The article draws on ten interviews with key informants and policy actors who form part of the 'issue network' interested in the promotion of safety in the NHS. The research purposely selected interviewees on the basis that our research required a range of stakeholder perspectives that interacted across multiple interest groups. The sample included the Department of Health, Monitor, CQC and a national patient safety agency.</p> | <p>Health Foundation, NHS Confederation, DH, NHS Litigation Authority, Monitor, CQC, NPSA</p> | | <p>1. Suggested that, in hospitals, debates about patient safety often took second or third place behind efforts to ensure that hospital finances and central performance targets were met.</p> <p>2. Boards are challenged by the regulatory environment that is designed around meeting the governance and risk based set by Monitor and CQC.</p> <p>3. Faith placed in external targets was largely connected to a lack of skills and understanding to make sense of patient safety issues and concerns.</p> <p>4. Limited knowledge and understanding of patient</p> | |

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| | | | | | <p>safety among board members, particularly non-executives, also meant they were often inhibited in challenging and posing critical questions about safety issues and concerns. This was exemplified by non-executives who tended not to have a clinical or operational background in healthcare.</p> <p>5. The role of chair was central to allowing open discussion at board meetings by encouraging members to raise salient issues. Non-executive directors were seen to be important if they could actively challenge executive decisions and hold the board to account.</p> <p>6. Enhancing the intelligence available to the board about hospital performance could be gained by members seeking to 'triangulate' hard performance data with different information sources.</p> | |
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Appendix 11: Summary of six papers from updated literature review

| Author/date | Aim of study/paper | Type of study/method | Strengths and limitations | Impact of board | Factors affecting board performance | Board processes |
|--|--|--|---|---|--|---|
| (2013) Ruth Endacott, Rod Sheaff, Ray Jones, Valerie Woodward 'Clinical focus and public accountability in English NHS trust Board meetings' | To what extent is there clinical focus in Board meetings in three types of NHS Trusts to consider the implications for public accountability | 1. Content analysis of published minutes of board meetings from 105 randomly selected NHS trusts in 2008/09. 2. Structured observation of 24 board meetings in a qualitative subsample of eight of the above trusts in 2008/09. | Limitations- 1. FTs were still adjusting to their new roles and to having two boards. 2. The study doesn't look at the impact of board makeup on clinical outcomes but instead looks more at the way composition affects effectiveness in procedures, etc. | | 1. Some chairs are notably better at encouraging discussion, debate and contributions. 2. Where NEDs (clinical directors) were confident and tenacious, there was greater depth and discussion of all issues, including clinical matters such as serious untoward incidents (SUIs). | 1. Discussion in board meetings driven heavily by current government policy initiatives. 2. Meetings were generally chair led with the conduct of the meetings determined by the direction provided by the chair. 3. Where members of the public had a formal representative role, the content and frequency of questions posed was variable. |
| (2014) Kline, Roger 'The snowy white peaks of the NHS: a survey of discrimination in governance and leadership and potential | Report considers the extent of the gap between diversity apparent in the workforce and local population, and that visible among trust leaderships and senior | FOI requests were made to all London trusts in order to determine ethnic composition of boards. Data on comprehensive data on trust board membership by ethnicity in 2006 was | Strengths- 1. Robust data that shows disproportionate recruitment number of white board members. Limitations- | Leadership boards that are significantly unrepresentative of their local communities, such as NHS Trust boards, will have more difficulty ensuring that care is genuinely patient | | 1. The data demonstrates that there remains a very significant gap between the composition of trust boards and national NHS bodies, and the rest of the workforce and the |

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| <p>impact on patient care in London and England'</p> | <p>management.</p> | <p>compared with 2014.</p> | <p>1. No new evidence for the impact on better care of more representative board-assumptions on this taken from previous studies.</p> | <p>centred.</p> | | <p>local population to whom services are provided.</p> <p>2. The proportion of London NHS Trust board members from a BME background is 8%, an even lower number than was found in 2006 (9.6%).</p> <p>2. Two-fifths of London's NHS Trust boards had no BME members (executive or non-executive) on them at all, whilst over half of London's trust boards either had no BME executive members or no BME non-executive report members.</p> <p>3. The proportion of women on boards is 40%; whilst this is a slight improvement on past figures, the proportion is still well below that of the NHS workforce or the local population.</p> |
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| <p>(2015) Dixon-Woods, Baker, Charles, Dawson, Jerzembek, Martin, McCarthy, McKee, Minion, Ozieranski, Willars, Wilkie and West</p> <p>‘Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study’</p> | <p>Aim to examine culture and behaviour in the English NHS</p> | <p>Mixed methods, including interviews, surveys, ethnographic case studies, board minutes, and publically available datasets narratively synthesised data across the studies to produce a holistic picture.</p> <ul style="list-style-type: none"> ▶ 107 interviews with key, senior level stakeholders from across the NHS and beyond; ▶ 197 interviews from the ‘blunt end’ (executive and board level) of NHS primary care and acute organisations, through to the ‘sharp end’ (frontline clinicians) where staff care for patients; ▶ over 650 h of ethnographic observation in hospital wards, primary care practices, and accident and emergency units; ▶ 715 survey responses from patient and carer organisations; ▶ two focus groups and | <p>Limitations-</p> <p>1. Synthesis of findings was interpretive and narrative and did not use a formal protocol. Others might reach dissimilar conclusions or interpretations in the data.</p> | <p>1. Consistent with the findings of the Francis Inquiry, boards were identified as particularly influential in setting the overall direction and demonstrating the commitment and organisational priority given to quality and safety.</p> <p>2. Given that many systems required significant improvement, it was disappointing that we found a clear trend of decreasing levels of board innovation, especially in relation to quality and safety.</p> <p>3. Observations, interviews and surveys all emphasised the importance of high quality management in ensuring positive, innovative and caring cultures at the sharp end of care.</p> <p>4. A strong focus by executive and board teams on their role in identifying and</p> | | <p>1. Questionnaire of board members showed that they rarely stated clear board objectives that were challenging and measurable.</p> <p>2. Found worrying evidence of boards failing to set clear goals for themselves as boards and for their organisation.</p> <p>3. The research confirms the importance of high quality intelligence (not just data) and making that intelligence actionable.</p> |
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| | | <p>10 interviews with patient and carer organisations;</p> <ul style="list-style-type: none"> ▶ team process and performance data from 621 clinical teams, drawn from the acute, ambulance, mental health, primary care and community trust sectors; ▶ 793 sets of minutes from the meetings of 71 NHS trust boards from multiple sectors over an 18-month period, including detailed analysis of eight boards' minutes. | | <p>addressing systems problems was powerful in supporting cultural change that delivered benefits for patients, and our observations and interviews identified many examples of impressive gains being made by the sharp and blunt ends working together around unifying goals.</p> <p>5. Consistent with Francis' findings, good management is as important as good leadership.</p> | | |
| <p>(2015) Thomas Tsai, Ashish Jha, Gawande, Huckman, Bloom and Sadun</p> <p>'Hospital Board and Management Practices are strongly related to hospital performance on clinical quality metrics'</p> | <p>Aim to examine the relationship among hospital boards, management practices of front-line managers, and the quality of care delivered.</p> | <p>Collected data from surveys of nationally representative groups of hospitals in the US and England.</p> <p>Primary data set was the healthcare component of the World Management Survey specific to the US and England. This data was then merged with data from a 2009 survey of US boards of trustees and 2010 survey of</p> | <p>Limitations-</p> <p>1. Non-random subset of hospitals so may not necessarily be representative.</p> | <p>1. Hospitals with more effective management practices provided higher quality care. Higher rated hospital boards had superior performance by hospital management staff.</p> | <p>1. Hospitals with boards that paid attention to clinical quality had management that better monitored quality performance. Hospitals with boards that used clinical quality metrics more effectively had higher performance by hospital management staff on target setting and operations</p> <p>2. Boards with a higher attention to quality had</p> | <p>1. High quality hospitals were more likely to have better management processes related to operations, monitoring, target setting, and human resources than low quality hospitals. Management scores were significantly higher in hospitals with boards that paid greater attention to quality and that were more likely to adopt effective practices related to the use of</p> |

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| | | <p>English boards of trustees. Data on hospital characteristics were then merged from the 2011 American Hospital Association annual survey and the NHS's HSCIC data. This data was then finally merged with hospital quality data from CMS Hospital Compare for US hospitals and CQC data.</p> <p>Quality of care variables- UK- quality rating programme 'overall quality services' score from the CQC (2009 survey of English boards and 2010 survey of US boards of trustees).</p> | | | <p>the highest management practices in monitoring quality. Second, hospitals with effective board practices that centred on the use of quality metrics showed a greater association with management scores in the domains of target setting and operations.</p> | <p>data on clinical quality metrics.</p> |
| <p>(2015) Rod Sheaff, Ruth Endacott, Ray Jones and Val Woodward</p> <p>'Interaction between non-executive and executive directors in English National Health Service trust boards: an observation study'</p> | <p>Aim to compare the non-executive directors' roles and interests in, and contributions to, NHS trusts boards' governance activities with those of executive directors, and examine non-executive directors' approach to their role in board meetings.</p> | <p>Non-participant observations of three successive trust board meetings in eight NHS trust in England 2008-09.</p> | <p>Strengths-</p> <p>1. Adds to evidence about governance and processes stewardship in NHS boards by focussing roles, interests and relationships</p> <p>Limitations-</p> <p>1. Does not study the practical consequences for the rest of the study</p> | <p>1. Article argues that avoidable patient deaths and mistreatment at mid-staffs shows that the NHS has no room for complacency on being able to challenge what managers say.</p> | <p>1. Non-exec board members in holding the exec team to account at board meetings were variable.</p> <p>2. The pattern of NED behaviours was on balance more indicative of an active, strategic approach to governance than of passive monitoring or rubber stamping.</p> | <p>1. Observational data revealed 6 types of questioning tactic; supportive; lesson learning; diagnostic; options assessment; strategy seeking; and requesting further work. Patterns of behaviour were more indicative of an active, strategic approach to governance than of passive monitoring or 'rubber-</p> |

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| | | | organisations for their org behaviour and accountability | | | stamping’. |
| (2015) Gianluca Veronesi, Ian Kirkpatrick and Ali Altanlar ‘Clinical Leadership and the changing governance of public hospitals: implications for patient experience’ | Aim to: 1) Investigate whether increased participation of clinical professionals on hospital boards has had a positive impact on performance- focus on patient experience different from previous study that focusses on clinical and financial outcomes. 2) Questions whether any impact of clinical participation on boards is moderated by organisational differences between hospitals and specifically if they are granted higher formal autonomy in their governance. | Quantitative data analysis using three sources: 1) Annual data NHS Trust Inpatient Survey (06-09) 2) Original database of governance information at the board level 3) Series of publically available data including the CQC hospital ratings and hospital activity indicators. | Strengths- 1. Uses patient experience data which has an advantage over performance indicators as these often fail to capture quality in the sense of impact or outcome. Patient experience data has also been found to be influenced by the quality orientation of senior management teams. | | | 1. Significant positive effects of the percentage of clinical directors on overall patient experience scores. 2. Having five or more clinical directors instead of two had an even greater significant positive impact on patient experience. 3. There was no significant finding between patient experience scores and organisational status (an FT or not). However, the results do find that FTs with more clinical professionals on their board, patient experience outcomes are higher. 4. The significant relationship between clinicians on the board |

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| | | | | | and patient experience disappears if the trust is not an FT. | |
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Appendix 12: Representativeness of respondents to the national survey

We issued survey invitations to a total of 1896 board members and board secretaries, excluding individuals from our database who we discovered were no longer in place (E.g., because they had resigned or retired). 381 respondents completed the whole survey (response rate 20%), with an additional 57 respondents (3%) answering some of the survey questions. At least one full response was received from 139 (90%) the 154 NHS hospital trusts and foundation trusts in England at that time.

Response rates were higher among board secretaries (31%) than among board members (19%) (see table 18). Response rates were particularly low among Finance Directors (11%). Board member response rates differed between regions of the country, ranging from 14% in London up to 26% in East of England (Chi-square=18.6, df=8, p=0.02). Response rates also tended to be lower as the size of the trust (number of beds) increased, although this was a relatively weak effect.

Table 18: Survey responses by role

Crosstab

| | | | Response to survey invitation | | Total |
|------|------------------|---------------|--|----------------------------|--------|
| | | | Did not respond or fully complete the survey | Fully completed the survey | |
| Role | Board Secretary | Count | 106 | 48 | 154 |
| | | % within Role | 68.8% | 31.2% | 100.0% |
| | Chair | Count | 115 | 43 | 158 |
| | | % within Role | 72.8% | 27.2% | 100.0% |
| | CEO | Count | 120 | 39 | 159 |
| | | % within Role | 75.5% | 24.5% | 100.0% |
| | Finance Director | Count | 149 | 19 | 168 |
| | | % within Role | 88.7% | 11.3% | 100.0% |
| | Medical Director | Count | 118 | 42 | 160 |
| | | % within Role | 73.8% | 26.3% | 100.0% |
| | Nursing Director | Count | 130 | 28 | 158 |
| | | % within Role | 82.3% | 17.7% | 100.0% |
| | Non-Executive | Count | 777 | 162 | 939 |

| | | | | |
|----------|---------------|-------|-------|--------|
| Director | % within Role | 82.7% | 17.3% | 100.0% |
| Total | Count | 1515 | 381 | 1896 |
| | % within Role | 79.9% | 20.1% | 100.0% |

(Chi-square = 35.8, df=6, p=0.000)

There were no statistically significant differences in response rates between different types of trust (acute, specialist; foundation, non-foundation), between trusts with different CQC Well-Led Ratings, or between female and male board members (Chi-square test, $p > 0.05$). Whether or not the board secretary had agreed to forward on emails to board members did not appear to affect response rates.

13 out of 34 (38%) of board member respondents from the London region were female. This is similar to the 40% figure found in a previous survey (Kline, 2014). 3 out of 34 (9%) of board member respondents from the London region were from black and ethnic minority backgrounds, again similar to the 8% figure found by Kline.

118 out of 331 (36%) of all board member survey respondents who specified their gender were female. The proportion of women performing each board role varied widely (see table #2). Most Directors of Nursing were female, as were board secretaries. Most Finance Directors were male, and about two thirds of Chairs and Non-Executive Directors. Approximately half of Chief Executives were female. Only 20 out of 328 (6%) of board member respondents were from BME groups.

Table 19: Gender of respondents completing the whole survey, by role

Crosstab

| | | | What is your gender? | | |
|------|------------------|---------------|----------------------|-------|--------|
| | | | Female | Male | Total |
| Role | Board Secretary | Count | 35 | 13 | 48 |
| | | % within Role | 72.9% | 27.1% | 100.0% |
| | Chair | Count | 13 | 30 | 43 |
| | | % within Role | 30.2% | 69.8% | 100.0% |
| | CEO | Count | 18 | 21 | 39 |
| | | % within Role | 46.2% | 53.8% | 100.0% |
| | Finance Director | Count | 2 | 17 | 19 |
| | | % within Role | 10.5% | 89.5% | 100.0% |
| | Medical Director | Count | 9 | 33 | 42 |
| | | % within Role | 21.4% | 78.6% | 100.0% |

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|------------------------|---------------|-------|-------|--------|
| Nursing Director | Count | 23 | 5 | 28 |
| | % within Role | 82.1% | 17.9% | 100.0% |
| Non-Executive Director | Count | 53 | 107 | 160 |
| | % within Role | 33.1% | 66.9% | 100.0% |
| Total | Count | 153 | 226 | 379 |
| | % within Role | 40.4% | 59.6% | 100.0% |

(Chi Square=60.6, df=6, p=0.000).

184 out of 331 (56%) of all board member survey respondents joined their current board after February 2013. A higher proportion of these more recent board members (10%) were from BME groups than was the case for board members who had been on the board for a longer period (1%). The gender breakdown was similar between more recent and longer serving board members. Chief executive respondents were more likely to have been longer serving than board members in other roles. 74% of CEO respondents had joined the board before March 2013, whereas only 40% of board members in other roles had joined their board before March 2013.