The Francis Report:

one year on

The response of acute trusts in England

Research report
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Contents

Foreword

One year after the publication of my report of the Public Inquiry into the Mid Staffordshire NHS Foundation Trust, there is a natural interest in what progress has been made in implementing the recommendations made in the report. This new Nuffield Trust research, with which I have been happy to be associated, provides helpful insights into how hospital trusts have responded.

It is reassuring to see that in large part the respondents to this research appear to have embraced the need to learn from the two inquiries in Stafford and the alarming events that they described. Rightly, many did not wait for the public inquiry report to begin making necessary changes, but exploited the learning available from the earlier report. Over the last year the health service has been confronted not only with the Public Inquiry report, and the governmental responses to it, but also by a welter of subsequent reports and reviews. These include Don Berwick's review into patient safety, Sir Bruce Keogh's mortality review, Anne Clwyd and Professor Tricia Hart's review into NHS complaints, and Camilla Cavendish's health care assistants review. It is therefore not surprising that only a start has been made in considering the necessary changes at local level.

Remarkably, all but a very few of the Public Inquiry's recommendations were accepted in full by the Department of Health, and all were in principle. The strong message thereby sent out to the health service by government was that important and fundamental change was required. This message has been reinforced by the words and actions not only of the Secretary of State personally, but by other NHS leaders.

What does this research tell us about what is actually happening closer to the front line? It is not surprising that many were shocked by the findings of the two inquiries and realised that changes were required to prevent similar events occurring in their own organisations. The persisting belief of some that the events reported were unique and unlikely to occur elsewhere is worrying. This is a dangerous misapprehension which is disproved by the findings of the Keogh review, among other recent reports. Importantly, poor standards were not found everywhere in the Mid Staffordshire NHS Foundation Trust; some good services were provided. The finding of good practice in some parts of a hospital is no guarantee that all is well everywhere. The vast majority of front-line staff, who are consistently hard-working, conscientious and compassionate, have to understand that criticism of poor and unacceptable practice is not aimed at them but is part of a struggle to support everything they stand for.

The general acceptance shown by this report that quality needs to be given much greater priority is very welcome, as is the recognition of the need for support of a high standard of front-line leadership, and better engagement of the talents and knowledge of front-line staff. Likewise there appears to be a widespread agreement that improvement is needed in the information made available on the effectiveness of the service provided. Many hospitals report now being engaged in trying to bring this about. The need for openness, transparency and candour seem to be generally accepted, and this research shows that front-line organisations do not have to wait for instructions from above to make positive progress in this regard. For too long, too

many in the health service have been inhibited in doing the right thing for patients by feeling obliged to wait to be told what to do.

Some respondents found the public inquiry report of "challenging" and "unhelpful" length and that the recommendations lacked prioritisation. The problems uncovered are not however amenable to simplistic, one-off solutions. Therefore it is inevitable that widespread change was called for. To the extent that there is a consensus around the Inquiry recommendations, whatever their number, it is surely incumbent on leaders at all levels to devise programmes for their implementation and an order of priority.

Some respondents in this research report that national bodies have persisted in some of the behaviours towards hospitals that evidently contributed to the problems identified by the two inquiries. This is a theme echoed coincidentally in the recent Point of Care Foundation report (Point of Care Foundation, 2014). Although the Nuffield Trust research is based on a relatively small number of interviews, the inconsistency of approach between regulators that some interviewees spoke of is of concern. Similarly it appears that some commissioners at least have yet to get to grips with their responsibilities with regard to quality. If all this is true, it would suggest that a lack of coordination and elements of the system-based culture so evident in the regulation and oversight of Mid Staffordshire have persisted in spite of the assertions to the contrary by the regulators. Changing this requires their immediate and constant attention.

Perhaps of most concern are the reports suggesting a persistence of somewhat oppressive reactions to reports of problems in meeting financial and other corporate requirements. It is vital that national bodies exemplify in their own practice the change of cultural values which all seem to agree is needed in the health service. This may mean a reconsideration of the expression of priorities, behaviour and language, and the reaction to the inevitable tension between finance and quality that will arise in some trusts.

If it is impossible, even with good practice, to provide the service required within the resources allocated then it is incumbent on leaders to communicate that openly to those responsible for commissioning and funding services. That then needs to lead to a frank discussion about what needs to be provided within the available resources and what cannot. It is unacceptable to pretend that all can be provided to an acceptable standard when that is not true.

Undertaking the necessary culture change in the NHS was never going to be easy or a short one-off task. Only time will tell whether the obvious enthusiasm for change demonstrated by hospitals taking part in this research, can translate into the relevant action. Regular reviews will be needed to monitor progress.

Robert Francis QC

This Nuffield Trust report explores the response of acute hospital trusts in England to the report by Robert Francis QC of the Mid Staffordshire NHS Foundation Trust Public Inquiry, published in 2013. The research asked questions about how hospital trusts responded to the main themes in the Francis Report, and for their reflections on the challenges of changing the quality and culture of care in a demanding environment. The research was based on 48 in-depth interviews with predominantly senior staff at five case study hospitals, and the responses of 53 hospital trusts to an electronic survey.

Key Points:

- The recommendations in the Francis Report aimed at improving organisational culture in trusts, through greater openness, transparency and candour, had been well received by the staff interviewed in the study. But leaders of the acute trusts recognised that genuine culture change is a slow process and that many staff may still not feel comfortable in raising concerns.

- Many senior leaders of the acute trusts said that the publication of the Francis Report had prompted them to reflect in greater depth on the quality of care being delivered in their organisations. It had also added legitimacy to their efforts to give greater weight to improve and assure the quality of care, alongside meeting financial and performance targets.

- Although the Francis Report was cited by senior leaders as reinforcing their efforts to prioritise quality of care as equal to, or more important than, financial performance, there remains a profound tension between the two goals. This is especially so if increasing staff is seen as the main route to improve safety and quality, at the expense of a more complicated (and politically challenging) reconfiguration of care pathways and services. This could prove unsustainable for some hospitals.

- The trusts we interviewed reported greater pressure from external bodies seeking assurance of quality in the wake of the Francis Report, including national regulators, NHS England's local area teams and clinical commissioners. In some cases, the collection and validation of data needed by these external bodies was proving onerous for hospitals.

- Some of the senior leaders noted that the culture of the external performance management and regulation system continued to feel punitive at times. Concerns were also raised about the degree to which national bodies were able to coordinate their monitoring and performance management of local trusts.

- Trusts reported that they had already been taking action to improve the quality of care in their hospitals prior to 2013, but that the publication of the Francis Report had added impetus to this, in particular to work on complaints handling, improving staffing levels in nursing and emergency care, and securing better engagement of staff.

- Many trusts in the study had embarked on their own initiatives to gather a wide range of data about different aspects of the quality of care, particularly at ward level, and often in real time. This work included the combining of clinical and patient-reported data, and some trusts had developed their own peer-led reviews of quality.

1. Introduction

The failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009 brought suffering to a large number of patients and may have been responsible for an unknown number of premature deaths. The trust-level factors that contributed to the distressing and degrading experience of these patients and their families were documented in an initial independent inquiry, chaired by Robert Francis QC and published in 2010 (Francis, 2010). The report highlighted a wide range of failings across the trust, including a board focused on finance at the expense of the quality of care being delivered to patients, understaffing and a culture of poor practice and neglect that many staff felt powerless to challenge.

The 2010 report also flagged up failings that went beyond the trust, among the regulatory bodies, commissioners and wider management system, locally and nationally. 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.* (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2010, p.1)

The report of this second public inquiry was published in February 2013 (Francis, 2013a). It examined the behaviour of a range of national and local supervisory and regulatory organisations and asked questions about the culture of the NHS as a whole. The final report set out an analysis of what went wrong 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. But what the inquiry heard about the culture and behaviour of the NHS 'system' as a whole, coupled with the numerous reports of failings in care in other institutions since 2009, led Robert Francis QC to conclude 'that Stafford was not an event of such rarity or improbability that it would be safe to assume that it has not been and will not be repeated' (Francis, 2013a, p.25, para 76).

In his press statement at the launch of the report, Robert Francis QC emphasised the need for urgent action at all levels in the system, including all those providing care to patients:

Government and the Department of Health have an important role to play in changing [the] culture, but this does not mean everyone else in the system can sit back and wait to be told what to do. Every single person and organisation within the NHS, and not only those whose actions are described in this report, need to reflect from today on what needs to be done differently in future. (Francis, 2013b, p.9)

This Nuffield Trust report is an exploration of how acute trusts in England perceived and responded to the 2013 public inquiry report (referred to hereafter as the Francis Report). It is based on 53 responses from acute hospital trusts in England to a questionnaire survey, an analysis of board papers of 37 trusts, and in-depth interviews with 48 members of staff, including chief executives and chairs in five case study trusts. Full details of the methods are on pages 13 and 14. Robert Francis QC has acted as an adviser to the project team.

Main themes in the Francis Report for acute trusts

Of the 290 recommendations contained in the report, many potentially apply to hospitals. In his press statement at the release of the Francis Report, Robert Francis QC identified five main themes according to which all NHS organisations needed to take action, namely:

• fundamental standards

• openness, transparency and candour

• nursing standards

• patient-centred leadership

• information (Francis, 2013b).

Fundamental standards

Many recommendations in the Francis Report relate to the development and enforcement of fundamental standards with regard to the quality of care. The report found that although quality standards existed at the time of the Mid Staffordshire scandal, they were confused in terms of their objectives and their enforcement through regulation. While responsibility for developing and enforcing the recommended fundamental standards lies with national bodies rather than acute trusts, 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, representing the public interest and being accountable to the wider public (recommendations 75 and 76).

Recommendations 109–122 relate to better handling of, and response to, complaints. The recommendations include trusts ensuring that they respond to and learn from all complaints (regardless of whether they are subject to formal investigations) and that external bodies such as commissioners and overview and scrutiny committees 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, 2013a, p.64, para 1.114). This lack of openness also characterised the conduct of some of the national managerial and regulatory bodies.

Some of the recommendations under this theme require legislation or action at a national level, notably the recommended statutory duty of candour on providers. Nevertheless, there is 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 has 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 an inadequate standard of nursing in Mid Staffordshire, characterised by poor leadership, recruitment and training (Francis, 2013a, p.45, para 1.14). Recommendations include:

- 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 avoid 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).

Also under this theme are a number of recommendations that relate to the care of older people, including:

- having robust arrangements for ensuring that patients are given food and drink

- better supervision of the administration of medication

- assessing whether a 'named clinician' needs to be in place

- discharge arrangements that do not allow patients to be released in the middle of the night

- proper systems in place for recording and using routine observations on the ward.

Patient-centred leadership

The Francis Report shed light on poor-quality leadership, both within Mid Staffordshire NHS Foundation Trust and beyond, focused on the wrong objectives at the expense of patient care, isolated and inclined to 'self promotion rather than critical analysis and openness' (Francis, 2013a, p.44, para 1.7). The report recommends 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, lies outside of the control of hospitals, many of the more general recommendations that relate to values are relevant for the leaders (executive and non-executive directors, and clinical directors and senior nurse managers) of hospital trusts. For example, all individuals working in the NHS should adhere to the values contained in the NHS Constitution, namely that 'the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos' (recommendation 4).

Information

The main recommendations that apply 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.

The context facing hospitals in this study

The acute hospitals that are the focus of this study have been operating within a highly complex and challenging environment. The Francis Inquiry has led to numerous initiatives that relate to improving and assuring the quality of care provided in hospitals, but there has also been a major reorganisation of the NHS in the wake of the Health and Social Care Act 2012, coupled with a freeze in funding of the NHS and real-terms reductions in adult social care budgets.

The government's response to the Francis Report

The government published an initial response to the Francis Report in March 2013. Entitled *Patients First and Foremost*, it set out some immediate measures that it was planning to take, for example adopting a rating scheme for health care providers (including hospitals) and setting up a chief inspector of hospitals and other kinds of providers (Department of Health, 2013a). A more comprehensive response, entitled *Hard Truths: The journey to putting patients first*, was published in November of the same year, which presented a detailed response to each recommendation, and set out new actions planned by the government, including requiring trusts to publish ward staffing levels monthly, and complaints data quarterly, and a proposal to legislate to create a duty of candour for providers and the development of a criminal charge of wilful neglect in the future (Department of Health, 2013b).

In its initial response to the Francis Report, 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' (Department of Health, 2013a, p.6). The government also requested that trusts feed back on the outcomes of these listening events by the end of 2013 (Department of Health, 2013b).

Parallel initiatives to improve quality and safety of care

Patients First and Foremost (Department of Health, 2013a) contained a summary of the initiatives either under way or planned that were directly or indirectly in response to the Francis Report, illustrating just how complex the initiatives relating to 'quality improvement' have become in the last two years. The document referred to five new initiatives 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 1. 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 1: Initiatives and reviews relating to the quality of hospital care 2012/13		
Title	Date	Remit
Bureaucracy and regulatory review, carried out by the NHS Confederation	November 2013	Government-commissioned review of bureaucracy and the burden of information collection
Report of handling of complaints by NHS hospitals in England, by Ann Clwyd MP and Professor Tricia Hart ('NHS hospitals complaints system review')	October 2013	Government-commissioned review of hospital trusts' handling of complaints
National Patient Safety Advisory Group in England, chaired by Professor Don Berwick ('Berwick review into patient safety')	August 2013	Government-commissioned review of safety
Review into the quality of care and treatment provided by 14 hospital trusts in England, led by Sir Bruce Keogh ('Keogh mortality review')	July 2013	Government-commissioned review of 14 hospital trusts that had been persistent outliers on measures of mortality
Independent review into health care assistants and support workers in the NHS and social care settings, chaired by Camilla Cavendish ('Cavendish report')	July 2013	Government-commissioned review of health care assistants
Review of aggregate assessment of providers of health and social care in England, carried out by the Nuffield Trust ('Ratings review')	March 2013	Government-commissioned review of the viability of rating hospitals and other providers
'Compassion in Practice: Nursing, midwifery and care staff: Our vision and strategy', carried out by Jane Cummings, Chief Nursing Officer for England, and Viv Bennett, Director of Nursing, Department of Health and Lead Nurse, Public Health England	December 2012	Chief Nursing Officer/NHS England vision and strategy document for nursing and other care staff

NHS reform and financial pressures

In addition to these multiple initiatives relating to quality, there has been a major reorganisation of the bodies responsible for managing and regulating NHS services. The Francis Report examined the values and behaviour of an NHS system that has since been comprehensively overhauled and in some cases examined institutions that no longer exist. The Health and Social Care Act 2012 abolished strategic health authorities, primary care trusts and Local Involvement Networks (LINks). All three of these were examined in the report. They have now been replaced by NHS England (and its local area teams), clinical commissioning groups (CCGs) and HealthWatch, respectively, all of which began their formal duties during 2013. In addition, the role of Monitor has been expanded and the CQC has also seen major changes to the way it inspects hospitals and other care providers, with the addition of chief inspectors and enhanced inspection regimes. A new body, the Trust Development Authority (TDA), has also been set up, to manage the performance of those remaining trusts that have not yet become foundation trusts.

All these new and reformed bodies are monitoring aspects of the quality of care provided in hospitals using a broad range of indicators, including extensive waiting-time and treatment targets inherited from the previous government. New quality standards are being developed and a new CQC inspection regime is being rolled out, with a greater emphasis on specialist inspectors. The latter is already having an impact on trusts, as a more exacting inspection process has been rolled out – in 2013 – with 18 trusts inspected under the new methodology (CQC, 2013a; 2013b).

The NHS budget has been frozen in real terms since 2010/11 and no significant increases will occur before 2015/16 (Nuffield Trust, 2013). Nuffield Trust research modelling the effect of rising pressure on services from a combination of more people living longer, rising rates of long-term conditions among all age groups, health care wage inflation and technological advances in medicine has estimated that the budget would have needed to grow by an average of four per cent over the decade to 2021/22 to accommodate these trends, unless productivities of a similar magnitude could be achieved (Roberts and others, 2012). The NHS has already identified that it needs to deliver savings equivalent to £20 billion between 2011/12 and 2014/15. To date, these savings have been generated through a variety of mechanisms that have had important impacts on hospital providers, notably reductions in the tariff paid for individual hospital procedures and a freeze on staff wages for all but the lowest paid (National Audit Office, 2012).

Signs of stress in the acute hospital sector are already apparent, most notably in the rising pressure on accident and emergency (A&E) departments and more trusts experiencing or forecasting a deficit. NHS trusts in England missed the four-hour waiting-time target twice in 2013; a symptom of increased demand and staff shortages, but also reflecting pressure elsewhere within trusts, for example in discharging patients who need a package of NHS and social care support in their own homes (The King's Fund, 2013). Adult social care budgets have been reduced in most local government areas, as central government allocations to local government have been cut by 20 per cent in real terms between 2010/11 and 2013/14 (Audit Commission, 2013), which is potentially hampering the prompt discharge of people from hospital (NHS Confederation, 2012).

The combination of increases in emergency admissions (particularly if they involve more acutely ill, older patients) and slow discharges can cause 'bottle-necks' of intense pressure, disrupting the flow of patients through hospitals (College of Emergency Medicine, 2013; NHS England, 2013).

Study objectives

This Nuffield Trust study examines how acute hospital trusts perceived and responded to the Francis Report following its publication in February 2013. The study is not intended to establish whether or not acute trusts acted on specific recommendations, but to understand the significance for hospitals of the Francis Inquiry findings, examined in the wider context of an evolving and complex environment of rising demand, finite resources and increasing regulatory scrutiny.

Through the methods outlined below, we explored a number of questions, including:

- What actions did acute trust hospital boards take to understand the contents and findings of the Francis Report?

- How did they disseminate the findings within their organisation and what sort of response did they perceive from staff, patients and the wider public to the Francis Report?

- What themes from the Francis Report did acute trust boards and leaders perceive as important, given the financial and regulatory context facing them in 2013?

- What sort of action did trust boards think they needed to take (if any) directly in response to the Francis Report, and what sort of actions were already under way in the trust that related to the findings of the report?

- What overall perceptions did trust leaders and staff have of the issues raised in the Francis Report?

Methods

The study used a combination of a national electronic survey of acute hospital trusts in England, and more detailed probing of the experience of five acute trusts in the form of case studies based on in-depth interviews and documentary analysis.

National survey of acute hospital trusts

Prior to designing the national survey, we conducted a rapid review of board papers and trust websites from a sample of 37 acute hospital trusts and foundation trusts. From this, we devised the survey, which was sent to chairs and chief executives at 158 acute hospital trusts and foundation trusts in England. To keep the sample to a manageable size, we excluded mental health and community trusts and focused instead on trusts providing acute hospital services to adults with primarily physical health problems, because this was the main focus of the two inquiries into care at Mid Staffordshire NHS Foundation Trust. A total of 53 trusts responded; a response rate of 34 per cent. The survey asked a series of multiple-choice questions about the dissemination of, and response to, the Francis Report, and also had free-text boxes for respondents to comment on specific items. Both are presented in the findings that follow.

Case study sites

For the case studies, we selected three regions and drew a sample at random of 12 trusts to approach. From this sample, five trusts came forward and agreed to take part. At each trust, we requested interviews with a cross-section of staff, including the chief executive, chair, non-executive and executive directors, governors (for foundation trusts), and medical and nursing staff at division and ward levels. Fieldwork was undertaken between October and December 2013. Because of the burdens on acute trusts with winter approaching and the tight timescale for the research, it was at the discretion of trusts to decide on the precise grade and number of staff members offered for interview. A total of 48 people were interviewed for up to an hour (Table 2).

Table 2: Role of interviewees at the case study sites	
Role	Number
Chief executives	4
Chairs	4
Non-executive directors	4
Other directors	12
Medical and nursing staff	18
Governors (foundation trusts)	6

The responses from the case study sites, like the national survey, were non-attributable. In the main body of the text we have identified the case study sites with a letter (A–E), but have removed them from the quotations to protect the anonymity of the interviewees.

2. Findings

This chapter sets out the findings of our research under the main thematic headings identified in the Francis Report, with an additional section describing how individual trusts set about responding to the report following its publication in February 2013. The chapter is drawn from the case study interviews and the 53 responses from chairs, chief executives, nursing and other directors, as part of our national survey of acute trusts.

Overall trust reactions and perceptions of the Francis Report

Publication of the Francis Report in February 2013: not a shock but...

In the case study sites, the research team asked every interviewee for their immediate, personal reaction to the publication of the Francis Report, regardless of their position within the trust. A common theme in many of the interviews was that the publication of the report was not a revelatory moment or surprise, suggesting that the themes and evidence emerging from the two inquiries into Mid Staffordshire (and possibly the first report into Mid Staffordshire by the Healthcare Commission, 2009) had already had an impact on staff.

Nevertheless, even though many interviewees were familiar with the content and themes arising from the Francis Inquiry, the publication of the final report was reported by many as having brought a powerful sense of professional shame:

> *I wasn't surprised by many of the things that came through in the report. But I think what it left you feeling as a professional was disappointment in the profession and disappointment in relation to the care that had been provided to patients, the staff, and their loved ones, during that time.* (Senior clinician, case study respondent)

Could it have happened here?

There were mixed views about the significance of the Francis Inquiry for interviewees' own trusts. Some people reported feelings of professional shame that failings of care could have happened at all in the NHS, but thought that Mid Staffordshire was unusual, an outlier; the product of a particular set of circumstances within and beyond that specific trust and health economy.

> *I can say for certainty that, if anything like that had happened on any of our wards, we would be jumping up and down, screaming from the treetops because something wasn't right.* (Ward manager, case study respondent)

> *I still find it very difficult to believe that somehow one hospital seemed to have managed to amalgamate every uncaring, uncompassionate person in the National Health Service all into one place in Mid Staffs. So that didn't really chime with me, so I was amazed that this had happened there.* (Public governor, case study respondent)

But there was another view expressed by many interviewees in the case study sites that although Mid Staffordshire may have been unusual in terms of the scale of failings, the Francis Report had forced them to question themselves about whether incidents of poor-quality care could be happening somewhere within their own trusts, of which they were not aware.

After reading both the Francis Reports and the other reports that are coming out more recently – Keogh and all of the other ones – you just think: 'Actually, this could happen.' So, if anything, what comes out of this is, I need to challenge myself to be vigilant at all times. (Nurse manager, case study respondent)

I could recognise the issues highlighted in the Francis Report. It's just that we hadn't been picked on. (Consultant, case study respondent)

Given that these views were offered in the case study sites, which necessarily had an uneven mix of staff taking part, it is not possible to generalise from these comments about the attitude of staff as a whole about their concerns of a Mid Staffordshire type situation happening in their midst.

Good familiarity with the content of the Francis Report

The more senior the interviewees, the more familiar they were with the content of the Francis Report. As detailed below, in the section on how boards responded to the publication of the report, most board members had been given copies of the report's executive summary, and some people had also read parts of the full report, or (more rarely) had looked at the transcripts of the evidence from patients and their families heard by the inquiry. Over two thirds (69 per cent) of the chairs and chief executives and others responding to the survey said that they had read both the full report and the executive summary, while all survey respondents reported reading some part of the report.

Bespoke summaries of the report were also common: 49 per cent of respondents to the survey said they had read a summary of the Francis Report produced by their own trust. A number of foundation trusts had provided briefings to governors. Almost half of trusts (48 per cent) had discussed the report with patients and public representatives, and half (50 per cent) had discussed it with local commissioners.

In the case study sites, there was a broadly similar pattern, where the board reported reading the report itself, while disseminating the report or its own summary of the report more widely within the trust. The board of Trust A, for example, described how the full report and executive summary had been circulated within the board and the trust. The director of nursing had also produced a summary of the report. A number of senior nursing staff and clinicians, and some members of the board, reported that they had read the full report. The frontline staff at Trust A were more likely to have relied on the summary report prepared by the director of nursing or briefings from other sources (such as royal colleges). The summary taken to the trust board was also discussed at meetings of ward managers and senior nurses, and at meetings focused on allied health professionals and health care scientists.

But was the Francis Report too long?

Even so, most interviewees who had seen the report felt that its length had been challenging: the executive summary is 125 pages long, including 290 recommendations, while the full report is over 1,700 pages in length. Seventy-seven per cent of the survey respondents considered that the length of the Francis Report and the number of recommendations had been a hindrance. In interviews, staff at trusts also mentioned that the breadth of issues covered by the report, which extended to many organisations beyond acute hospitals, had also been a challenge. For some respondents, this had made it difficult to distil the particular messages and recommendations for their organisation (as opposed to the wider system, or other organisations).

Two hundred and ninety recommendations, which weren't prioritised, which were often transactional, rather than really trying to get to grips with a profoundly important emotional debate. If I produced a report for my board with 290 recommendations that weren't prioritised, it would be a very, very brief agenda item. (Chief executive, case study respondent)

What is clear, though, is that the report lost a lot of its impact by being so long and having so many recommendations. (Survey respondent)

Nevertheless, over 93 per cent of survey respondents felt that their trust's board had had sufficient time to reflect on the Francis Report, suggesting that the length had not been a hindrance to understanding the importance of the messages contained in the report.

The Francis Report as part of a linked set of reports on quality

Although it was common to hear that the Francis Report itself was long, many of the board members interviewed also viewed the report as part of a broader agenda about quality of care in the NHS, typically seeing it as the trigger for a suite of reports, including the Berwick Report on patient safety (National Advisory Group on the Safety of Patients in England, 2013) and the Keogh Report on 14 trusts with high mortality rates (Keogh, 2013), both of which were shorter and had more explicit recommendations aimed at acute trusts. In Trust C, for example, interviewees from the executive team felt that the Berwick and Keogh reports had provided more practical lessons for acute trusts. The straightforward 'checklist' provided by the Keogh Report, and the clear cultural messages in the Berwick Report that could easily be transmitted to staff, were easier to draw out and begin to implement. Both reports were seen in a sense to be extensions of the Francis Inquiry.

Some of the free text survey responses indicated that the first Francis Report, published in 2010, was regarded as being more relevant to acute providers (Francis, 2010). It was recognised as being focused on the workings of the hospital, whereas the public inquiry report (Francis, 2013a) examined the whole health care system. Some emphasised the importance of the Berwick Report and its emphasis on culture in the delivery of high-quality, safe care, which was perceived as being 'more in tune' with their organisation.

How the boards responded

Publication of the report of the Francis Inquiry had been widely anticipated by trusts. Unsurprisingly, therefore, 100 per cent of trusts responding to the survey and all the case study sites reported that the Francis Report had been discussed at a board meeting. A smaller proportion of trusts (just over 28 per cent) also said that they had convened an extra or additional board meeting specifically to discuss the report. Discussion at a subcommittee of the board that has responsibility for quality and/or safety was near universal, with 98 per cent of trusts that responded to the survey reporting that they had done this.

Two thirds of trusts in the survey also reported having trust-wide meetings to disseminate and discuss the report, and 84 per cent reported that it was discussed at scheduled meetings with staff. This was reflected in the case study sites also. In Trust B, for example, 'Francis roadshows' had been held in the autumn of 2013, with a cross-section of staff with different roles from across the trust being invited to sessions with executive and non-executive directors, facilitated by staff with lead responsibility for quality and safety initiatives. Staff had been asked to reflect on the themes in the

Francis Report, and discuss and report back on how the trust was faring in relation to these. Trust B interviewees explained that it made more sense to hold such sessions when people had had time to reflect and act on the report, hence the roadshows being later in the year. This deliberative approach was reported to be working well, and there were plans to continue this as a form of staff engagement.

A typical trust response to the Francis Report has been to assign a senior individual (or sometimes two individuals) to act as a 'lead' on the trust's work related to the report. The majority (94 per cent) of trusts responding to the survey reported that they had assigned someone at board level to lead the trust's response. Most commonly, this was the director of nursing, sometimes in conjunction with the medical director, but in almost a fifth of trusts it was the chief executive, and in a sixth it was the medical director. One trust commented that there was no lead individual as their trust's response "is very deliberately led by the whole executive team". Joint leads involving the director of nursing and medical director were also reported in a minority of cases, and there was an example of a trust appointing a non-executive lead for each of the themes in the Francis Report.

An action plan or not?

There are copious references in the first volume of the 2013 Francis Report to the use of action plans by the board of Mid Staffordshire, which were not always followed up, and sometimes used as a device to postpone action while simultaneously reassuring internal and external stakeholders that something was being done. This message appears to have been heard by some of the respondents in our research.

> *The 'Francis challenge' is not [about] taking actions or tracking them, it is [about] delivering results.* (Survey respondent)

The case study interviews revealed a mixed set of approaches to identifying and implementing any changes that the board thought were needed as a result of the Francis Report.

In Trusts A, B and D, the board had asked the Francis lead (or similar) to assess which recommendations were potentially relevant to the trust, and identify the extent to which the trust thought that it was compliant with the recommended actions. Trust B had produced a formal action plan, although interviewees were aware that there were risks attached to badging things specifically as 'Francis' due to the potentially temporary nature of the impact of such work, particularly as the novelty of the Francis Report would recede over time:

> *The NHS will never be the same after Francis, but we need to start changing the language away from 'Francis'.* (Chief executive, case study respondent)

Another trust, by contrast, self-consciously chose to avoid drawing up anything that could be deemed as a 'Francis action plan', because the board concluded that action plans were typical of a knee-jerk, ineffective approach to quality improvement that characterised the management culture that led to events such as Mid Staffordshire in the first place.

> *We [the board] concluded there is no way in the world we were going to put an action plan together to address all of those recommendations because that would be reinforcing historical behaviour, rather than getting to grips with the issue that Francis was trying to address.* (Chief executive, case study respondent)

This trust reported that it had instead identified the themes that it thought were important in the Francis Report and tied them into a major piece of work on culture and values that had already been initiated in the trust. The same interviewee, however, reported that the trust's commissioners had already pressed it for just such an action plan:

> *I've recently had something from the Commissioning Support Unit, asking me to fill in a template with the actions against Francis and I've refused to do it.* (Chief executive, case study respondent)

The first Francis report had begun the process of change

One of the reasons why some of the trusts in the case studies were self-consciously avoiding a 'knee-jerk' action plan was that they thought that the work in response to the failings at Mid Staffordshire NHS Foundation Trust had begun much earlier in their trusts, in response to the publication of the first Francis Inquiry report in 2010. In one of the trusts, for example, work began in 2009, as the first inquiry unfolded. The trust's chief executive led a programme of work to anticipate likely themes in the failings at Mid Staffordshire, and to assess to what extent they could be applied to the trust. The chair described the outcome:

> *We got the bullet points and we did a very quick and dirty 'Could we be the next Mid Staffs?' And I think the answer was, 'Yes, maybe.'* (Chair, case study respondent)

This sense that the first Francis Inquiry report was a key driver of action to improve all aspects of care and governance was reflected in the national survey of trusts. Most of the trusts (70 per cent) considered that, by the time the 2013 Francis Report was published, they already had measures in place to improve and assure the quality of care that aligned with the Francis recommendations. Sixty-seven per cent of trusts either agreed or strongly agreed with the statement 'the trust took action after the publication of the 2010 Francis Report and is confident that these adequately reflect the recommendations of the 2013 report'. Nevertheless, 82 per cent of trusts reported that they were taking some new actions or initiatives directly as a result of the final (2013) report.

Fundamental standards

The interviews in the case study sites revealed two distinct themes under the heading of fundamental standards. The first was efforts within the trust to develop (or build on existing) home-grown definitions of what constituted good standards of care. The second theme was the existing suite of externally defined standards, and the impact of the action taken by regulators and other external bodies to ensure that the trust maintained these standards.

Trust-specific or 'home-grown' standards of care

The interviews in the case study sites revealed a broad range of activity in participating trusts to understand what good standards of care look like and how these might be measured.

In terms of scope, many of these related to nursing care in wards, but also included a focus on standards in A&E and clinical standards in specialty care.

Trust B, for example, had developed a comprehensive set of nursing metrics at ward level, which were measured and reported in real time. The data were also published for patients and families to read. The same trust also now uses peer review of wards and departments, and has set up a nurse response team to intervene when a ward or department is shown up as underperforming against these metrics.

Another of the case study trusts had set up what it informally called 'mini-Keogh reviews':

> *We've taken the word 'Keogh' out because we were frightening people to death by using that. It's an area where we're picking up a number of different indicators which are not ideal, shall we say. We're not using mortality as the big thing. It isn't just one thing, it's complaints, incidents, perhaps more falls than they usually have, not picking up on VTE prophylaxis, all sorts of things like that. But looking at where we seem to have a bit of inconsistency and a bit of a mixed bag of things that aren't quite right.* (Senior clinician, case study respondent)

Trust A also had a set of ward-level metrics, including staffing levels, pressure ulcers and falls, which acted as early warning systems. A number of staff at this trust reported that their threshold for acting on concerns had changed, and they believed they were now more receptive to what patients had to say about the quality of their care. They had also set up 'mock' internal CQC visits as a means of strengthening personal accountability among staff. Prior to the publication of the Francis Report, Trust E had already developed a suite of quality metrics on a clinical specialty level, in collaboration with its consultants in each area, which are now published on the trust's website.

This was reflected in some of the survey responses, with some respondents reporting that their trusts had also introduced their own, internal 'Keogh reviews' involving local commissioners. One trust highlighted activity to partner trusts in special measures, and another was considering introducing external peer review of its services. Linked to this were efforts to improve board visibility of quality and patient experience, with a number of respondents highlighting the importance of 'walkabouts' or 'quality walks' in enhancing board assurance.

In many ways, these internally driven mechanisms for peer review and assessment seemed to represent an attempt to move the onus away from external validation. Some comments from survey respondents reflected concern about an over-emphasis on external regulation and inspection, including its impact on culture.

> *What the NHS response to Francis utterly misses is that external inspection and assurance should not be relied upon, yet nationally most of the response de-powers boards and inflicts upon them endless duplicative models of assurance.* (Survey respondent)

National standards, now and in the future

Most interviewees in the case study sites had an ambivalent attitude to the current national standards and their regulation. On the one hand there was respect for the findings of previous CQC inspections and the renewed professionalism of the new inspection regime being developed by Sir Mike Richards, and there was no doubting the galvanising effect that a poor report on aspects of care had had on individual trusts.

> *We had a very bad experience a while back where we failed the CQC inspection on a [number of care-related indicators]. And it was a very shaming and humbling experience, actually. Now, it doesn't matter what I thought of that report: that is irrelevant. There's something about public confidence, staff confidence and patient confidence. Now, as I say, we're not perfect, but I do think we do focus on quality. I've got a director of nursing who I'd be happy to look after me when I was ill. That's the basis on which I appoint people these days. And we've already done things like changed the way we recruit against values.* (Chief executive, case study respondent)

On the other hand, many of the interviewees also drew attention to some negative aspects of the current standards and inspection regime. First, in some cases standards were not deemed to be coherent across regulators. One of the case study trusts, for example, had been flagged as 'green' by the CQC for its performance on a specific quality measure, but had been failed by Monitor, which had declared the trust as being 'in breach' for poor performance against the same dimension of quality.

> *So it's very difficult to marry the two, currently. And then that's very difficult messaging to give to staff and to patients, really.* (Senior manager, case study respondent)

The second criticism aimed at current national standards was the scale of effort needed to respond to multiple bodies needing assurance that the trust is meeting standards. The bodies mentioned in the interviews included local commissioners, Monitor, the CQC, the TDA, NHS England and its local area teams, and the GMC. One senior clinician in one of the case study trusts remarked that trusts still felt "culturally done unto" by external bodies and felt that they often focused too much of their energy on responding to external requirements and reports. In the case of this trust, frequent telephone calls from the TDA on the performance of the emergency department against its four-hour target were cited as an example:

> *So when the only phone call that I'm getting from the TDA's senior management team is about my ED [emergency department] performance and that's the only contact I've had from the senior management team at the TDA in seven months, and I'm told that now the Prime Minister is having a weekly meeting and the only thing he concentrates on is the ED performance, then I am quite concerned. It feels like it did five or six years ago.* (Chief executive, case study respondent)

The quote above reveals an interesting tension that came out of the interviews in relation to the current national standards. In several of the case study sites, interviewees tended to put meeting financial goals and waiting-time targets in the same conceptual category, as something that was not capturing 'quality'. For example, a senior manager in one of the trusts described how missing 'targets' and poor quality care may not be the same thing:

> *We're giving good-quality care here. Yes, we're not hitting targets but… I've managed A&E now for three years and I can hand on heart go down there and know that we are giving good care to patients, and good care can take longer than four hours.* (Senior manager, case study respondent)

The four-hour A&E target was most often talked about in this way. Some interviewees conceded that prompt treatment was an important facet of quality from a patient's perspective.

> *At the end of the day, many studies have said that the four-hour target helps to improve patient safety and quality of care; there is no doubt.* (Senior clinician, case study respondent)

Nevertheless, there was a sense that the four-hour target had perhaps become disconnected from quality in the minds of people working in the trusts:

> *We try to pitch the four-hour target as a safety target; that's in my team brief every single month. But I think that horse has bolted. I don't think you can make that link, the staff don't believe it. It was launched as a target, the majority of them still think it's a government target and nothing to do with patient safety. However hard you try to*

say 'look, when people wait, mortality tends to go up, it's not good care', it's a damaged target in my opinion and I think the sooner we change it to a different measure the better actually. I struggle to sell it. (Chief executive, case study respondent)

Fundamental standards: the tension between quality and money

An important theme in many of the interviews related to an observation that came out of the Francis Report: that the board and wider system in Mid Staffordshire were focused on financial matters ahead of the quality of care given to patients. Some interviewees felt that there had not yet been a fundamental shift in the values of these powerful external bodies who manage the performance of hospitals, particularly Monitor, towards the need to prioritise quality above financial health.

The trouble is, as I see it, is that Monitor is looking at it from a legal, contractual point of view and that's the only way they can look at it. We're looking at it from a human point of view and a patient point of view and those two don't go together properly. (Public governor, case study respondent)

Not everyone perceived Monitor as solely finance driven, however. Interviewees from one of the case study sites, which had experienced a failed bid for foundation trust status a few years earlier, reported that their experience of Monitor the second time around had been transformed. The quality of care had been very closely scrutinised by Monitor in the application process, in complete contrast with their first experience. However, their contact at senior level was still characterised by an emphasis on financial matters.

Interestingly, when we got to the board-to-board [meeting] with Monitor, the questions were still predominantly around finance and that felt a bit odd actually, it felt a bit odd that they'd just got onto quality questions right at the tail end of the interview process. So I was expecting to be grilled by the board-to-board and in fact it turned out it was finance that was being grilled again. (Senior clinician, case study respondent)

Interviewees in another of the foundation trust sites felt that Monitor was less confident of its role in assessing the quality dimensions of a trust's performance and, as a result, tended to focus on specific targets, such as the four-hour A&E target or other waiting-time targets. One informant commented that Monitor "don't quite know where to find themselves with all of this [quality agenda] yet".

Fundamental standards: more intensive scrutiny from local commissioners?

Forty-one per cent of survey respondents reported that commissioners had asked them for new or additional information as a consequence of the Francis Report, had conducted visits to the trusts (36 per cent) or had revised their approach to monitoring the quality of services in the trusts (26 per cent). One respondent said that their trust's commissioners had increased support to the trust, while another reported that the Francis Report had been discussed at a board-to-board meeting with commissioners.

Many interviewees from the case studies also reported that commissioners had been more active in seeking data and assurance that the trust was complying with care quality standards in the wake of the Francis Report. However, there were concerns that commissioners could also be more inclined to focus on finance ahead of quality. In Trust A, for example, there were mixed views about weight given to quality in the scrutiny of commissioners. One interviewee reported that 80 per cent of the discussion at contract meetings with commissioners concerned performance and finance, "with

just 20 per cent on quality, if you're lucky". Another thought that finance, performance and quality were given equal weighting and were part of a 'three-legged stool', but thought that if one was not managed well, everything would be off balance.

A similar view was expressed by a senior manager in another of the case study sites, who felt that although the dialogue with commissioners was generally more healthy since the creation of CCGs – who were perceived as more willing than their predecessors to talk about how to tackle the wider problem of rising admissions to acute hospitals – commissioners were seen as under considerable financial pressure themselves. This was felt to undermine efforts by the trust to persuade commissioners to invest in additional quality-focused initiatives in the trust:

> *We had a very interesting meeting with our commissioners last week around contract, in which the discussions were: 'Well, we know Francis says this but this is actually what we've got to meet and that's our challenge.' So, regardless of the recommendations that are coming out, there is still messaging around targets and what needs to be achieved and the consequences of not achieving that.* (Senior manager, case study respondent)

A contrasting view came from another case study site, which had found a more sympathetic response from the new clinical commissioners, in contrast with their primary care trust predecessors:

> *We sat with the CCG, with the GPs in the room, talking to them about the issues we've got here, and how we need to get patients through faster, and how they can help us with it. They want to help us with it. They're not standing to one side and saying, 'Well, that's your problem.' And, when we've needed extra funding – as we have – they, as the GPs, have been supportive.* (Chief executive, case study respondent)

Although many of the interviewees reflected a broadly positive attitude towards their commissioners, there were two main caveats. One was the sheer volume of work that was required from the trusts to respond to their requests on top of what already had to be done for regulators and other external bodies – one person described it as a "massive industry" of reporting. The other caveat was the worry that the underlying quality of care from a patient's perspective could be lost in this scramble for assurance, which rested on expectations that were essentially unrealistic.

> *I've got people just increasingly risk-averse – really risk-averse. The number of forms I've had to fill in to cover other people's arses about how I can guarantee safety around winter or guarantee that no harm will ever happen to anybody, ever, in this hospital.* (Chief executive, case study respondent)

Wider system still too top-down and focused on targets?

A theme running through many of the interviews was that although the Francis Report had been very critical of a top-down NHS management style, overly focused on targets and financial compliance at the expense of the quality of care, nothing had really changed in the wider regulatory system, and things had possibly got worse.

In one of the case study sites, for example, one interviewee who come from outside the NHS into their current role, described being shocked by the "bullying culture". A board member from the same trust described "an appalling lack of trust in senior and experienced professionals to get on with the job".

A similar theme emerged from another of the trusts in relation to attitudes from the former strategic health authority, which were seen as persisting.

> *We had an interesting thing last year where, in our plan, to hit the savings – we had a million pounds, I think – to close a ward. And the board decided not to close the ward. We didn't half get beaten up.[The] chair of the SHA [strategic health authority][…] gave me a bollocking for not hitting our control total. We, as a responsible board said, 'We cannot, in conscience, take a ward out of this hospital.' But [the chief executive] got called to brutal meetings; I got called to brutal meetings. So, when they talk about the pressure on trusts, it's still there.* (Chair, case study respondent)

There was a strong sense from some senior managers and chairs interviewed that until performance management of acute trusts changed, efforts to bring about cultural change internally could be undermined. There was a perception that it is hard for boards and senior managers to engender a culture of compassion, support and mutual learning inside trusts when they experience a form of external management that is seen as punitive at times. One senior clinician said: "If management behaviour is punitive, shouty and target driven, that filters down", and described efforts to make messages to staff more positive, less target driven and more focused on the benefit to patients.

The contrast between this style of central management and the emphasis on building a non-blaming, enabling approach in the Berwick Report (National Advisory Group on Patient Safety, 2013) was pointed out by one of the case study trust chairs:

> *[B]lame is not a useful tool; if you want to get staff not to challenge or find or share problems, you know, not to be open to improving, then blame them, because they'll keep their heads down and they won't raise things, not through being malicious, they'll just naturally do it because the consequences of putting your head above the parapet don't feel that good.* (Chair, case study respondent)

A chief executive summed it up in straightforward terms:

> *I think, at the moment, there's a blame storm going on. I think people are fighting to see who can beat the industry up the most. I've never, in my whole career, felt more regulated.* (Chief executive, case study respondent)

Openness, transparency and candour

The Francis Report identified a lack of effective communication both within Mid Staffordshire NHS Foundation Trust and across the wider health care system with regard to sharing information and concerns. At the heart of the failure was a lack of openness, transparency and candour in the information emanating from Mid Staffordshire. There was a lack of willingness on the part of multiple external bodies to heed the messages, link them up or take follow-up action. The message for trusts (and external bodies) on this (from Francis) is therefore to make sure they have multiple sources of intelligence, and robust ways of assessing these and following them up.

Candour and better handling of complaints

Themes relating to openness, transparency and candour emerged frequently in the case study interviews. Trust B, for example, had decided to focus its energy specifically on these areas, including complaints, as a result of its gap analysis against the thematic contents of the Francis Report, as well as prior concerns that had been raised about the trust's handling of complaints.

Before the publication of the Francis Report, 'candour' was reported by interviewees to be a term that was unfamiliar to many staff, and some trusts used the Francis briefings as an opportunity to explore what was meant by it and how staff might take a different approach to sharing information about care with patients and their families. In many cases, candour was understood as a greater willingness to be open when things went wrong (not just serious events; also more routine problems), and was allied with better handling and use of complaints.

In Trusts B and D, a need to improve the handling of complaints was already known to the trusts' boards as an issue requiring attention, but the Francis Report was reported to have added impetus to work to improve performance in this area, particularly in relation to removing a backlog of complaints, having a more streamlined process, and meeting much more frequently with complainants.

Trust B has had a fundamental review of how it handles complaints and now tries to always telephone or meet with families and patients before getting into written dialogue about a complaint. The trust has encouraged complaints to be made directly to the chief executive, who refers complaints and issues immediately to the rapid response team in the hospital for initial attention.

> *Quite often, people will email me when they get home from evening visiting. They'll say, 'I don't think my gran is being very well looked after' or whatever, and if it's really fraught, I can phone in and the night team will go and visit. And then the next day there can be a broader meeting with the family.* (Chief executive, case study respondent)

The same trust is now treating falls as something that should always be reported to families in the spirit of a duty of candour, and has worked hard on developing more transparent and systematic approaches to discussing other serious incidents with families and patients. However, it was noted that this is hard work to pursue, in a climate of monitoring and regulation, and it is placing a burden of work on the shoulders of already busy chief executives.

Transparency and candour were key areas of activity for respondents to the survey. Trusts reported strengthening their arrangements for sharing actions and outcomes from complaints and incidents with staff, patients and the public. A number highlighted work on the duty of candour and some had refreshed their whistleblowing policy. Some identified the duty of candour as being an area that would require targeted developmental support. A number of trusts reported holding 'listening events' with staff as part of efforts to improve communication, and also to empower staff at all grades to challenge and resolve problems. Many detailed activity to increase patient and public engagement.

> *We now cover almost all business in public. Our incident systems and risk register are now available to all staff on our intranet and will shortly go public on our internet. The aim is to make sure that nobody thinks someone else has already raised a concern but also to make sure everyone can track and challenge improvement.* (Survey respondent)

Listening to patients goes beyond having good complaints handling

People in several of the case study sites talked about the importance of having multiple channels for hearing what patients, families and staff have to say about quality of care, rather than relying on formal complaints.

Trust B, for example, reported undertaking 'goldfish bowl' events as part of activity on culture and candour. These events work by inviting some complainants to the trust to tell their story to a facilitator, with ward staff observing and listening, but not able to join in. The facilitators have a follow-up discussion and reflection with the staff about what they have heard, and what it means for care. This is reported as being a powerful form of learning for staff. Videos are also being made of patients recounting their experiences, for use in staff development sessions.

> *We've tried to push the message all the time that we want to be open; there is no place for defensiveness; if there are problems – let's surface them.* (Chief executive, case study respondent)

Another of the case study sites has developed a series of DVD-based interviews with patients or their families talking about their experience of care, which were reported as being popular with both staff and patients.

> *We actually get patients and relatives who haven't had a good experience to come and tell us about it and tell us why it wasn't a good experience. I mean, I was one of them: they filmed me, talking about my father's care. And I know they use those DVDs in training programmes and things like that. And I think, when it comes from a patient – a relative – it's very sort of powerful – probably more powerful than just looking at the Francis Report. It's much more personal to our trust.* (Public governor, case study respondent)

Listening to staff: beyond whistleblowing

There was a widespread perception that a key contributor to what happened at Mid Staffordshire was a closed culture, where raising mistakes and serious problems was discouraged by a set of managerial priorities that saw quality as something to "get away with", while finance and targets remained the focus. This was widely agreed to be something that had in the past been endemic in the NHS, as described by an interviewee at one of the case study sites:

> *I think many, many trusts were very much of that psyche. I think there was certainly the candour, the openness was something that would appear not to be there in terms of the culture and I got a sense it was a culture that said we don't want to know about the problems, we'll get away with that element, so we don't have to focus too much about it.* (Senior manager, case study respondent)

Three of the case study trusts reported work on refreshing or renewing their whistleblowing policies. But there was a recognition that this was one of the hardest areas in which to change behaviour and create an environment where staff felt safe when raising concerns. One of the case study sites had developed its own trust-wide initiative to improve care, based on work aimed at changing values, but the chief executive observed that this was a very slow process:

> *I still get anonymous letters from staff, raising concerns, which begs the question for me, 'Why do you feel that you need to behave anonymously? You must be concerned that something would happen to you if we knew who you were.'* (Chief executive, case study respondent)

Even where trust leaders had made efforts to increase the opportunities and means for staff to raise concerns, some staff were apparently still not confident to go to senior leaders with concerns.

I don't feel I can go to the chief executive and tell… my concerns, even though [they say] I can. (Ward manager, case study respondent)

Nursing staff in Trust A, by contrast, voiced more willingness to report problems, but thought that doctors might be more reluctant. Trust A also reported that it had invested in a software package that allows real-time reporting of incidents. Staff, including doctors, were thought to be more willing to use the software incident reporting system, although it was felt that there was a long way to go until doctors used it routinely and no significant increase in the number of incidents had been reported. A duty of candour had been incorporated into the system by asking whether the duty had been completed. Root cause analysis of incidents recorded on the system was thought to be more robust and detailed. One area for improvement identified in Trust A was in feeding back to staff involved in an incident. Some interviewees lacked confidence that actions were taken in response to concerns that had been escalated to senior colleagues.

Trusts also reported experimenting with new ways of hearing what staff had to say. Trust B, for example, has developed a new forum for junior medical staff where once a month the doctors talk with medical and clinical directors about concerns, adverse events and things they feel the trust needs to watch out for. In addition, an associate medical director at the trust is developing a social media network across the organisation for the sharing of information and ideas – 850 people have signed up so far. The intention is to use this for positive feedback loops, and more real-time staff engagement.

Openness: are there limits?

There were some expressions of caution about how far a trust could be open. In relation to patient complaints, for example, where litigation was involved, an interviewee from one of the trusts felt that on occasions they were having to fend off the CCG and the local area team of NHS England:

[T]hey're expecting much more openness and transparency in relation to serious incidents or complaints and can be very critical, even when it is going through an inquest process where, actually, it's very difficult to give a family all the information until you've been through a process where the coroner can clearly indicate a cause of death and whether there was any contributory factors to that. (Senior clinician, case study respondent)

Interviewees in Trust A, which was preparing for foundation trust status, feared that transparency would be lessened if it was authorised, because the board would conduct less of its business in public.

Some interviewees expressed concern that the focus on the number of deaths attributed to poor treatment in media coverage of Mid Staffordshire served to discourage candour about mistakes.

Once you're being accused – once that group of staff are accused, in effect, of killing people, you change the whole tone of the debate. One of the things I learnt here early on is that you have to create an atmosphere where people will come forward and say, 'I'm sorry, I cocked that up.' If they don't tell you, you can't do anything about it. (Chair, case study respondent)

These sentiments were also reflected in the responses of survey respondents, who raised concerns about building an open culture against the threat of criminal action. Some respondents highlighted the responses of the media, regulators and commissioners to

the Francis Report and the impact of this in terms of reputational damage for trusts that demonstrate openness. One respondent attributed "a noticeable lack of interest" in senior and non-executive positions within the trust to a "heightened risk and blame profile".

Genuine cultural change is important but takes time

The survey similarly revealed that many trusts report giving attention to the cultural climate, including introducing initiatives to refresh organisational values and to strengthen staff engagement. One trust has encouraged staff to make a personal pledge for how they intend to improve patient care. Others highlighted efforts to revise quality strategies to integrate common and clear values, and standards of compassionate care.

> *We have engaged large numbers of clinical staff in discussions about the real meaning of Francis and the culture, attitudes and mindsets that underpin good care.*
> (Survey respondent)

> *If the culture is not right, no amount of policy, guidance, or regulation will deliver safety.*
> (Survey respondent)

An important message from the senior managers, clinicians and non-executive directors interviewed in the case studies is that genuine cultural change, particularly in relation to staff feeling they could raise concerns safely, is one of the biggest challenges for trusts arising out of the Francis Report.

Many interviewees agreed that the 'values and culture matter' message had taken off in a big way (since the Mid Staffordshire events first blew, but much more so since the 2013 Francis Report), and was part of a bigger picture, where the NHS as a whole is trying to 'get beyond a top-down defensive approach' to complaints and challenge.

In Trust B, for example, work had been undertaken with a management consultancy firm to develop a 'cultural barometer' for use in the trust, and this was said to have revealed interesting – and at times disappointing – results. The sheer pace of emergency work that dominates the trust, along with a predominantly older and frail patient population, meant that there was an ever-present fear of staff burnout, and nurse leaders were looking at how they could introduce something like Schwarz Center Rounds (Goodrich, 2011), which offer staff a regular opportunity to reflect on social and emotional issues they face in caring for patients.

Another of the case study trusts had begun a programme of change on care and compassion, prior to the Francis Report, which was designed to bring about an enduring change in culture, rather than being a one-off initiative or action plan. But the process of culture change was a slow one, according to the chief executive:

> *The way you change the culture of the organisation is by having conversations that don't result in action plans. We talk about it! So we had a presentation at our executive meeting last week on the latest feedback from the staff survey about bullying and harassment and there's something in there which says it's still prevalent – including at senior management and executive levels – within the organisation. Now, I said, 'Well, look, this is what they're telling us. We need to really think about this.' What I want the organisation to know is we've talked about it. Changing culture – it is about signs, symbols and iconography and it's about lots of things. You change the culture by talking.*
> (Chief executive, case study respondent)

Compassionate, caring and committed nursing

Francis as a lever for extra investment in nursing

One of the most common forms of new action reported by respondents to the survey was to review nurse staffing levels and skill mix, and to strengthen the reporting of staffing numbers at board level and beyond, including displaying on wards real-time information about staffing numbers and grades.

> *Francis brought forward our agenda to look critically at staffing ratios, particularly in those challenging areas of elderly, complex care.* (Survey respondent)

In some of the trusts, particularly A, B and C, the Francis Report was described as having added momentum to previous efforts to invest more in their nursing establishment. Inadequate nursing staff levels were flagged as a contributory factor in the failings at Mid Staffordshire (Francis, 2013a, p.45), but the Francis Report stopped short of recommending a minimum staffing level, recommending instead that NICE develop evidence-based tools for 'establishing the staffing needs of each service' (Francis, 2013a, p.69, para 1.132).

One of the trusts reported that it had invested between £300,000 and £500,000 in additional nursing, at a time of constrained finances. Another trust had invested well in excess of £1 million in additional nursing, drawing on its reserves.

The director of nursing at another of the case study sites felt that having some evidence base about the likely staffing needs for nursing would be valuable:

> *[T]he work that is now being proposed, from a NICE perspective, around nurse staffing levels… And that's not about having minimum nurse staffing levels but it's about having some information to be able to clearly articulate, as a professional, the recommendations you would be giving to your board.* (Senior clinician, case study respondent)

The challenge most commonly cited by survey respondents arising from the Francis recommendations related to ensuring the correct levels of qualified nurses in the context of financial constraints.

> *Nurse staffing levels and skill mix is a challenge at a time when we need to achieve six per cent cost improvement programme…* (Survey respondent)

Strengthening the supervisory role of ward managers

The Francis Report contained recommendations about the importance of ward managers, particularly the need for them to be supernumerary, in order to fulfil their supervisory role more effectively.

This chimed with interviews in Trusts B and C: interviewees had expressed similar sentiments as a result of their process of listening to staff much more. Interviewees in Trust B described how staff had been found to feel very frustrated, recognising some of the Mid Staffordshire failings, but struggling to have the time to deliver and monitor care in the way they knew was needed. The trust was moving to having all ward managers as supernumerary and supervisory, with the intention that they will "really lead and be a consistent presence", knowing their patients, listening to concerns, and advocating for patient care and safety. In a few cases, this work was reported to be "flushing out some ward managers who are not suited to the resilience of running a ward". A development programme for ward managers was also being put in place.

A number of trusts' plans to make ward managers more visible and in some cases supervisory were also cited in the free text responses to the survey.

Health care support workers

Increased attention to the recruitment and conduct of health care support workers was a strong theme in the Francis Report, and the trusts in this study reported having engaged in different strands of work to improve the quality of this group of staff. In Trust A, for example, nursing staff considered health care support workers to be central to embedding some of the learning from the Francis Report, emphasising that they stay in post longer and are at the patient bedside more often, than any other staff member. One described them as "the trained nurse's eyes and ears". The trust had developed a Code of Conduct for health care support workers. The Francis Report was thought to have increased the impetus for this and to garner trust board approval for the associated costs. All support workers in Trust A participate in the national apprenticeship programme and must complete a competency framework, but they receive no financial reward for achieving this. Aspirations were expressed to have a proper career structure for support workers.

Other trusts also reported using the Code of Conduct for Healthcare Support Workers (Skills for Care and Skills for Health, 2013). Trust D reported that it was also reviewing its recruitment process for health care support workers, and developing minimum standards of experience of care for potential recruits.

Better care for older patients with dementia

In many of the case study interviews, the failings in care at Mid Staffordshire were closely associated with older patients, particularly those with dementia, who were felt to be most at risk of substandard care in general. One of the trusts described using an acuity tool to assess the needs of patients on the wards, and funding a pilot programme to educate staff on wards about the needs of patients with dementia. There was some debate within the trust about the wisdom of setting up a bespoke 'dementia ward' or whether it was better to spread learning more generally across wards to understand and meet the needs of confused patients. A trust policy objective of having one-to-one nursing ratios for people with dementia has had to be adapted in the face of the financial realities of supplying staff, and focuses on the avoidance of falls.

> [W]hat we've had to do is we've said, 'Well if you've got patients who are all at risk of falling we need to cohort them into a bay, so that you're actually putting a nurse in the bay,' because you can't have one-to-one with every patient, and we do have high numbers of dementia patients. (Senior manager, case study respondent)

Strong, patient-centred leadership

In relation to the failings in the leadership of Mid Staffordshire NHS Foundation Trust, the 2013 Francis Report reinforced the findings of the earlier report published in 2010. The leadership at Mid Staffordshire, particularly the board and other senior leaders in the trust, had 'an engrained culture of tolerance of poor standards, a focus on finance and targets, denial of concerns, and an isolation from practice elsewhere' (Francis, 2013a, pp.43–44, para 1.6). In addition, the report concluded that the trust management had no culture of listening to patients and was focused on 'self promotion rather than critical analysis and openness' (p.44, para 1.7).

Valuing quality above money and targets

There was a strong theme running through the interviews with many of the chief executives (and other senior executive figures) reporting that the Francis Inquiry had given them much more traction to champion the cause of quality of care for patients, over and above external pressure to meet targets, whether financial or performance.

> [T]hat's the big thing it seems to me that Francis has changed, which is a very important culture change, which you can't ignore, in that I'd rather be hung for money than for quality and safety. (Chief executive, case study respondent)

This confidence in the face of external, regulatory pressure was reflected in an interview with a senior manager in one of the case study trusts, which had recently received a warning from Monitor about compliance with waiting-time targets. The interviewee recalled the attitude of the chief executive as bullish in the face of such pressure:

> There's a lot of pressure there, and [the chief executive] and other execs were saying, 'They're not criticising us about our quality of care, and therefore, actually, we've got the moral high ground here. (Senior manager, case study respondent)

There were also doubts expressed in another case study site about the sustainability of such a position, particularly as finances are undeniably constrained in most acute hospitals, and the management and regulatory system ultimately requires financial balance alongside high performance in terms of patient care.

> The one good thing Francis has done, the really good thing, is it has ensured that safety and quality have become much more prominent – that's really important. But I am left with a real concern about the do-ability of it all and the need for us to find a way forward. (Chair, case study respondent)

In another of the case study sites, by contrast, senior leaders felt that there was still considerable mileage to be had in improving quality and reducing costs at the same time, and that as a trust they were still some distance from the "trade-off frontier" between quality and costs. Part of the leadership challenge was described in terms of understanding and being able to communicate the potential for generating savings by reducing waste, in a way that made sense to clinicians and the public.

> So if I was to say, 'We've got to get 20 per cent cost out of this particular pathway', then immediately everyone gets defensive and looks for reasons why it can't work, but if I was to say, 'Let me describe this pathway', and you do the usual description of someone going from pillar to post, from the GP to diagnosis to other outpatients, to a cancelled op, and you say, 'Is that good quality?', and people go, 'Well no, that's terrible quality, but it's also incredibly expensive. We're wasting all the money on poor quality.' (Chair, case study respondent)

Involving clinicians

The Francis Report noted that in Mid Staffordshire, consultants were disengaged from management issues and there was no 'collective responsibility or engagement for ensuring that quality care was delivered at every level' (Francis, 2013a, p.44, para 1.8).

The survey revealed a particular focus on clinical leadership, especially on nursing leadership at ward level. One respondent said that their trust had introduced ward matron rounds at visiting times to meet families and address concerns at the point of care.

One trust had begun a leadership development programme in the previous 18 months, aware that there were not enough clinical and medical leaders in the organisation. This had been supplemented by restructuring larger divisions into small business units, led by clinicians. One of the trusts had also had a sustained push on getting more clinicians involved in management, which has been very successful, according to their chair:

> *We've moved from a situation where it was difficult to get clinicians in leaderships jobs to now, they're oversubscribed. You know, we have three or four applicants per place for, say, an associate medical director or a clinical director, which is a good indicator of that sort of absolute critical ingredients in trusts, which is no gap between… you know, chasm between the clinical group leadership and the managerial leadership.*(Chair, case study respondent)

Trust A had taken a different approach to create clinical leadership.In April 2013, it had reorganised eight business units into three divisions, each led by clinicians. The divisions were described by one interviewee as being "as close to autonomous mini-hospitals as it is as possible to get". The trust leadership believed that it had made clinical managers more visible in the running of the organisation and had demanded a change in culture for non-clinical managers. The trust executive charged each division with considering the implications of the Francis Report and it was a standing item on the agenda for the divisions. Each has its own risk and governance structure, and escalates risks to the trust board and its subcommittees. Generally, the new divisional structure was welcomed, although there was some concern about the time commitment for clinical leaders and the implications of this for their clinical work. As one said: "There is a lot of talk about clinical engagement and clinical leadership, but actually there is no time to do it." One interviewee perceived the restructuring to simply have added additional layers to the hierarchy.

The chief executive of another case study trust argued that the advice of clinicians in both leadership and non-leadership roles was vital, particularly in navigating the boundary between improving quality and saving money. This approach pre-dated the Francis Report.

> *Since I've been here, when we do our savings programmes, I've always ensured that every single programme is signed off by a medical director and my nursing director and then, every single savings programme is reviewed by an independent group of senior clinicians in the organisation who are not in managerial positions. So, any chief executive that goes against the advice of his medical director or nursing director is an idiot.*
> (Chief executive, case study respondent)

More vigilance from non-executives on trust boards

The Francis Report (2013a, p.44, para 1.10) concluded that the Mid Staffordshire NHS Foundation Trust board as a whole had had a 'vestigial' clinical governance system and, as a result, had been 'blind' to the concerns that were eventually uncovered by the Healthcare Commission (2009) investigation. In several of the case study sites, increased vigilance and a more questioning approach from non-executives were mentioned in interviewees with executive staff, whether managerial or clinical.

> *Three years ago, most of the discussions used to be on numbers and performance indicators. It's completely changed and our non-execs are very challenging. They don't excuse us on any of the quality issues, and because I'm a lead for the quality of the trust, they usually give me as much of a hard time as they can.* (Senior clinician, case study respondent)

This shift in attitude seems to pre-date the publication of the 2013 Francis Report, although some felt that it had become amplified since February 2013.

> *I've only sat at the board for a year but I would say it's increased, the anxiety and the amount of information that's needed and they're [the non-execs] almost wanting to manage down and have every bit of information that's available. And I think it's finding that balance between assurance and reassurance at the minute but I don't think we're unusual in that.* (Senior clinician, case study respondent)

In Trust A, a recurring theme in interviews with the board related to accountability. There was some question in the mind of the chief executive over whether both executive and non-executive members of the board fully understood their accountability for quality. Without the Appointments Commission, an accountability mechanism for non-executive directors was thought to have been lost. The trust board was relatively new, with only one member having been with the board for some time. Challenges around maximising the contributions of non-executive directors were raised, together with a risk that they could be easily lured into ticking boxes in terms of quality. One non-executive director emphasised the importance of maintaining some distance as a non-executive in order to see what was happening with "fresh eyes".

This echoed the national survey, which found that strengthening accountability was a theme underpinning many of the actions reported by respondents. Initiatives include making senior managers more visible and accessible, investing in leadership development, and improved staff appraisal.

Governors

The Francis Report focused some comments towards governors, although most of the problems at Mid Staffordshire happened before it became a foundation trust. Two thirds of responses to the survey came from foundation trusts. There was little evidence from the survey that the Francis Report will change the way foundation trust boards engage with governors, although many reported that governors are playing an important role in developing their trust's response to the report. Most felt that their governors have a good understanding of the quality of care provided by their trust.

Trust A was preparing for foundation trust status, and interviews at this site reflected a degree of uncertainty about the accountabilities of foundation trust governors, which were described as "vague". In another of the case study sites, which has been a foundation trust for nearly a decade, governors spoke about their role as still evolving, particularly in relation to their scrutinising of care. One recently appointed public governor felt that governors needed much more training to fulfil their role. Another felt that historically governors had tended to agree with managers and that the quality of the debate at governors' meetings was often poor.

> *I remember speaking to a couple of the governors after that workshop we had and they both were saying, 'Oh, gosh! I didn't really realise we have such a role to play in scrutinising the trust.' And I think the words 'holding the board to account' hadn't really entered into a lot of people's heads before, to be quite honest. Although, now, we're talking about it much more.* (Public governor, case study respondent)

More comprehensive training was now being developed and offered to governors, particularly to assist them in understanding the clinical and performance data being generated by the trust. Many of the governors interviewed also emphasised that they

had a key role in being the "eyes and ears" of the trust, able to move around the trust and talk openly to patients, families and staff.

> *I have never felt blocked from asking anything, seeing anything or doing anything.*
> (Public governor, case study respondent)

The chair at another case study site felt that some of the governors had become confused about their remit in the wake of the Francis Report, particularly in relation to understanding the quality of care:

> *I know some governors have felt personally that they are responsible for quality, and that's not helpful. I mean, we have our governors come along alongside non-executive directors on 'go-see' visits, and I'm quite clear that the major purpose of a 'go-see' visit is to improve soft intelligence. It is not for non-executives or governors to inspect because that's a professional activity.* (Chair, case study respondent)

Despite better training and a clearer sense of their role in holding the board to account, several governors talked about the difficulty in finding meaning in their role as representatives of a wider public.

> *I think this is a dilemma for governors… I'm supposed to represent some of the people in [place name]. I don't honestly know how I do that and I don't know how a lot of other governors do it either. I do the best I can: I talk to lots of people; I belong to all the groups where I talk about the hospital. It's very difficult and I don't think I actually represent them really.* (Public governor, case study respondent)

An absence of leadership at health economy level?

A theme that emerged from some of the case study interviews was that although attention was being paid at trust level to developing leadership that was genuinely focused on patients, there was a leadership gap in the system, at the level of the local health economy, where it was not always clear who should take the lead. Relations with local commissioners were mixed, sometimes characterised in interviews as demonstrating a shared commitment to improving quality and sometimes appearing to be locked into a more contractually focused debate about meeting financial and performance targets. National bodies were described as too remote to engineer meaningful local change. The chair of one of the trusts in the case studies observed that there was an absence of leadership at the level that mattered most: the local health economy.

> *[W]e have a situation where the power and the money is both too high and too low. It's too high, it's at the national levels, which is not a meaningful level in terms of making change happen really, but it's also too low because it's the level of trusts or of CCGs or at the level of boroughs and the like. It's not at an intermediate level, which I think is the critical level, which is a local health economy and at the level of where population and health is a meaningful issue.* (Chair, case study respondent)

Accurate, useful and relevant information

The Francis Report diagnosed a collective failure to share information between management and regulatory bodies, but also noted that the information itself was not comprehensive in capturing the full experience and outcomes of patients. The report recommended, therefore, that trusts 'should develop and publish real time information on the performance of their consultants and specialist teams in relation to mortality,

morbidity, outcome and patient satisfaction, and on the performance of each team and their services against the fundamental standards' (Francis, 2013a, p.81, para 1.222).

In addition, the report recommended that any such information should be available to the outside world, including the public and commissioners, alongside information from investigations and complaints.

The survey revealed that an important area for action has been around governance, including strengthening reporting structures, developing integrated governance reports and introducing 'heat maps' to help boards identify the early warnings signs of a problem. Linked to this has been activity around data quality and assuring the validity of data.

Understanding what's really happening: combining soft and hard intelligence

A large proportion of the case study interviews reflected a concern with information in its widest sense:

- enabling multiple channels of communication from staff and patients

- gathering real-time data from wards and clinical specialties

- making better use of complaints

- mandated data collections on waiting times, safety, hospital activity and costs.

In his introductory letter in the final inquiry report, addressed to the Secretary of State for Health, Robert Francis QC observed that it "should be patients – not numbers – which counted" (Francis, 2013a, p.4). Many of the interviews with senior staff in the case studies explored the difficulty of balancing the hard, quantitative data, with softer, anecdotal data, be it from patients or staff wishing to flag up problems. In one trust from the case studies, which had set up its own process of intensive reviews, the medical director described the challenge of balancing types of information:

> *[T]hat to me was one of the important things, to be sure that we really were picking up issues, triangulating wherever possible, three soft issues equals probably a hard issue. But if you only get one soft and you don't hear about the other two then you don't necessarily do something about it.* (Senior clinician, case study respondent)

Another trust described a process of collating soft information against a parallel process of analysing a suite of 27 indicators on safety and quality at ward level:

> *[T]he question is, 'What are the three things that you have in your head that you as medical director and nursing director and chief exec go home at night and think oh I'm worried about that?' So what we do is we track that, so this is the soft intelligence bit. The metrics will tell you so much but what you're picking up on the ground or people are telling you in the pub, where is the opportunity to bring that into the open and for me to say, 'I was with the junior doctors and they told me this,' and for [fellow executive] to say, 'Yes, actually somebody told me that as well.'* (Senior clinician, case study respondent)

The chief executive in Trust A also described placing emphasis on soft intelligence and spends up to an hour in different parts of the organisation daily, starting with the operations centre to find out about activity during the night. Emphasis was placed on understanding pressure points and how staff had responded to them out of hours.

The board at another case study trust had taken steps to see how they could use existing sources of information in a more productive way. They described how the initial response and board discussion following the publication of the Francis Report focused on looking at indicators that the board at Mid Staffordshire had not used successfully to identify failings, specifically opinions from staff surveys.

> *What staff were saying about the service came out quite strongly for us from that. So I think we'd done a lot on what the patients were telling us about the service. And patients were telling us they thought the service was getting better, but actually that wasn't what staff were telling us through staff surveys. So we got this kind of slightly weird divergence, which I think we were becoming aware of, but thinking it through in response to Francis was the thing that made that really clear for us.* (Chief executive, case study respondent)

Challenges of developing a bespoke, outcomes-based dataset

One of the case study sites had already begun its own project to develop and publish outcome metrics by specialty, which are published on the trust's website. The process involved getting consultants to develop their own measures, but it has not been straightforward, according to the senior clinician leading the work:

> *So one of the projects that we've been doing over the last few years is asking our specialties to come up with the three metrics that they'd like to be measured by. And it's taken ages and it's not complete and I've learnt that I can't do this on my own so I've employed somebody else to do it. But the idea there was 'you tell us what you think is important rather than what the system is telling you', and of course they found it quite difficult and it is difficult to get outcome measures rather than process or input type measures because that's the way it is in some specialties.* (Senior clinician, case study respondent)

Information overload?

In one trust, respondents emphasised how easily a board, particularly non-executive directors, can drown in detail. One interviewee observed that board reports had not always accurately reflected the parts of the organisation that staff expressed anxieties about. Attention had been given, therefore, to making information to the board more succinct and there were plans to streamline the integrated performance report. With the development of a Quality Accountability Framework, the trust is moving towards entering data into a single repository to provide unambiguous messages about quality. There was a sense that the trust held a lot of data that had not always been used to best effect. One interviewee said: "I have felt at times overwhelmed by the data flow and not being able to see the message".

3. Discussion

Taken at face value, the vast majority of views captured in this study suggest that the Francis Report has been taken very seriously by those working in NHS acute trusts and that the welfare of patients and high-quality care are uppermost in their minds. The interviewees referred to a great deal of activity taking place to understand and improve the quality of care. It was beyond the scope of the study to assess whether any of the initiatives referred to in interviews have been implemented effectively and produced results, or to verify whether claims made about the behaviour of external organisations are true. What this study does offer, however, is some insight into the perceptions of those running large organisations, working under considerable pressure in a complex system, subject to multiple challenges from constrained budgets, organisational reform and rising demand from patients.

One straightforward conclusion that can be drawn from the evidence in this study is that the impact of the Francis Report published in 2013 cannot be easily disentangled from the first report in 2010, or the impact of the evidence as it emerged during the hearings for both inquiries. Furthermore, the broad scope of the 2013 Francis Report and the large number of recommendations did not lend itself to a 'big bang' impact on hospital trusts, and it was also followed by several other linked reports, most notably the Keogh (2013) and Berwick (2013) reviews, which also have implications for hospital trusts.

What does seem clear from the interviews and responses from the survey is that a number of key messages from the failures at Mid Staffordshire NHS Foundation Trust appear to have been heard. The first relates to the observation that the board at the helm of Mid Staffordshire 'lacked insight and awareness of the reality of the care being provided to patients' (Francis, 2013a, p.64, para 1.114).

There was a clear understanding emerging from the interviews in this study that hospital boards need to have multiple and different sources of data and intelligence about what is happening to patients being treated inside their trusts. There were many examples given of initiatives to track the quality and safety of care, and the case studies are striking in their attempts to use a wide range of metrics to monitor basic aspects of care, such as falls, pressure ulcers, staffing levels, nutrition and infections, as well as 'soft' intelligence. Some trusts had invested in their own 'home-grown' internal peer reviews of specific wards or specialties, or had devised review processes that involved peers from other trusts.

Staff were seen as important sources of information and there were multiple routes to understanding staff perspectives, ranging from formal surveys, through regular engagement exercises to informal contacts. There were also plenty of initiatives relating to understanding what was happening to patients, including new approaches to handling complaints and disseminating patient stories in different media to board meetings or other staff fora.

In their analysis of the findings of a large-scale study of culture and behaviour in NHS hospital trusts, Dixon Woods and others (2013) draw an important distinction between behaviours in gathering data, characterising them as either 'problem-sensing' or 'comfort-seeking'. The latter refers to behaviours that are focused on seeking to reassure managers both internally and externally that problems are not occurring, based on a limited range of data and at the expense of softer intelligence. Comfort-seeking tends to demonstrate a preoccupation with positive news and a dismissiveness of critical comments. A phenomenon identified by both Francis inquiries was that the board at Mid Staffordshire had a defensive mindset that reacted badly to negative criticism.

Changing this mindset requires an underlying cultural change, which was the second key lesson absorbed by the trusts in the present study from the Francis Report: namely that the board in Mid Staffordshire NHS Foundation Trust was blind to failings not simply because it lacked information, but because it did not have a culture that valued the quality of patient care.

It was striking how the interviewees in the case studies particularly described changing culture as much more challenging to achieve than other initiatives relating to training or data collection, because it is likely to take time and its success is much harder to measure. The presence of new initiatives and methods of gathering intelligence within trusts does not, of itself, prove that an underlying shift in cultural values has taken place, and it is for this reason that trusts are being encouraged to develop and use 'cultural barometers' to assess whether genuine cultural change is taking place right across the organisation (Department of Health, 2013b).

The Francis Report placed a great deal of emphasis on cultural change, particularly in relation to openness. Without this, staff are unlikely to come forward to report problems, depriving leaders – however well intentioned – of important intelligence about the quality of care. This research study was only able to get a very limited glimpse of opinion among 'front-line' staff, but what we heard suggested that some staff still do not feel comfortable in raising concerns and, certainly, some senior managers were aware that openness was some way from being achieved within their trust. There is a growing body of evidence that an engaged workforce is closely linked to better clinical outcomes (Point of Care Foundation, 2014). The challenge for NHS trusts and other kinds of providers will be to deliver this in a very difficult financial environment.

Valuing quality above money

The NHS, as a tax-funded system with a limited budget, has always faced uncomfortable trade-offs between the quality and volume of services that might, in an ideal world, be provided and the funds available to pay for them. Since 1948 when the NHS was launched, the question of where the responsibility ought to lie for the rationing decisions that inevitably flow from this resource constraint has never been resolved.

Since the 1990s, the NHS system has attempted, with varying degrees of success, to decentralise responsibility for some of these rationing trade-offs. In the hospital sector, individual hospital trusts are legally required to balance their books while meeting quality and performance targets, and the creation of foundation trust status signalled a desire on the part of policy-makers to grant some autonomy to individual trusts about how they should best decide to spend these limited resources. But, at the same time, overall political accountability for the running of the NHS has remained with the

Secretary of State for Health, and the past two decades have seen periods of intense, centrally driven performance management as the centre has attempted to ensure that local NHS bodies stay within their limited budgets, while at the same time delivering a growing number of quality and performance targets.

The 2013 Francis Report concluded that the search for financial balance was in the ascendant during the period that the care at Mid Staffordshire NHS Foundation Trust failed. The report noted that 'the Trust was operating in an environment in which its leadership was expected to focus on financial issues, and there is little doubt that this is what it did' (Francis, 2013a, p.45, para 1.11).

Since the period when the Mid Staffordshire scandal started to unfold, there has been a proliferation of initiatives to measure and assure the quality of care. The inspection regime of the CQC has been overhauled in response to the Francis Inquiry, and has abandoned the self-assessment approach to regulation that drew specific criticism from Robert Francis in favour of increased professionalism and a much broader range of methods and metrics to assess the quality of care. Assessing quality alongside financial competence now forms a key part of Monitor's assurance processes. It should be noted that these new approaches to assessing quality have been added to, but have not replaced, the previous performance targets, which were focused primarily on some narrow issue of quality – waiting times for treatment and hospital-acquired infections.

One striking finding from this research is how both Francis Inquiries and reports have emboldened many of the senior leaders in the trusts involved to talk about prioritising the quality of care as equal to, or more important than, financial balance. This was evident from their descriptions of how they are conducting board meetings and setting organisational priorities, but particularly in their interactions with external organisations. Executives and non-executives interviewed for the study recognised the central message from both Francis Inquiries that in Mid Staffordshire, the board's priorities became distorted in favour of financial performance. It was also instructive that some of the interviewees tended to put waiting-time performance targets in the same category as financial performance, in contrast with the definitions of quality measured by patient experience and other outcomes measures.

In some of the trusts, this appears to have been interpreted by some interviewees that, wherever possible, 'quality trumps finance' and has resulted in decisions to improve quality by spending more resources on additional nursing and A&E staff. It was more unusual to hear the view that poor-quality care is itself wasteful and that improving quality is a route to saving money.

However, the pressure to stay within limited budgets that existed at the time of Mid Staffordshire has not gone away but has intensified, as funding increases for the NHS have been frozen in real terms since 2011/12. Resolving concerns about poor-quality care with additional expenditure on staff is likely to be challenging for trusts, as they try to ensure safe staffing levels and skill mix within the context of often stringent cost improvement programmes and the pressure to meet their financial objectives.

One result of this 'quality trumps finance' stance taken by some trusts is to bring them into potential conflict with the external commissioning and regulating bodies. The evidence from this study suggests that in some cases the trust leadership was more militant about pushing the political pain of prioritising quality over money – in effect making tough rationing decisions – outwards and upwards in the NHS hierarchy. This

highlights an important dilemma touched on in the Francis Report, which is what the board of Mid Staffordshire should have done if it had had a more 'patient-centred' culture. The report concludes:

> *The Board of the time must collectively bear responsibility for allowing the mismatch between the resources allocated and the needs of the services to be delivered to persist **without protest or warning of the consequences**. However, they were able to fail in this way because of deficiencies in the system around them.* (Francis, 2013a, pp.45–46, para 1.16, emphasis added)

It would appear, judging from some of the responses in this study, that trusts may in the future be more ready to protest about the unpalatable consequences of resource constraints. This raises the question of how the wider system, including commissioners and regulators, should reasonably respond to such protests or warnings. The development and application of tools to assess appropriate staffing levels by NICE is critically important here, as this will inject some evidence-based clarity into what otherwise might become an uncomfortable stand-off between hard-pressed trusts and equally hard-pressed commissioners. But it leaves unresolved the question of what a reasonable or fair response to a trust that is resisting further efficiencies on the grounds of safety or quality ought to be. The Statement of Common Purpose signed by the Department of Health and other national bodies in the government's full response to the Francis Inquiry states that '[w]e will be balanced in what we do and what we expect, with the patient interest at the heart of it' (Department of Health, 2013b, p.7). Some of the interviews in this study suggested that there may be conflicting views about which level of the system has the best understanding of 'the patient interest'.

Values of the wider system

A striking theme that emerged from some of the interviews and survey responses concerned the interviewees'/respondents' description of the behaviour and culture of external bodies. Some interviewees were suggesting that the focus on financial balance still appeared to be uppermost in the minds of some of the commissioners and regulators they dealt with. Likewise, some respondents asserted that the top-down, and sometimes 'oppressive' manner of performance management in the wider system that was singled out for criticism in the Francis Report was still in existence.

This raises the question of whether a parallel shift in the values of the wider system – to value what is happening to patients as the most fundamental principle – is taking place alongside what is hoped for within hospital trusts. It was beyond the scope of this study to hear the accounts of local commissioners, area teams and regulators, or to explore whether the 'top-down' culture of the NHS that was identified in previous external assessments commissioned by the Department of Health and the NHS is still active (Institute of Health Care Improvement, 2008; Joint Commission International, 2008). But it is worth noting that although the Department of Health's full response to the Francis Inquiry (Department of Health, 2013b) contains initiatives to encourage hospital trusts and other health care providers to improve their culture and measure the results using 'cultural barometers', there is currently no mechanism for assessing the degree to which culture has changed through the regulatory and managerial system; in other words, there is no 'cultural barometer' for external regulators and commissioners and the way they individually and collectively engage with each other and with trusts.

Similarly, there is also an absence of detail in the government's response to the Francis Report about how to assess whether the overlap and confusion about the roles of regulators and other supervisory bodies that were identified as a contributory factor to the failures in Mid Staffordshire have been resolved. It was clear from the interviews for this study that many leaders in the trusts felt that they experienced an excessive amount of external assurance and scrutiny, and that sometimes there was dissonance between the findings of the different bodies. In particular, some interviewees asserted that the continuing desire of the central NHS management system to be assured that hospitals are meeting financial and other performance targets (especially the four-hour A&E waiting-time measure) was leading to significant and sustained pressure on chief executives and their teams, which in turn could undermine work to improve and manage services more widely.

This raises a question as to what form of quality monitoring and performance management would be appropriate for the NHS in the future. In this research, some trusts reported that they are keen to undertake mock CQC visits of different wards and departments within their organisation, or to establish local 'Keogh reviews' where they will invite external clinicians and peers into the trust to assess services. These grassroots-driven and locally owned initiatives aimed at assuring quality of care were popular with trusts in this study, but the Francis Inquiry drew attention to the risks of basing an external regulatory approach on self-assessment and self-declaration. There is a challenge for national bodies such as the CQC, Monitor and the TDA to allow trusts the space to develop and learn from such initiatives, and how these should relate to their own assessments of organisational quality and safety.

The more immediate risk in relation to regulation and supervision in the wake of the Francis Report is that the NHS will resort to even more extensive assurance and monitoring by multiple bodies. This would be detrimental if it crowded out the internal service improvement work that trusts are carrying out, and distract managers and clinical leaders from supporting local service development priorities and initiatives. The Francis Report warned of the scourge of the NHS 'action plan', where local organisations reassure themselves by writing plans in response to external challenge and regulation, yet all too often lack the resource, will or time to put intended actions into practice. From this research, it is clear that trusts continue to experience multiple external assessments and reviews, while seeking to have the space and time to foster an approach to quality improvement and safety that is internally driven.

Leadership and management post-Francis

This research suggests that many boards, executive teams, clinical directorates and wards have been taking the lessons of the Francis Report seriously and this has led to significant new areas of work, for example:

- undertaking systematic peer reviews of hospital services

- boards and executives 'walking the floor' much more extensively and regularly

- running deliberative events to elicit staff views of services

- meeting with the majority of complainants and their families

- mounting mock CQC and Keogh reviews.

Continuing this work in the longer term would be laudable and could indeed be exciting for NHS quality and safety. But whether senior managers and clinicians will have the time and personal resources to continue in this vein, alongside other commitments is questionable:

First, will they have the time and personal resource to continue in this vein, alongside other commitments and, if so, what will be dropped to make way for this? Second, as financial pressures mount across the public sector, how boards and executives handle the tension of quality versus finance, referred to earlier in this chapter, will be critical. A measure may be whether boards and senior managers will feel able to make a stand over the quality of care, if this means financial problems for the organisation, or difficult implications for other clinical services in the hospital or wider health economy, without adversely affecting their collective future as a board or individuals' careers.

Seasoned managers, directors of nursing, medical directors and boards may well weather the pressures and find ways of sustaining work on quality and safety as part of wider work to reshape the organisation of services within the hospital. For new and less experienced managers, senior clinicians or boards, it will be much more difficult. It has to be borne in mind that Mid Staffordshire NHS Foundation Trust had a chief executive in his first post, something that is often the case in smaller district general hospitals, which, while seeming to be the more straightforward NHS management jobs, entail some of the most difficult challenges in terms of service sustainability and leading clinicians and local people through often unpopular change. Post-Francis, senior managers, clinicians and boards will need sustained support as they grapple with the tensions of managing for both quality and productivity. Without such support, the hostile and blame-laden culture that led to the events at Mid Staffordshire in the first place is likely to be re-created.

The implications for future health and social care configuration

The hospitals studied in this research were investing in additional staff for A&E, general medicine and the care of older people in particular. In the main, this was focused on ensuring adequate staffing levels for existing models of care, rather than entailing major reconfiguration of how services are organised within the hospitals – although some trusts explained their plans to try to do this in the medium to long term.

Although the Francis Report avoided making any recommendations about changing the system of provision to address the growing numbers of older, sicker adults who are being treated in hospital, it was clear that many of the interviewees were grappling with this wider question. What is clear is that the challenge of giving compassionate and well-coordinated care to frail older people, including those with dementia admitted through A&E, is a health and social care system-wide problem. Getting care right within hospitals will not solve this wider problem. The case study hospitals emphasised that the only way they could see of resolving the money–quality tension was by having more radical changes made to how services are organised across primary, community health, mental health, social and hospital care. One of the case study sites was using financial reserves to commission intermediate nursing and social care (separate from CCG and local government commissioning), as a way of enhancing the flow of emergency and older patients, and avoiding them remaining in hospital when medically fit, but this could only be a short-term measure.

Taking safe and high-quality care for this group of vulnerable patients to its logical conclusion – by ensuring seven-day working of hospitals, better-resourced social and primary care services, and reorganising hospitals along the lines set out in a recent report entitled *Future Hospital* (Future Hospital Commission, 2013) – will require political bravery and strong leadership at the level of health economies. The new bodies set up to enable better planning and implementation of service change at the local level – CCGs and health and wellbeing boards, with the input of NHS England's local area teams – are still evolving, and it is too soon to assess whether they will be more effective than the strategic health authorities that came before them in bringing about these changes.

4. Conclusion

The Francis Report delivered a damning verdict on an individual trust and a wider regulatory and supervisory system that had been periodically reorganised and changed, and allowed vital aspects of patient safety and care to be overlooked when the trust should have provided protection, improvement and accountability. The complexity of the system was such that multiple opportunities to spot and act on the failings in care in Mid Staffordshire were missed by health professionals, managers, commissioners, regulators, patient organisations, GPs and others.

In terms of how hospital trusts have responded, many of the themes and lessons from the Francis Report – together with the Keogh (2013) and Berwick (2013) reports – were recognised by the hospital leaders and front-line staff in this study, who described their efforts to give greater weight to the quality and safety of patient care, and the underlying culture that drives quality. Nursing is receiving a significant degree of attention, in particular in staffing levels, the role of ward managers, and ensuring fundamental standards of care. Staff engagement is a higher priority than before, as is a renewed approach to the handling of patient complaints and the reporting of hospital performance.

The hospital leaders in this study described a wider NHS system that seemed to them at times incoherent and overbearing in how it regulated and managed trusts. This begs the question as to how far the NHS response to the Francis Report and the reforms of 2012/13 have changed the culture of the system and fixed the failings identified by the Francis Report in commissioning, supervision and regulation. It is unclear how the requirements of the CQC, Monitor, NHS England, the TDA and clinical commissioners are interacting at a local level, and it is equally unclear how the functioning, culture and behaviour of these bodies will be measured.

This research is based on a glimpse of the activity and views of one third of hospital trusts. What remains to be seen is whether the Francis Report will result in measurably improved care for patients and how extensive this is across hospital trusts more generally. Critical to this is the fundamental tension between commitments to care quality, safe staffing and zero harm, on the one hand, and the relentless financial constraints facing the NHS for the foreseeable future, on the other.

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