Ely and After – summary of symposium on NHS Inquiries held at the Health Foundation on 14 November 2018

By Nicholas Timmins

This year is the 50th anniversary of the Ely inquiry. For those to whom the name Ely means only – and understandably – a fine fenland town, Ely Hospital in Cardiff was the scene of gross mistreatment of psychiatric patients and people with learning difficulties. The publication in 1969 of the inquiry into those events helped make the name of its chair, Geoffrey Howe QC, who went on to become chancellor of the exchequer and foreign secretary - not least because he resisted strong pressure from the Ministry of Health to dilute its findings.

Ely is widely seen as the first public inquiry into the NHS – it was in fact held in private but, crucially, its findings were published in full – and to mark the event The Health Foundation in November hosted a day-long symposium to examine it and its aftermaths. A brief inquiry into inquiries, so to speak.

Since Ely there has been no shortage of inquiries. Well over 120 on what is acknowledged to be an incomplete count, the definition of an NHS inquiry being an imprecise one. The really big ones – many of them established under the Inquiries Act and its predecessors, laced with lawyers and cost – resonate down the years. Ian Kennedy's inquiry into children's heart surgery deaths at Bristol, published in 2001. Janet Smith's into the serial killer Harold Shipman. Mid-Staffs, the shorthand being enough for everyone in the NHS to know what that means. Not to mention the string of inquiries subsequent to Ely into long stay hospitals – South Ockenden, St Augustine, Normansfield to name just a few – and more recently Morecambe Bay (maternity), Oxford children's heart surgery (again), and Gosport (another case of misuse of opiates). Two significant inquiries are currently under way – into the infected blood scandal of the 1970s and 1980s, and into Ian Paterson, the breast surgeon who maimed patients in both the public and private sectors – both of which have been the subject of previous inquiries.

It was Ian Kennedy who once remarked of his findings at Bristol "that you could pretty much have substituted Ely for Bristol throughout" and the same or remarkably similar findings recur time and again. Professional and/or geographic isolation. Weak leadership. Inter-personal, and sometimes inter-professional, conflict. Failures in communication. A reluctance to listen to patients, families and staff. Denial in the face of the evidence and bullying of those who raise concerns. All of which can lead to a normalisation of the abnormal. Plus in some cases an over-focus on finance at the expense of care and quality, along with, in some of the more recent cases, an obsession with seeking foundation trust status at the expense of all else. "When will we ever learn?" is a common refrain from those who examine the impact of previous inquiries.

The last of those causes, seeking foundation trust status, has, for now, disappeared. But if the symposium did not – it was not designed to – produce complete answers to the often multi-factorial causes of so many of the scandals, it did raise some key management questions and offer some hope.

The questions included whether more attention should be paid to isolated, or relatively isolated, district general hospitals. There the recruitment and other challenges can often be greatest, yet these hospitals are often seen as the first post for a new chief executive, when in practice they can be among the toughest. There were clear voices arguing that better leadership training should be delivered for managers (including clinical managers), with perhaps a clearer set of professional qualifications and a much more effective "fit and proper person test" – namely the ability to bar from any further NHS appointment any director whose behaviour has been beyond the pale. That is something which the recent Kark review has recommended, and which may indeed be acted on. Together with Sir Ron Kerr's recent report on improving NHS leadership, these arguments and reports point to the case for spending money on management training and qualifications, along with better talent management, rather than waiting to spend yet more millions on a public inquiry that is likely to produce essentially the same findings.

But what of the inquiries themselves? The symposium was built around four academic papers on inquiries over the years but had also in the room practitioners and lawyers, plus former and current civil servants who had faced the challenge of responding to inquiry reports. Ian Kennedy for example, and Brian Langstaff who was counsel to the Bristol inquiry and is now chairing the infected blood inquiry. Tom Kark who was counsel to Mid-Staffs. Bill Kirkup who conducted the Morecambe Bay inquiry among others, plus academics who have also been practitioners as panel members or advisers, including Brian Jarman (Bristol), Judith Smith (Mid-Staffs) and Kieran Walshe. The symposium lacked sufficient representation of the patient and family experience, in part because we gave that far too little weight and in part because some who were invited could not make it on the day. It drew also on the writings of some who have conducted inquiries but could not be there – by, for example, Janet Smith who chaired the Shipman Inquiry and Michael Bichard who ran the Soham inquiry which was not strictly an NHS inquiry but whose findings more than just touched the service.

It debated the purpose of inquiries. A mix of the forensic, the social and the remedial, as Ian Kennedy has put it. The forensic includes establishing the facts to discover the truth – what happened and why. The social includes catharsis for those affected. Healing, as far as possible, with that being part of the remedial as the inquiry seeks to hold individuals and/or systems to account. The inquiry is then usually expected, from the learning about what went wrong, to produce recommendations. Recommendations aimed at preventing recurrence.

These purposes can, however, as the symposium acknowledged, be in conflict. And none of them are simple. Even what many see as the opening purpose of an inquiry – establishing what happened and why – is complicated by the fact that there can be more than one version of "the truth". Which raises the question of who is best to run them. They are often run by judges – judges being seen as genuinely independent. But judges operate in court systems

designed, through cross examination, to get to a single version of the truth when, particularly in inquiries that involve clinical judgement for example, there can be genuine and legitimate differences of opinion.

Governments tend to see the primary purpose of inquiries as establishing the facts - getting to the truth – with that leading to recommendations. But as the day wore on, catharsis, and as far as possible healing, was seen by many in the room as an absolutely key purpose – listening to those affected, helping them understand what happened and why. Indeed, in too many cases, having their concerns listened to properly for the first time – something that can apply to staff as well as patients and relatives. But a word of warning is needed here. An inquiry can also prolong, or indeed revive and compound, feelings of grief and the demand for accountability among those who have been affected, without either catharsis or healing being achieved – points well made in Sara Ryan's forthcoming paper in a series for *Political Quarterly* that will form part of the symposium's output.

Among the many weakness of the current approach is a notable absence of robust research into the subsequent attitudes and sense of satisfaction – or otherwise – felt by patients, families and staff who are at the heart of many NHS inquiries: and thus how far catharsis and healing are achieved or not.

Which leads to questions about the support that patients and relatives receive during inquiries, and about their format. The Bristol inquiry, in something of a precedent that others have followed, deliberately went for a non-court like setting. While many of the families whose children had been affected had legal representation, as did many of those who might face personal criticism for their actions, there was no cross-examination of witnesses by lawyers. All questions were directed through counsel to the inquiry, whose task was to guide it through the evidence.

There are questions about whether the chair should sit alone or with a panel, or with assessors – arguments have been made for both approaches, although the more recent tendency has been to have a panel. But given that each inquiry is some way unique, there may be an element of horses for courses. Janet Smith, for example, has argued that sitting alone for the first part of her inquiry – aimed only at establishing as accurately as possible just how many people Shipman killed – was an advantage. "It would have been immensely time consuming to have to discuss each individual case with a panel." She has reported much more "mixed feelings" about whether she should have sat with a panel for other elements of the inquiry which included death certification and the use of controlled drugs.

Something of a split emerged during the day between the health services researchers – Kieran Walshe and Nick Black, for example – and some of those who had sat on inquiries about how rigorously expert evidence is tested in some inquiries: which led on in part to the issue of recommendations.

There tend to be far too many of them was the general view. Among the major inquiries, that into Beverly Allitt, the children's nurse who killed four and attempted to kill three more patients, made just thirteen recommendations. Bristol produced 198 but had been asked to

make recommendations for the NHS as a whole that stretched well beyond just the events in Bristol. The Francis report on Mid-Staffordshire produced a near indigestible 298.

There were questions from those who have worked within government about how well-equipped inquiries are to make policy recommendations – that being an area where some saw an advantage in there being panel members, or advisers, with precisely that experience. Recommendations need to be implementable to be successful. Yet few inquiries consider the sorts of issues that government inevitably has to address – cost versus benefit, for example; possible downsides; and sometimes (which has to be an issue for the politicians) the sheer politics of getting a recommendation through.

Once an inquiry reports, politicians are under heavy pressure to implement the recommendations. Inquiry chairs are frustrated when they are not. And governments of course do not always implement. Many of the Bristol recommendations were accepted – a fair few providing important reinforcement for directions in which the government was already going. The creation of the Commission for Health Improvement, for example, as a wider-ranging NHS inspectorate than anything that had gone before. Against that, Bristol's recommendation for a no-fault compensation scheme in place of litigation was quietly ignored, as have other attempts over the years to persuade governments of various colours to go down that road. Some of Janet Smith's recommendations over the use of controlled drugs were rejected on the grounds that they would have made serious pain relief in the community (Shipman, after all, was a GP) vastly more difficult. The government sought to achieve similar ends by different means.

There is a case that tightly focussed recommendations stand more chance. Michael Bichard's inquiry into the Soham murders, for example, had just 31 recommendations, most of them enablers to get to what is now the Disclosure and Barring Service.

There is, of course, a challenge here. Governments should, of course, implement the desirable and implementable (itself a matter of judgement) while rejecting or quietly shelving the less wise or over-burdensome. But after the government's formal response to a report there is no established follow up mechanism to see whether what has been promised in fact happens. Some inquiry chairs do pursue government over their findings. Others understandably return to their day job. Michael Bichard took the innovative step of insisting on formally following up his recommendations six months later as his means of holding the government to account. But as others, including the Institute for Government, have suggested there should perhaps be more formal follow-up of government decisions. Select committee hearings, for example, as has sometimes happened, but far from consistently. Or perhaps the National Audit Office.

Behind the day's proceedings lay two big questions. Are public inquiries in the NHS worth the cost? And are there satisfactory alternatives? Full scale public inquiries do not come cheap. Bristol cost £14m. Shipman £21m. The Francis inquiry into Mid-Staffs cost some £13.7m, on top of the cost of his earlier inquiry, with the Department of Health and the rest of the NHS incurring costs of some £6m in preparing and submitting evidence to the second Francis report. These are small sums in a £125bn health department budget, but still

significant ones. Money that is not spent on patient care, or indeed on seeking to ensure that the lessons learnt from previous inquiries are implemented.

Even some of those who have conducted inquiries have questioned their value. Janet Smith has said that the first part of her inquiry into Shipman – establishing how many he killed, which she estimates cost around £10m - was worth it "beyond doubt". Because "it provided the families with reliable answers to their questions, in a reasonably short time" while revealing Shipman's methodology: with that providing the basis for the later parts of the inquiry into what might be done to prevent a repetition. Partly because her recommendations were not all implemented, she has been less sure about whether the subsequent parts of the inquiry were worthwhile. On balance "yes", she has said, but "a close run thing".

Are there satisfactory alternatives? Outside health, apparently so. As was noted at the symposium, the public seems, for example, willing to accept the findings of the Air Accident Investigation Branch into plane crashes. A major part of the resolution of Hillsborough (though not the criminal prosecutions which are still under way) came not from a public inquiry but the Hillsborough panel. Indeed, it is that approach that was recently used within the NHS for Gosport. More recently, aside from Gosport, the Oxford cardiac inquiry, Morecambe Bay and the Liverpool Community Health NHS Trust review have been billed more as "investigations" or "reviews" than inquiries. It is hard to make this judgement empirically, but each has appeared, at least in part, to fulfil the exposure and cartharsis elements that are often given as among the key purposes of a public inquiry. Their "lessons learned" have often been that the lessons from previous inquiries have not been learnt and – although this is a bit of a wide generalisation – their recommendations, where they have been made, have tended to emphasise what needs to be done within the organisation under review, rather than proposing major policy departures. They definitely come cheaper – Morecambe Bay cost £1.1m while still hearing from 118 witnesses against the 164 who gave evidence to the Mid-Staffs inquiry.

Against that, as was acknowledged at the symposium, a full-blown, judge-led, public inquiry, with all the evidence in public, is still most often seen by those who have been affected as the "gold standard" for any form of NHS inquiry. With public distrust of authority high, they remain hard to resist.

Given their cost, it is therefore best that they are best run - with lessons from the procedures of previous inquiries learnt. In fact there is no central repository for that in government, and as the National Audit Office pointed out earlier this year, ministers have failed to follow up on promises made to two Parliamentary committees to do just that. It is not just the NHS but government itself that can be slow to learn the lessons from inquiries. There is, however, a good and wide-ranging guide produced by the Centre for Effective Dispute Resolution.

But to end on a more positive note – the note of hope mentioned earlier. Public inquiries clearly can and do lead to positive change. Sometimes structurally, sometimes culturally. On the structural side Ely, for example, produced the very first NHS inspectorate in the form of the Health Advisory Service which was limited to long stay hospitals. Bristol helped make

the case for the first wider one - the Commission for Health Improvement – for the clinical standards work of NICE, and for the publication and use of much more clinical data. Soham produced the Disclosure and Barring Service. There will always be debate about the operation and effectiveness of such institutional changes. Few now would abandon them.

Cultural change – which new institutions are meant to help produce – is clearly more challenging. As the Bristol inquiry observed, "it takes time and can be slow, requiring patience and forbearance." But patients and families are now routinely told about the risks of procedures and operations – which was not the case in Bristol. And research presented at the symposium suggests that the "duty of candour", recommended by Bristol and reinforced a dozen years later by Mid-Staffordshire, has been taken seriously by hospital boards and leadership in respect of ensuring its application within clinical practice - despite new cases of concern at, for example, Shrewsbury and Telford. It is less clear how far the duty of candour has had a positive impact on NHS management practice and wider NHS culture.

This can be only a short introduction to a day that tangled with these and other issues around inquiries and their impact. It included an overview paper by Martin Powell of the University of Birmingham; a historical look at Ely by Claire Hilton from Queen Mary University London which underlined that Ely did not happen out of the blue; research by Judith Smith from the University of Birmingham and Naomi Chambers from the University of Manchester on the impact of the Francis report on hospital boards and leadership; the role of the public in public inquiries by Ruth Carlyle of Health Education England, and the problem of culture and cultural change by Dawn Goodwin of Lancaster University. Plus two panel-led discussions that drew on the expertise of people who have been involved directly in inquiries in one form or another.

Materials from the day are available elsewhere on the HSMC website, including slide presentations and a video summary. Much was covered, much was not. It produces, if not conclusions, much food for thought.