Fifty years of inquiries in the NHS

Chaired by **Nick Timmins**, Senior Fellow , Institute for Government and The King's Fund

November 2018

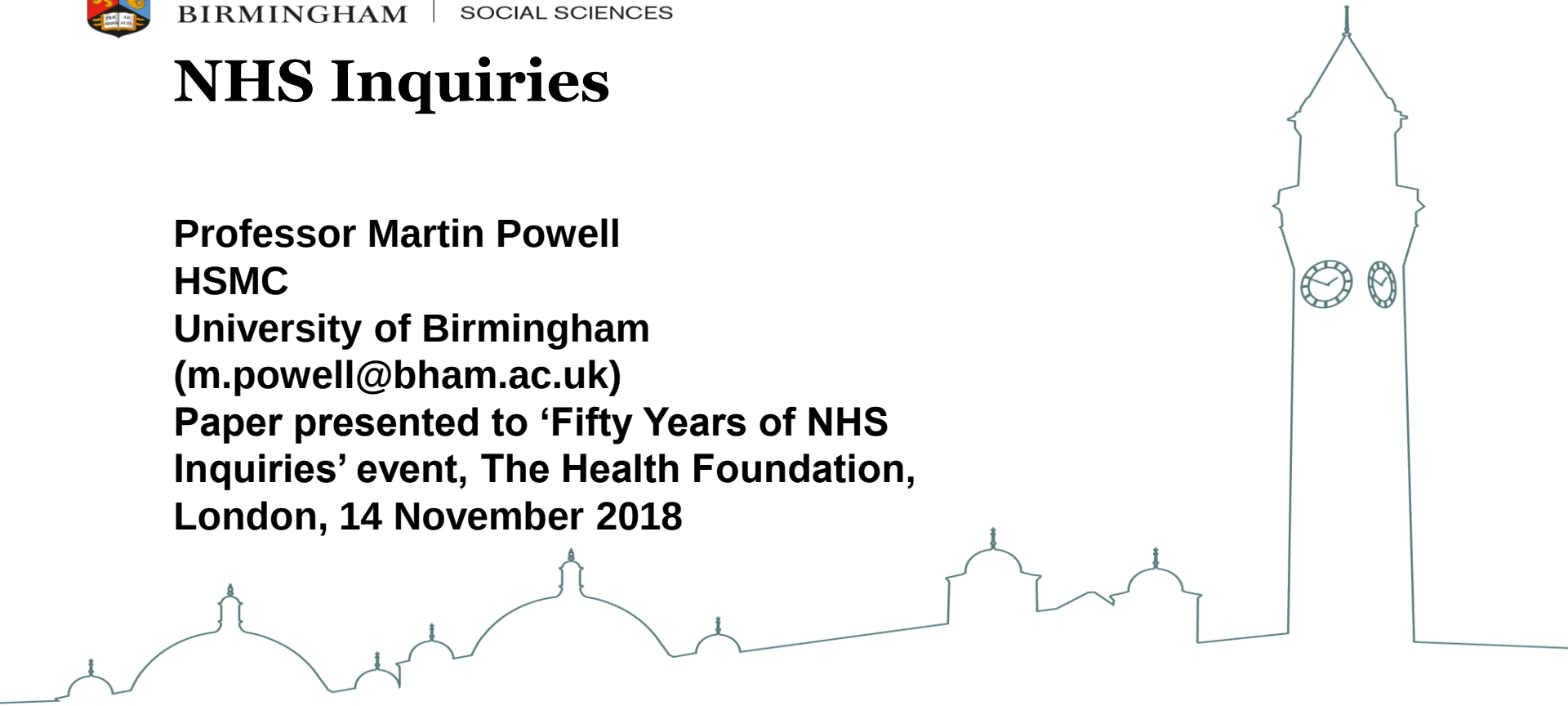
The Health Foundation

UNIVERSITY OF BIRMINGHAM | COLLEGE OF SOCIAL SCIENCES

NHS Inquiries

Professor Martin Powell
HSMC
University of Birmingham
(m.powell@bham.ac.uk)

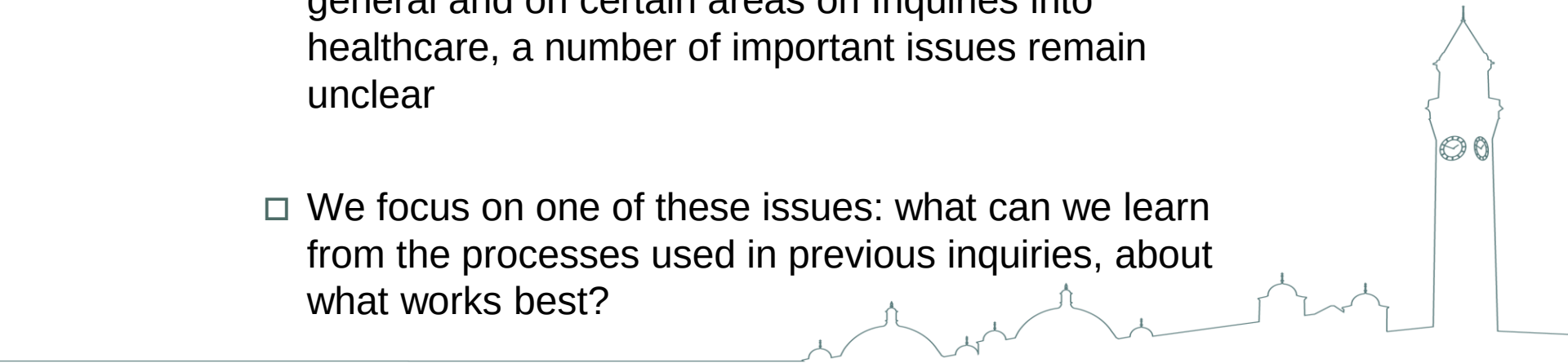
Paper presented to ‘Fifty Years of NHS Inquiries’ event, The Health Foundation, London, 14 November 2018



Introduction

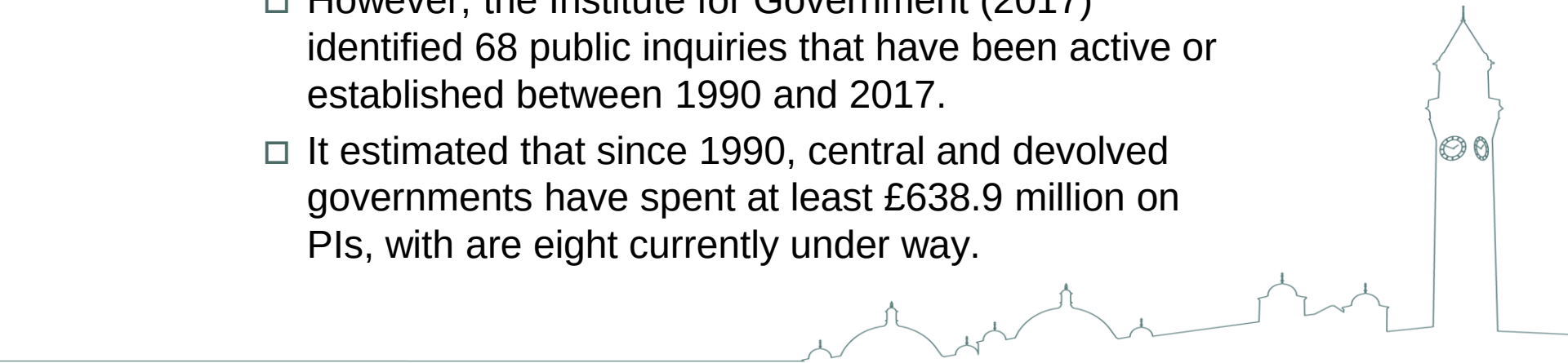
Although there has been much work on Inquiries in general and on certain areas on Inquiries into healthcare, a number of important issues remain unclear.

- Although there has been much work on Inquiries in general and on certain areas on Inquiries into healthcare, a number of important issues remain unclear
- We focus on one of these issues: what can we learn from the processes used in previous inquiries, about what works best?



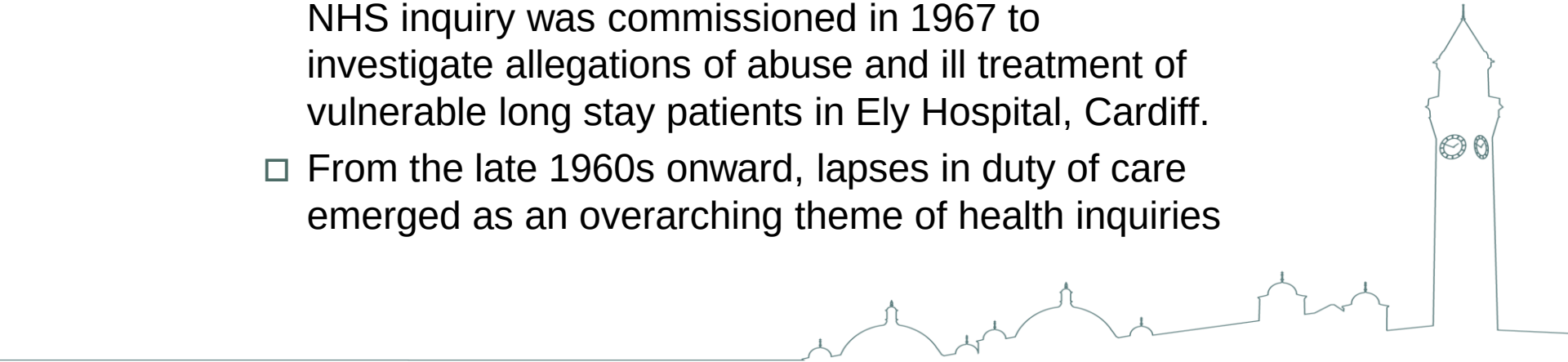
Inquiries

- It has been argued that Public Inquiries (PI) have become a pivotal part of public life in Britain, and are now a permanent fixture in public life.
- It has been argued that the term ‘public inquiry’ (PI) is a loose one, with different criteria, and PIs come in various forms and with different purposes.
- However, the Institute for Government (2017) identified 68 public inquiries that have been active or established between 1990 and 2017.
- It estimated that since 1990, central and devolved governments have spent at least £638.9 million on PIs, with are eight currently under way.



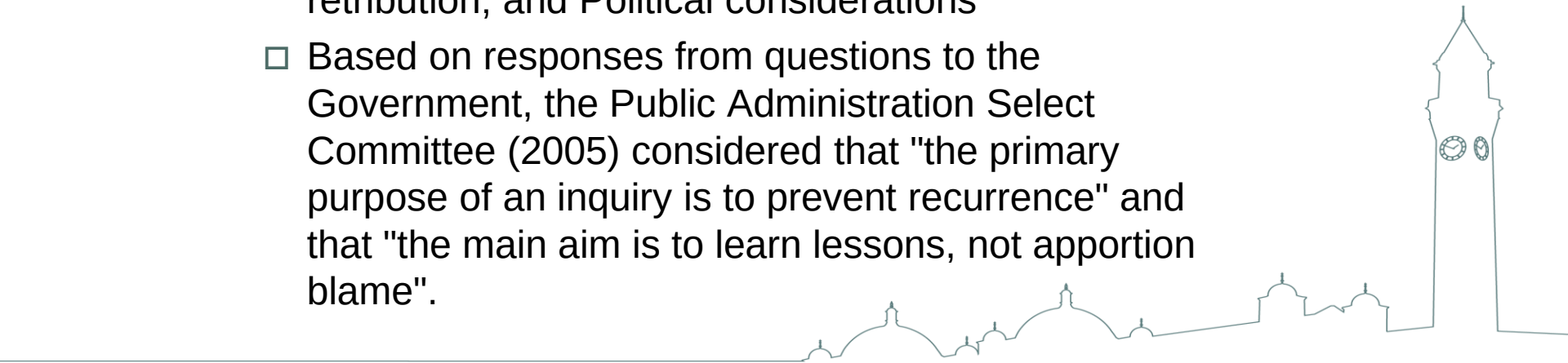
Inquiries in the NHS

- PIs into the quality of health care facilities have a long history in England and Wales, going back to 19th century investigations of workhouse infirmaries.
- It is difficult to establish a comprehensive or definitive list of PIs in the NHS, but it has been suggested that some 126 took place between 1945 and 2005.
- Most commentators suggest that the first modern NHS inquiry was commissioned in 1967 to investigate allegations of abuse and ill treatment of vulnerable long stay patients in Ely Hospital, Cardiff.
- From the late 1960s onward, lapses in duty of care emerged as an overarching theme of health inquiries



Purposes

- PIs have many purposes (eg Sir Geoffrey Howe; Sir Ian Kennedy).
- Kieran Walshe (2003) sets out a framework based on a number of sources: Establishing the facts; Learning from events; Catharsis or therapeutic exposure; Reassurance; Accountability, blame and retribution; and Political considerations
- Based on responses from questions to the Government, the Public Administration Select Committee (2005) considered that "the primary purpose of an inquiry is to prevent recurrence" and that "the main aim is to learn lessons, not apportion blame".



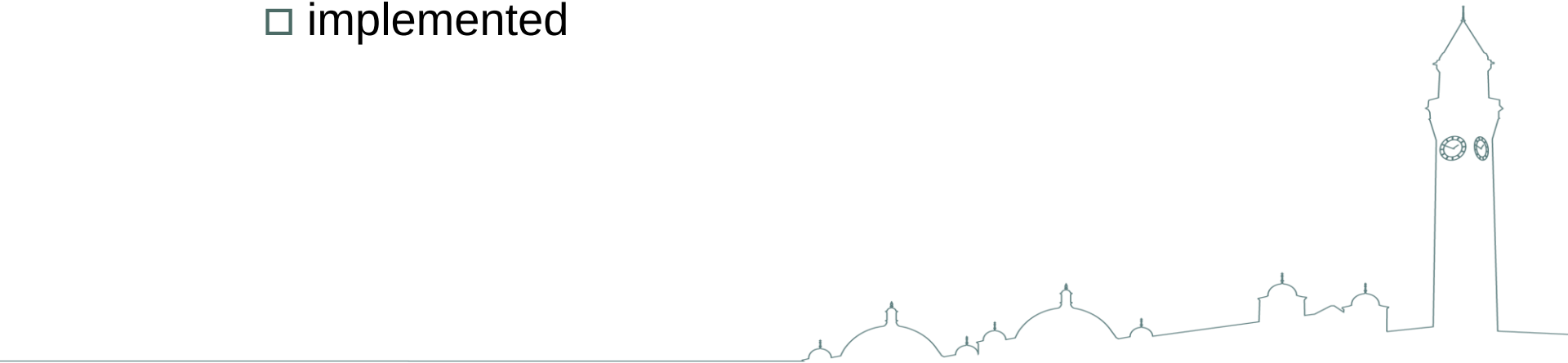
Similar Findings

- A number of commentators point to some similarity of Inquiry findings.
- For example, Williams and Kevern (2016) point out that some authors have identified themes in the findings of NHS Inquiries which recur repeatedly across time, setting and service.
- ‘Groundhog Day’…… Leadership….. Culture…..?
- It’s déjà vu all over again…..

Recommendations and Impact

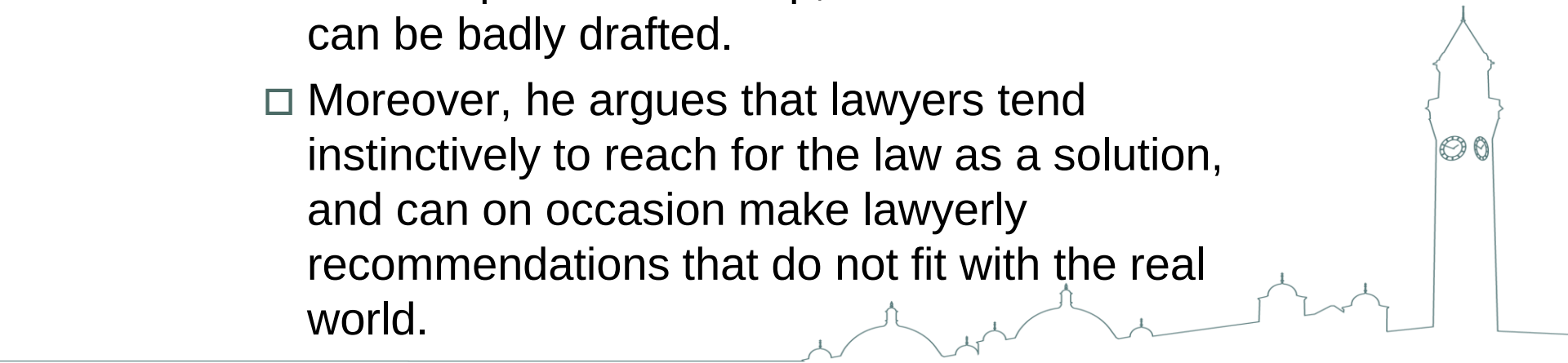
- If one of the key reasons for an Inquiry is to learn lessons and prevent similar events from reoccurring, Recommendations must be:
- implementable

  and
- implemented



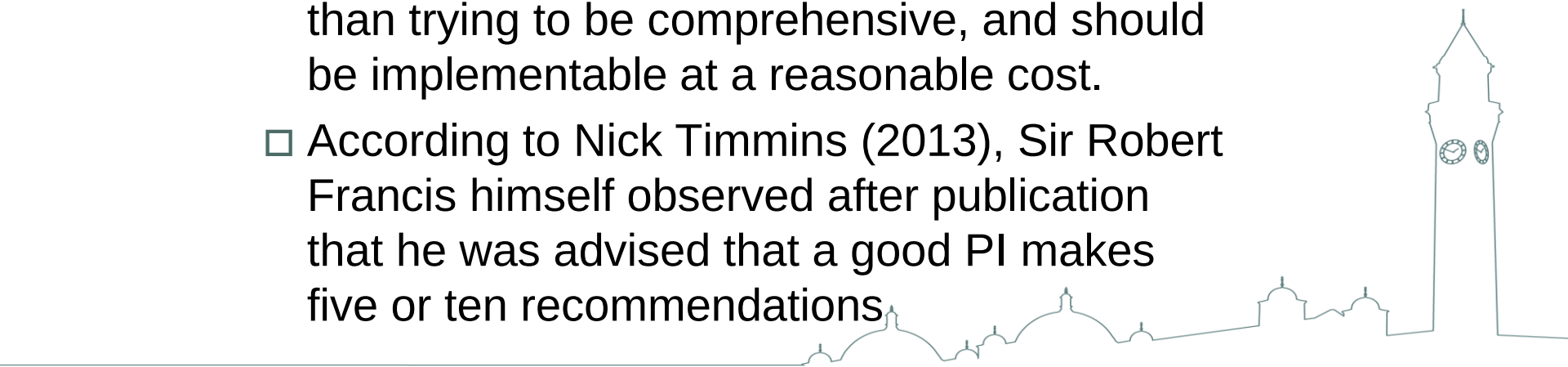
Implementable?

- According to the Sir Liam Donaldson (2000) , Inquiry recommendations are not always sufficiently helpful or focused.
- Nick Timmins (2013) argues that in the heat of the “something must be done” moment when inquiries are set up, terms of reference can be badly drafted.
- Moreover, he argues that lawyers tend instinctively to reach for the law as a solution, and can on occasion make lawyerly recommendations that do not fit with the real world.



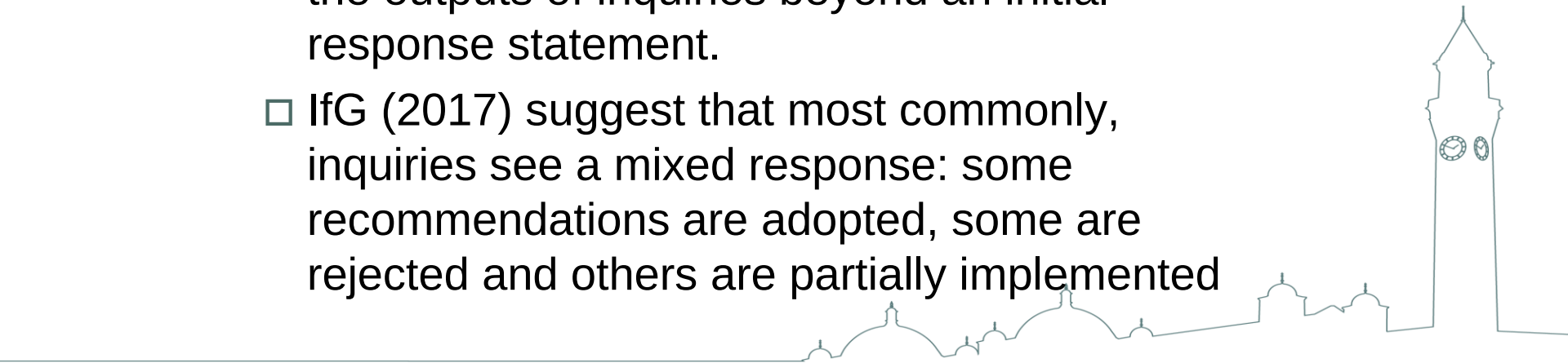
Implementable?

- Recommendations can be too many and too diffuse.
- Nick Black and Nick Mays (2013) state that it is clear that any recommendations should be few in number, focusing on priorities, rather than trying to be comprehensive, and should be implementable at a reasonable cost.
- According to Nick Timmins (2013), Sir Robert Francis himself observed after publication that he was advised that a good PI makes five or ten recommendations.



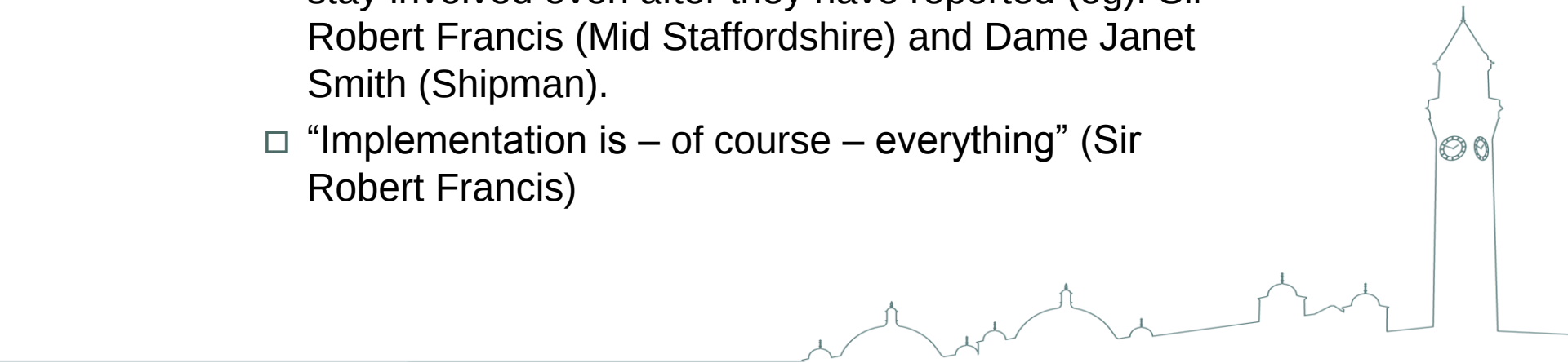
Implemented?

- There is no requirement for government to act on the findings of a PI.
- There are few mechanisms for holding government to account for what it does with the outputs of inquiries beyond an initial response statement.
- IfG (2017) suggest that most commonly, inquiries see a mixed response: some recommendations are adopted, some are rejected and others are partially implemented



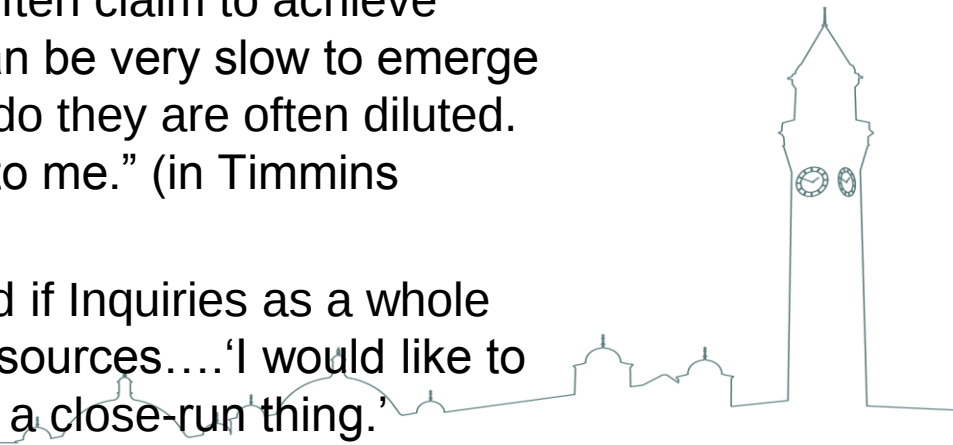
Implemented?

- IfG (2017) point out that of the 68 inquiries that have taken place since 1990, only six have received a full follow-up by a select committee to ensure that government has acted.
- IfG (2017) state that some inquiry teams choose to stay involved even after they have reported (eg): Sir Robert Francis (Mid Staffordshire) and Dame Janet Smith (Shipman).
- “Implementation is – of course – everything” (Sir Robert Francis)



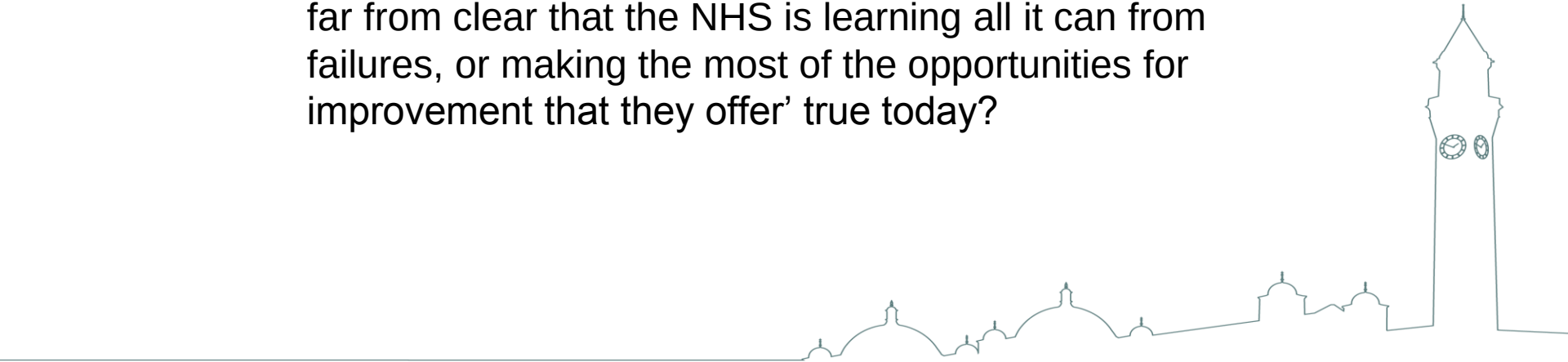
Implemented?

- Mixed record of take up of Recommendations in health care and other areas such as social care.
- In relation to some of her Recommendations around the professional regulation of doctors, Dame Janet Smith later stated "If the success of public inquiries is judged in terms of changes in regulations and legislation then we cannot often claim to achieve that….Positive proposals can be very slow to emerge and even if they eventually do they are often diluted. It's an issue of great regret to me." (in Timmins 2013).
- More broadly, she wondered if Inquiries as a whole are worth the money and resources….'I would like to say yes, but I think it's often a close-run thing.'



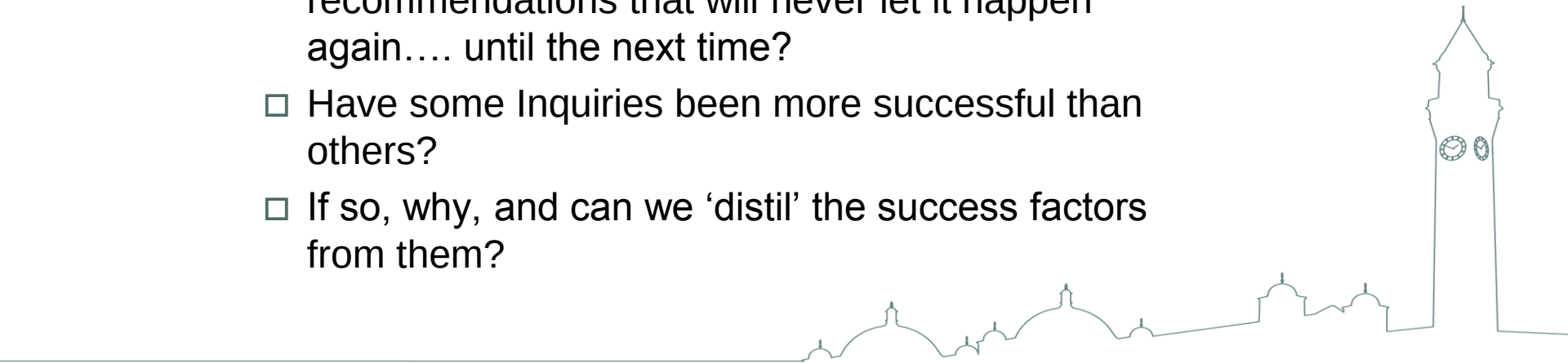
Limited Learning?

- The Ely inquiry is generally regarded as a ‘success’.
- However, as long ago as 2000, Sir Liam Donaldson (2000) concluded that inquiries, and in particular external inquiries, are not always effective learning tools for the NHS.
- Is Kieran Walshe’s (2003) view that ‘at present it is far from clear that the NHS is learning all it can from failures, or making the most of the opportunities for improvement that they offer’ true today?



Conclusions

- After well over 100 Inquiries, is the NHS a ‘learning organisation’ or a ‘forgetting organisation’?
- Is the problem more that Recommendations are not implementable or implemented?
- Is there a Groundhog Day’ situation with a repeated pattern of discovering a scandal, and making recommendations that will never let it happen again…. until the next time?
- Have some Inquiries been more successful than others?
- If so, why, and can we ‘distil’ the success factors from them?



References

Black, N. and Mays, N. (2013) Public inquiries into health care in the UK: a sound basis for policy-making? *Journal of Health Services Research & Policy* 0(0) 1–3

Chief Medical Officer (2000) *An organisation with a memory*. Report of an expert group on learning from adverse events in the NHS, London: TSO

Institute for Government (2017) *How Public Inquiries Can Lead To Change*, London: IfG

Public Administration Select Committee (PASC) (2005) Government by Inquiry: First Report of Session 2004 – 5, Vol. 1, HC-51-I.

Timmins N. (2013) Are public inquiries worth the time, money and resources? Institute for Government Blog, http:// www.instituteforgovernment.org.uk/blog/5567/are-public- inquiries-worth-the-time-money-and-resources/

Williams, M. and Kevern, P. (2016) The role and impact of recommendations from NHS inquiries: a critical discourse analysis, *The Journal of New Writing in Health and Social Care* Volume 2 Issue 2.

Walshe, K. (2003), *Inquiries: Learning From Failure in the NHS?* Nuffield Trust, London.

Ely was pivotal, but was it the first? Barbara Robb and the Ely Inquiry

Claire Hilton

November 2018

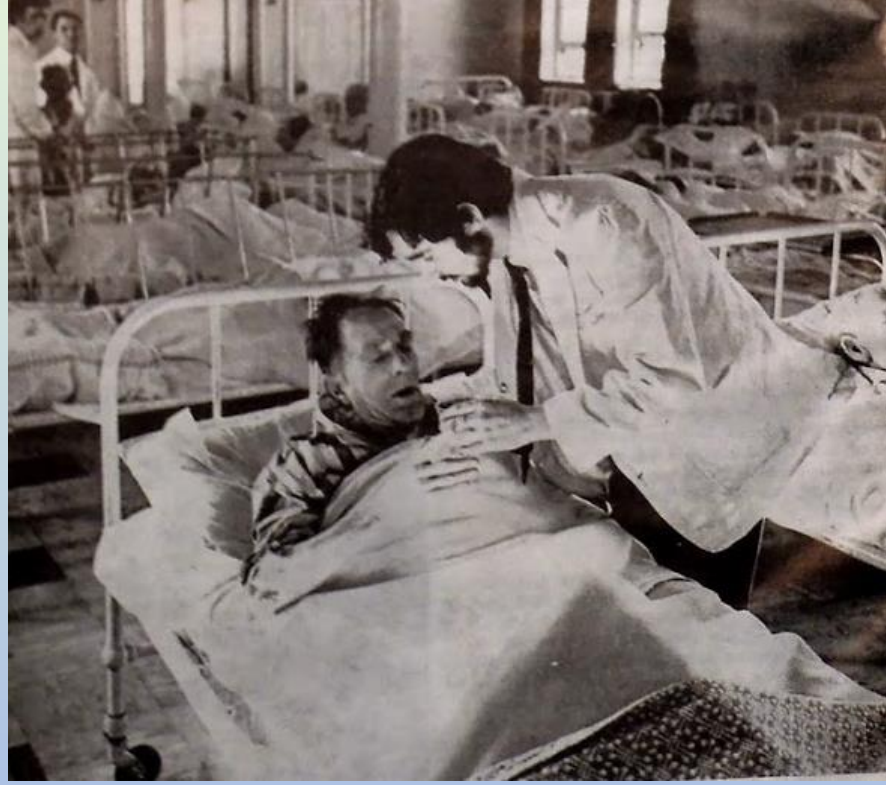
Two questions

- Was Ely ‘first’ ‘modern’ inquiry?
- If not, what came before it? – Ely’s relationship with Barbara Robb’s campaign (1965-75) to improve (older people’s) psychiatric care, and her book *Sans Everything: A case to answer*

  ……..

- *Ward F 13*, 1968, documentary

https://www.youtube.com/watch?v=UzjeBaBFWqw



Barbara Robb (1912-76) and *Sans Everything* (*SE*)

- 1965, visited Amy, age 74, at Friern Hospital. Shocked by what she found
- Kept diary of visits, became part of *SE* (1967)
- *SE* included solutions:
  - Brian Abel-Smith: NHS inspectorate, ombudsman, complaints procedures
  - Tony Whitehead: psychogeriatric treatment to keep older people as healthy as possible in their own homes
  - Peter Thomson: build homes on surplus hospital land to generate income

Planning the *Sans Everything* inquiries

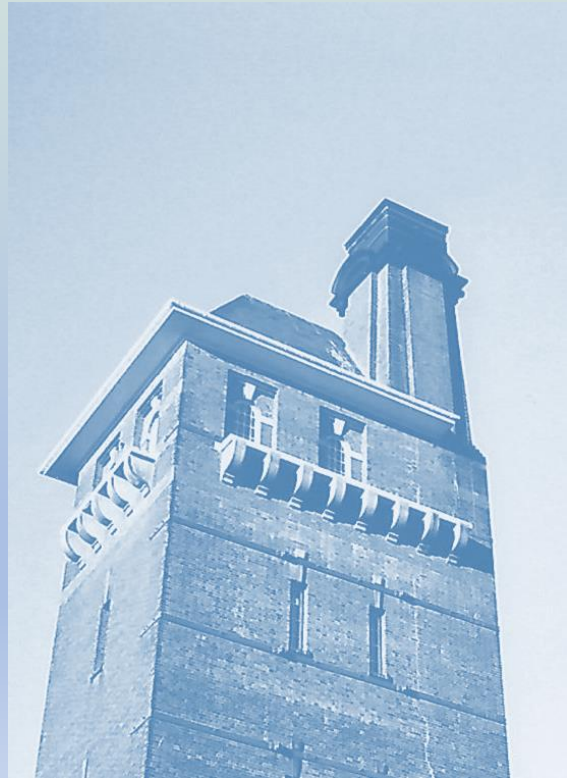
- Ministry (MoH), to protect staff, ‘restore public confidence’; Robb aimed to protect patients
- Council on Tribunals, for a nation-wide crisis of confidence, parliament should establish inquiry with CoT oversight (NHS Act, 1946, s.70)
- MoH: *SE* allegations unsound rather than serious, so not use s.70
- MoH delegated inquiries to RHB responsible hospital. No CoT oversight
- Set own standards for evaluating evidence, usually based on views of senior staff within the hospital, even if unacceptable elsewhere

Logical fallacies etc

- Discredited complainants if new or untrained staff. Did not evaluate evidence
- Rejected allegations as ‘exaggerations’
- Judged by what they *thought* rather than *knew*. e.g. ‘Sister has…the habit of swearing at patients….we do not think she would ever deliberately ill-treat...’
- Malpractice vindicated if unintentional / understandable e.g. due to understaffing
- Leading questions: ‘You have never seen anything like that at all, have you?’
- Not question mantra of ‘best health service in the world’
- 1 RHB summarised report for publication: 1 altered signed inquiry report

‘Fairly well rigged’, said Richard Crossman

- Max Beloff: ‘danger with our close-knit political-administrative network is that most inquiries are so manned that they turn out to be nothing but the system looking at itself…finding more to admire than to blame.’ (Aberfan: National Coal Board, none prosecuted or sacked)
- Outcome: White paper. Kenneth Robinson, July 1968: ‘I deeply regret the anxieties which have been caused…allegations which are now authoritatively discredited.’ Not mention recommendations e.g. improve wards, food, staff levels. Defensive, conceal problems.
- Allowed those involved with Ely to consider strategy



Ely early warnings and responses c.1960-67

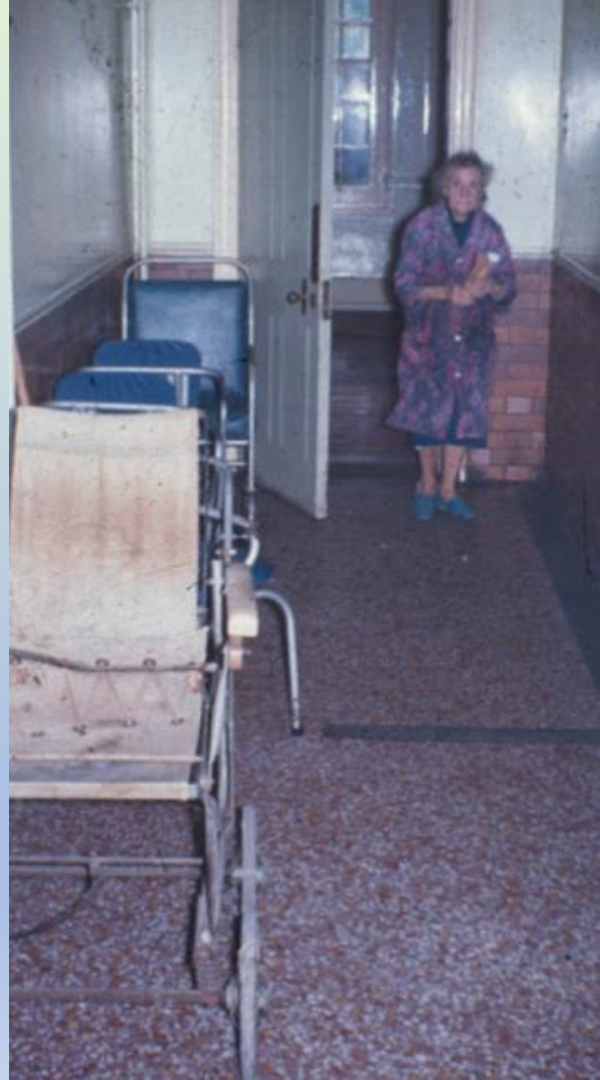
- Hospital Management Committee (HMC) reports: gradual shift from good to worrying
- 1965 ‘reduce the overcrowding in this hospital, urgently’; ‘staffing situation is deteriorating and calls for urgent attention’. MoH visited. Filed deplorable report. No action
- 1967 Ely HMC report to RHB: ‘We are, of course, assured by the senior officers…that there is no inhumanity in the treatment of patients…’

SE triggered Ely, and more

- June 1967, David Roxan, *News of the World,* announced *SE*
- Michael Pantelides, nursing assistant, Ely, wrote to Roxan, e.g. staff hit patients, pilfered food, lied about patients' injuries
- Pantelides agreed that Roxan send report to MoH
- MoH feared Roxan would discredit them, so must investigate
- 1967/71 Farleigh Hospital, ill treatment
- 1967/72 Whittingham, e.g. strike with key strap; lock in coal-house
- 1968/74 South Ockendon, severe injuries to patient
- Disbelief, fear, cover-ups, 4+ convictions (including 1 manslaughter) etc delayed inquiries

The Ely Inquiry: same status, different people

- Abel-Smith and Geoffrey Howe students at Cambridge. Abel-Smith recommended Howe QC, Conservative politician, at Aberfan inquiry: different approach
- Lacked logical fallacies of *SE* inquiries
- Unclear evidence: ‘probably true’ (rather than ‘probably false’)
- Upheld many complaints
- 45 recommendations: e.g. more domestic staff; time to handover between shifts; in-service training; link to local community; disciplinary proceedings against nurse who ‘contrived complaints’; NHS inspectorate



From inquiry to publication in full

- Howe determined that the full inquiry report was published
- ‘Under pressure’ from DHSS Howe made summary, stated e.g. authorities sought to conceal damaging information. Would whet journalists’ appetites
- Abel-Smith ensured Crossman received reports. Crossman decided to publish full version, otherwise ‘at the mercy’ of Howe who could ‘go on the tele’
- Abel-Smith informed Robb. Crossman feared Robb: ‘dangerous woman…people write to her, the most terrible stories….She is always ready with some great scandal to break, and there are, God knows, enough scandals to break’
- Crossman ‘could only publish and survive politically’ if announced new policy: Abel-Smith’s and Howe’s inspectorate

27 March 1969: Ely Report

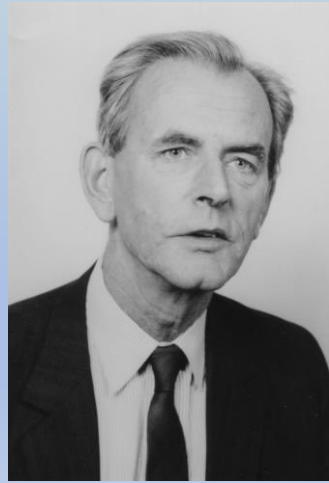
- Crossman announced: ‘a springboard for action rather than a setback for morale’. It was credible, and it provoked constructive responses
- *Why so different from SE?*
- **Robb set agenda:** publicised problems / remedies; drip-fed public about hospital malpractice and NHS flaws, via media; ‘dented the bureaucratic shell’
- **Team effort:** Howe determined to achieve justice; Crossman feared Howe and Robb; Abel-Smith coordinated

After Ely

- Crossman:
  - Hospital Advisory Service: evaluate and guide long-stay hospitals
  - visited long-stay hospitals, creating publicity
  - cajoled hospital authorities
  - more funding to long-stay hospitals
  - Post-Ely Working Party (community services, mentally handicapped)
- Keith Joseph (Conservative, 1970-74, Crossman's successor):
  - NHS ombudsman
  - Review NHS complaints procedures
  - DHSS blueprints for developing mental health services

Discussion

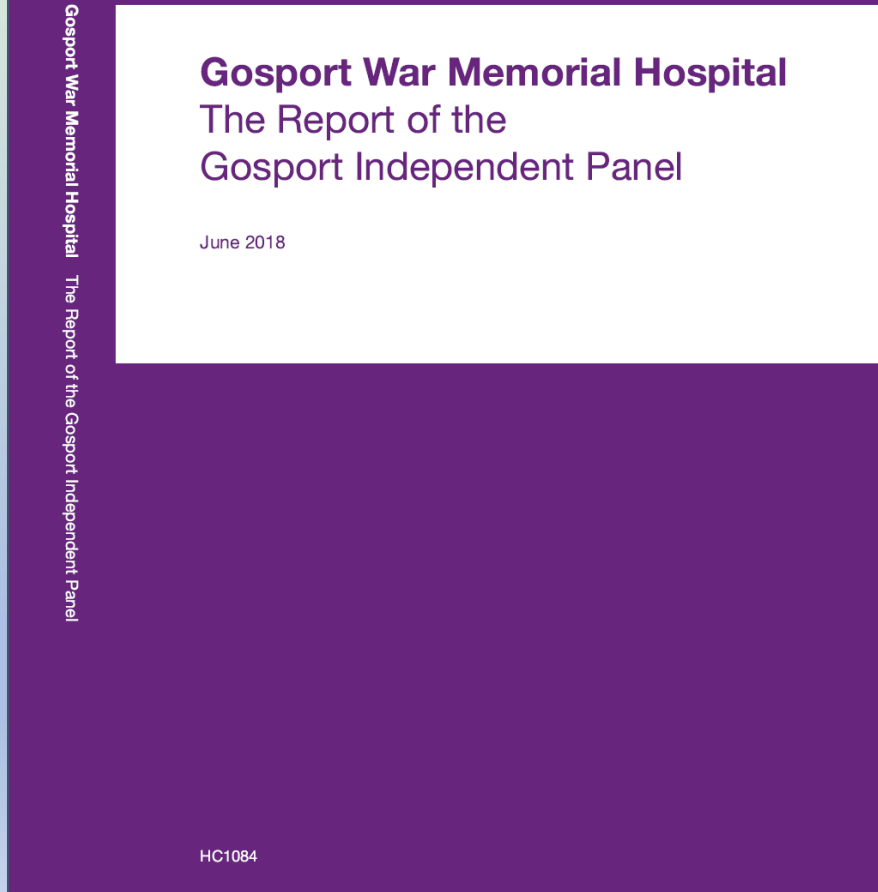
- Ely: 1st NHS inquiry to find hospital inhumanity: Howe's candid analysis
- 1st full publication: Abel-Smith, Crossman, Howe and Robb committed to the cause
- Scandals and inquiries recur, not mention predecessors; recommendations re-invent the wheel
- Unequal distribution of power (vulnerable *v.* in authority): past campaigners, e.g. Robb, Elizabeth Fry; William Wilberforce, would be busy today. All brought inhumanities into public arena, but their actions cannot prevent abuse today.



Today, can we change culture?

…what has to be recognised by those who head up our public institutions is how difficult it is for ordinary people to challenge the closing of ranks of those who hold power.

The Right Reverend James Jones KBE
Chair, Gosport Independent Panel,
June 2018



Fifty years of inquiries in the NHS

November 2018

Break – 11.15 -11.30

The Health Foundation

MANCHESTER 1824
The University of Manchester
Alliance Manchester Business School

UNIVERSITY OF BIRMINGHAM

Mid-Staffordshire: a case study of failed governance and leadership?

Professor Judith Smith
Professor Naomi Chambers

The Health Foundation
14 November 2018

Agenda

- Reflecting on governance and leadership at Stafford
- The conundrum of ‘culture’
- What more do we know now?

REFLECTING ON GOVERNANCE AND LEADERSHIP AT STAFFORD


Stafford Hospital
May 2011
(c) Alistair Rose

An isolated organisation

- Stafford was a district general hospital (DGH) on the periphery of an NHS region
- In a town that is bypassed by major transport routes
- Like many DGHs, it struggled to secure clinical workforce
- A local hospital with strong public support, yet needing to be more clearly networked with other hospitals and services
- It is not always evident how the NHS has confronted and addressed its DGH legacy from the Hospital Plan of the 1960s
- Other DGHs remain in special measures

A vulnerable management team

- Stafford had a chief executive in his first CEO role
- DGH roles are arguably some of the toughest in the NHS, yet are typically considered as ‘first step’ CEO posts
- An executive team and board that seemed out of touch with clinical services, patient and carer experience, and the effects of major operational changes
- A board that was looking upwards to regulators and the strategic health authority, more than inwards to its staff, patients and services, or outwards to the local population
- A board overly focused on targets, and in particular the pursuit of foundation trust status

The people who made the case

Some of those who should have acted

- The clinical leaders of the trust
- Ward managers
- Staff going onto wards – doctors, allied health professionals, social workers
- Local GPs and practice-based commissioners
- Patient groups, Patient Advice & Liaison Service
- Primary care trust as commissioner
- Strategic health authority as performance manager
- Department of Health
- Monitor as approver of foundation trust status
- Healthcare Commission as regulator
- Foundation trust governors
- The hospital board – executives and non-executives
- And others…

Robert Francis' conclusion about governance and leadership at Stafford

'What brought about this awful state of affairs? **The Trust Board was weak**. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention.

'**It did not tackle the tolerance of poor standards and the disengagement of senior clinical staff from managerial and leadership responsibilities**.

These failures were in part due to a focus on reaching targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable standards of care.'

Sir Robert Francis QC, 6 February 2013

This was also a wider failure of governance

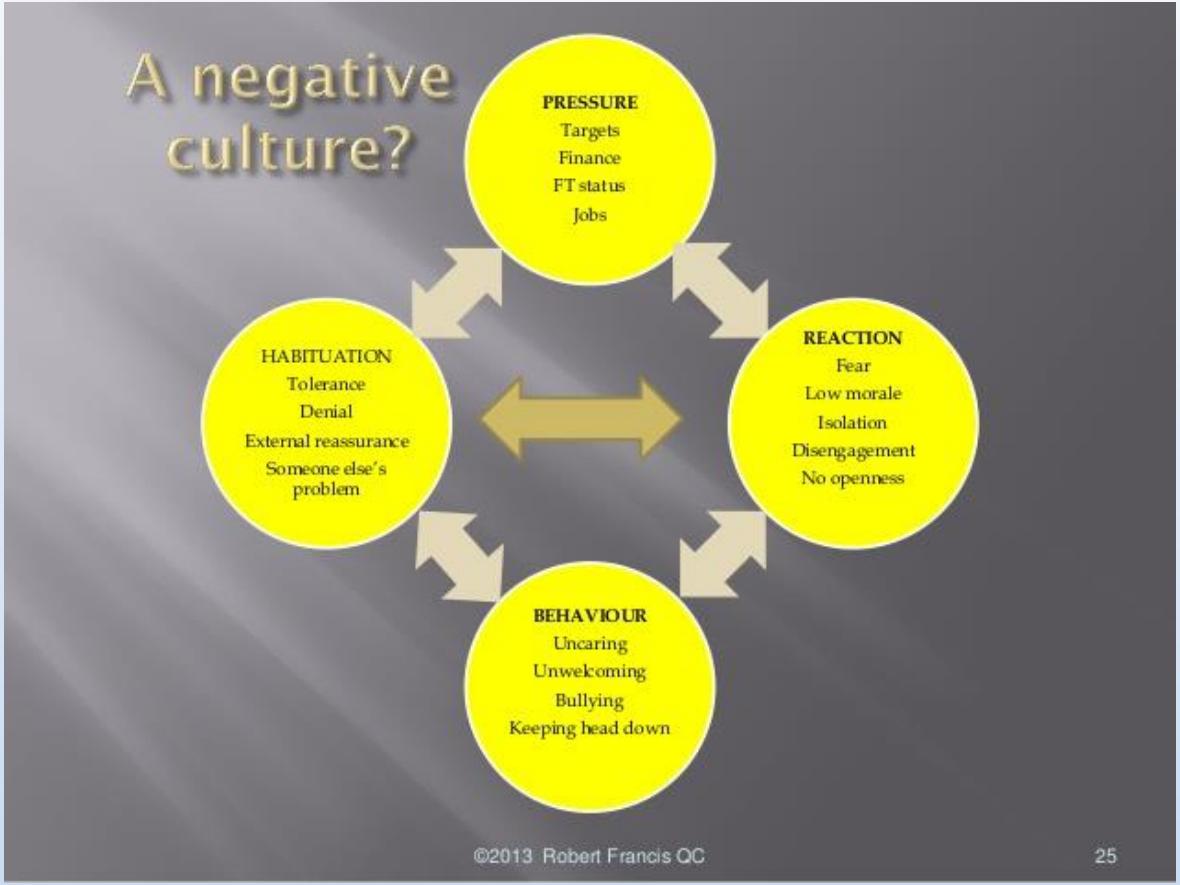
- Those who did not notice - or if they did, failed to act - held a wide range of governance roles
- Formal roles such as the trust board, external regulators, and NHS management structures
- Professional and clinical governance roles where members each have their codes of conduct
- University training assessors who accredit placements
- Local scrutiny bodies including the local council who failed to see the full picture
- NHS commissioners who should act as agents of patients and taxpayers, and assure care quality
- The reasons for these failures are profound and critical

THE CONUNDRUM OF ‘CULTURE’

Francis' diagnosis of culture at Stafford

- Lack of compassion
- Fear of trouble
- Disengaged staff
- Failure of leadership
- Regulators missing what was important for patients
- Professional and other groups not thinking enough of patients

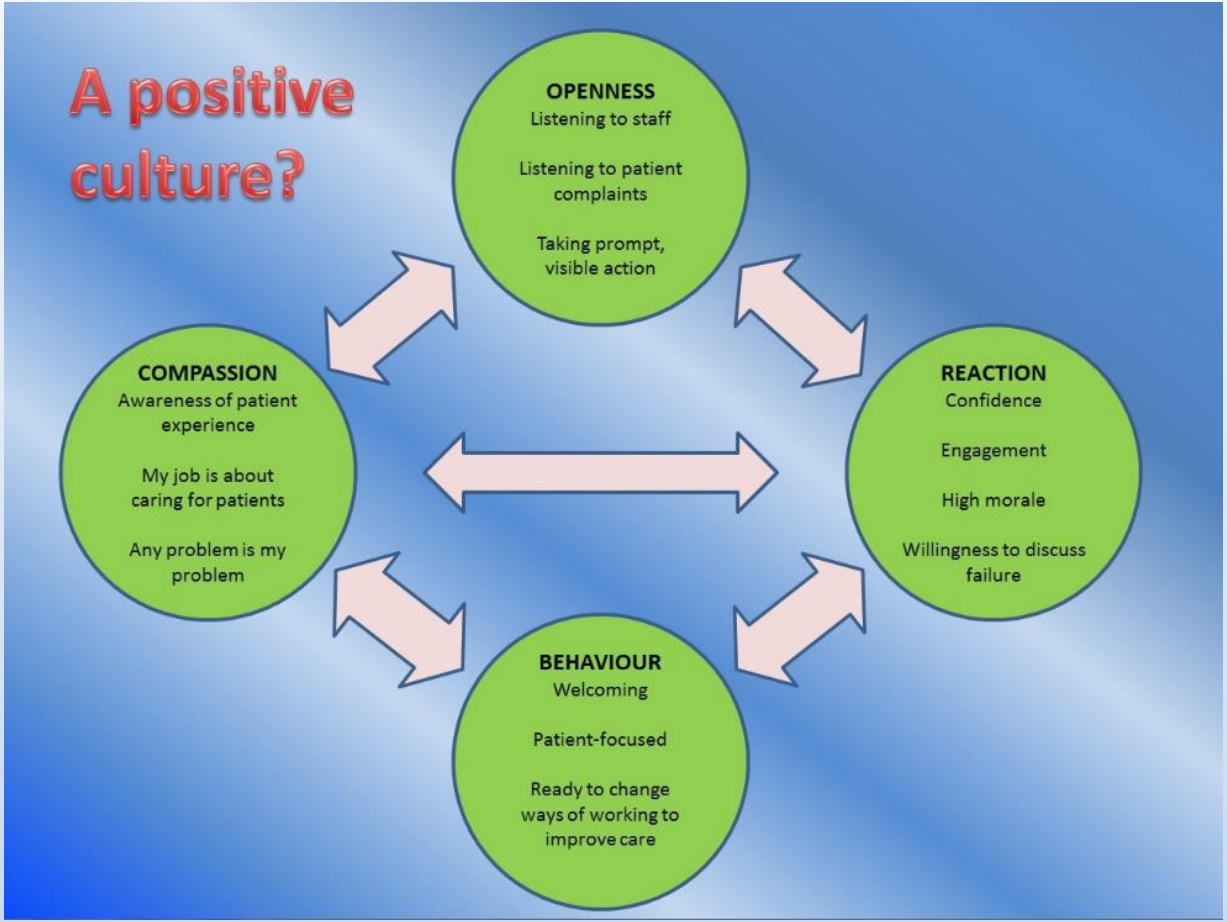
'Focus on the system's business, not the patients'


A negative culture?
PRESSURE
Targets
Finance
FT status
Jobs
REACTION
Fear
Low morale
Isolation
Disengagement
No openness
BEHAVIOUR
Uncaring
Unwelcoming
Bullying
Keeping head down
HABITUATION
Tolerance
Denial
External reassurance
Someone else's problem
©2013 Robert Francis QC
25

Reflections from two of Francis' advisors

(Newdick and Danbury, 2013; Smith, 2013)

- **Patient voice** – which still needs serious strengthening, as we have not got anywhere near what we had with community health councils, and that was nowhere near enough
- **Duty of candour** – which needs to apply beyond the clinical realm, and with real teeth, if managers in particular are to be emboldened
- **Managerial culture** – getting beyond the 'good news' focus, and enabling boards to feel and act as though the patient and population are central to decisions
- **Department of Health and political centre's treatment** of the NHS and its managers. The 'how' matters as much as the 'what' in policy implementation


A positive culture?
OPENNESS
Listening to staff
Listening to patient complaints
Taking prompt, visible action
REACTION
Confidence
Engagement
High morale
Willingness to discuss failure
BEHAVIOUR
Welcoming
Patient-focused
Ready to change ways of working to improve care
COMPASSION
Awareness of patient experience
My job is about caring for patients
Any problem is my problem

WHAT MORE DO WE KNOW NOW?

Selected findings from study of changes in NHS board leadership since Francis

- Naomi Chambers, Professor, University of Manchester (lead)
- Judith Smith, Professor University of Birmingham
- Ruth Thorlby, Assistant Director of Policy at the Health Foundation
- Alan Boyd, Research Fellow, University of Manchester
- Nathan Proudlove, Senior Lecturer, University of Manchester
- Russell Mannion, Professor University of Birmingham

This presentation is based on independent research commissioned and funded by the NIHR Policy Research Programme ((PR-R11-0914-12003 Learning from leadership changes made by boards of hospital NHS trusts and foundation trusts following the Francis Inquiry report June 2015-June 2017)). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, the Department of Health, 'arms' length bodies or other government departments

Aims of the research

- To identify how boards and senior leaders of NHS acute hospital trusts sought to implement the recommendations on organisational leadership in response to the Francis Inquiry report
- To explore the intended and unintended effects of implementing recommendations of the Francis Inquiry
- To uncover the enablers and barriers to improving senior leadership
- To advance theoretical understanding of effective healthcare boards
- To synthesise findings to inform a set of practical and evidence-based learning points for boards and senior leadership teams

Desirable characteristics of healthcare boards

from scoping interviews with 13 national opinion leaders (2015)

- Are palpably focussed on patient care
- Give priority to quality, safety and learning for improvement
- Are more problem sensing than comfort seeking
- Know what's going on (worries of patients, staff, regulators)
- Receive detailed and timely data on patient and staff concerns
- Hardwire quality improvement through the organisation
- Support staff, heed concerns & protect from negative pressures
- Promote a certain culture, insist on certain behaviours, ensure good governance, enable climate for compassionate care
- Use data and information as the basis for improvement

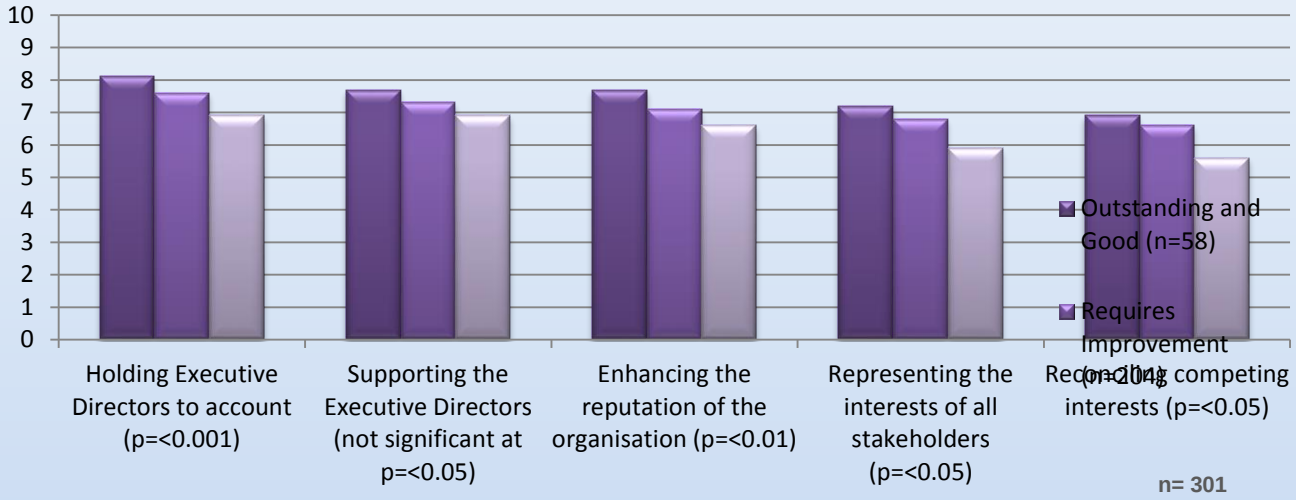
Selected findings from national survey

(2016 n=381)

'The Francis report has acted as a reminder of what sort of an organisation we don't want to be like, and continues to be a reminder' [non-executive director]

- Trusts have developed or revised a raft of policies including in relation to the handling of complaints, serious incidents, listening to patients & staff engagement
- The main self-reported challenges for trusts are patient safety, finances, dealing with regulator demands, and some poor relationships in the local health economy
- Big efforts to improve patient experience and staff engagement *but*
- Board members felt they knew more about what was important to regulators than to patients and staff
- Duty of candour has had a positive impact on culture of openness, patient confidence and opportunities for organisation learning
- Higher Care Quality Commission ratings (Good and Outstanding) are related to greater board diligence

Correlation between self reported strength of board emphasis on purposes and Care Quality Commission Ratings from national survey of NHS board members 2016



Selected findings from case studies
(2016/17)

- Differences in leadership cultures in the case studies: classy, courageous, defiant, ramshackle, recovering and shiny
- Patient safety deemed more important than long-term financial sustainability, despite tensions, and increasing workforce pressures
- Quality improvement culture is work in progress, and systems and processes are variable
- Variation in capacity, capability and empowerment of middle management
- Continuing problem of variation in the ability to provide patient-centred care
- Contradictory findings about the impact of strengthened regulation

Suggested roles for ‘full service’ boards

(Chambers et al 2018)

Board as conscience of the organisation: leading the development, upholding and review of a core set of cultural values and behaviours

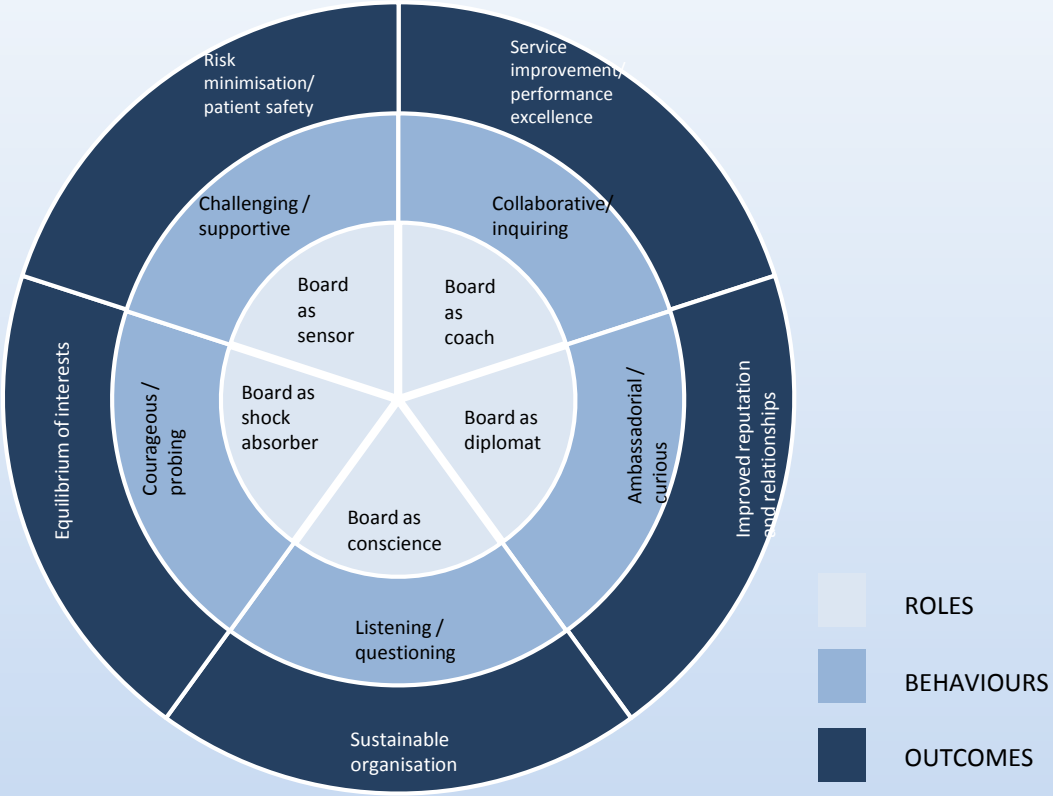
Board as sensor: discerning and acting upon performance issues and problems drawing from a diverse range of internal and external sources of intelligence

Board as diplomat: listening, gauging and attending to the various stakeholder interests and perspectives that have a bearing on the organisation

Board as shock absorber: supporting the organisation when subject to regulatory scrutiny, offering motivation and encouragement, and helping to prioritise areas for action

Board as coach: setting ambition and direction, assessing performance, agreeing areas for development, and instilling a restless urge for improvement and the achievement of higher ambitions

A question of character? Inter-connectedness of roles, behaviours and outcomes of the dynamic board, organisation and system



Mid-Staffordshire as a case study of failed governance and leadership: some conclusions

- Mid-Staffordshire demonstrated the overwhelming evidence of the impact of **culture** on governance and leadership
- Listening to and acting on **patient voice** is key
- Beneficial impact of Francis on the leadership **intentions** of senior hospital managers
- Continuing variation in the quality and consistency of leadership **practices**
- Importance of **courage** and **diligence** in creating a climate for kind and safe patient care
- Relevance of a comprehensive leadership **repertoire** of roles and behaviours

MANCHESTER 1824
The University of Manchester
Alliance Manchester Business School

UNIVERSITY OF BIRMINGHAM

To discuss further

Professor Judith Smith
j.a.smith.20@bham.ac.uk
@DrJudithSmith
www.bham.ac.uk/hsmc

Professor Naomi Chambers
naomi.chambers@manchester.ac.uk
@NaomiChambers11
www.research.mbs.ac.uk/health/

Fifty years of inquiries in the NHS

Expert panel one: Reflections on NHS inquiries; aims and processes

Chair: **Nick Timmins** - Senior Fellow, Institute for Government & The King's Fund
Panel: **Dame Janet Smith** - Chair of Shipman and Savile Inquiries
Tom Kark QC - QEB Hollis Whiteman Chambers and Counsel to Mid Staffordshire Inquiry
Professor Brian Jarman - Emeritus Professor, Imperial College

The Health Foundation

Fifty years of inquiries in the NHS

Lunch – 13.00 -14.00

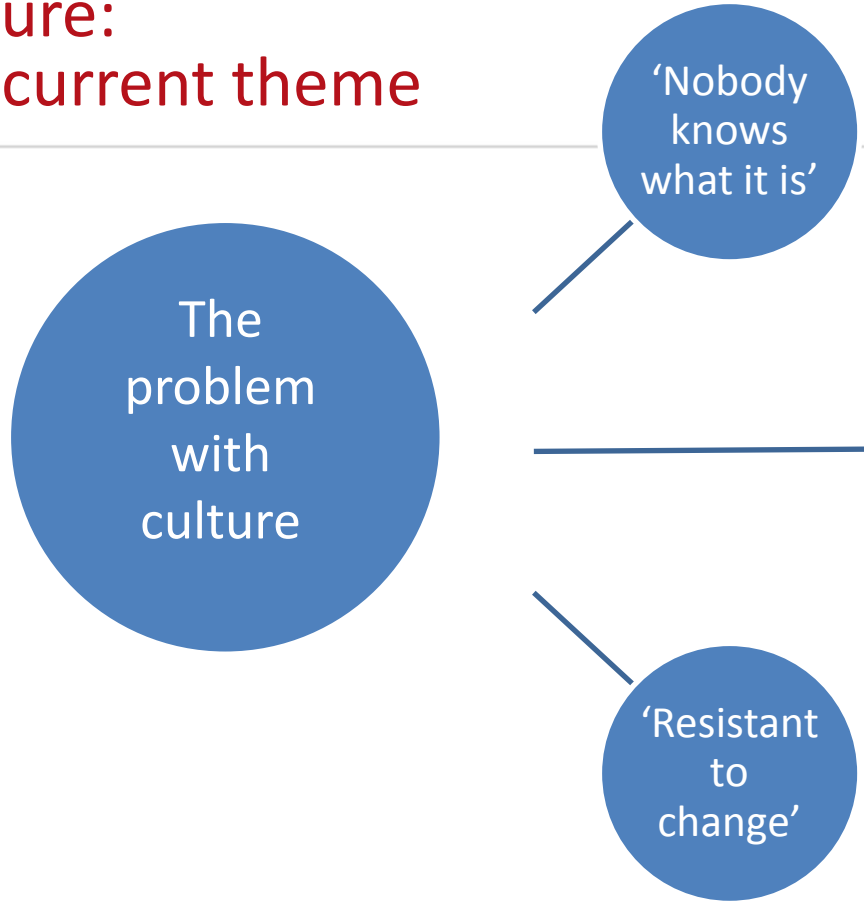
November 2018

The Health Foundation

NHS inquiries and the problem of culture

Fifty years of inquiries in the NHS, November 2018
Dr Dawn Goodwin, Lancaster University

Culture:
A recurrent theme



- 'little consensus among scholars over the precise meaning of organizational culture' (Scott et al, 2003)

- 'Easy to recommend; almost impossible to implement' (Delamothe, 2013)
- 'recommendations about culture… aspirational and broad brush' (Davies and Mannion, 2013)

- 'because they are deeply ingrained within both day-to-day social practice and tied to wider social conditions' (Waring, 2013)

Culture is…

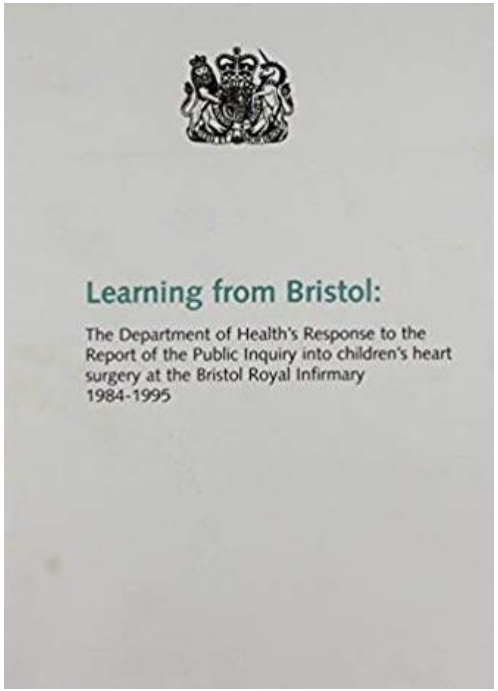
- ‘the prevailing beliefs, values, assumptions and attitudes, and from these the local norms of behavior. These shared ways of thinking and behaving help to define what is legitimate and acceptable within an organization.’ (Mannion et al, 2009)

- ‘the shared, overt and covert understandings that constitute conventions and practices, and the ideas, symbols, and concrete artifacts that sustain conventions and practices, and make them meaningful. ‘(Napier et al, 2014)

- ‘culture is not a power, something to which social events, behaviors, institutions, or processes can be causally attributed; it is a context, something within which events, behaviors, institutions, and processes can be intelligibly – that is, thickly – described’ (Geertz, 1973)

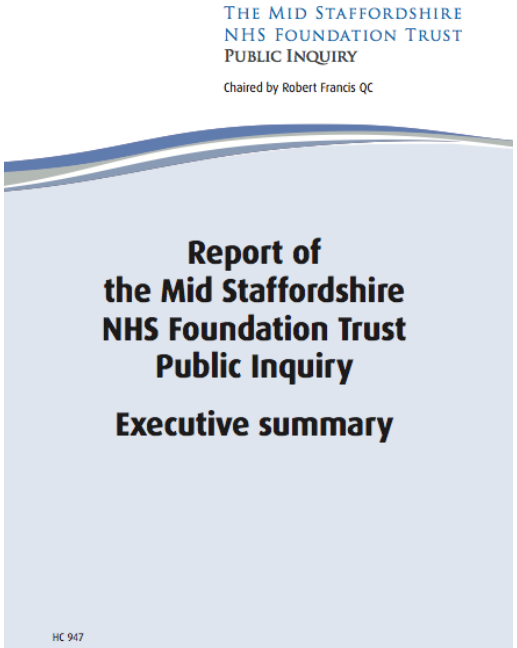
Bristol: a ‘club culture’ amongst the leadership

- Senior appointments depended on ‘fit within the club’
- Too much power in the hands of too few
- Preference for oral communication
- A rigid distinction between clinical and managerial matters and one which prioritised ‘clinical freedom’
- Paternalistic attitude towards patients
- Team structure ‘profoundly hierarchical’ and of single disciplines



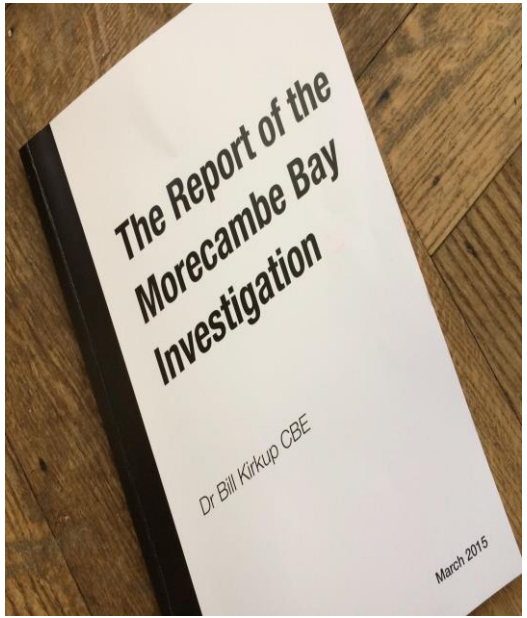
Mid Staffordshire: ‘insidious negative culture’

- Managerial preoccupation with financial pressures and achieving Foundation Trust status
- A lack of basic care arising from inadequate staffing
- Tolerance of poor standards
- Bullying, fear of adverse repercussions, and low morale amongst staff
- A consultant body largely dissociated from management
- Management/leadership failure to remedy the deficiencies in staff and governance



Morecambe Bay: Tribal and insular culture

- Dysfunctional working relationships between midwives, obstetricians and paediatricians
- Professional ideology of ‘normal birth’ plays into professional politics and boundaries
- Poor clinical decision-making
- Declining knowledge and skills
- The geographical and professional isolation of the unit
- Internal investigations/governance procedures inadequate and overly protective of staff



Same or different cultures?

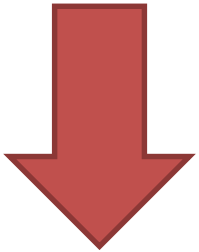
Thematic points of contact…

- Poor teamwork resulted in poor clinical decisions (Bristol and Morecambe Bay)
- Hierarchy (Bristol and Morecambe Bay)
- Senior clinical staff disengaged from managerial decision-making (Bristol and Mid Staffordshire)

… but different manifestations in day-to-day circumstances

Seeing similarities, erasing differences

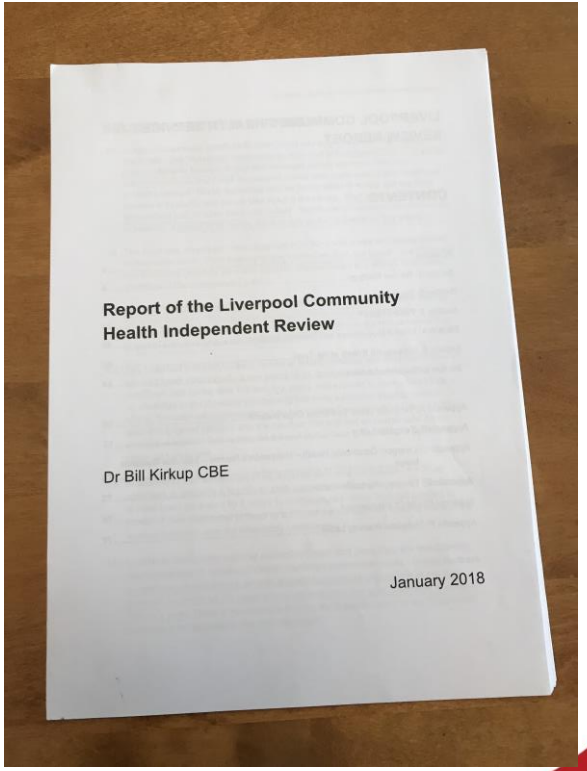
- Extracting events out of daily activity
- Explanatory frameworks – use of current theories and concepts from safety science



- Talking of problems in terms of culture brings similarities to the foreground and pushes differences to the background
- Suggests warning signs will be obvious and self-evident, but more difficult to recognise in one's own daily practice

Liverpool: Intolerant and bullying leadership culture

- Inexperienced leadership intent on attaining Foundation Trust status
- Workforce reductions resulted in inability to deliver care to a sufficient and safe standard
- Incident reporting discouraged
- Bullying, harassment and intimidation
- Fear of repercussions and demoralization of staff
- Denial of root causes of problems and inattention to governance and quality improvement



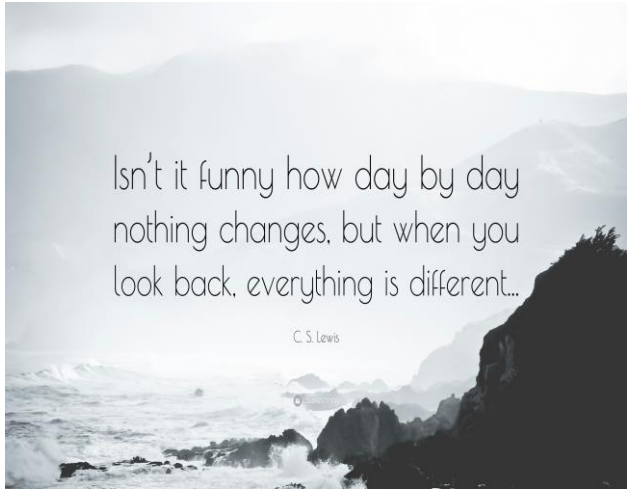
Cultural Change

Lancaster University

Culture is difficult to change

OR

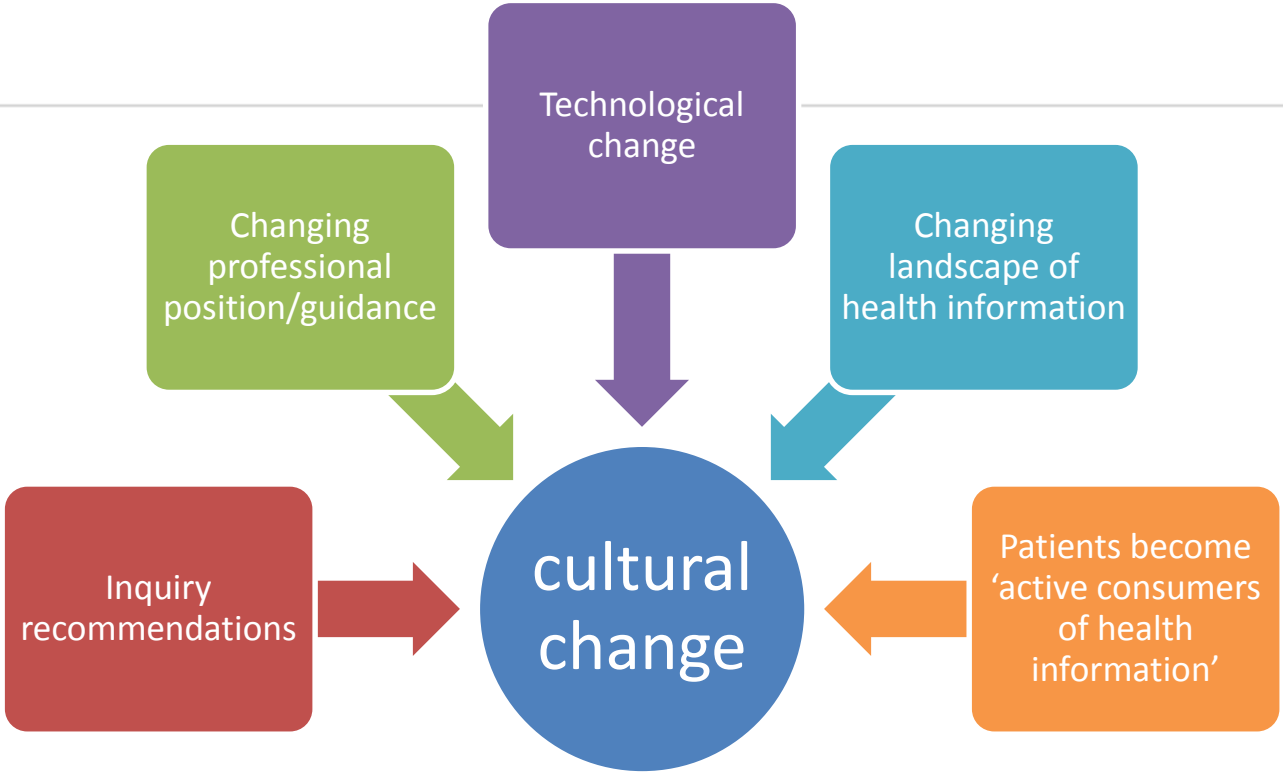
Culture is changing all the time



Example: The demise of paternalism…

- ‘The sense is gained that informing parents and gaining their consent to treatment was regarded as something of a chore by the surgeons.’ (Kennedy, 2001: 7)

- ‘It is not a question of the professional judging what the parent needs to know. It is the parent who should make that decision. At the time, however, the prevailing view was that parents should be protected from too much information.’ (Kennedy, 2001: 220)


Technological change
Changing professional position/guidance
Changing landscape of health information
Inquiry recommendations
cultural change
Patients become 'active consumers of health information'

What is difficult is about cultural change is controlling it

- Incomplete control:
  - change involves internal and external factors which may pull in different directions
- Unanticipated effects of interventions:
  - falls reduction target on an elderly care ward unintentionally created ‘a culture of restriction and limitation where patients were encouraged to remain in their chairs and use bedpans or commodes rather than be helped to a toilet.’ (Hillman et al, 2013: 946)

What does it do to talk about culture?

i. Allows us to appreciate the effects of less tangible aspects of practice
ii. Foregrounds similarities while pushing differences to the background
iii. Understand the need for cultural change as a gradual, emergent and reflexive process of changes to practice and context

The public in NHS public inquiries

Ruth Carlyle

50 Years NHS Inquiries Symposium, November 2018

Overview

- Understanding of ‘public’
- Public involvement in the NHS
- Insights from NHS inquiries:
  - Ely Hospital, Cardiff, 1969
  - Normansfield Hospital, Teddington, 1978
  - Bristol Royal Infirmary, 2001
  - Mid-Staffordshire NHS Foundation Trust, 2010 and 2013
- Roles of the public in NHS public inquiries

Understandings of ‘public’

Procedure: public vs. private

Priority: ‘public concern’ requiring impartial investigation (Howe, 1999)

Audience: addressing ‘public confidence’ (Walshe and Higgins, 2002)

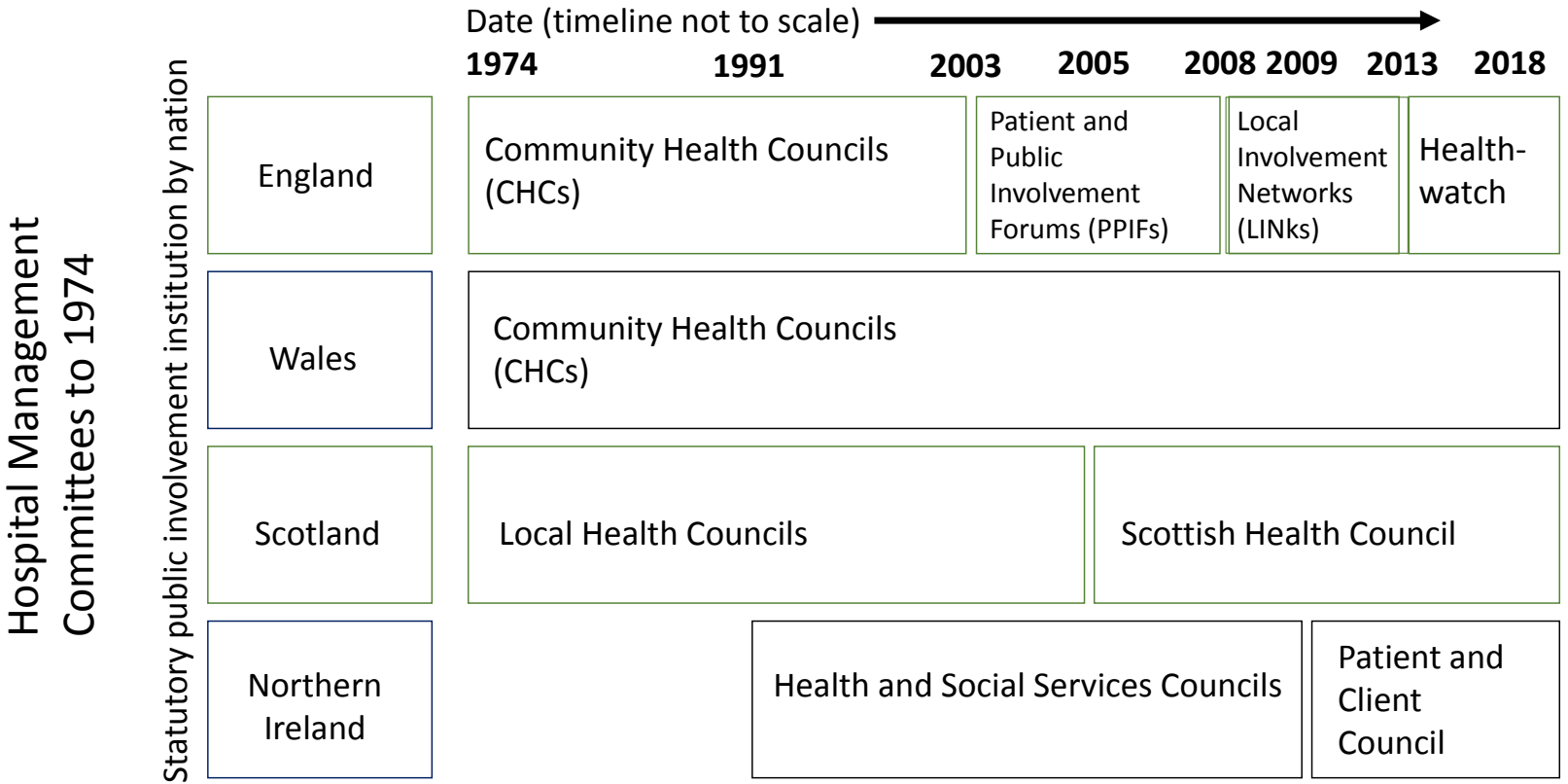
Participant: trigger, inquiry member, witness, disseminator or implementer of findings

Public involvement in the NHS

‘Involvement of members of the public in strategic decisions about health services’ (Florin and Dixon, 2004)

- NHS-led involvement
- Voluntary sector
- Crisis-formed groups
- Statutory public involvement institutions

Changes to public involvement institutions



Changing faces of public involvement

Community Health Councils

Patient and Public Involvement Forums

Assessing role of the public

Framework
Establishing the facts
Learning from event
Catharsis or therapeutic exposure
Reassurance
Accountability, blame and retribution
Political considerations

NHS Inquiries
Ely Hospital, Cardiff, 1969
Normansfield Hospital, Teddington, 1978
Bristol Royal Infirmary, 2001
Mid-Staffordshire, 2010 and 2013

Source for framework: Walshe and Higgins, 2002
from Howe, 1999

Ely Hospital, 1969

NEWS OF THE WORLD

Alarm raised by former nursing assistant

Patients and families unable to speak for themselves

Lay members Hospital Management Committee:

- Rarely visited (on basis of rota, every 20 months)
- Not 'battling for' patients at Ely
- Lack of members from mental health interest groups
- Too close to management to represent consumer interests

Secretary of State:

'the main recommendation of the Report is that a new system of regular visiting and inspection is needed. I agree.' (**Richard Crossman**)

Ely Hospital, 1969

Framework	Role of public involvement
Establishing the facts	Attempted, but 'owing to the severe disabilities of most of them, little information was available from this source'
Learning from event	Creation of visiting, referral, and consultation rights for Community Health Councils
Catharsis or therapeutic exposure	Private inquiry process did not allow for catharsis
Reassurance	Policy committee leading to creation of Hospital Advisory Service and Community Health Councils
Accountability, blame and retribution	Blame included lay members Hospital Management Committee
Political considerations	Policy committee leading to creation of Hospital Advisory Service and Community Health Councils

Normansfield, 1978

Inquiry triggered by first NHS staff strike, not CHC

‘I welcome the continued interest of the Community Health Council and its persistent efforts to improve conditions at Normansfield.’ (**David Ennals**, Secretary of State)

Community Health Council:

Access information – regular visits, including comparative;

Decision making – CHC identified that proposed unit not suitable and did not fulfil regulations;

Challenge – referred issues to AHA, RHA, Secretary of State & media;

Co-ordinate interests – Minister of State referred others to CHC

Normansfield, 1978

Framework	Role of public involvement
Establishing the facts	One of 22 chapters in inquiry devoted to CHC and its findings from visits
Learning from event	Acknowledgement of visiting role by CHCs
Catharsis or therapeutic exposure	Limited for those affected, as CHC represented families
Reassurance	Inspection role of CHC and comparative visits to other services valued
Accountability, blame and retribution	Specific staffing changes; actions placed in hands Area and Regional Health Authorities (with CHC input)
Political considerations	CHC member of inquiry committee; responsibility for future steps placed regionally (with CHC input)

Bristol, 2001

Inquiry triggered by staff member reporting statistically high deaths

'I took the decision to abolish CHCs because I took the view that patients needed to have a voice inside the NHS. As you know, this is the point that was made very forcibly by Professor Sir Ian Kennedy in his inquiry into the tragic events at Bristol Royal Infirmary' (**Alan Milburn**)

Community Health Council:

- Information – lacked statistical data
- Decision making – described as external and not in partnership
- Challenge – 'tolerated mechanisms for venting public concern, because ultimately they could do nothing'
- Co-ordinate interest – Bristol inquiry suggested representation should be by 'a wide range of individuals and groups'

Issue of CHC inhibiting staff from raising concerns

Bristol as transition to greater dependence on statistics. New Commission for Health Improvement was expected to identify trends from data and to visit.

Bristol, 2001

Framework	Role of public involvement
Establishing the facts	Comparative data trends not available to public ('awash with data' but 'little if any…available to the parents or the public')
Learning from event	CHC 'on the outside'; learning though data and internal culture
Catharsis or therapeutic exposure	Open process, including online engagement and seminars; witness role of Bristol Heart Children's Action Group
Reassurance	Statistics rather than visits as grounds for assurance
Accountability, blame and retribution	Embedding public involvement to create "no blame" culture
Political considerations	Rationale for formalised inspection mechanism at arm's length from Secretary of State

Mid-Staffordshire, 2010 and 2013

Cure the NHS

Contacted Healthcare Commission

Collected evidence

Called for inquiry

PPI Forum:

Chair too close to NHS trust Board

Member expelled for releasing *C. difficile* rates to a newspaper

Low awareness of referral rights

National Quality Board:

LINks central to patient and public scrutiny

Recommended further review to improve public early warnings

Staffordshire LINk:

Closed by County Council

Not accessing data or interests

Stafford Hospital not a priority

Mid-Staffordshire, 2010 and 2013

Framework	Role of public involvement
Establishing the facts	Cure the NHS [local group] took on role of establishing facts and called for inquiry
Learning from event	Demonstrated that need patient experience, not just data; and value of visiting services
Catharsis or therapeutic exposure	Involvement of Cure the NHS and family members in inquiry process; online witness schedule and transcripts
Reassurance	Initial Healthcare Commission and independent inquiry did not provide, so reassurance core to public inquiry
Accountability, blame and retribution	Public expectation of accountability; PPI Forum blamed for not raising alarm (Andy Burnham)
Political considerations	Distancing through inspectorate structures does not always satisfy the public

Overview of public involvement in inquiries

	Establishing the facts	Learning from events	Catharsis or therapeutic exposure	Reassurance	Account-ability	Political consider-ations
Ely	Attempted	✓	✗	✓	✓	✓
Normansfield	✓	✓	Limited	✓	✓	✓
Bristol	✗	✗	✓	✗	✗	✓
Mid Staffs	✓	✓	✓	✓	✓	✓

Public involvement institutions & NHS Inquiries

- NHS inquiries have changed the nature of public involvement:
  - Creation of CHCs (Ely)
  - Replacement of CHCs with embedded mechanisms and reduction of ‘watchdog’ powers such as complaints management (Bristol)
  - Re-establishment of health-system based public involvement referral and governance (Mid Staffs)
- Complex interrelationship between statutory public involvement institutions and NHS inquiries:
  - Strong bodies limit catharsis (Normansfield)
  - Weak bodies limit prevention or early intervention (Mid Staffs)
  - May be blamed for not alerting to problems or not resolving issues (Ely, Bristol & Mid Staffs)

The public in NHS public inquiries

- Not just an audience, but a participant
- May be involved in any of the key functions of an inquiry
- Digital and online engagement increases opportunities for catharsis as not dependent on patient representatives
- Role of public involvement depends upon relative value placed on data versus experience/observation
- Political expectations of the public and the roles played by the public are dimensions to understanding NHS public inquiries

Fifty years of inquiries in the NHS

Break – 15.00 -15.15

November 2018

The Health Foundation

Fifty years of inquiries in the NHS

Expert panel two: Fifty years of inquiries: what needs to change

Chair: **Nick Timmins** - Senior Fellow, Institute for Government & The King's Fund

Panel: **Dr Bill Kirkup CBE** - Independent Investigation Chair, Morecambe Bay Inquiry

Professor Sir Ian Kennedy - Chair of Bristol Inquiry & Emeritus Professor of Health Law, Ethics and Policy at University College London

Professor Kieran Walshe - Health Policy and Management, University of Manchester

Professor Sir Nick Black - Health Services Research, London School of Hygiene & Tropical Medicine

The Health Foundation

Close

Chaired by **Nick Timmins**, Senior Fellow , Institute for Government and The King's Fund

November 2018

The Health Foundation

Thank you

The Health Foundation