

INQUIRIES: LEARNING FROM FAILURE IN THE NHS?

Kieran Walshe PhD

*Reader in Public Management and Director of Research
Manchester Centre for Healthcare Management, University of Manchester*

Foreword by Professor Joan Higgins and John Wyn Owen CB

A paper summarising the findings of this research into the use and impact of inquiries in the NHS was first published in the *British Medical Journal* in 2002 (BMJ 2002; 325:895-900) and we are grateful to the editor of the BMJ for allowing us to reproduce some of that material in this report.

ISBN 1-902089-76-6
© The Nuffield Trust, 2003

Published by The Nuffield Trust
59 New Cavendish Street
London W1G 7LP

Telephone: 020 7631 8450
Facsimile: 020 7631 8451

E-mail: mail@nuffieldtrust.org.uk

Website: www.nuffieldtrust.org.uk

Charity Number: 209201

Designed by Nicholas Moll Design

Telephone: 020 8879 4080

Printed by The Ludo Press Ltd

Telephone: 020 8879 1881

Contents

Foreword	iv
Executive summary	1
1. Introduction	5
2. Background: the history of NHS inquiries	6
3. The purpose of inquiries	10
4. How and why inquiries are set up	12
5. Inquiry processes and methods	14
6. Inquiry findings, recommendations and impact	21
7. Research issues and policy implications	24
References	26



About the author

Dr Kieran Walshe is Director of Research and Reader in Public Management at the Manchester Centre for Healthcare Management, University of Manchester. He has been a health services researcher and policy analyst for around thirteen years, and worked previously at the University of Birmingham and at the King's Fund in London. He began his career as a manager in the NHS.

His research focuses on issues concerning quality and performance in healthcare organisations, and his current interests particularly concern the role of regulation in healthcare, systems for clinical governance and quality improvement, and the investigation of major organisational failures in healthcare organisations. He has advised the National Audit Office on healthcare matters for some years, and was an expert witness to the Bristol Royal Infirmary Inquiry. In 2000 he was a Commonwealth Fund Harkness Fellow, and spent a year at the University of California at Berkeley researching the regulation of healthcare organisations.

Correspondence to:

Dr Kieran Walshe
University of Manchester, Devonshire House,
University Precinct Centre, Oxford Road,
Manchester, M13 9PL, UK.
Tel: [0161] 275 3852. Fax: (0161) 273 5245.
Email: kieran.walshe@man.ac.uk

Foreword

The number of inquiries into failures of care in the NHS has increased markedly in recent years. The early inquiries date back to the late 1960s and the consistent patterns of failure, which have been revealed over more than 3 decades, are striking. They raise major challenges for public policy and for the protection of individuals in public care. This paper asks about the purposes of inquiries; it looks at the different types of inquiry which have been established and at the methods and processes used. It also explores the results of inquiries and the changes in policy which have arisen from their recommendations. Some of these inquiries have examined high profile cases, which attracted great publicity, while others have escaped the glare of national attention. Nevertheless, all of them are important for what they tell us about the quality of care provided to individuals in the NHS.

This paper argues that it is vital to examine the ways in which we conduct inquiries. They consume vast resources (particularly financial and human) and it is important that they satisfy their purpose in the most appropriate way. It concludes that there is more we can learn from failures of care, in the past, in order to improve the health service of the future.

John Wyn Owen CB
Secretary
The Nuffield Trust

Professor Joan Higgins
Director and Professor of Health Policy
The Manchester Centre for Healthcare Management

Executive summary

THIS PAPER EXPLORES the use of inquiries in the NHS. It presents an overview of their history and development; describes their purposes and how and why they are set up; discusses the models, methods and processes that inquiries use; and reviews how their findings and recommendations are used. It concludes by outlining some lessons for policymakers and other stakeholders in the NHS, which might inform the design and conduct of future inquiries and further research in this area.

The development of NHS inquiries

An inquiry is a retrospective examination of events or circumstances, specially established to find out what happened, understand why, and learn from the experiences of all those involved. It can be in public or in private; may be independent of those who established it; may have some judicial powers to summons witnesses and gather evidence; and usually reports formally to whomever commissioned it, though its findings may also be of interest to a wider audience. Over the last 30 years there have been many inquiries in the NHS, most of them of limited scale and scope and of largely local interest, though some have addressed important issues of national significance and received widespread public and media attention. No complete chronology of inquiries is available.

A number of trends in the use of inquiries in the NHS can be identified. Firstly, the numbers and scope of inquiries is increasing. In the last three years there have been five major inquiries - into security and other issues at Ashworth Hospital; pathology services at Alder Hey Hospital; the conduct of gynaecologist Rodney Ledward; paediatric cardiac services at the Bristol Royal Infirmary; and the activities of general practitioner Harold Shipman. Secondly, inquiries have increasingly become concerned with issues to do with the clinical performance of doctors and other health professionals, often in acute care areas. Thirdly, the conduct of inquiries has become more open and more formalised. Problems which in the past might have been dealt with internally, or in private are now more likely to be examined independently and externally, and made public. Fourthly, there is considerable duplication between inquiries and many events have been the subject of more than one inquiry.

There have been a number of important developments in recent years which will affect the current and future conduct of NHS inquiries. The Commission for Health Improvement has been established, with a formal remit to investigate serious instances of failure in the NHS; systems for professional self-regulation are being comprehensively reformed; and new NHS agencies responsible for patient safety and clinician performance have been created.

The purpose of inquiries

Inquiries are established to serve many purposes, which can be summarised under six main headings:

- Establishing the facts - providing a full and fair account of what happened
- Learning from events - and so helping to prevent their recurrence
- Catharsis or therapeutic exposure - providing an opportunity for reconciliation and resolution
- Reassurance - rebuilding public confidence after a major failure
- Accountability, blame and retribution - holding people and organisations to account
- Political considerations - serving a wider political agenda for government

Major public inquiries are set up by government, through powers set out in various statutory legislation, but many inquiries are also commissioned by other NHS organisations. Often, inquiries are triggered by an egregious event which demands some action be taken, and results in a high level of media attention or considerable pressure from patients, families or other groups. However, three main criteria for establishing an inquiry can be identified:

- Serious harm or loss to patients has occurred
- New or poorly understood issues of concern exist
- There is widespread public concern and loss of confidence

Inquiry methods and processes

There is enormous variation in the nature of inquiries - from, at one end of the spectrum, a small scale internal investigation in an NHS trust carried out by a panel of executive and non-executive directors with some external advice from, for example, one of the medical Royal Colleges; to, at the other end of the spectrum, a full-scale statutory public inquiry chaired by an eminent lawyer with a panel of experts, equipped with huge legal and other resources, which reports to the Secretary of State and to Parliament. In broad terms, we can identify four main types of NHS inquiry:

- An internal NHS management inquiry, usually commissioned by an NHS trust, health authority or the NHS Executive and carried out by an NHS panel with a limited degree of independence from the matters being investigated.
- A Commission for Health Improvement investigation, which may be initiated by CHI in response to concerns from a wide range of sources or through a request from the Department of Health.

- An external private NHS inquiry, usually commissioned by the Department of Health, the NHS Executive or a regional health authority and carried out by an independent (non-NHS) chair and panel.
- A statutory public inquiry, set up by the Secretary of State for Health under s84 of the NHS Act 1977 or by Parliament under s1 of the Tribunals of Inquiry (Evidence) Act 1921.

Whichever model is adopted, an inquiry should aim to be open, fair and rigorous, and to follow procedures which reflect its purpose. Only statutory public inquiries are fully open, in the sense that both inquiry proceedings and reports are in the public domain. While private inquiries may have some advantages when dealing with sensitive or delicate matters, there is a growing societal and legal expectation that inquiries should be open. Most inquiries are inquisitorial, and the inquiry chair and members have responsibility for ensuring fairness and due process, and ensuring that the rights of participants are not infringed. Each inquiry is different, and few arrangements exist either to carry learning and the inquiry process over from one inquiry to another, or to set common standards for how inquiries are carried out.

Inquiry findings, recommendations and impact

The primary output of most inquiries is usually seen as its report. Few reports are brief, and some are very lengthy, and most make many recommendations. The report is formally made to whomever commissioned the inquiry - most commonly Parliament, the Secretary of State for Health, the Department of Health or an NHS organisation. However, since most inquiry reports are published they have many other audiences as well, such as other NHS organisations, clinical professionals and managers, politicians, the media and the general public. Inquiries rely on their credibility and persuasive power to achieve change - they have no formal powers or authority at all. For this reason, effective communication and dissemination are very important. Few people will actually read the full report themselves, so executive summaries, digests and press reports are their main source of information. The inquiry process itself can also have considerable influence, and in some cases may be viewed as just as important as the report which is its outcome.

Many inquiries produce similar findings about the causes or reasons for failure, even when they are focused on quite different clinical areas. Five common themes in reports are:

- Organisational or geographic isolation which inhibits the transfer of innovation and inhibits peer review and constructive critical exchange
- Inadequate leadership, lacking vision and unwilling to tackle known problems
- System and process failure - in which organisational systems and processes are either not present at all or not working properly
- Poor communication both within the NHS organisation and between it and patients or clients, which means that problems are not picked up

- Disempowerment of staff and patients/clients which means that those who might have raised concerns were discouraged or prevented from doing so

There are few formal mechanisms for following up the findings and recommendations of inquiries. Responsibility for implementation generally rests with whoever commissioned the inquiry in the first place.

Research issues and policy implications

The way that inquiries are used in the NHS is changing rapidly, and demand for statutory public inquiries is growing. However, such inquiries should be seen as a last resort, to be used only when other faster and less costly approaches will not work. In the future, internal NHS inquiries and private NHS inquiries seem likely to be used less. Commission for Health Improvement investigations seem likely to be used much more frequently, and to offer an important continuity of investigatory expertise which has been lacking in the past.

The use of inquiries in the NHS has not been widely researched - the last major study in this area was undertaken in the early 1980s - and this overview of the issues has identified a pressing need for work in a number of areas:

- What can we learn from the processes used in previous inquiries, about what works best? How can public resources be used to best effect in pursuing inquiries? A retrospective review of past inquiries, their methods, processes, reports and recommendations would provide information about the incidence of inquiries in the past which is not currently available, and would produce a structured, comparative and longitudinal analysis of inquiry methods and results.
- How can we engage the public and key stakeholders such as patient organisations, professional bodies and NHS organisations in a debate about the size, scope and nature of future inquiries? A qualitative study of the use of inquiries would draw on the extensive recent and current experience of major inquiries in the NHS (see table 1), using interviews with inquiry members and staff, participants (such as witnesses and observers) and other stakeholders, and could help to promote a greater dialogue about the future use of inquiries.
- What models of inquiry are suitable in what circumstances, and what criteria should be used to determine whether an inquiry is needed and what kind of inquiry is indicated? A comparative review of different models of inquiry, looking both at experience in the NHS and at non-health and non-UK practices and models, would provide an informed analysis to support future decisions about the design and remit of future inquiries in the NHS.

In conclusion, the NHS is making more use of inquiries than ever before. Examining instances of major failure in the NHS through inquiries or investigations, though sometimes a painful and difficult process, can undoubtedly contribute to future improvement. However, 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.

1. Introduction

IN THE LAST FEW YEARS, the NHS has been the subject of a series of major inquiries. Established to investigate poor clinical performance, service failures or even criminal misconduct, inquiries have become increasingly commonplace as a governmental or managerial response to problems in the health service. This trend might be seen as evidence of greater transparency and openness in government and public management; or as a sign of changes in the public consciousness and in public expectations of professional accountability; or as a political response to difficulties in the health service, intended to diffuse or divert responsibility. While there is a long history of inquiries in the NHS¹ going back over thirty years, the last few years have seen a significant increase in their number, size and scope, which in turn has generated a growing debate about the purposes, methods, costs and effects of NHS inquiries.²

This paper explores the use of inquiries in the NHS. It presents an overview of their history and development; describes their purposes and how and why they are set up; discusses the models, methods and processes that inquiries use; and reviews how their findings and recommendations are used. It concludes by outlining some lessons for policymakers and other stakeholders in the NHS, which might inform the design and conduct of future inquiries and further research in this area. The paper draws extensively on discussions at an invitational seminar about NHS inquiries which was hosted by the Nuffield Trust and conducted under the Chatham House rule.³

2. *Background: the history of NHS inquiries*

OVER THIRTY YEARS AGO in July 1967, serious allegations of abuse and ill-treatment of vulnerable, long-stay patients at the Ely Hospital in Cardiff led the Secretary of State for Health and Social Security, Richard Crossman, to establish an independent inquiry through the Welsh Hospital Board, chaired by Geoffrey Howe. Earlier similar allegations of widespread failings in long term care⁴ had been examined rather cursorily and dismissed rather too readily.⁵ The Ely Hospital inquiry report,⁶ produced in 1969, is often seen as the first modern inquiry into the NHS. It confirmed the truth of the allegations and described problems of poor clinical leadership, an isolative and inward-looking culture, inadequate management structures and systems and inadequate resources in terms which eerily parallel the findings of the public inquiry into paediatric cardiac surgery at the Bristol Royal Infirmary, published this year.⁷ The Ely Hospital report was followed by (and can be argued to have precipitated) a succession of similar inquiries during the 1970s into serious failings at other long-stay institutions for people with learning difficulties, the elderly, and the mentally ill - Farleigh, Whittingham, Napsbury, South Ockenden, Warlingham Park, Darlington, St Augustine's, Normansfield and many others.¹

An inquiry is a retrospective examination of events or circumstances, specially established to find out what happened, understand why, and learn from the experiences of all those involved. It can be in public or in private; may be independent of those who established it; may have some judicial powers to summons witnesses and gather evidence; and usually reports formally to whomever commissioned it, though its findings may also be of interest to a wider audience. Since the Ely Hospital inquiry and its successors, there have been many other internal and external inquiries into failures or problems in the NHS over the years - most of them of limited scale and scope and of largely local interest, though some have addressed important issues of national significance and received widespread public and media attention. There is no complete chronology of such inquiries available, but table 1 below provides a structured summary of some of the major inquiries in the NHS between 1969 and 2001. For ten examples, it outlines the issues investigated, the initiation and method of inquiry, and the findings and recommendations which resulted.

Table 1. A selection of major inquiries in the NHS from 1969 to 2001.

Date	Issues investigated	Inquiry details	Findings and recommendations
1969	Ill treatment, abuse and neglect of long stay patients at Ely Hospital in Cardiff in 1967.	Committee of Inquiry set up by Welsh Hospital Board, chaired by Geoffrey Howe QC. Conducted in private, evidence given in confidence, no powers to summon witnesses. Held 15 days of hearings, 52 witnesses, transcript of hearings was 1,029 pages. Inquiry took about 16 months.	Allegations generally found to be well justified, and a result of poor staff training, little leadership, low clinical standards and resource constraints. Made 44 recommendations including the setting up of an independent hospitals inspectorate. ¹
1978	Allegations of poor care, conflict and breakdown of working relationships at Normansfield Hospital for learning disabilities in Middlesex in mid 1970s.	Committee of inquiry set up by the Secretary of State under s70 of the NHS Act 1946. Had 124 days of hearings, 145 witnesses, transcript of hearings was 14,856 pages. Inquiry took over a year to complete.	Allegations generally found to be justified. History of conflict between consultant in subnormality and many other staff, culminating in a strike. Long history of problems not addressed by inadequate senior management. Made recommendations including many staff changes.
1986	Deaths from food poisoning of 19 elderly patients at Stanley Royd Hospital, Wakefield in 1984.	Public inquiry set up under s84 of NHS Act 1977 chaired by J Hugill QC. Conducted in public, with power to summons witnesses. Had 32 days of hearings, 113 witnesses (and a further 77 who gave written statements only), considered 15,000 pages of documents. Inquiry took 14 months.	Problem found to result from failure in basic food hygiene, resulting from poor staff training and supervision. Made 25 recommendations to improve catering management, strengthen inspection, and plan more effectively for infectious disease outbreaks. ⁸
1992	Deaths and injuries to children at Grantham and Kesteven Hospital in 1991 caused by enrolled nurse Beverley Allitt.	Private inquiry commissioned by Secretary of State and Trent Regional Health Authority and chaired by Sir Cecil Clothier QC. Conducted in private with no formal powers. Had 35 days of hearings, 94 witnesses, and considered "thousands" of documents. Inquiry took 11 months.	Found failings in management and leadership at the hospital, which permitted Allitt's crimes and delayed detection. Made 13 recommendations concerning health screening for clinical staff, the role of coroners, and the monitoring of untoward events."
1994	Care and treatment of Christopher Clunis, a mentally ill man who killed Jonathan Zito in a chance encounter in London in December 1992.	Private inquiry commissioned by North East Thames and South East Thames Regional Health Authorities and chaired by Jean Ritchie QC. Conducted in private with no formal powers. Held hearings over a 5 month period and received evidence from 143 witnesses. Inquiry took 7 months.	Found a "catalogue of failure and missed opportunities" in communication between professionals/agencies, resource shortages and management of care. Made 82 recommendations for better assessment of patients' needs, care planning and coordination, and interagency liaison."
1999	Serious breaches of security and illegal activities at Ashworth High Security Hospital in 1995-6.	Public inquiry set up under s84 of NHS Act 1977 chaired by Peter Fallon QC. Conducted in public, with power to summons witnesses. Had 69 days of hearings. Inquiry took 23 months.	Allegations of major failings generally supported, and problems of dysfunctional management found. Made 58 recommendations including that Ashworth should close, and major changes in high security/forensic psychiatry services should be made. "

Date	Issues investigated	Inquiry details	Findings and recommendations
2000	Removal, retention and disposal of human tissue and organs from children after death at the Royal Liverpool Children's Hospital (Alder Hey).	Independent confidential inquiry set up under s2 of NHS Act 1977 chaired by Michael Redfern QC. Hearings conducted in confidence. Had 6 weeks of hearings, with 120 witnesses, scrutinised 50,000 pages of documents. Inquiry took 14 months	Serious failings in clinical practice and managerial arrangements found. Made 67 recommendations covering changes to NHS/university structures, coroners' role and function, consent arrangements and wider systems for dealing with the bereaved. ¹²
2000	Serious failures in the clinical practice of Rodney Ledward at the South Kent Hospitals NHS Trust 1990-96.	Independent confidential inquiry commissioned by the Secretary of State and chaired by Jean Ritchie QC. Hearings conducted in confidence with no powers to summons witnesses or evidence. Heard from over 160 patients and many other witnesses. Inquiry took 14 months.	Clinical failings documented and confirmed. Made 103 recommendations for changes to quality systems in the NHS and private sector, and consultant appraisal and disciplinary procedures. ¹³
2001	The management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995.	Public inquiry set up under s84 of NHS Act 1977 chaired by Professor Ian Kennedy. Conducted in public with powers to summons witnesses. Had 96 days of hearings, with 577 witnesses (many submitted written statements), examined 900,000 pages of documents including 1,800 patients' medical records. Also held 7 seminars. Inquiry took 2 years 9 months.	Found serious clinical and organisational failings and concluded that 30-35 more children had died than would have if BRI service had met standards elsewhere. Made 198 recommendations regarding service organisation, leadership, safety, professional competence, public involvement and the care of children. ⁷
2001	The conduct of Dr Harold Shipman, a general practitioner in Hyde, Derbyshire who was convicted in Jan 2000 of murdering 15 patients.	Public inquiry set up under section 1 of Tribunals of Evidence (Inquiries) Act 1921 chaired by Dame Janet Smith. Conducted in public with powers to summons witnesses. Inquiry commenced in February 2001 and will have three phases.	The inquiry is expected to report in 2003. ¹⁴

Some important trends or changes in the use of inquiries in the NHS can be identified from this review of past practice. Firstly, it appears that both the numbers of inquiries and their scale and scope seems to have increased. Most obviously, the recent major inquiries listed in table 1 - Alder Hey, Bristol, Ledward and Shipman - have been huge undertakings, and have received extensive media attention both during their proceedings and when their reports have been published. More such inquiries seem likely to follow in the future when significant clinical failures in the NHS come to light - for example, in cases such as those of surgeons Richard Neale¹⁵ and Steven Walker.¹⁶ Secondly, the focus of inquiries seems to have shifted, from non-clinical issues like abuse or neglect in low-profile areas like long term care; to more clinical issues like the quality of surgical practice in higher-profile areas like acute services. Thirdly, it seems that the nature of inquiries has been changing, with an increasing demand for formality,

rigour and transparency in the way they work. In the past, many inquiries were internal affairs, took place in private, worked relatively rapidly and informally, had limited formal powers to gather evidence, and did not publish the evidence they have considered. Some inquiry reports were not even published, or were not published in full. Now, there seems to be a justifiable belief that internal inquiries are not sufficiently objective or detached from the issues being investigated, and those who carry them out lack appropriate investigatory skills and expertise. There is a growing public and professional expectation that inquiries should be more formally constituted, take place in public, and publish their reports in full - all of which probably means that they cost more and take longer. Fourthly, it is evident that there is considerable overlap and duplication between different types and forms of inquiry. Some overlap is probably inevitable - for example, an incident may be the subject of a coroner's inquiry, a police investigation, and an inquiry by a professional regulatory body such as the General Medical Council, all of which serve different and legitimate purposes. However, all the recent major inquiries listed in table 1 were preceded by other internal and external NHS inquiries which covered substantially the same ground and often reached similar conclusions.

There have also been important legislative and policy developments over the last few years which affect the use and conduct of inquiries in the NHS. Firstly, the Commission for Health Improvement was established as a new non-departmental public body by the Health Act 1999 with a statutory remit to investigate serious instances of failure in the NHS.¹⁷ CHI has already conducted five such investigations and published its reports, and two more are in progress.¹⁸ Secondly, a wholesale reform of the professional self-regulatory machinery has been set in train, with some major changes to regulatory arrangements already introduced and further changes aimed at making the regulatory bodies more accountable and increasing oversight of their work now being proposed.¹⁹ Thirdly, two new NHS authorities have been created - the National Patient Safety Agency to manage a national adverse event reporting system which will collect information on clinical failures and problems,²⁰ and the National Clinical Assessment Authority which will provide support and assessment services to help deal with problems of poor clinical performance.²¹ The Department of Health has recognised the case for rationalising the use of inquiries in the NHS, has proposed some changes to reduce duplication and inconsistency, and has indicated that it will issue further guidance on this matter.²⁰

3. *The purpose of inquiries*

INQUIRIES SERVE A NUMBER OF PURPOSES. Some of those involved in undertaking past inquiries have written about their purpose or objectives, and the framework set out below tries to draw together their ideas^{7,22,23,24} under six main headings:

- *Establishing the facts.* One purpose of almost every inquiry is to provide a full, fair and accurate account of the circumstances being investigated, which can then provide a foundation for subsequent actions by the inquiry and by others. For inquiries in which the facts are disputed, where the course or sequence of events is not clear, or where the causation and contribution to what happened is not self-evident, this fact-finding task may be a primary purpose of the inquiry.
- *Learning from events.* Again, almost all inquiries set out to use the events being investigated to synthesise or distil important lessons for the future, often in the form of recommendations for changes in policy or practice. The intention is that by making such changes, the likelihood of future recurrence is reduced or eliminated.
- *Catharsis or therapeutic exposure.* By their very nature, inquiries often investigate issues of high drama and great emotive power - quite literally, matters of life and death. They can bring the protagonists in the events being investigated face to face with each others' perspectives and problems. While this aspect of an inquiry may be painful for some of those involved, and is difficult to manage, it may have a therapeutic value for individuals or a community harmed by the events at the heart of the inquiry. The inquiry may offer a cathartic release, and an opportunity for reconciliation and resolution.
- *Reassurance.* Inquiries play an important role in sustaining or rebuilding public confidence after a major failure in the NHS. By demonstrating that problems have been fully investigated and dealt with, an inquiry can help to reassure patients and the public about the quality of care they will receive in the future. Of course, when inquiries find major underlying problems which are difficult or costly to address, their findings may be far from reassuring.
- *Accountability, blame and retribution.* Although there are other ways in which organisations and individuals can be held to account for their actions (such as employers' disciplinary systems, professional regulatory oversight, civil litigation or even criminal proceedings) it is quite legitimate to see inquiries as an important accountability mechanism, which may be more immediate and accessible than some

of the others listed. More controversially, some stakeholders are likely to see the attribution of blame and fault as part of the inquiry's function, though others may regard this as unfair or unhelpful and best left to some of the other systems mentioned above (such as civil litigation, or professional regulation). By providing a definitive account of events, inquiries may contribute indirectly to the blaming process by providing evidence for other systems to use. Beyond blame, lies retribution in which individuals or organisations face punishment or must make amends in some way. Again, inquiries do not exact retribution directly (though appearing before an inquiry in the full glare of public attention may be seen by some as a form of retribution) but their results may be used indirectly in this way.

- *Political considerations.* Most major inquiries (and all statutory public inquiries) are established by government, and it would be naive to ignore the political purposes they may serve. For example, setting up an inquiry may be seen as an effective way to defuse tensions and concerns over an issue, and show that "something is being done". By the time that the inquiry reports, the political importance of its subject may have reduced. Alternatively, establishing an inquiry could also be construed as a way to keep an issue on the political agenda through continuing media attention, and to provide government with leverage to pursue particular policies. In these and other ways, inquiries may have an explicit or implicit political purpose.

Of course, some of these purposes are likely to conflict. It may also be worthwhile considering what purposes an inquiry is not well suited to serve. Most obviously, an inquiry should not be a substitute for other more appropriate forms of investigation such as a disciplinary hearing, a coroner's or police investigation, or a professional regulatory body inquiry.

4. *How and why inquiries are set up*

MOST MAJOR NHS INQUIRIES have been formally commissioned by the Department of Health. Statutory inquiries are formally established by a motion of both Houses of Parliament under the Tribunals of Inquiry (Evidence) Act 1921 or by the Secretary of State under the NHS Act 1977. In the past, the NHS Executive and regional health authorities also played an important role in initiating inquiries, and many smaller scale or more local inquiries have been commissioned by health authorities and NHS trusts themselves.

The decision to establish an inquiry - particularly a major one - is often acutely political in nature. Politicians, policy makers, civil servants and NHS managers tend to view inquiries with considerable caution, because they can be a mixed blessing. On the one hand, in the short term they often defuse the tension and concern over the problems to be investigated. Moreover, in the longer term inquiry proceedings and their reports can provide important leverage to secure change. On the other hand, the relative independence of most inquiries means that their findings can rebound on their commissioners. Inquiries can bring to the fore unwelcome evidence, make deficiencies explicit, and produce recommendations which are costly and difficult to implement.

Many inquiries are triggered by an egregious event - something which because it is so obviously harmful, dangerous or troubling forces those responsible to face the wider problem which the event signals. For example, it might be argued that the sequence of events which led to the public inquiry into paediatric cardiac surgery in Bristol was triggered by the death of one child in particular - Joshua Loveday.²⁵ Some inquiries are probably initiated because extensive and continuing media attention to the event demands a political or managerial response. In some cases, patient and family representatives or groups campaign either to secure an inquiry or to influence its format and terms of reference, and may be successful in doing both. It is therefore inevitable that some inconsistency in decision-making results, and inquiries may be more likely to be established in some more high-profile and acute-care oriented areas of the NHS than in other more prosaic or less visible areas, regardless of merit.

Even so, it is possible to identify some criteria which can be used to help determine whether an inquiry of some form is worthwhile. Some established rules or guidelines exist in government²³ which speak of needing an inquiry because of "the gravity of the incidents and the belief that both the public anxiety they cause and the interests of the

victims can only be satisfied by such an inquiry. In some cases public confidence may be undermined if there is not a perception that an inquiry is full, wide ranging and independent of government." The Department of Health itself suggests that an inquiry should be considered "where a service failure results in serious harm to larger numbers of patients, where there is serious national concern, or where a major issue of ethics or policy is raised for the first time by an incident."²⁰ Lord Justice Clarke, in his report on the Marchioness disaster, discusses the rationale for past decisions to commission inquiries and concludes that their justification revolves around the exercise of the public interest. He argues that "a public inquiry should only be ordered in exceptional cases. Public inquiries are very expensive in terms of time and money and in very many cases the facts can be established and lessons learned without such an inquiry."²⁴

In these and other observations, three main reasons for setting up an inquiry can be discerned:

- *Serious harm or loss to patients or services.* Most inquiries are focused on circumstances in which serious harm has been done to a number of patients, or NHS services to patients have been severely disrupted in ways that directly or indirectly impact on patient care.
- *New or poorly understood issues of concern.* Inquiries are often a response to unusual or novel circumstances or to events which are difficult to understand. The inquiry can then be seen to be seeking new knowledge or lessons from those events which can be used elsewhere. If a very similar problem happens again elsewhere, it is less likely to be seen as a candidate for an inquiry because the scope for learning is less.
- *Widespread public concern and loss of public confidence.* If a problem has been the subject of extensive media attention, perhaps because of the scale of harm or loss to patients or the nature of the performance failure which caused it, then an inquiry may be needed simply to deal with the resulting public anxiety and concern by demonstrating that a "full, fair and fearless"²⁴ investigation is taking place.

The balance of these three justifications, and their relative importance, goes some way to determining not just whether an inquiry is needed, but what form it will take, which is discussed in more detail below.

5. *Inquiry processes and methods*

THERE IS ENORMOUS VARIATION in the nature of inquiries - from, at one end of the spectrum, a small scale internal investigation in an NHS trust carried out by a panel of executive and non-executive directors with some external advice from, for example, one of the medical Royal Colleges; to, at the other end of the spectrum, a full-scale statutory public inquiry chaired by an eminent lawyer with a panel of experts, equipped with huge legal and other resources, which reports to the Secretary of State and to Parliament. In broad terms, we can identify four main types of NHS inquiry:

- An internal NHS management inquiry, usually commissioned by an NHS trust, health authority or the NHS Executive and carried out by an NHS panel with a limited degree of independence from the matters being investigated.
- A Commission for Health Improvement investigation, which may be initiated by CHI in response to concerns from a wide range of sources or through a request from the Department of Health.
- An external private NHS inquiry, usually commissioned by the Department of Health, the NHS Executive or a regional health authority and carried out by an independent (non-NHS) chair and panel.
- A statutory public inquiry, set up by the Secretary of State for Health under s84 of the NHS Act 1977 or by Parliament under s1 of the Tribunals of Inquiry (Evidence) Act 1921.

Table 2 provides a comparative analysis of these four main models of inquiry - showing an example of each one, and describing their legal authority and powers, panel membership and support, proceedings, reporting arrangements, timescale, cost and other characteristics.

Table 2. A comparison of different models of inquiries.

Type of inquiry	Internal NHS management inquiry	Commission for Health Improvement	External private NHS inquiry investigation	Statutory public inquiry
<i>Example</i>	Inquiry into the conduct of research trials in North Staffordshire Hospital NHS Trust (chaired by Professor Rod Griffiths) ²⁸	Inquiry into abuse and neglect of elderly patients at Garlands Hospital in Cumbria, managed by Lakeland Healthcare NHS Trust ²⁷	Inquiry into deaths and injuries to children at Grantham and Kesteven Hospital in 1991 caused by enrolled nurse Beverley Allitt (chaired by Sir Cecil Clothier) ⁹	Inquiry into the management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995 (chaired by Professor Ian Kennedy) ⁷
<i>Legal authority</i>	None beyond general powers of section 2 of NHS Act 1977	Section 20 of Health Act 1999.	None beyond general powers of section 2 of NHS Act 1977	Section 84 of NHS Act 1977 or section 1 of Tribunals of Inquiry (Evidence) Act 1921
<i>Specific legal powers of inquiry</i>	None	Limited statutory powers to require evidence from NHS organisations/staff	None	Wide statutory powers to gather evidence and require witnesses to appear. NHS Act inquiries limited to NHS issues, while TI(E) Act inquiries have no such limits
<i>Inquiry lead and panel</i>	Usually led by a senior NHS manager or clinician, often from another NHS organisation, along with some external assessors/experts	Led by CHI medical director and investigations manager, along with external assessors drawn from other NHS and related organisations	Usually led by a legally qualified and experienced person (QC, judge etc) sitting with external assessors with relevant content knowledge	Generally led by a legally qualified and experienced person (QC, judge etc) usually sitting with external assessors with relevant content knowledge
<i>Secretariat and support</i>	Drawn from the organisation itself - eg health authority or NHS Executive. Limited resources	Provided by CHI investigations staff and resourced by CHI.	Established by inquiry chair. Secretary is usually seconded civil servant or NHS manager. Usually well resourced	Established by inquiry chair. Secretary is usually seconded civil servant. Well resourced
<i>Legal support or expertise</i>	Usually limited or no legal expertise and support	No expertise on inquiry team, but advice provided by Treasury solicitors	Usually have legal expertise on inquiry panel, plus in-house legal staff	Usually have legal expertise on inquiry panel, plus in-house legal staff
<i>Time taken</i>	Variable, from a few days to a few months	Six to nine months	One to two years	Two years or more
<i>Cost</i>	Low - a few thousand pounds	Medium - cost of about £150-200k	Medium to high - from £200k upwards	High - cost measured in millions of pounds
<i>Proceedings</i>	Conducted in private, usually without specific rules or procedures	Conducted in private following CHI's own procedural guidelines	Hearings conducted in private or in public at discretion of inquiry chair	Hearings conducted in public following rules set down by inquiry chair, though may choose to hear some witnesses in closed session

Type of inquiry	Internal NHS management inquiry	Commission for Health Improvement	External private NHS inquiry investigation	Statutory public inquiry
<i>Reporting and publication</i>	Report may or may not be published in part or in full; evidence not published	Evidence taken in private and remains confidential but report is published	Reports to Secretary of State. Report then generally published in full, but may not be	Reports to Secretary of State and Parliament. Full report published, and often most or all evidence
<i>Status of findings and recommendations</i>	Addressed to NHS organisation which commissioned inquiry	Addressed to Secretary of State and relevant NHS organisations	Addressed to Secretary of State. Department of Health usually issues a formal response	Addressed to Secretary of State and Parliament. Department of Health issues a formal response

It seems self-evident that an inquiry should set out to be open, fair and rigorous and should follow procedures which reflect the purpose set out in its terms of reference. But translating those principles into practice can be complex. These three key objectives - openness, fairness and rigour - are each discussed below, and then some of the advantages and disadvantages of the four different models of inquiry are summarised.

Openness

Only in the statutory public inquiry - the largest, longest and most expensive of the four models described in table 2 - are the proceedings and report fully in the public domain. In each of the other three models, part or all of the inquiry process takes place in private and in some the report may not be published in full. Some eminent and experienced inquiry chairs would argue that private inquiries are more effective as investigatory tools, allowing witnesses to give evidence and speak frankly without the fear of disclosure or public attention. They are also likely to be less costly, and somewhat quicker. However, for many stakeholders including patients and their families as well as healthcare staff and their representatives or professional organisations, private inquiries do not satisfy the need for public scrutiny, and the lack of transparency leads to distrust of the inquiry process and its results. Anyone likely to be criticised in an inquiry may feel their ability to respond and defend themselves is hampered by proceedings being held in private. It is unlikely that a private inquiry can achieve the cathartic effect or therapeutic exposure which was discussed earlier as one of several purposes for inquiries. In the past, the courts have supported the use of private inquiries in the NHS so long as they could be shown to be conducted fairly.²⁸ However, in an important legal ruling in 2000,²⁹ families of the victims of Dr Shipman and media organisations were successful in overturning the Secretary of State for Health's decision to hold the Shipman inquiry in private because to do so would not be consistent with legitimate expectations based on past practice and precedent in such inquiries, and would also breach article 10 of the European Convention on Human Rights (incorporated into British law by the Human Rights Act 1998) which deals with freedom of expression including the freedom to receive and impart information. In

2001, an application to the High Court for judicial review of the Home Secretary's refusal to establish an inquiry into the death of a prisoner in custody was successful, and the court ruled that "an obligation to procure an effective official investigation arises by necessary implication in articles 2 and 3" of the European Convention on Human Rights [which deal with the right to life and to be free from inhuman or degrading treatment).³⁰ The inquest into the death was not judged to meet the requirements for such an investigation. These rulings may make it difficult to resist future calls for inquiries into deaths or instances of serious harm to patients in the NHS, and difficult to hold any future major inquiry in private.

Fairness

All the models of inquiry set out above are inquisitorial, which means that the inquiry chair and its legal counsel frame the issues to be addressed, lead the investigation, call and cross-examine witnesses, select documentary evidence to examine, and so on. It has been suggested that this inquisitorial approach helps the inquiry to get at the truth while avoiding it becoming a kind of substitute court with an adversarial, confrontational style of interaction and complex legal rules and protocols. It represents a more managed and interventionist style of judicial process which may be more efficient and effective, but is also somewhat at odds with the prevailing approach in the British legal system.³¹ Large public inquiries often involve an uneasy combination of the inquisitorial approach with some aspects of the traditional adversarial format for legal proceedings. For example, the legal representatives of interested parties to the inquiry may be allowed to cross-examine witnesses as well as the inquiry's own legal counsel, to a limited extent. Though the inquisitorial approach seems to serve the investigatory purpose of an inquiry very well, and there are established procedures for protecting the interests of individuals affected by an inquiry,^{32,33} there are still times when the process of investigation can seem to conflict with the need for justice and due process.²²

To the non-lawyer, the legal complexities of inquiries can seem daunting, especially when there are parallel investigations being undertaken by other bodies such as the police or the General Medical Council. Ensuring that the inquiry adheres to due process and the rules of natural justice and that the rights of witnesses and other stakeholders are not infringed or prejudiced demands at the very least some legal support and advice, and probably considerable legal expertise. If problems arise, inquiry proceedings are open to judicial review, and a number of such legal challenges have been mounted in the past. Partly for this reason, most major NHS inquiries have been chaired by a senior Queen's Counsel or high court judge. However, there is a risk that the legal background and mindset of the inquiry chair can result in a subtle juridification of the inquiry itself through the procedures it adopts and the way it works. As Kennedy noted, the inquiry is "not a trial - it is an inquiry into events which is held in public... it is perfectly possible to conduct a public inquiry with the most careful attention to the legal requirements of fairness without having to behave like a court."⁷

Rigour

It is evident from table 1 that major public inquiries involve a huge commitment of time and resources, conduct an exhaustive review of available evidence, and make use of a wide range of different qualitative and quantitative methods. However, sheer scale of investment is no guarantee of methodological rigour, nor of the Tightness of findings and recommendations. Inquiry reports tend to be taken at face value and read with considerable respect, and their findings often carry considerable weight. Even so, the methodology of inquiries deserves more discussion and might be more contested than it generally is.

There are no accepted standards or guidelines defining how an inquiry should be undertaken. Each public inquiry establishes its own rules of procedure, and its approach is very much shaped by its chair and secretariat. Those conducting inquiries may have little previous experience of such endeavours - few people are involved in more than one or two major inquiries, and there is no standing secretariat in government to support inquiries and provide continuity from one inquiry to another. For these reasons, it is hard to see how learning from the conduct of one inquiry contributes to the design and conduct of future inquiries, and there seems to be no mechanism to assure the quality of the inquiry process. One notable exception is the Commission for Health Improvement, which has begun to develop guidelines for the initiation and management of its investigations, and whose standing remit to conduct investigations should allow it to build up considerable in-house expertise.

It may be helpful to think of inquiries as case studies in failure - in which events in a single organisation or setting are examined and used to draw wider lessons for the NHS. There is a well established tradition of case study research in health services³⁴ and frameworks which have been developed for evaluating the quality of case studies³⁵ may be of some help in both designing and reviewing inquiries. Most obviously, case study methods are open to challenge on the generalisability or transferability of their findings. Inquiry reports tend to extrapolate their findings quite readily to the rest of the NHS, on a presumption that similar circumstances or problems elsewhere are likely to exist. However, inquiry methodologies often seem to lack a wider, epidemiological dimension, in which the prevalence or incidence of those circumstances in the wider NHS is considered, and the issues of generalisability and transferability are not usually explicitly addressed by inquiry reports.

In more general terms, it is not unreasonable to expect that inquiries should conform with the standards expected of any primarily qualitative methodology. The credibility, dependability and confirmability³⁶ of inquiry findings should be assessed, and the risks that the preconceptions and biases of inquiry chairs and panels shape their reports need to be more widely considered.

Advantages and disadvantages of different models of inquiry

Each model of inquiry has different potential advantages and disadvantages, some of which are summarised in table 3. For example, internal NHS inquiries certainly cost the least and are the fastest to report, but they lack independence (or the appearance of independence), transparency and rigour. Those who conduct such inquiries may not have sufficient investigatory expertise and have rarely had much legal support or advice. The findings from such inquiries are easily called into question on grounds of procedure and process, and are unlikely in controversial or sensitive areas to produce findings which command widespread support.³⁷ The Department of Health has already indicated that the use of such internal inquiries in the future should be confined to straightforward issues of limited, local interest only, or to scoping the need for an inquiry of another kind.²⁰

Table 3. A comparison of the main advantages and disadvantages of different models of inquiry.

Type of inquiry	Advantages	Disadvantages
<i>Internal NHS management inquiry</i>	<ul style="list-style-type: none"> • Can be set up and report quickly • Low cost, can often be conducted from within existing resources and with seconded existing staff 	<ul style="list-style-type: none"> • Lacks independence from NHS organisations and professions being investigated • May not have trust of patients and other user groups, unlikely to have finding accepted if controversial • Closed process conducted in private, not transparent or open • Inquiry team may lack skills and experience needed, so method may lack rigour • No powers - relies on co-operation of all stakeholders • Report not necessarily published in full or even at all
<i>Commission for Health Improvement investigation</i>	<ul style="list-style-type: none"> • Has accumulated expertise in investigation methods and processes • Some legal powers - can require NHS organisations to co-operate • Relatively quick and low to medium cost • Report published in full 	<ul style="list-style-type: none"> • Closed process conducted in private, not transparent or open • May not be seen as sufficiently independent of NHS • No powers over non-NHS bodies or individuals - relies on their co-operation
<i>External private NHS inquiry</i>	<ul style="list-style-type: none"> • May find out more by dealing with sensitive or delicate matters in private • Generally seen as independent and fair, though this may depend on chair and circumstances 	<ul style="list-style-type: none"> • Closed process conducted in private, not transparent or open • No legal powers - relies on cooperation of all stakeholders
<i>Statutory public inquiry</i>	<ul style="list-style-type: none"> • Provides the most exhaustive and comprehensive exploration of events • Generally accepted to be independent and fair • Conducted entirely in the open, with both evidence and report published • Gains public and media attention for findings and recommendations 	<ul style="list-style-type: none"> • Generally slow and very costly • Highly dependent on inquiry chair and panel, both in methods adopted and findings and recommendations

Turning to the inquiries or investigations carried out by the Commission for Health Improvement, it seems from the limited track record to date that there is reason to see its role and approach as a distinct improvement on past practice. CHI is likely to build up a significant level of experience in undertaking investigations which it will carry forward from one inquiry to another. It has access to a wide body of clinical and other expertise in the NHS, and has the necessary legal support and advice as well. It may be useful to conceptualise CHI as fulfilling the need in the NHS for what have been called "technical inquiries"²³ in other settings - akin to the statutory investigatory functions for major incidents in other areas which are held by bodies such as the Marine Accident Investigation Branch, the Air Accident Investigation Branch, the Railways Inspectorate, the Health and Safety Executive, and so on. Like those organisations, CHI's investigations are currently conducted in private, and even the identities of witnesses can be concealed. Although its reports are in the public domain, the lack of openness and transparency in the inquiry process seems likely to prevent CHI taking on the more important, controversial or sensitive inquiries, and may in any case be subject to future legal challenges.

The third model of inquiry - the external private NHS inquiry - seems likely to be used less in the future than it has been in the past. Although such inquiries have been used very successfully, it seems that the advantages of being conducted in private are increasingly outweighed by the disadvantages. Experienced inquiry chairs seem to concur that the public interest purpose of inquiries can only really be satisfied by conducting such inquiries in public²⁹ and, in any case, attempts to hold major inquiries in private are likely to face legal challenges from patients, families or other interested parties.

The fourth model - the statutory public inquiry - is an expensive, lengthy and hugely demanding investigatory tool which should probably be used quite rarely and reserved for matters of great national importance for the NHS. It can be argued that both the Bristol and Shipman inquiries meet the established criteria for such a public inquiry. However, it cannot be in the public interest for public inquiries to be held whenever a major service failure occurs in the NHS. The familiarity in the public and the media with this mechanism produced by recent experience seems to be leading to far more frequent calls for a public inquiry in circumstances which, in the past, would not have merited such consideration. Some of this demand for statutory public inquiries probably results from perceived deficiencies in the other models of inquiry - particularly a lack of openness, transparency, rigour and independence. It is also worth noting that the legal costs of interested parties (such as patient and family groups) are generally met by government in a statutory public inquiry, but would not normally be covered in other forms of inquiry. This may mean there is a somewhat perverse incentive for some stakeholders to seek a statutory public inquiry rather than other forms of investigation.

6. Inquiry findings, recommendations and impact

THE PRIMARY OUTPUT of most inquiries is usually seen as its report. Few reports are brief, and some are very lengthy, stretching to several hundred pages with many annexes or appendices of supporting information. Virtually all reports make some recommendations - as table 1 shows, the number of recommendations can vary from just 13 to almost 200. The report is formally made to whomever commissioned the inquiry - most commonly Parliament, the Secretary of State for Health, the Department of Health or an NHS organisation. However, since most inquiry reports are published they have many other audiences as well, such as other NHS organisations, clinical professionals and managers, politicians, the media and the general public.

All NHS inquiries rely ultimately on their credibility and persuasive power to secure change. There is a striking contrast between the considerable judicial powers wielded by the chair of a public inquiry when gathering evidence, and the absence of any formal powers whatsoever when it comes to reporting findings and making recommendations. In that light, effective communication and dissemination is clearly essential, targeted on key audiences and structured to present the inquiry findings in ways that will maximise acceptance and uptake. In practice, inquiries seem to focus most of their attention and their resources on the process of the inquiry and the production of its report, which is often very lengthy, comprehensive, densely written and hard to read briefly. They appear to invest much less time and resources in a planned programme of dissemination, or to use innovative or proactive approaches to dissemination. Inquiry reports are not usually directed at the full range of audiences set out above, and are probably not very good tools for communication. In practice, relatively few people are likely to read the reports in full, especially when they run to several hundred pages, and list hundreds of recommendations. Most will read a summary if one is provided, or will gain their understanding from professional or popular press coverage.

In statutory public inquiries, the inquiry process may be at least as influential as its eventual report, and some recent inquiries have made efforts to maximise their impact in this way. For example, inquiry websites have been used to publish their proceedings, and to put key documents such as reports and witness statements in the public domain. Some inquiries have used invitational seminars, workshops or other forums to gather expert views and to test out early findings, and some have produced interim reports. In this more formative model of the inquiry process, the final report may become a formal

summation of findings and recommendations which have already been disseminated and acted upon, rather than the primary tool for dissemination and change, and the point of the inquiry becomes the process as much as its formal outcomes.

One of the frequently cited reasons for undertaking an inquiry, discussed earlier, is to learn lessons for future policy and practice in the NHS. However, it has been observed that many inquiries produce quite similar findings, despite addressing failures in the quality of care which on the face of it have little in common. The parallels between some of the problems raised by the Bristol Royal Infirmary inquiry report on paediatric cardiac surgery in 2001 and the Ely Hospital inquiry report on long-stay care for the elderly and mentally ill in 1969 have already been remarked upon. Although the circumstances in different organisational contexts may vary widely, Higgins³⁸ suggests that five key factors are generally present in some combination:

- *Isolation* - in organisational or geographic terms, which leaves clinicians and others left behind by developments elsewhere, unaware of new ideas or suspicious of them, and unexposed to constructive critical exchange and peer review.
- *Inadequate leadership* - by managers or clinicians, characterised by a lack of vision, an inability to develop shared or common objectives, a management style which can be weak or bullying, and a reluctance to tackle problems even in the face of extensive evidence.
- *System and process failure* - in which a series of organisational systems and processes are either not present or not working properly, and the absence of these checks and balances allows problems to occur or develop. Systems involved may include those for clinical audit, appraisal, personal development, business planning, performance review, budgeting and so on.
- *Poor communication* - affecting both communication in the healthcare organisation and between healthcare professionals and service users such as staff and patients. It is common to find that many stakeholders knew something of the problems subsequently investigated by an inquiry but no-one was able to see the full picture in a way that would prompt action.
- *Disempowerment of staff and service users* - in which those who might have raised problems or concerns were discouraged from doing so either because of a learned sense of helplessness in the face of organisational dysfunction or because the cultural norms of the organisation precluded such actions.

The consistency with which the same or similar issues have been raised by inquiry after inquiry in areas like long term care and child protection should give some cause for concern, since it may suggest that the lessons from inquiries, embodied in their findings and recommendations, are not resulting in sufficient change in policy and practice to prevent their repetition. Many of the common problems outlined above are largely cultural in nature, but it is difficult for inquiries to make concrete recommendations for change in this area. Instead, their prescriptions are often structurally focused, proposing new procedures and systems. While those systems and structures may be necessary to prevent similar problems recurring, they may not be sufficient in themselves. Changes

in attitudes, values, beliefs and behaviours may be needed too. When inquiries are commissioned on the basis that they will provide lessons for future policy and practice in the NHS, there may be a case in future for greater scepticism about the potential for new learning. Inquiries may provide a useful reiteration of past lessons rather than really saying anything new.

There are no formal mechanisms for following up most inquiry reports. At the conclusion of the inquiry, the panel and its support team is generally disbanded, and responsibility for responding to the report findings and recommendations rests with whoever commissioned the inquiry in the first place. In the case of statutory public inquiries, the Department of Health produces a formal response some while after the report has been published, but for many inquiries it is difficult to tell, in retrospect, whether their recommendations have been implemented or not, and why. It might be argued that more explicit follow-up mechanisms would help to ensure that findings are implemented where they need to be, and change really happens as a result. For example, the reports from statutory public inquiries could be followed up by the Health Select Committee, or by a body such as the National Audit Office. The Commission for Health Improvement could be more formally tasked with follow-up within the NHS, for these reports and also for the findings from its own investigations.

7. Research issues and policy implications

THE WAY THAT INQUIRIES ARE USED in the NHS is changing. Past models - often using internal NHS panels and conducted in private - are increasingly seen as failing to come up to modern public and professional expectations of openness, fairness and rigour, despite the fact that the products of such inquiries in the past have often been very well regarded. Of the models outlined in table 2, two - the public inquiry and the CHI investigation - seem more likely to be used in the future.

Demand for public inquiries is likely to continue to grow unless credible and appropriate alternatives are available. Statutory public inquiries are seen by some as the "gold standard" against which other forms of inquiry should be judged. But it may be more appropriate to think of them as a last resort, to which we turn only when other models of inquiry have failed or are unlikely to be successful. Public inquiries should be used rarely, not simply because they are costly but also because they are slow and unwieldy mechanisms for investigation. The increasing demand for public inquiries in the NHS probably reflects a lack of public confidence in the alternative models of inquiry which are available, and in the quality of care that the NHS provides. It is worth noting that there has never been a public inquiry into an aircraft accident in the United Kingdom, which may suggest that the public trust industry safety standards and the work of the Air Accident Investigations Branch, part of the Department of Transport, Local Government and the Regions. Until relatively recently, there had never been a public inquiry into a railways accident - investigations were carried out by the Railways Inspectorate - and it can be argued that a failure of public confidence in the railways has led to public inquiries into crashes at Clapham, Hatfield and elsewhere in the last few years. Demands for public inquiries in the NHS seem likely to continue to grow but they would probably reduce if credible alternative mechanisms for inquiry were available, and if general levels of public confidence in the NHS were higher.

It is too soon to make a judgement about whether the Commission for Health Improvement will become the predominant body responsible for investigations in the NHS, playing a role akin to that of, for example, the Air Accident Investigations Branch in relation to air crashes. Early indications suggest that it has the opportunity to develop the necessary reputation for independence, integrity, openness and rigour in its investigations, and is well placed to provide a continuity of investigatory expertise which has been lacking in the past. However, it seems likely that some aspects of its

current procedures, such as the lack of openness and public scrutiny in the investigation process, will need to be revised, if only to meet new legal obligations under the Human Rights Act 1998 and the European Convention on Human Rights.

The use of inquiries in the NHS has not been widely researched - the last major study in this area was undertaken in the early 1980s¹ - and this overview of the issues has identified a pressing need for work in a number of areas:

- What can we learn from the processes used in previous inquiries, about what works best? How can public resources be used to best effect in pursuing inquiries? A retrospective review of past inquiries, their methods, processes, reports and recommendations would provide information about the incidence of inquiries in the past which is not currently available, and would produce a structured, comparative and longitudinal analysis of inquiry methods and results.
- How can we engage the public and key stakeholders such as patient organisations, professional bodies and NHS organisations in a debate about the size, scope and nature of future inquiries? A qualitative study of the use of inquiries would draw on the extensive recent and current experience of major inquiries in the NHS (see table 1), using interviews with inquiry members and staff, participants (such as witnesses and observers) and other stakeholders, and could help to promote a greater dialogue about the future use of inquiries.
- What models of inquiry are suitable in what circumstances, and what criteria should be used to determine whether an inquiry is needed and what kind of inquiry is indicated? A comparative review of different models of inquiry, looking both at experience in the NHS and at non-health and non-UK practices and models, would provide an informed analysis to support future decisions about the design and remit of future inquiries in the NHS.

In conclusion, the NHS is making more use of inquiries than ever before. Examining instances of major failure in the NHS through inquiries or investigations, though sometimes a painful and difficult process, can undoubtedly contribute to future improvement. However, 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.

References

- ¹ Martin JP. Hospitals in trouble. Oxford: Blackwell, 1984.
- ² Smith R. Inquiring into inquiries. British Medical Journal 2000; 321:715-6.
- ³ <http://www.riia.org/meetings/rule.html> (Accessed 27 November 2001).
- ⁴ Robb B. Sans everything: a case to answer. Edinburgh, Thomas Nelson, 1967.
- ⁵ National Health Service. Findings and recommendations following enquiries into allegations concerning the care of elderly patients in certain hospitals. Cmnd 3689. London: HMSO, 1968.
- ⁶ Department of Health and Social Security. Report of the committee of inquiry into allegations of ill-treatment of patients and other irregularities at the Ely Hospital, Cardiff. London: HMSO, 1969.
- ⁷ Department of Health. Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. London: The Stationery Office, 2001.
- ⁸ Department of Health and Social Security. The report of the committee of inquiry into an outbreak of food poisoning at Stanley Royd Hospital. London: HMSO, 1986.
- ⁹ Department of Health. The Allitt inquiry: independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital during the period February to April 1991. London: HMSO, 1994.
- ¹⁰ North East Thames Regional Health Authority. The report of the inquiry into the care and treatment of Christopher Clunis. London: HMSO, 1994.
- ¹¹ Department of Health. Report of the committee of inquiry into the Personality Disorder Unit, Ashworth Special Hospital. London: The Stationery Office, 1999.

- ¹² Department of Health. Royal Liverpool Children's inquiry report. London: The Stationery Office, 2001.
- ¹³ Department of Health. An inquiry into quality and practice within the National Health Service arising from the actions of Rodney Ledward. London: Department of Health, 2000.
- ¹⁴ <http://www.the-shipman-inquiry.org.uk/home.asp> (Accessed 27 November 2001).
- ¹⁵ Dyer C. Gynaecologist struck off the medical register. *British Medical Journal* 2000;321:258.
- ¹⁶ Dyer O. Surgeon faces medical council hearing over botched operations. *British Medical Journal* 2001;323:652.
- ¹⁷ Department of Health. A first class service: quality in the new NHS. London: Department of Health, 1998.
- ¹⁸ <http://www.chi.nhs.uk/eng/inv/index.shtml> (Accessed 28 November 2001).
- ¹⁹ Department of Health. Modernising regulation in the health professions: consultation document. London: Department of Health, 2001.
- ²⁰ Department of Health. Building a safer NHS for patients. London: Department of Health, 2001.
- ²¹ Department of Health. Supporting doctors, protecting patients. London: Department of Health, 1999.
- ²² Howe G. The management of public inquiries. *Political Quarterly* 1999; 70(3):294-304.
- ²³ Lord Chancellor. Disasters and the law: deciding the form of inquiry. In: Clarke LJ. The Thames safety inquiry: final report (Annex D). London: The Stationery Office, 2000.
- ²⁴ Clarke LJ. The Thames safety inquiry: final report (Annex D). London: The Stationery Office, 2000.
- ²⁵ Walshe K, Offen N. A very public failure: lessons for quality improvement in healthcare organisations from the Bristol Royal Infirmary. *Quality in Health Care*, 2001; 10:250-256.
- ²⁶ NHS Executive (West Midlands). Report of a review of the research framework in North Staffordshire Hospital NHS Trust. Birmingham: NHS Executive, 2000.

- ²⁷ Commission for Health Improvement. Investigation into the North Lakeland NHS Trust: report to the Secretary of State for Health. London: Commission for Health Improvement, 2000.
- ²⁸ Crampton v Secretary of State for Health, 1993.
- ²⁹ R v Secretary of State for Health ex parte Wagstaff and R v Secretary of State for Health ex parte Associated Newspapers Ltd, 2000 [2001 1 WLR 292].
- ³⁰ R v Secretary of State for the Home Department ex parte Wright, 2001.
- ³¹ Maclean M. How does an inquiry inquire? A brief note on the working methods of the Bristol Royal Infirmary inquiry. *Journal of Law and Society*, 2001; 28(4):590-601.
- ³² Salmon. Royal Commission on tribunals of inquiry. London: HMSO, 1966.
- ³³ Council on Tribunals. Tribunals: their organisation and independence. Cmnd 3744. London: HMSO, 1997.
- ³⁴ Yin R. Case study research: design and methods. Newbury Park, California: Sage, 1993.
- ³⁵ Yin R. Enhancing the quality of case studies in health services research. *Health Services Research* 1999; 34(5):1209-1224.
- ³⁶ Miles MB, Huberman M. Qualitative data analysis: an expanded sourcebook. Thousand Oaks, California: Sage, 1994.
- ³⁷ Hey E, Chalmers I. Investigating allegations of research misconduct: the vital need for due process. *British Medical Journal* 2000; 321:752-758.
- ³⁸ Higgins J. The listening blank. *Health Service Journal* 2001; 111(5772):22-25.