Policy and organisational responses to public inquiries in health: will we ever learn?

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Policy and organisational responses to public inquiries in health: will we ever learn?

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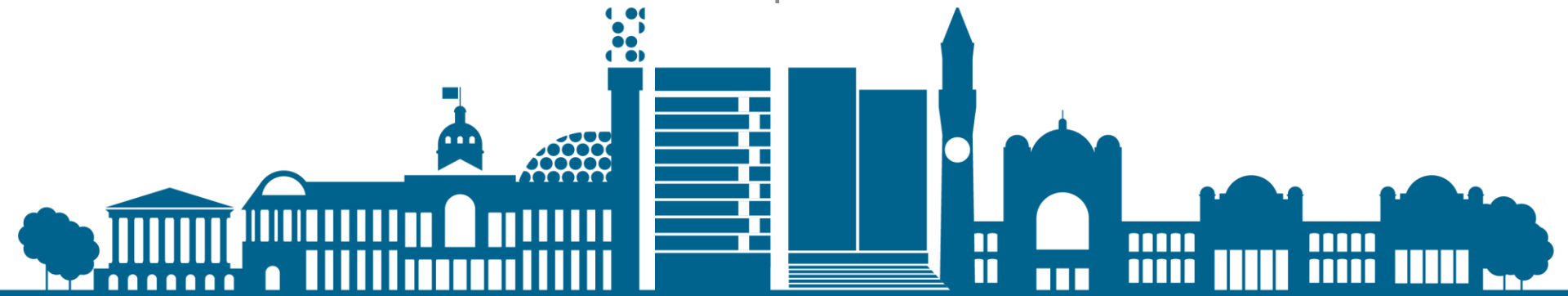


The context for today

- Public Inquiry into Mid-Staffordshire NHS Foundation Trust (2010-2013) chaired by Sir Robert Francis QC
- Chris Newdick and Judith Smith were expert advisers and witnesses to the Inquiry
- We wrote academic papers after the Inquiry reflecting on its themes
- I did work with my Nuffield Trust team, and then in a study for NIHR at the 1-year and 5-year marks
- Now almost 10 years, so seems fitting to take stock

Agenda

- Historical context
- Recurring themes
- Progress made
- How will we ever learn?

HISTORICAL CONTEXT


Stafford Hospital
May 2011
(c) Allstair Rose


The Shrewsbury and Telford Hospital NHS
NHS Trust
Welcome to
The Princess Royal Hospital
This Hospital is
SMOKEFREE
The Shrewsbury and Telford Hospital NHS
Welcome to
Royal Shrewsbury Hospital

Over 50 years of inquiries in health

• Ely Hospital Cardiff considered to be the first modern NHS inquiry, reported in 1969 by Richard Crossman & counsel was Geoffrey Howe

• There have been over 100 inquiries, public or otherwise independent

• Usually concern lapses in duty of care to patients

• Purposes of inquiries may be unclear or contested. Kieran Walshe (2003) suggested:

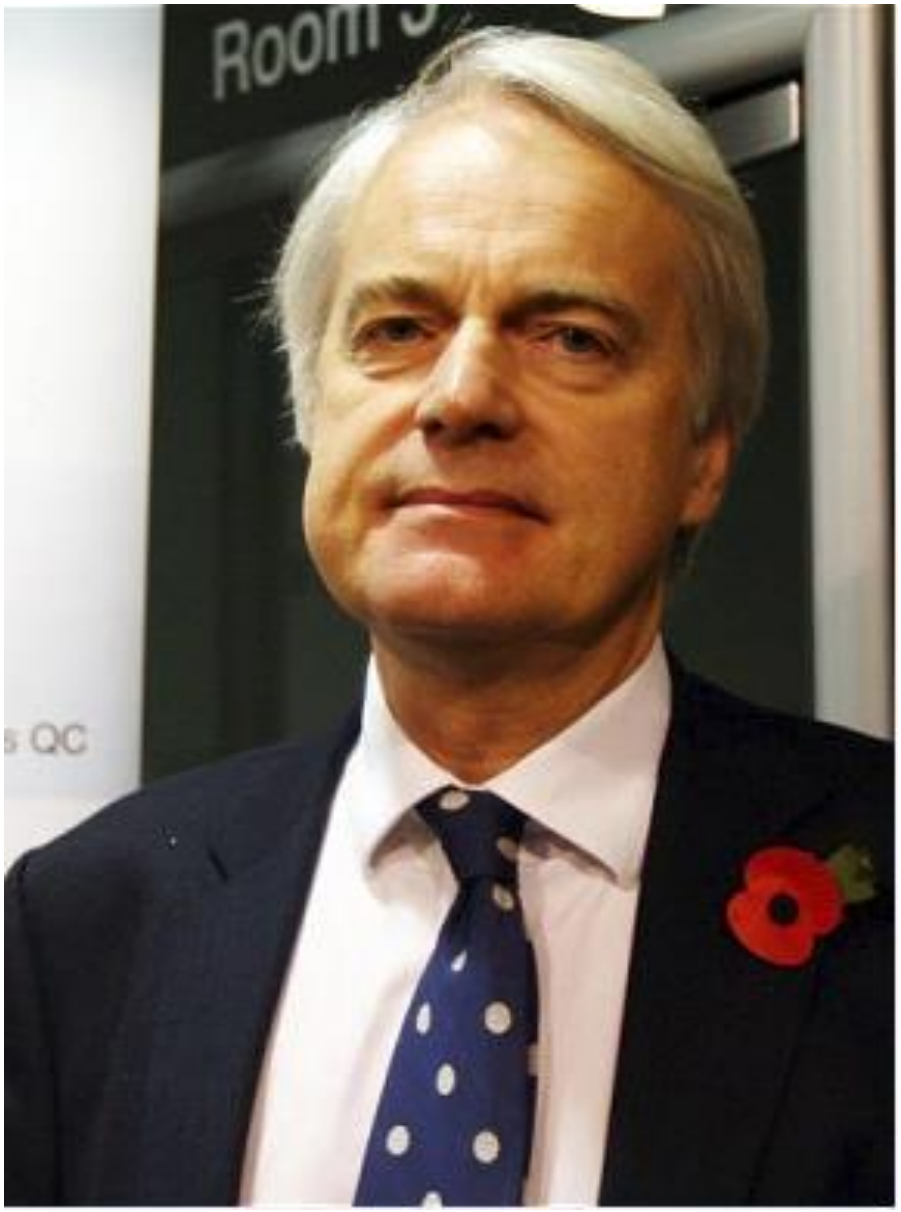
- –Establishing the facts
- –Learning from events
- –Catharsis or therapeutic exposure
- –Reassurance
- –Accountability, blame and retribution
- –Political considerations

•Williams and Kevern (2016) – noted that themes recur repeatedly over time, setting and service

Recommendations of inquiries

- Powell (2019) argued that if there is to be real learning and action from inquiries, then recommendations must be:
  - Implementable
  - Implemented

- This presupposes that terms of reference have been well-drafted which is not easy in ‘something must be done heat of the moment’ (Timmins, 2013)
- May be too many recommendations – the Stafford problem
- Process for accountability often not clear, with ‘action plans’ a plenty, but rarely Select Committee or similar scrutiny
- Inquiry chair may remain involved, as did Janet Smith and Robert Francis


Room
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RECURRING THEMES

The persistent concerns

Hearing and heeding the patient voice

• Not listening properly or systematically to patients and families, and lacking deep curiosity about their insights and concerns

• Lack of policy attention to serious public and patient engagement and advocacy, and regular changes to what mechanisms there are

Enabling staff to speak up with confidence

- Not having an organisational culture that encourages this
- This being the case at all levels of the NHS, including between senior managers and civil servants or politicians
- Professionals do not always feel able to adhere to their code of conduct, for managerial as well as clinical matters
- 'Walking by on the other side' is not always seen as complicit with poor care

From Ward to Whitehall (Bailey, 2013)

The persistent concerns (2)

System pressures

- Staffing shortages and multiple vacancies
- Serial reorganisations and associated turmoil
- Financial constraints and cost improvement targets
- Multiple priorities – if everything is important, nothing is

NHS culture as enacted from the top

- Centralised management approach where policy instructions are often enacted in a bullying manner
- 'Targets and terror' (Bevan and Hood, 2006)
- 'No noise' culture where bad news is not welcomed
- Defensive response to criticism or challenge
- Unable to be self-critical or demonstrate learning

A negative culture?

The persistent concerns (3)

Regulation and inspection as a cure

- An understandable response to organisational failure
- But regulators or boards can sometimes be reassured rather than assured
- Has its place, but must not crowd out problem-sensing and softer approaches

PROGRESS MADE

Examples of change resulting from inquiries

Ely Hospital Inquiry

•The Hospital Advisory Service set up to start investigations and inspections of long-stay care

• NHS Ombudsman established

• Policy to close long-stay institutions and develop community care

Bristol Royal Infirmary Inquiry

• Public reporting of clinical outcomes data, by hospital, service and consultant

• Understanding of the risks of 'club culture'

• Context for establishing the Commission for Healthcare Improvement (now the CQC)

Examples of change resulting from inquiries (2)

Francis Inquiry

•The ‘duty of candour’ seems to be enshrined in clinical (but not managerial) practice at trust level

• Public reporting of ‘red flag’ shifts and staffing levels

• Well-led board standards as part of CQC reporting

• Fundamental standards of care built into CQC work

•Quality accounts have formal status alongside financial (but do they have teeth?)

•**Ockenden Inquiry (potential change)**

• Challenge to ‘normal birth’ as guiding philosophy of care, instead to have ‘safe birth’

• Midwifery staffing standards and associated investment

• Continuity of carer model to be paused or ceased

HOW WILL WE EVER LEARN?

‘Patients want an honest, transparent and candid system. Yet the patient’s voice is strikingly absent in the circumstances that have led to these [Mid-Staffordshire Inquiry] reports.’

Newdick and Danbury, 2013 p960

What still needs to be done

(Newdick and Danbury, 2013; Smith, 2013; Thorlby et al, 2014; Smith and Chambers, 2019)

- **Patient voice** – still needs serious strengthening, as we have not got anywhere near what we had with community health councils, and that was inadequate
- **Duty of candour** – needs to function effectively and apply beyond the clinical realm and in that of management, and with real teeth, if leaders are to be emboldened to speak up
- **Managerial culture** – getting beyond the 'good news' or 'no noise' focus, and enabling boards to feel and act as though the patient and population are central to decisions
- **DHSC, NHS England & Improvement and political centre's treatment** of the NHS and its managers has to change. The 'how' matters as much as the 'what' in policy implementation

‘…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.’

Bishop James Jones, Chair Gosport Independent Panel, 2018

What still needs to be done (2)

- Requiring that the Health Select Committee follow up on public inquiry recommendations
- Having an agreed approach to managing and supporting small district general hospitals (Vaughan et al, 2018)
- Having formal accreditation and CPD for all NHS managers, with a Code of Practice
- Heeding the evidence of the distraction or harm caused by most health service reorganisation (Smith et al, 2001)
- Having a formal and funded workforce plan for health and social care, to address the 120,000 vacancies, if safe and compassionate care is to be assured

To conclude

‘The common culture of caring requires a displacement of a culture of fear with a culture of openness, honesty and transparency, where the only fear is the failure to uphold the fundamental standards and the caring culture.’

Francis 2013, para 1.180, exec summary, p75

To discuss further

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