

Public inquiries into health care in the UK: a sound basis for policy-making?

Nick Black and Nicholas Mays

J Health Serv Res Policy published online 13 June 2013

DOI: 10.1177/1355819613489545

The online version of this article can be found at:

<http://hsr.sagepub.com/content/early/2013/06/13/1355819613489545>

Published by:



<http://www.sagepublications.com>

On behalf of:

NHS Confederation (HSRN)

Health Services Research Association of Australia & New Zealand (HSRAANZ)

Additional services and information for *Journal of Health Services Research & Policy* can be found at:

Email Alerts: <http://hsr.sagepub.com/cgi/alerts>

Subscriptions: <http://hsr.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

>> [OnlineFirst Version of Record](#) - Jun 13, 2013

[What is This?](#)



Public inquiries into health care in the UK: a sound basis for policy-making?

The Francis Inquiry 2013

‘Patients died due to appalling care’, ‘Union chiefs call for head of NHS to resign’, ‘Families of the dead are calling for criminal prosecutions’. Headlines such as these have dominated discussion and debate about health services in England since the publication in February of the findings of an official inquiry into poor quality care in one small acute NHS hospital, Stafford General.¹ The inquiry, carried out by leading lawyer Robert Francis, had been established by the incoming Coalition Government in 2010 to investigate the commissioning, supervisory and regulatory bodies responsible for the hospital. The shortcomings in care at the hospital had already been thoroughly documented in an earlier inquiry also led by Robert Francis, published earlier that year.²

History of public inquiries

Public inquiries into the quality of health care facilities have a long history in England and Wales, going back to 19th century investigations of workhouse infirmaries.³ However, modern use of this means of assessing and understanding failings in care has its origins in the inquiry into Ely Hospital, Cardiff in 1969, a facility for people with learning difficulties. Over the following 20 years, aside from many local inquiries, 15 national inquiries into individual hospitals were undertaken.⁴ Since the late 1980s, inquiries have rather faded from fashion as both routine quantitative monitoring of quality and performance management of institutions have become established. The principal exception was the inquiry into paediatric cardiac surgery in Bristol in the 1990s.⁵

Purposes of public inquiries

In the face of public knowledge of a health care organization’s failings, governments in the UK have chosen to hold public inquiries for several reasons. They may be held to allay public alarm, or to discover the ‘facts’ concerning individuals’ and/or organizations’ behaviour, or to explain personal and/or organizational failings as a basis for developing higher standards of care and reforming policy. Governments may also use inquiries to gain advantage over political opponents

with the aim of exposing the latter’s past failings. For example, it seems unlikely that the second Francis Inquiry would have been established if the previous Labour Government had remained in power. Regardless of the primary objective, the common aim of all inquiries is to shake up the institution in question and to de-freeze established patterns of management and practice so as to facilitate change. Inquiries are not in themselves capable of initiating and implementing improvements. The most they can do is focus attention on an issue and recommend change to the appropriate authorities. Despite this, there is usually an assumption that they will lead to changes in policy.

Form of public inquiries

The form and conduct of public inquiries into health care vary widely, partly determined by the primary purpose. Most, but not all, are led by a judge or senior lawyer who may or may not have experience of health care matters. Such lawyers will often forego substantial personal earnings to take on this public role, motivated by a mix of altruism and self-advancement. The first modern health care inquiry, into Ely Hospital, was led by a politically ambitious lawyer, Geoffrey Howe, who went on to become Chancellor of the Exchequer. Others may have less lofty aspirations. In some inquiries, the lawyer or judge chairs a small group composed of relevant health care experts such as a senior specialist doctor, nurse and non-clinical manager. However, in other inquiries, such specialist experts act purely as assessors or advisors rather than as equal members of a team. And in rare instances, the lawyer acts alone without assistance from those with expertise and experience of health care, as was the case in the recent Francis Inquiry, suggesting it was perceived by its architects as a process in which specialist knowledge of clinical and non-clinical aspects of patient care and the wider system was not required in making judgments or even a potential handicap in providing an independent assessment. Given that the first Francis inquiry was focused on establishing the facts about the very poor standard of care, whereas the second was ostensibly about the systems of supervision and external regulation that had allowed poor care to occur, the absence of specialist expertise within the inquiry team itself seems surprising.

The nature of evidence in public inquiries

Unlike in a British criminal court, health care staff, patients and their relatives are generally questioned by a single advocate acting for the inquiry. While witnesses' views and testimony may be questioned, this is with the aim of clarification rather than as part of the challenge and counter-challenge of a British court. There is no provision for contentious issues to be explored explicitly through the involvement of people with alternative perspectives. For example, in the Francis Inquiry, the originators of hospital all-cause standardized mortality ratios argued for their validity as measures of the overall quality of care of a hospital that the hospital board should have responded to, without other experts having the opportunity to challenge such a view.

Comparison with research

From a researcher's perspective, it is striking how little attention seems to be given to the selection of the membership, methods and processes of public inquiries in the UK. At a recent seminar, those who had led public inquiries described the often hurried, ad hoc and informal ways in which inquiries have been established, processes which seemed greatly at odds with their serious subject matter and implications.⁶ A research project with a similar size of budget (say, the £13 million of the second Francis report) would have required a detailed proposal with a justification of the budget, several independent peer reviewers and the deliberation of a multi-disciplinary funding committee before any decision to proceed. The objectives (terms of reference in inquiry terms) would have been scrutinized, as would the composition of the team and the methods, for their ability to answer the questions posed.

Impact of public inquiries

There have been no formal evaluations of inquiries to establish their cost and impact (i.e. their value) and the question of value is rarely mentioned even after the event.^{7,8} Given that some are undertaken for purposes that are difficult to measure, such as to allay public concerns, it can be difficult in some cases to determine their value. Whether the impact of such policy-making goes beyond assuaging the public and media calls for some action to be taken is unclear.

A sound basis for policy?

In some cases, specific and long-lasting changes in policy occur following inquiries; in 1969, the

Government's response to the Ely Hospital inquiry was to establish a long stay hospital inspectorate and to commit to reducing the number of people living in such hospitals, a move mirrored in 2013 by the creation of a Chief Inspector of Hospitals in response to the Francis Inquiry. The Ely inquiry is generally regarded as a 'success'. However, the impact of the Ely inquiry has to be judged in light of an already mounting tide of research evidence and opinion in favour of 'desinstitutionalization'. It is difficult to ascertain the precise contribution of the inquiry.

Whether an inquiry, which in research terms is an extended case study, should influence wider policy directly without taking other evidence into account is questionable. For example, Robert Francis undertook no comparisons with other hospitals, action that would have enabled him to determine if there were causal associations between the unsatisfactory management and regulation of services he identified at Stafford and the poor humanity of care many patients suffered. In this regard, this recent inquiry is no different to all its antecedents.

Whether or not a public inquiry is a sound basis for policy-making, 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. The contrast could hardly be greater between the 1969 Ely Hospital report (12 pages and a few important recommendations) and the Francis Report of 2013 (almost 2000 pages and 290 recommendations). Among this plethora of suggestions are many based solely on the judgement of Francis himself for which there is no evidence of their potential effectiveness let alone any consideration of their cost, a basic requirement for any other type of policy-making.

There is a case for treating public inquiries more like research projects and 'normal' public policy interventions, and thus subject to some more exacting form of ex ante and ex post value for money assessment if they are to be judged in terms of their contribution to policy and service improvement. However, perhaps such criticisms of public inquiries are ultimately misplaced (despite the influence they often have). Instead they should be recognized as public exercises in catharsis, a way of purging public anger whilst also highlighting areas of serious concern and policy failure that need remediation.

References

1. The Mid Staffordshire NHS Foundation Trust Inquiry. Report of the Mid Staffordshire NHS Foundation Trust public inquiry (Chair: Robert Francis). February 2013.

2. The Mid Staffordshire NHS Foundation Trust Inquiry. Independent Inquiry into care provided by the Mid Staffordshire NHS Foundation Trust: January 2005 – March 2009 (Chair: Robert Francis). February 2010.
3. Lancet Commission. Reports on Metropolitan Workhouse Infirmaries 1865–7, <http://www.workhouses.org.uk/Lancet/> (1867, accessed 15 May 2013).
4. Martin JP. *Hospitals in trouble*. Oxford: Basil Blackwell, 1984.
5. Bristol Royal Infirmary Inquiry (Chairman: Professor Ian Kennedy). The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995: learning from Bristol. July 2001.
6. Institute of Government. Challenges running a public inquiry, <http://www.instituteforgovernment.org.uk/events/challenges-running-public-inquiry> (2013, accessed 15 May 2013).
7. Butler R. A vital tool for healing and holding to account. *The Guardian*, 27 March 2013, 40.
8. Timmins N. 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/> (2013, accessed 15 May 2013)

Nick Black and Nicholas Mays

*Department of Health Services Research and Policy,
London School of Hygiene & Tropical Medicine
London, WC1E 9SH, UK*