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# The role and impact of recommendations from NHS inquiries: a critical discourse analysis

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## Abstract

A National Health Service Inquiry is set up after an adverse event in order to ascertain the facts, learn from them and so prevent similar events happening in the future. However, several researchers have suggested that they are more complex social performances whose complexity renders them relatively ineffective in bringing about change.

The current study tested this interpretation by an analysis of the formal Recommendations from the 14 large scale NHS Inquiries which took place in the period from 1967 to 2014. Their content was critically analysed for divergent themes, and similarities and differences between Inquiries were considered by reference to the historical circumstances of their production. Some support was found for the interpretation of Inquiries as complex symbolic events.

In contrast to their apparent function as simple instruments to drive change, Inquiry Recommendations can be shown to be produced in the service of divergent ends. These may create tensions in the final text which will impede the implementation of changes. To avoid this outcome, consideration of the ways and means of implementing change needs to be included in the Inquiry process.

Keywords: Inquiries; Recommendations; Discourse Analysis; Implementation

## Introduction

The concept of a formal, public inquiry is embedded in the institutional fabric of the United Kingdom as part of its political and judicial process. Its explicit function is to conduct "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" (Walshe and Higgins 2002, p.895). It is presented as a means by which society, collectively, learns from the past in order to inform the future: it therefore has a key role in initiating, guiding or promoting institutional change.

A National Health Service (NHS) Inquiry is a particular type of formal Inquiry. It is a statutorily-constituted process initiated by the Secretary of State for Health under the NHS Act 1977 (s84) or by Parliament under the Inquiry Act 1921 and 2005. It has the legal power to call witnesses and tends to be reserved for situations which have given rise to broad public concern or raised matters of principle and policy (Inwood & Johns 2014). NHS inquiries typically occur in response to poor clinical performance, service failures, or even criminal activity (Walshe 2003, p.5).

NHS Inquiries attract particular attention because of the widespread public unease that is triggered whenever the NHS appears to be failing to deliver on its public commitments. One reason for this concern is, clearly, because of the potential consequences for individuals and communities: when the NHS falls short, people are likely to suffer or die as a result. But there is potentially an additional reason for this concern in the unique social and cultural prominence given to the institution: "The National Health Service is the closest thing the English have to a religion, with those who practice in it regarding themselves as a priesthood" (Lawson 1992,

p.613). In order to maintain public trust and confidence, this 'religion' needs to demonstrate that it has the capacity to reform itself: to learn from events and to make changes that ensure that failures of delivery (along with unnecessary suffering or death) that have been identified are corrected.

The primary artefact generated by an Inquiry is its Report, which takes a standardised form. Its final and most prominent 'output' is the set of Recommendations which purport to summarise the learning and the changes that the Inquiry wishes to see as a result of the process.

It follows that Inquiries (and in particular their Recommendations) have a particular, and important, role in intiating change within the NHS. But if this is the intention of an NHS Inquiry, then initial surveys suggest that it is rarely if ever achieved to any degree. Some authors (Smith 2010; McLuhan 2001) have identified themes in the findings of NHS Inquiries which recur repeatedly across time, setting and service (see also Lehane 2015; Gay and Sear 2012; Foot 2012). Higgins (2001) identifies the following recurring themes in their Recommendations:

- Organisational or geographical isolation which inhibits innovation and learning.
- Inadequate leadership, lack of vision and lack of willingness to tackle known problems.
- System and process failure or lack of systems or processes.
- Poor communication within the NHS organisations and lack of communication with patients which results in problems not being picked up until they have become endemic.
- Disempowerment of staff or patients which results in them being unwilling to raise concerns.

All of these will be familiar to users or workers in a range of NHS settings. Similarly, Walshe and Shortell (2004) compare the Recommendations of the Ely Inquiry (1967) with the Francis Inquiry (2013) as a means of determining parallels between the first recognised NHS Inquiry and the final Inquiry completed at the time of writing. They conclude that because key themes (lack of leadership, poor communication, lack of defined process and person centred care) are present in the Recommendations of both Inquiries, no progress has been made with the underlying issues.

But the recurrence of the same themes despite repeated Inquiries raises the two possibilities: either the NHS as an institution is unable or unwilling to implement the changes embodied in the Recommendations; or the Recommendations themselves are incapable of being implemented because of the way in which they are produced or expressed. The purpose of this study is to evaluate the second of these possibilities: that the Inquiries system is unable to provide sufficiently clear, practical or persuasive Recommendations because of the limitations of the Inquiries process itself.

## Background: two models of the Inquiries process

According to the description of Walshe and Higgins (2002) given above, the main purpose of such Inquiries is to bring about change in order to ensure that the failures identified never recur in the future. There is a linear progression through three processes: establishing the facts; analysis and reflection; and prescriptions for change. Their main input is the historical information from witnesses or written sources; their main output is the Recommendation, of which there are a number at the end of each Inquiry Report. In theory, if the Recommendations are a correct interpretation of the evidence and are acted upon by politicians, policymakers and executives, change should be assured and inevitable. This is the public account given of the role and purpose of Inquiries, which for the purposes of this paper we will term the 'Instrumental' model.

However, the inquiry process may also have to fulfil a number of symbolic roles against a background of public or institutional concern, such as allaying public concern, apportioning blame and providing a ritual for public catharsis (Timmins 2013). From this perspective, they

may be seen not so much as failed attempts to enforce constructive change as complex social or ritual performances in their own right that develop a discourse and narrative in response to a particular set of triggers (e.g. Peay, 1996; Howe, 1999). For the purposes of this paper, we have termed this the 'Symbolic' model.

There is some empirical evidence for this suggestion that Inquiries have to respond to a number of divergent, if not contradictory, pressures. Thus Maclean (2001, p.592) considers that the need to restore public confidence is the trigger for public inquiries generally, and may therefore be expected to dominate their structure and outputs; and Lehane (2015 p.30) has evaluated the NHS Inquiries over the last five decades and has determined that there are three main reasons for establishing them. One of these is, as expected, isa safety breach or serious incident, which causes death or serious harm to patients and which prompts the search for causes and possible remedies. But in addition, an Inquiry may be called proactively to scrutinise new areas of concern which are not well understood; or as a public ritual to address loss of public confidence or public concern.

Similarly, in a wide-ranging analysis of the content and outcomes of NHS Inquiries, Walshe (2003) identifies six purposes: to establish the facts around service failures and encourage learning from events; but also to promote cathartic change, provide reassurance, hold those responsible to account and address the political aspects of the circumstances of the inquiry.

These "broader, perhaps more delicate tasks" (House of Commons Library, 2004) may conceivably impede and complicate the primary aim of bringing about change by reflection on past failings. Perhaps this is the reason why, in the event, public inquiries may bring about very little change (Timmins 2013), in which case the Recommendations cannot, in themselves, be expected to make much difference. To the extent that the 'symbolic model' accurately relfects the complex of demands made upon Inquiries and inscribed in their Recommendations, they will be inhibited from effecting change in established practices.

There is practical significance in this rather arcane debate about how to interpret Inquiries for policymakers, health service managers and senior health professionals who are charged with managing change in response to such Inquiries. If the first model is the more correct one, then the failure of Recommendations to bring about change is an operational matter: the relevant executives have failed to act appropriately in response. However, if the broader interpretation is more accurate, the Recommendations themselves may be assumed to fulfil a complex social and rhetorical function not confined to, or even primarily for, the purposes of bringing about change. In that case, the cause of the failure of Inquiries to bring about lasting change is not the inertia of change managers, but is intrinsic to the structure and constitution of the Inquiries themselves.

## Methodology and Design

The framework for this study is a model of Critical Discourse Analysis provided by Fairclough (1995, p.2) who proposes that a socially-situated discourse should be subjected to a threefold examination: 'analysis of discourse, analysis of discourse practice (processes of text production, distribution and consumption) and analysis of discursive events as instances of sociocultural practice'. From this perspective, an analysis of NHS Inquiries should ideally include an analysis not just of the texts produced, but also of the process of production of the texts (i.e. the history of the Inquiry) and its ethnographic significance as an event (Bhatia et al 2008).

The subject of the current study is the capacity of the Inquiry to effect change, through its published output. This restricts the focus to the Recommendations of each Inquiry, as the output which will be read and pondered with a view to future implementation. The advantage of being able to restrict the analysis in this way is that it leaves a manageable dataset which can justify, or challenge, the claims of the 'instrumental' interpretation: that the

Recommendations represent the distilled learning for the events which provided the occasion for the Inquiry; and that their principal function is to bring about change.

Given this focus on the final output from the Inquiries, it is appropriate that the main emphasis of the critical discourse analysis will be a study of the text of the Recommendations themselves. However, the other two aspects of Fairclough's (1995) scheme – the analysis of discourse practice and of discursive events – will of necessity be drawn on in order to account for anomalies in the data from particular Inquiries.

## *Sample*

For the purposes of the study, we chose to restrict the dataset to those Inquiries where the main focus or party under investigation was an institution or set of events within the NHS itself (so excluding, for example the Victoria Climbie Report (Laming, 2003), where the main focus was the response of the Social Services); where the injured party or parties was under the direct care of the NHS (so excluding, for example, Inquiries into prison or care home care); and where the events which occasioned the Inquiry sufficiently serious to concern actual or potential loss of life. A start-point was provided by the Ely Inquiry of 1967 (Howe, 1969) which was the first example of an overarching review into NHS failings in the UK. Including this Inquiry, and taking the end point as the publication date of the second Francis Report (Francis 2013), the study included a total of 14 Inquiries, listed in Table 1. The Recommendations were gathered and collated from each of the Inquiry reports in turn, and these provided the sample for the analysis.

For the purposes of analysis, Inquiries were initially sorted into categories which corresponded to the NHS sector being subjected to scrutiny. This was to aid the evaluation of the data, as it was hypothesised that successive Inquiries in the same sector were more likely to show dependence on their predecessors, and that similarities between them might therefore be more pronounced.

## *Method*

The process of analysis adopted was a semi-quantitative one in which each Inquiry Recommendation was examined against a framework originally proposed by Walshe and Higgins (Walshe 2003; Walshe & Higgins 2002).

We hypothesised that, if Inquiries can validly be understood to have these divergent (and to some extent contradictory) purposes, they will be to some extent inscribed and detectable in the Recommendations which provide the chief output. If this proves to be the case, the findings will provide some indirect empirical support for the validity of the symbolic model and its implications for change management.

For each Inquiry, Recommendations were scored against Walshe's (2003) list of purposes according to the following criteria:

- *Establishing the facts.* Where the recommendation reflects or reports the facts as determined in the main body of the inquiry.
- *Encourage learning from events.* Where the recommendation provided a clear mitigating action against the facts outlined in the report.
- *Promote cathartic change.* Where the recommendation could reasonably be expected to address areas of poor practice identified in the inquiry.
- *Provide Reassurance*. Where the Recommendations purpose was clearly reassurance or rebuilding public confidence after a major failure.
- *Hold those responsible to account*. Where individuals or groups were named as having contributed to the presenting issues
- *Political considerations.* Where the Recommendation focused around the context or need for change at the political or policy making level

Scoring was simply on the presence or absence of each of the six purposes outlined above. Blumenfeld-Jones (1995, p.68) outlines a similar approach but "weights" the results according to how far they met the criteria. This approach was considered in the current study but weighting could not readily be established, and a Recommendation was deemed to have either met or not met a particular criterion. A single researcher (Williams) undertook this exercise; but the inter-rater reliability of this approach was tested by giving two colleagues a random sample of the Recommendations (n= 30 per researcher) to categorise. They replicated the primary researcher's results in 100% of cases, suggesting a high level of objectivity in the exercise.

### *Analysis*

Data on the Recommendations for each Inquiry was collated and tabulated. The primary goal was to establish whether, as hypothesised, the recommendations could be understood to serve multiple divergent purposes. In addition, where there appeared to be anomalies in the data (such as a very low incidence of a single category for a given Inquiry) contextual data were sought and considered relating to the Inquiry as a discourse practice and as a discursive event (Fairclough 1995).

## Findings

The nature of the data effectively preclude any statistical analysis, because there is no reason to assume that the Recommendations have a comparable role, or equivalent weighting, in each of the Inquiries under investigation. On the contrary: the variability in the use of Recommendations is manifest in the way the number of Recommendations per Inquiry varies widely, and according to no discernible pattern. The extreme example of this phenomenon is represented by the two Francis Inquiries,(Francis 2010; Francis 2013) which yielded 15 and 295 Recommendations respectively. Consequently, it is reasonable to suppose that contextual and situational factors are predominating over any fixed expectations of the form and role of the Inquiries, and these factors will be considered in the course of the discussion below.

**Table 1**. Inquiry Recommendations tabulated by Inquiry category and theme frequency (percentage incidence in brackets)

| Inquiry category | Inquiry | No of Recomm-endations | 1.Establish facts | 2.Learn from events | 3.Therap-eutic exposure | 4. Reass-urance | 5. Account-ability | 6. Political |
|---|---|---|---|---|---|---|---|---|
| **Mental Health/ Learning Disability Institutions.** | Ely (Howe 1969) | 44 | 10 (23) | 37 (84) | 16 (36) | 8 (18) | 9 (20) | 18 (4) |
| | Rampton (Boynton, 1975) | 205 | 176 (86) | 178 (87) | 178 (87) | 189 (92) | 184 (90) | 164 (80) |
| | Normansfield (Spencer, 1978) | 7 | 0 | 2 (6) | 0 | 0 | 0 | 0 |
| | Ashworth Hospital (Blom-Cooper, 1992) | 57 | 3 (5) | 57 (100) | 54 (94) | 55 (97) | 55 (97) | 11 (20) |
| **Infection control** | Stanley Royd (Deer 1985) | 25 | 21 (85) | 22 (88) | 23 (92) | 23 (92) | 23 (92) | 23 (92) |
| | Maidstone and Tunbridge Wells NHS Trust (Health Care Commission, 2007) | 18 | 2 (11) | 18 (100) | 10 (94) | 10 (94) | 18 (100) | 0 |
| | Northern Ireland NHS Trust (Hine, 2011) | 12 | 8 (67) | 12 (100) | 11 (92) | 11 (92) | 8 (67) | 3 (25) |
| **Increased mortality rates** | Mid Staffs I (Francis, 2010) | 13 | 12 (92) | 13 (100) | 13 (100) | 13 (100) | 13 (100) | 13 (100) |
| | Mid Staffs II (Francis, 2013) | 290 | 243 (84) | 273 (94) | 206 (71) | 278 (96) | 278 (96) | 261 (90) |
| | Keogh (2013) | 79 | 77 (97) | 78 (99) | 77 (97) | 78 (99) | 73 (92) | 1 (1) |
| **Malpractice** | Bristol (Kennedy, 2002) | 198 | 38 (27) | 188 (95) | 174 (88) | 196 (99) | 196 (99) | 12 (6) |
| | Alder Hey (Redfern, 2010) | 69 | 38 (55) | 68 (98) | 66 (96) | 68 (98) | 69 (100) | 3 (4) |
| **Murder** | Allitt (Clothier, 1992) | 13 | 6 (46) | 7 (54) | 8 (62) | 11(85) | 11 (85) | 12 (92) |
| | Shipman (Smith, 2005) | 48 | 31 (65) | 47 (98) | 42 (88) | 47 (98) | 46 (96) | 4 (8) |
| **Overall No (%) prevalence** | | **1078 (100)** | **665 (48)** | **1000 (93)** | **878 (81)** | **987 (92)** | **983 (91)** | **525 (49)** |

Nevertheless, there are some marked regularities in the data when sorted into individual themes, and the following broad conclusions may be drawn:

1. It appears that Walshe and Higgins' (2002) categories are broadly applicable across the Recommendations from a range of Inquiries.

2. As the frequency data show, a given recommendation is likely to fall into more than one of the categories suggested by Walshe and Higgins (2002). This indicates that a Recommendation may be crafted to serve divergent ends which may be in conflict (Howe 1999).

3. There is a consistently high incidence of statements in the Recommendations relating to:

- Establishing the facts
- Learning from events
- Therapeutic exposure
- Reassurance
- Accountability

Although the Inquiries relating to Mental Health institutions are something of an outlier in this regard, and particularly in relation to establishing the facts.

4. By contrast, there was a very wide variation in the extent to which Recommendations which had an explicitly Political dimension.

It is now necessary to widen the analysis to include practical and contextual factors which may explain the two egregious anomalies in the data above: the relatively low incidence of Recommendations concerned with establishing the fact sin relation to Mental Health Institutions; and the wide variations between Inquiries in the proportion of the discourse that can be considered 'political'.

## *The Inquiries at Mental Health Institutions*

The **Ely** Inquiry is in the anomalous position of being the first Inquiry, and so having to establish its own operating procedures. The lack of concern for establishing the facts is best explained as a feature of the process of textual production: the report's authors express their own lack of confidence in their ability to robustly establish the facts and focus on recommendations for improvement to an obviously inadequate system:

6.The Committee's request for [a solicitor's] assistance was not granted. In consequence, and notwithstanding the manful assistance of the Committee's Secretary in a host of roles (from enquiry agent and unofficial process server to chauffeur of elusive witnesses), the risks which the Committee had in mind in making the request were far from being eliminated.

7. Subject to the guidance already referred to the Committee was left to evolve its own method of work.

9. We experienced considerable difficulty as a result of the partially blindfolded way in which the Inquiry had to be conducted. Without any knowledge of the matters about which any particular witness was likely to speak our investigation necessarily had an incoherent and disorganised quality (Howe 1969, Introduction sections 6,7,9).

The **Normansfield** Inquiry (Spencer 1978). took place in exceptional circumstances. Its focus was not on establishing facts (which were agreed) but on determining what should have happened to provide evidence for the dismissal of the majority of management staff and senior clinicians in the hospital. Consequently, the circumstances in which it took place as a discursive event prevented it from generating the sort of organisation-wide learning from Inquiry Recommendations which was apparent in the Rampton Inquiry (Boynton 1975).

The Recommendations of the **Ashworth** Inquiry (Blom-Cooper 1992) can also be seen as being driven by the symbolic role of the Inquiry as a discursive event. It was triggered by

complaints following the death of a patient and went on to inquire into allegations of ill-treatment and improper care of patients in four specific cases.

The key focus of the discourse in these Recommendations features upon the government reassuring the public and press that these events could not be repeated and that key individuals would be held to account for the conduct of the hospital in the future.

### *The variation in political content in the Recommendations*

The analysis of the Stanley **Royd** Inquiry shows one of the highest prevalence of political discourse. Deer (1985 p.22) highlights the activity of the Royal College of Nursing at the time, who were lobbying on behalf of those they represented arguing that low staffing levels (both nursing and housekeeping) had made the events inevitable. These Recommendations responded to unacceptable conditions, they constituted a set of minimum standards which remained for twenty-two years until the necessity for more rigorous controls became apparent. The unusually high level of political content is therefore explainable in terms of the role of the Inquiry as discursive event.

By contrast, in Infection Control Inquiries generally the incidence of political content in Recommendations is low. This can be understood as a consequence of the processes of discourse production and consumption. Infection outbreaks were assumed to be due to failings in system and process, so Recommendations would be directed to hospital managers and political considerations did not arise.

Similarly, the occasion for the Inquiries in to **Bristol**, **Alder Hay** and **Shipman** was an acknowledged failure of individuals or teams at the level of delivery and (in the form the issue was presented) did not raise wider political questions.

A more difficult anomaly is evident in the contrast between the two **Francis** Inquiries and the **Keogh** report: the Francis Reports which have great emphasis on political discourse and the Keogh recommendations have none. Here, the wider political and social circumstances of the production of Recommendations presumably has a significant part to play. The Francis reports were addressing identified shortcomings at a single hospital, so a major finding was that the shortcomings were poitentially widespread. The Keogh Review was a partial response to these findings, in that it analysed mortality trends and their reasons in 14 Hospital Trusts. But it was briefed to look at management and delivery of services rather the national context. A flavour of its basic approach is given in the extract below:

*"These organisations have been trapped in mediocrity, which I am confident can be replaced by a sense of ambition if we give staff the confidence to achieve excellence. This is consistent with the ambitions that I know the new clinical commissioning groups have for their local populations and the legal duties they have to secure continuous improvements in the quality of services provided to patients."* (Keogh 2013, p3).

## Discussion

The results reported above seem, broadly, to confirm the viability of a 'symbolic' model of the Inquiries as complex social rituals that serve a variety of ends (Howe 1999) and produce an output (Recommendations) that reproduces the complexity. This can be traced in the content of the Recommendations themselves when analysed under the divergent headings supplied by Walshe (2002). Furthermore, variations in the content and emphasis of Recommendations between Inquiries seems to be satisfactorily explained within the scheme offered by Fairbairn (1995) by consideration of the circumstances of their production and consumption; and the wider historical and contextual circumstances surrounding the Inquiry as an event.

These findings contribute to a composite picture in which Inquiry Recommendations are fulfilling divergent functions and cannot be seen simply as blueprints for constructive change.

In particular, and in the light of the findings above, it is possible to imagine the following impediments to the use of Recommendations as simple instruments for change:

1. Some Recommendations may have a different primary purpose, such as issuing a statement of intent for public reassurance
2. Some may be directed at the wrong agents (for example asking hospital managers to bring about change that can only be achieved at the political level)
3. Some may be constrained by the circumstances of their production; for example, having to rely on faulty information or being precluded by the Inquiry's Terms of Reference from addressing certain key impediments to change
4. To the extent that the Inquiry is a social performance, public and executive interest may wane rapidly after its completion
5. Recommendations in themselves do not ensure the provision of resources for implementation of change.

## Conclusion and Recommendations

The overall picture emerging from this study is of NHS inquiries as complex social and symbolic performances that are constrained by historical circumstance and their limited control of their own outputs in the Recommendations. These complicating factors appear to offer at least a partial explanation for Timmins' (2013) conclusion that they tend to achieve very little real change.

The main practical implication for health professionals charged with leading change in the NHS is that Inquiry Recommendations, on their own, are likely to remain ineffective instruments for driving change. The current process of NHS inquiries focusses on producing Recommendations rather than on the outcome of these Recommendations. The circumstances of their production, reception and implementation are the sites of divergent pressures and purposes. This produces Recommendations which are not "user friendly" to the majority and are not disseminated widely (Potter and Weatheral 1987, p.94).

One response would be to accept that the Recommendations are incomplete instruments of change, and pay more attention to the process of implementation. For example Higgins discusses the process of NHS inquiries, and argues that it could be beneficial to transform them into a more protracted process which would lobby for Recommendations to be enshrined in legislation and suggests it would be useful for the panel of the inquiry to remain in place to monitor their implementation (Higgins 2001). This is a tempting position, but may require a commitment of decades rather than years on the part of the Inquiry members, so could prove impossible in practice. A more realistic position might be to acknowledge the role of existing agencies (such as the Care Quality Commission and HealthWatch) along with service user groups and third sector organisations in driving the interpretation, implementation, application and monitoring of changes initiated by the Inquiries.

NHS inquiries make Recommendations in response to specific circumstances and situations. They contribute to improving the quality assurance and accountability within the organisation but do not purport to do this as a standalone measure, and nor are they intended to. The Recommendations are the first part of a complex process, and rely upon the activities and interrelationship of a variety of social and cultural institutions in order to bring about lasting change.

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