Learning from NHS Inquiries: Comparing the Recommendations of the Ely, Bristol and Mid Staffordshire Inquiries

MARTIN POWELL

Abstract
If one of the key reasons for an inquiry is to learn lessons and prevent similar events from reoccurring, recommendations must be implementable and implemented, but it is clear that lessons have not been learned and recommendations not implemented. This paper compares the 'implementability' of recommendations from the three inquiries of Ely, Bristol and Mid Staffordshire to stress the importance of learning lessons. It examines two broad issues of 'who?' and 'what?'. First, some 80 per cent of the Ely recommendations were aimed at the institution, while 72 per cent of the Bristol and Mid Staffordshire recommendations were aimed at the system. Moreover, about 7 per cent of Ely's forty-four recommendations have a clearly identified agent, compared to 15 per cent at Bristol and 41 per cent at Mid Staffordshire. Second, the policy tool of 'sermons' accounts for some 89 per cent of Ely recommendations, compared to 66 per cent at Bristol and 63 per cent at Mid Staffordshire. However, the earlier sermons did not appear to prevent the events at Mid Staffordshire occurring. Pulling these issues together, it can be suggested that, given the large number of potentially responsible agencies, recommendations should be 'active' with a clearly identified agent and that a clear policy tool or mechanism should be identified rather than rely on a vague tendency to sermonise.

Keywords: NHS, inquiries, recommendations, learning

Introduction

IT HAS BEEN noted that if one of the key reasons for an inquiry is to learn lessons and prevent similar events from reoccurring, recommendations must be implementable and implemented. However, it seems that in a version of *Groundhog Day* it is stated that 'lessons will be learned' but it is clear that this has not always been the case. A number of commentators point to some similarity of inquiry findings. For example, Sheard stated that most of the hundred plus NHS inquiries that have been held since the Ely inquiry have highlighted common areas for concern: inadequate leadership, system and process failures, poor communication, disempowerment of staff and patients.[1] Williams and Kevern took up this point.[2] The recurrence of the same themes despite repeated inquiries raised 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.

This paper compares the 'implementability' of recommendations from the three inquiries of Ely, Bristol and Mid Staffordshire in order to stress the importance of learning lessons.[3] The Ely inquiry was set up in 1967 to look into allegations of various forms of misconduct on the part of members of the staff at the Ely Hospital, a psychiatric hospital in Cardiff (see Hilton, in this issue). It was chaired by Geoffrey Howe, the future Conservative Chancellor of the Exchequer in the Thatcher government, and reported in 1969. The Bristol inquiry was set up in 1998 to examine the 'excess deaths' in paediatric cardiac surgery at the Bristol Royal Infirmary between 1984 and 1995, with Professor Sir Ian Kennedy as chair. It reported in 2001.

Published by John Wiley & Sons Ltd, 9600 Garsington Road, Oxford OX4 2DQ, UK and 350 Main Street, Malden, MA 02148, USA

The (second) Mid Staffordshire inquiry was set up in 2010, into the serious failings at the Mid Staffordshire NHS Foundation Trust between 2005 and 2008 (see Smith and Chambers, in this issue). It was chaired by Robert Francis, who had chaired the first inquiry that reported in 2010. This second report focussed on the wider NHS system, reporting in 2013.

The Ely report consisted of about 134 pages of 565 paragraphs, in some 64,000 words. It contained forty-four recommendations taking up some 2000 words, which were not clearly numbered as such, but numbered as paragraphs within the report. The Bristol report was composed of twenty-nine chapters and 461 pages in two sections: describing events 'The Bristol Story' and 'The Future' which focussed on learning lessons set out in a number of themes. It contained 198 recommendations. The Francis report on Mid Staffordshire consisted of three volumes of nearly 1,700 pages. The 290 recommendations ran to some 16,000 words, and were set out at the end of each of the twenty-six chapters. Although the recommendations tended to cluster together, they were not numbered consecutively. In addition, chapter 27 presented a table of recommendations by twenty-two themes.

Groundhog Day or déjà vu all over again?

Bell and Jarvie stated that Bristol, Oxford, Tunbridge Wells, Mid Staffordshire, Gosport, Lanarkshire, the Vale of Leven and Aberdeen are just some examples of places where NHS services had, in recent years, been the subject of inquiries or reviews regarding standards of medical and/or nursing care.[4] Six of these inquiries had reported within the last two years, with hundreds of recommendations seemingly having limited effect. They cited Professor Sir Ian Kennedy's evidence to the Mid Staffordshire inquiry. He drew similarities between Bristol and Mid Staffordshire, noting that 'the history of the NHS is littered with the reports of Inquiries and Commissions: most have been consigned to gather dust on shelves'. He considered that, unlike other industries, the NHS does not appear to learn lessons: 'there is something in the NHS that militates against recommendations like this entering the DNA of an organisation' and asked 'what is it about healthcare and the NHS that it does not seem able to learn lessons … to prevent their recurrence?'. Bell and Jarvie consider that Walshe's statement that 'at present it is far from clear that the NHS is learning all it can from failures, or making the most of the opportunities for improvement that they offer' appears true today.[5] Conversely, there was much evidence to show how other industries, including aviation and oil, have learned from past breaches in safety and adapted their practices successfully.

Similarly, Francis stated that the experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent.[6] He continued that 'It is respectfully suggested that the subject matter of this Inquiry is too important for it be allowed to suffer a similar fate'. According to Francis, Professor Sir Brian Jarman pointed out that at the Bristol inquiry, in which he was a member of the inquiry panel, there were 120 mentions of the word 'hindsight' in the evidence. However, Francis pointed out that unhappily, the word 'hindsight' occurred at least 123 times in the transcript of the oral hearings of the Mid Staffordshire inquiry, and 'benefit of hindsight', 378 times.[7]

Implementable?

Mackie and Way focussed on creating effective follow-on: 'from recommendations to outcomes'.[8] They argued that an inquiry will have failed to achieve one of its core purposes if what it concludes is not implemented. They suggested some ways of improving the effectiveness of and implementation of recommendations. For example, in writing recommendations, thought needs to be given to how to provide practical recommendations which are actually capable of or, indeed, likely to be performed. If a recommendation is likely to be difficult to achieve or unwanted by the group that is tasked with carrying it out, then steps

should be taken to ensure that the recommendation is broken down and is actually a series of practical doable steps. They added that it is also worth thinking about subsequent surveillance of recommendations and how this might occur, as there was no requirement that a body should implement any recommendation made by an inquiry. One of their recommendations involved an 'implementation action plan'. In order to ensure that the body authorising the inquiry will take appropriate action, they argued that there should be a time period set at the outset of an inquiry, within which the authorising body will respond to recommendations, and explain its intentions with regards to such recommendations.

The National Audit Office pointed that one of the thirty-three recommendations of a 2014 House of Lords Select Committee was to ensure that on the conclusion of an inquiry, the secretary delivers a 'lessons learned paper' from which best practice can be distilled and continuously updated.[9] However, this has only been done for three inquiries to date (which did not include a healthcare inquiry). It continued that eight inquiries have concluded since the government's response to the House of Lords report was published, but the Cabinet Office was not able to give any examples of lessons learned reports that had been produced as a result of these inquiries. However, there was 'readily accessible information on progress against each recommendation' for four inquiries (including both healthcare inquiries in their sample: Mid Staffordshire and Morecambe Bay).

Analysis

As noted above, this paper focusses on the degree to which recommendations are implementable. This may be seen in terms of two broad issues. First, is it clear who the recommendations are aimed at? Second, is the problem soluble in the sense of a clearly identified policy tool, or mechanism, or tool to implement, which suggest a clear course of action?

1. Who?

The first issue regards the clarity of the recommendations in the sense of: to whom they are aimed and who will take ownership of the problem? This may be seen in a very broad analysis of micro (individual patients and clinicians); meso (institution) or macro (system) level. For Ely, 'meso' refers to the Hospital and Hospital Management Committee (HMC), while 'macro' refers to the Regional Hospital Board (RHB) and the wider system. For Bristol, meso refers to the Hospital Trust. For Mid Staffordshire, macro refers to the Strategic Health Authority (SHA), the national healthcare regulators and the wider system. The following table gives some examples of coding.

Table 2 suggests that while some 80 per cent of the Ely recommendations were aimed at the institution, 72 per cent of the Bristol and Mid Staffordshire recommendations were aimed at the system. To some extent, this is linked with the terms of reference of the inquiries. For Ely, these were (para. 4): to investigate the allegations made by XY in a statement to the *News of the World* about ill-treatment of patients and pilfering by members of the staff at Ely Hospital; to examine the situation in the wards in the hospital at the present time; and to make recommendations.

However, the Bristol inquiry was asked to make recommendations which could help to secure high quality care across the NHS. The Mid Staffordshire report of 2013 followed on from an earlier inquiry by Robert Francis in 2010, which focussed on the trust. As Francis explained in his second inquiry, it was not within the first inquiry's terms of reference to examine the involvement of the wider system in what went wrong. However, he was clear that there needed to be an investigation of the wider system in order to consider why these issues had not been detected earlier and to ensure that the necessary lessons were learned. The terms of reference for the second inquiry were to examine the operation of the commissioning, supervisory and regulatory organisations and other agencies.[10]

Moreover, the focus on level is compatible with statements from the reports. The Ely report stated that almost all the matters discussed fell, to a greater or lesser extent, within the HMC's area of responsibility: standards of nursing care and discipline; the establishment, status and training of staff; investigation of, and reaction to,

Table 1: Recommendations at the micro, meso or macro levels

Micro

- Nurses must not be permitted to take meals on the ward (Ely, para. 585)
- In a patient-centred healthcare service patients must be involved, wherever possible, in decisions about their treatment and care (Bristol, para. 1).
- Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient (Mid Staffordshire, para. 199).

Meso

- The prospective booklet about Ely, for the guidance of patients, relatives and others, needs to be prepared to a high standard and as soon as possible (Ely, para. 557).
- Clinical audits must be fully supported by Trusts (Bristol, para. 144).
- The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest (Mid Staffordshire, para. 75).

Macro

- There is a clear need for closer and more effective co-operation between the three branches of the present NHS administrative structure if Ely is to be enabled to play a proper role within the concept of community care. A final solution of the difficulties will only be found within a new and more closely integrated administrative structure (Ely, para. 560).
- One body should be responsible for co-ordinating all action relating to the setting, issuing and keeping of clinical standards: this should be the National Institute of Clinical Excellence (NICE) (Bristol, para. 122).
- There should be a single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts. (Mid Staffordshire, para. 19).

complaints or other adverse reports; overcrowding and standards of amenity on the wards; the lack of occupational therapy or other activity for patients; and the absence of clearly defined areas of responsibility for each of the hospital officers. Moreover, in the four representative fields which were considered—nursing establishment, nurse training, occupational therapy and overcrowding—it was apparent that the HMC had not in fact achieved any significant progress towards an improvement in standards. However, there was an acknowledgement of the wider system: Ely's efforts to relieve overcrowding had been largely frustrated by 'the system'—itself understandably restrained by the chronic shortage of money.[11] Nevertheless, it concluded that the HMC and its officers and advisers must accept the principal responsibility for the shortcomings identified: an ineffective system of administration; the effective isolation of Ely from the mainstream of progress; and the absence of any well-informed stimulation towards an improvement of standards.[12]

The Bristol report stated that it was 'not an account of bad people': healthcare professionals working in Bristol were victims of a combination of circumstances which owed as much to the general failings in the NHS at the time than to any individual failing. According to the Francis report, the story of 'appalling suffering of many patients' was 'primarily caused by a serious failure on the part of a provider trust board'. However, the wider NHS system of checks and balances which should have prevented serious systemic failure of this sort did not detect the problems. It was clear that not just the trust's board but the system as a whole failed in its most essential duty: to protect patients from unacceptable risks of harm and from unacceptable—and in some cases inhumane—treatment that should never be tolerated in any hospital. Announcing the second Francis inquiry, Secretary of State, Andrew Lansley, argued this was a failure of the trust first and foremost, but it was also a national failure of the regulatory and supervisory system.[13]

Some of the recommendations were clearly targetted. The most clear and explicit were those with an active voice: for example 'the Care Quality Commission (CQC) should…' rather than a passive voice of 'consideration should be given to…'. Others may be more

Table 2: Inquiries by level and policy instrument

	Micro/ clinicians	Meso	Macro/ wider system	Stick	Sermon	Carrot
Ely		Hospital/ HMC	RHB and wider			
Introductory (5)	0	60	40	0	60	40
Nursing care and administration (12)	0	100	0	0	100	0
Administrative matters (4)	0	100	0	0	100	0
Medical care and amenities (12)	0	100	0	0	100	0
HMC (6)	0	83	17	0	100	0
General matters (5)	0	0	100	60	40	0
Total (44)	**0**	**80**	**20**	**7**	**89**	**5**
Bristol		Trust				
Respect and Honesty (37)	56	29	15	8	92	0
A Health Service which is well led (19)	0	5	95	47	53	0
Competent Healthcare Professionals (49)	0	15	85	20	78	2
The Safety of Care (16)	0	6	94	50	50	0
Care of an Appropriate Standard (35)	0	9	91	34	63	3
Public Involvement Through Empowerment (10)	0	10	90	0	90	10
The Care of Children (32)	16	19	65	38	62	0
Total (198)	**12**	**15**	**72**	**32**	**66**	**2**
Mid Staffordshire		Trust and Commissioners	SHA and wider			
Accountability for implementation of the recommendations (2)*	0	0	0	0	100	0
Putting the patient first (6)	33	0	67	33	67	0
Fundamental standards of behaviour (4)	25	25	50	0	100	0
A common culture made real throughout the system (6)	0	0	100	83	17	0
Responsibility for, and effectiveness of, healthcare standards (41)	0	2	98	59	41	0
Responsibility for, and effectiveness of, regulating healthcare systems governance—Monitor's healthcare systems regulatory functions (27)	0	7	93	56	44	0
Responsibility for, and effectiveness of, regulating healthcare systems governance—Health and Safety	0	0	100	25	75	0

Table 2: Continued

	Micro/ clinicians	Meso	Macro/ wider system	Stick	Sermon	Carrot
Executive functions in healthcare settings (4)						
Enhancement of the role of supportive agencies (18)	0	0	100	28	67	6
Effective complaints handling (14)	0	79	21	21	79	0
Commissioning for standards (15)	7	93	0	27	60	13
Local Scrutiny (1)	0	100	0	0	100	0
Performance management and strategic oversight (6)	0	0	100	83	17	0
Patient, public and local scrutiny (7)	0	71	29	14	71	14
Medical training and education (21)	0	0	100	33	67	0
Openness, transparency and candour (12)	0	42	58	100	0	0
Nursing (29)	0	31	69	17	83	0
Leadership (8)	0	0	100	25	75	0
Professional regulation of fitness to practise (14)	0	0	100	14	79	7
Caring for the elderly (8)	25	75	0	0	100	0
Information (29)	0	45	55	17	83	0
Coroners and inquests (13)	0	46	54	23	69	8
Department of Health leadership (5)	0	0	100	0	100	0
Total (290) (*288 for level as first 2 apply to all in NHS)	**2**	**27**	**72**	**35**	**63**	**2**

implicit. For example, while it is not stated that, say, 'the General Medical Council (GMC) should…', the action seems to fall within the province of the GMC. The vaguest recommendations involve either a lack of clarity regarding who they are aimed at, or are seemingly aimed at everyone. For example, Francis' first two recommendations that 'require every single person serving patients to contribute to a safer, committed and compassionate and caring service' may be seen as 'everybody's concern but no one's responsibility'.

The inquiry reports tended to group their recommendations in broad sections. For example, Ely had a section on 'HMC', but this included one recommendation that 'the RHB should give consideration to…'. Similarly, Francis had clear sections aimed at Monitor, the Health and Safety Executive, and the Department of Health, but also included other sections such as 'fundamental standards of behaviour'. However, Bristol had rather generic sections such as 'respect and honesty' and 'the care of children'. A rough estimate can be made of active and explicit recommendations, albeit with a fairly wide margin of error owing to difficulties of interpretation. My estimates suggest that just three of Ely's forty-four recommendations (7 per cent) have a clearly identified agent. For Bristol, it is thirty of 198 (15 per cent), of which some four are joint. Finally, for Mid Staffordshire, it is 118 of 290 (41 per cent), of which some twenty-one are joint.

There were fewer agents in the relatively simple NHS world of the Ely era. The agents mentioned in the reports are listed in Table 3 below:

Table 3: Agents mentioned in the Ely, Bristol and Mid Staffordshire reports

Ely	Ely Hospital HMC, RHB, local authorities, Ministry of Health, and a (proposed) new system of inspection.
Bristol	Department of Health, NHS Modernisation Agency, NHS Leadership Centre, (proposed) NHS Appointments Committee, (proposed) Patient Advocacy and Liaison Service, (proposed) Council for the Quality of Healthcare, (proposed) National Patient Safety Agency, (proposed) Council for the Regulation of Healthcare Professionals, (proposed) Medical Education Standards Board, Cabinet Committee for Children's and Young People's Services, Royal College of Surgeons of England, General Medical Council, Nursing and Midwifery Council, Commission for Health Improvement, (proposed) Office for Information on Healthcare Performance (part of the CHI), National Institute of Clinical Excellence, (proposed) National Director for Children's Healthcare Services, (proposed) Children's Commissioner in England, National Specialist Commissioning Group, trusts, primary care trusts/groups, (proposed) patients' forums, (proposed) patients' councils, voluntary organisations, universities, local research ethics committees.
Mid Staffordshire	Secretary of State for Health, Department of Health, Care Quality Commission, General Medical Council, Nursing and Midwifery Council, Monitor, the NHS Commissioning Board; clinical commissioning groups, National Institute for Health and Clinical Excellence, trust boards, strategic health authorities, overview and scrutiny committees, foundation trust governors, the NHS Trust Development Authority, the NHS Litigation Authority, the Health and Safety Executive, the National Patient Safety Agency, the Health Protection Agency, Public Health England, Local Healthwatch, local health and wellbeing boards, postgraduate deans, local educational training boards, the Royal Colleges, the National Quality Board, Health Education England, the Professional Standards Authority for Health and Social Care (formerly the Council for Healthcare Regulatory Excellence), the Health and Social Care Information Centre, the Parliamentary and Health Service Ombudsman, the UK Statistics Authority, coroners, the Chief Coroner, and the Lord Chancellor.

In particular, the last two inquiries pointed to a complex and ever-changing NHS landscape. Some of the institutions mentioned or proposed by Bristol had been abolished or had changes in names or functions by the time of Francis. Even if recommendations were clearly aimed at a single agency, they faced the problem of finance, priority or opportunity costs. For example, the Ely recommendation that the projected adolescent unit should, if possible, be accorded higher priority means that other issues must be accorded a lower priority. Sometimes, the problem requires multiple agencies to work together, but 'joined-up government' has always been problematic. For example, apart perhaps from the language, the Ely recommendation that greater efforts should be made to reduce and prevent overcrowding by more frequent discharge of patients to local authority hostel accommodation, more of which is urgently needed in the area could be made to today's NHS.[14]

2. What?

The second issue concerns policy instruments or tools. There are many possible classifications, but a widely used and simple tool is given by Bemelmans-Videc et al.[15] They discussed three broad types of policy instruments, which have been variously termed: incentives, authority and persuasion; the economic, legal and communications families; but most usually, 'carrots, sticks and sermons'. The first type consisted of incentive tools such as the conditional transfer of funds or charges and fines. The most popular incentive tools included inducements, charges, and sanctions. The second type used coercion as their principal resource. Governments employed them through their hierarchical system, and their most common typologies include permissions, guidance, and compulsory actions. The third type of persuasion referred to a series of discursive strategies aiming to change behaviour through providing information or the active exploitation of

normative and moral-based arguments. The recommendations have been coded in a fairly simple way, which is clearly open to challenge. 'Carrot' words include: financial, incentive, and motivation. 'Stick' words include: inspection, compulsory, and offence. 'Sermon' words include: consider, review, encourage, recommend, inform, and needs (to be). In some ways, sermons may be a residual category. For example, an action 'should' be taken, but with no indication of a carrot or a stick. The following table gives some examples of the policy tools.

As shown in Table 2, sermons are the main policy tool, accounting for some 89 per cent of Ely recommendations, compared to 66 per cent at Bristol and 63 per cent at Mid Staffordshire.

Table 4: Examples of policy tools used in recommendations

Carrots
These overriding objectives, along with others indicated below, can only be achieved if substantially increased financial resources are made available (Ely, para. 576).
Financial resources must be made available to enable members of the public to become involved in NHS organisations (Bristol, para. 164).
The financial incentives at levels below level 3 should be adjusted to maximise the motivation to reach level 3 (Mid Staffordshire, para. 92).
Sticks
There is a clear need for some system of inspection of a hospital like Ely, which will ensure that those responsible for its management are made aware of what needs to be done to bring it up to the desired standards (Ely, para. 561).
Clinical audit should be compulsory for all healthcare professionals providing clinical care and the requirement to participate in it should be included as part of the contract of employment (Bristol, para. 145).
It should be an offence for death or serious injury to be caused to a patient by a breach of these regulatory requirements (Mid Staffordshire, para. 29).
Sermons
Every effort should be made to establish a League of Friends for Ely (Ely, para. 556).
The education and training of all healthcare professionals should be imbued with the idea of partnership between the healthcare professional and the patient (Bristol, para. 2).
The Department of Health should promote a shared positive culture by setting an example in its statements by being open about deficiencies, ensuring those harmed have a remedy, and making information publicly available about performance at the most detailed level possible (Mid Staffordshire, para. 290).

Conclusions

This section returns to the two issues of 'who?' and 'what?'. The first issue suggests that, in line with the inquiries' terms of reference, some 80 per cent of the Ely recommendations were aimed at the institution, while 72 per cent of the Bristol and Mid Staffordshire recommendations were aimed at the system. My rough estimates indicate that about 7 per cent of Ely's forty-four recommendations have a clearly identified agent, compared to 15 per cent at Bristol and 41 per cent at Mid Staffordshire. This suggests that more could be done to arrive at practical recommendations of a series of practical doable steps that are clearly 'owned' by an identifiable agent.

Turning to the second issue, sermons account for some 89 per cent of Ely recommendations, compared to 66 per cent at Bristol and 63 per cent at Mid Staffordshire. Although Ely was a very different type of hospital in a different era, it seems that the Bristol sermons did not prevent the failings at Mid Staffordshire. This suggests either that sermons in general do not work, or that these sermons did not work, as they were either not implementable or implemented. The Bristol 'meta-sermon' that 'the aim of all our recommendations is to produce an NHS in which patients' needs are at the centre' appears very similar to the Francis 'meta-sermon' that 'the patients must be the first priority in all of what the NHS does'. It can certainly be argued that vague sermons such as Mid Staffordshire's, as in 'these recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service' are difficult to implement. Francis appeared to inject some 'sticks' into earlier 'sermons' about the NHS constitution in terms of 'expectations', 'values' and 'ethos'. Recommendation 7 stated that: 'All NHS

staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.' Similarly, the recommendations on 'openness, transparency and candour' involved some sticks of 'enforcement of the duty', 'statutory duties' and a 'statutory obligation', 'criminal liability' and 'criminal offence' and 'enforcement': 'observance of the duty should be policed by the Care Quality Commission, which should have powers in the last resort to prosecute in cases of serial non-compliance or serious and wilful deception'.[16]

Pulling these issues together, it can be suggested that, given the large number of potentially responsible agencies, recommendations should be 'active' with a clearly identified agent (for example, 'the CQC should…') and that a clear policy tool or mechanism should be identified rather than rely on a vague tendency to sermonise. Although it is not the responsibility of inquiries to cost their recommendations, some thought should ideally be given to cost or at least feasibility of implementation. More widely, it is clear that learning lessons from inquiries is a vital ingredient in achieving a safer NHS. Howe considered that all NHS inquiries follow the pattern of Ely, but the issue of 'how to ensure lessons are learned' remains.[17] Kennedy gives a more forthright version in the Bristol inquiry, (hopefully) entitled *Learning from Bristol*: 'It would be reassuring to believe that it could not happen again. We cannot give that reassurance. Unless lessons are learned, it certainly could happen again, if not in the area of paediatric cardiac surgery, then in some other area'.[18]

Notes

1 S. Sheard, 'Can we never learn? Abuse, complaints and inquiries in the NHS', *History & Policy*, 26 February 2015; http://www.historyandpolicy.org/opinion-articles/articles/why-we-never-learn-abuse-complaints-and-inquiries-in-the-nhs (accessed 23 April 2019).
2 M. Williams and P. Kevern, 'The role and impact of recommendations from NHS inquiries: a critical discourse analysis', *The Journal of New Writing in Health and Social Care*, vol. 2, no. 2, 2016, online, no pagination.
3 G. Howe, *Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and other Irregularities at the Ely Hospital, Cardiff*, Cmnd 3975, London, HMSO, 1969. Sir I. Kennedy, *Learning from Bristol*, Cmnd 5207, London, HMSO, 2001. R. Francis, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, three volumes, HC 898 (I-III), London, HMSO, 2013.
4 D. Bell and A. Jarvie, 'Preventing 'where next?' Patients, professionals and learning from serious failings in care', *Journal of the Royal College of Physicians of Edinburgh*, vol. 45, no. 1, 2015, p. 4.
5 K. Walshe, *Inquiries: Learning From Failure in the NHS?*, London, Nuffield Trust, 2003.
6 Francis, *Mid Staffordshire*.
7 Ibid., pp. 24, 29 and 30.
8 K. Mackie and F. Way, *Setting Up and Running a Public Inquiry*, London, Centre for Effective Dispute Resolution, 2015.
9 National Audit Office, *Investigation into Government-funded Inquiries*, HC 836, London, HMSO, 2018; https://www.nao.org.uk/wp-content/uploads/2018/05/Investigation-into-government-funded-inquiries.pdf (accessed 21 May 2019).
10 Francis, *Mid Staffordshire*, p. 16.
11 Howe, *Ely Hospital*, paras. 402–413.
12 Ibid., para. 566.
13 Francis, *Mid Staffordshire*, pp. 9–15.
14 Howe, *Ely Hospital*, paras. 591–592.
15 M. Bemelmans-Videc, R. Rist and E. Vedung, eds., *Carrots, Sticks and Sermons: Policy Instruments and their Evaluation*, New Brunswick NJ, Transaction Publishers, 1998.
16 Francis, *Mid Staffordshire*, recommendations 181, 183 and 184.
17 G. Howe, 'The management of public inquiries', *The Political Quarterly*, vol. 70, no. 3, 1999, pp. 294–304.
18 Kennedy, *Learning from Bristol*, p. i.

