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The Francis Inquiry Report - One Year On

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A year on from the Francis Report (Francis 2013), several further reports have followed from the government, mostly on strategy and safety: its own response Hard Truths (Department of Health 2014), and the Berwick (National Advisory Group on the Safety of Patients 2013), Cavendish (2013) and Clywd (2013) reports. Some real steps have been taken in particular towards greater transparency, for example, quarterly reports on complaints, the professional and organisational duty of candour, the publication of 'never events', and the proposed new criminal offence of wilful neglect.

Far less progress, it seems to us, has been made on accountability. For example, it seems that the fit and proper person test will apply formally only to trusts, but not to clinical commissioning groups or to NHS England. Whistleblowing remains challenging, despite the progress we have made in understanding the reasons that people do not speak up when they know that something is wrong. Less progress still has been made towards achieving patient-centredness; the debacle over Care.data (Triggle 2014) is a case in point – using patient data without consent is hardly an example of 'nothing about me without me.' Real change in the NHS has, as usual, come from within, rather than from the top.

There is no doubt that the Francis report came as a shock and a challenge. We looked into the mirror and we didn't like what we saw. That has certainly been the case with health and care regulators. In our paper *Asymmetry of Influence*, published by the Health Foundation last year (Bilton and Cayton 2013), we reviewed the regulatory landscape, starting with Berwick's observation that "the current regulatory system is bewildering in its complexity and prone to overlaps of remit and gaps between different agencies. It should be simplified" (National Advisory Group on the Safety of Patients in England 2013). Professional health and care regulation demonstrates this complexity admirably.

Professional Regulators

There are nine UK health professional regulators, one of which also regulates social workers in England. Three other organisations regulate social workers in Scotland, Wales and Northern Ireland. Some regulate single professions, some regulate multiple professions. The Health and Care Professions Council regulates 16, including social workers in England. Some are huge– the largest is the Nursing and Midwifery Council (NMC) with a register of nearly 700,000; some are tiny – there are around 2,800 chiropractors registered with the General Chiropractic Council. Some are old – the General Medical Council (GMC) was established by the Medical Act 1858 – while some are only a decade old. The General Optical Council regulates students, but no one else does.

The organisations have common functions of keeping the register, setting out standards, receiving and investigating complaints, and quality assuring courses of higher education that lead to registration. However, they have different legislation, standards, approaches and sanctions, and different levels of efficiency and effectiveness.

It is not of course just people who are regulated, and different kinds of regulation have different influences on outcomes, which is why we called our paper *Asymmetry of Influence*. The array of regulators of different aspects of care, in addition to the professional regulators, is enormous. It includes the Medicines and Healthcare Products Regulatory Agency (MHRA, regulating products), the National Institute for Health and Care Excellence (NICE, regulating processes), Monitor (regulating health sector), the Competition Commission (regulating prices), the Care Quality Commission, Healthcare Improvement Scotland, the Regulation and Quality Improvement Authority and Healthcare Inspectorate Wales (CQC, HIS, RQIA and HIW in England, Scotland, Northern Ireland and Wales respectively) regulating places.

Despite this array of regulators, in public discussion more regulation is often invoked as if it will make the world a better place. Regulation is often described as if a Utopian enterprise; regulation is cited as the answer to all sorts of problems. However, in reality regulation is endlessly utilitarian, seeking the adequate good of the greatest number. The various regulatory functions require staff to work patiently and accurately with vast quantities of detail. The last doctor or nurse added to the GMC's or the NMC's register is the last to have been deemed just good enough to practise.

Here we find the source of one of the great fallacies in the debate about the role of regulation – the conflation of the good enough with quality improvement. This confusion of regulation, quality improvement and additionally inspection has been manifest in the past confusion in role of the Care Quality Commission. The new Chief Inspectors have made a real difference, in part because of the real concentration, thought and engagement of CQC, but also because of personality and style, and the quality of the people involved.

One of the practical consequences of the multiplicity of regulatory organisations is the plethora of advice, guidelines and standards telling people and organisations how to act. Carthey and colleagues (2011) found that the NHS Library had a list of 152 publishers of guidelines and 17 references to guidelines about how to develop guidelines. They also found over 3,000 guidelines on the Department of Health's website and 1,000 on the NICE website. The authors conclude that "clinical guidelines are undoubtedly an essential foundation of high quality patient care. However, their extraordinary and uncoordinated proliferation in the NHS confuses staff, causes inefficiencies and delay, and is becoming a threat to patient safety. We need to recognise the problems caused by current approaches and introduce greater rationalisation and standardisation at both national and local levels".

Lessons to Learn

The real lesson from Francis is still to be learned. We don't need yet more rules, regulations and guidelines. We need more personal responsibility, more professionalism, and more decision-making near to patients. We also need to treat health and social care professionals with dignity, respect and compassion, for how else can we expect them to show dignity, respect and compassion to patients and their families? There is much evidence that people behave well, and do high quality work when they are engaged, empowered and respected. To achieve this we need more management and less administration. As the King's Fund said in a 2011 report, "there is appreciable evidence that the NHS is over-administered as a result of extensive, overlapping and duplicating demands from both regulators and performance managers", and the report cited evidence pointing to a conclusion that 'the NHS, particularly given the complexity of health care, is under- rather than over-managed (King's Fund Commission on Leadership and Management in the NHS 2011).

We are slowly learning more about how regulation and humans interact – what might be called the social psychology of regulation. The more we learn, the more it becomes apparent that more regulation is seldom the answer, because all regulation has unintended consequences which may be the opposite of the intended outcome. In an excellent editorial in the BMJ Goldacre and Spiegelhalter (2013) looked at the evidence relating to cycle helmets and safety. Although a number of studies have shown that people wearing helmets are less likely to have a head injury, they point to evidence that suggests other, less desirable effects of making helmet wearing compulsory. For example, drivers may give more room on the road to somebody who is not wearing a helmet. Making helmets compulsory may reduce the number of people who wish to participate in cycling, thus resulting in individuals losing out not only on the health benefits of cycling, but also the 'safety in numbers' effect achieved by increased cyclist density on the road.

We have also been interested in research which has looked at the consequences of taking regulations away, leaving people to make their own judgements about the best way to proceed. The most striking example of this is the 'shared space' treatment of Exhibition Road, in South Kensington, London, where street signs and markings have been removed, requiring pedestrians, cyclists and drivers to focus on what is in front of their eyes to avoid collisions and accidents (Moore 2012). It introduces an element of uncertainty, which requires everyone to be more vigilant for their own safety. While the success of the project may be contested, it seems clear to us that if people are given responsibility for self-management, mostly they will behave responsibly.

Personal responsibility is central to professionalism, is empowering and is an important motivator for safe practice. This includes personal responsibility for error; while the Berwick report observed that fear in the workplace is toxic both to safety and improvement, this should not be at the expense of people being responsible for their own actions and mistakes. The role of regulation in relation to professionalism is to provide a framework in which it can flourish,not to be a substitute for it.

There has been much done in the last year by the CQC, GMC, NMC and others to identify common objectives and values and a shared model of regulation, but progress is hampered by inconsistent legislation, and a lack of clarity from government as to what regulation is for, as policy swings between red tape cutting and regulating everything that moves. In the year ahead we need focus on working hard at achieving a culture of professionalism and responsibility. That includes how we behave personally, for all of us are the makers of the culture in which we work.

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