REGULATION AND COMPASSION
Can we? Should we?
Reflections on the NHS post Mid-Staffs

Jonathan Montgomery, Professor of Health Care Law, University College London
Jonathan.Montgomery@ucl.ac.uk

Disclaimer: I hold, or have held, a number of public service roles and have drawn on my experience of these when preparing this paper. These include chair of a number NHS organisations in Hampshire; two NHS Trusts, a strategic health authority, a large PCT (and then a cluster of PCTs during the transition to the 2013 reforms). Nationally, I was chair of the Human Genetics Commission from 2009-12 and of the Advisory Committee on Clinical Excellence Awards from 2005-14. I currently chair the Health Research Authority (an NDPB established under the Care Act 2014) and the Nuffield Council on Bioethics. I was a member of the panel of advisors to the *Morecambe Bay Investigation*, established by the Secretary of State for Health under the chairmanship of Dr Bill Kirkup, which reported in March 2015. The views expressed in this paper are personal and do not represent the position of any of these bodies.

Abstract

This paper deals with the challenges of regulatory reach - essentially arguing that the learning from NHS institutional failures is not that we should regulate to require compassionate care so much as that the compliance mindset that regulation tends to produce also tends to squeeze out compassion in favour of more easily measurable externally observable actions. The paradox is therefore that regulating for compassion may produce the opposite. I also speculate that this could be seen as a challenge to the idea that law should be seen as a system of rules and also to the view that clinical freedom is a problem and requires closer regulation.

TARGET 6,000 WORDS

PART A: DIAGNOSING THE PROBLEM

Francis I: FUNDAMENTAL FAILURES OF COMPASSION IN MID-STAFFS
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018

A.1 Patients

- Left in excrement in soiled bed clothes for lengthy periods;

- Assistance not provided for patients who could not eat without help;
- Water was left out of reach;
- In spite of persistent requests for help, patients not assisted in their toileting;
- Wards and toilet facilities left in a filthy condition;
- Privacy and dignity denied, even in death;

A.2 Professional staff

- Triage in A&E by untrained staff;
- Staff treated patients and those close to them with what appeared to be callous indifference.
- Lack of basic care across a number of wards and departments;
- Consultant body largely dissociated itself from management;

A.3 Culture

- Culture at the Trust not conducive to providing good care for patients or providing supportive working environment for staff;
- Atmosphere of fear of repercussions;
- High priority placed on targets;
- Low morale amongst staff;
- Lack of openness, acceptance of poor standards;

A.4 Governance

- Management failure to remedy the long-term deficiencies in staff and governance
  - absence of effective clinical governance;
- Lack of urgency in the Board's approach to governance problems;
- Statistics and reports preferred to patient experience data: Focus on systems, not outcomes;
- Lack of internal and external transparency regarding problems at the Trust.

PART B KEY REGULATORY RESPONSES

Francis II: 290 Recommendations (numbers of recommendations in brackets0

B.1 A regulatory approach:

- Values & principles: NHS Constitution (3)
- Standards and accountability for compliance (including managers) (9,10 13-18)

B.2 Nursing: Creating a culture of caring (185)

- Education for compassionate care
  - Aptitude test (188) for student selection (185)
  - Hands-on experience during training (186-7)
  - Common qualification/assessment (189)
  - National competencies (190)
- Values-based recruitment to 'qualified' & 'unqualified' staff nursing jobs (191)
- Clear identification & roles for health care support workers (207-8); registration (209), code of conduct (210), training standards – NMC role (212-3)

NB Much had already been in place (e.g. student selection, hands-on experience during training)
NB Seems to assume that extending professional regulation to support staff solves problem, while report criticises regulated professions
NB needs to be seen in conjunction with consideration of recommendations in relation to culture of organisations in which care is delivered.

B.3 Responsible Persons

- Director accountabilities, 'fit & proper person' test (79-86)
- Leadership accreditation/regulation (214-221)
- Responsible Officer' for nursing (192)

Implementation: *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regs 5 & 19*

Staff must be

(a)… of good character, (b).… qualifications, competence, skills & experience … necessary for the relevant office or position or … work.

In addition, directors (or equivalents) also not have (reg 5)

(d)… been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity.

http://www.cqc.org.uk/content/regulation-5-fit-and-proper-persons-directors

Indicators of bad character: Schedule 4 Part II sets out matters to which regard should be had:

> 7. Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.

8. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

NB 'Any offence' no limit of type of concept of spent conviction?

Understanding 'good character': Care Quality Commission Guidance
http://www.cqc.org.uk/content/regulation-5-fit-and-proper-persons-directors#guidance

> 'Character determines the response to any given situation and good character will ensure that the response is the correct one, regardless of the circumstances and within agreed processes and systems. It is not possible to outline every character trait that an individual should have. However, among them we would expect to see that the diligence processes take account of honesty, trust and respect.'

NB An internal attitude that 'ensures' an externally observable response
BUT what can be measured in relation to this and how?

> 'Caring is one of CQC's key questions against which we rate and we expect this attribute to be at the core of those delivering health care. During inspections we explore whether staff are caring towards people receiving services and whether they are treated with compassion. One way of doing this is by asking people receiving services how they feel when they are being treated or spoken with by staff in that service, and asking staff how senior leaders set the tone and culture of the organisation in this respect.'

Some reasons to be cautious about 'good character':

Stock v Central Board of Midwives [1915] 3 KB 756: Living with a man not her wife

Ward v Bradford Corp (1972) 70 LGR 27, 35: Woman expelled from teacher training college for allowing man to stay in her room overnight

> 'This is a fine example to set for others! And she a girl training to be a teacher! I expect the governors and staff all thought she was an unsuitable person… she would never make a teacher. No person would knowingly entrust a child to her care.' (Denning J)

Some reasons to be cautious about the responsible person test:

The scope of 'Privy to':

> CQC 'complicit'
> DAC Beachcroft 'evidence to suggest the individual was aware of serious misconduct or mismanagement but did not take appropriate action to ensure it was addressed.'

January 2015: Health Service Journal reported a 'mass referral' of 20 senior NHS Managers, including current and former CEOs, Medical Directors and senior board directors by a 'group of

whistle-blowers and campaigners' alleging that they 'are unfit for board level positions because of their past actions of behaviour

The outcomes are not yet known, but it is clear that this is a new opportunity for a blame culture.

Fundamental problem in regulatory response that separates individuals and cultures? Can compassion be secured by individual good character or is it a cultural problem?

B.4 Duties of Candour (173-184)

- Disclosure to Monitor in FT process (70)
- Staff reporting of concerns, with feedback (12)
- Gagging clauses to be banned (179)
- Disclosure & support where death or serious harm may have been caused by act or omission or organisation or staff (174)
  - Statutory duty (181) with remedy for breach
  - Criminal offences for misleading(183)

Implementation *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20*

Where there is…

'any unintended or unexpected incident' 'in the reasonable opinion of a health care professional, could result in, or appears to have resulted in… the death' 'or… severe harm, moderate harm or prolonged psychological harm to the service user.'

The provider must

'provide an account… include an apology'

'"apology" means an expression of sorrow or regret'

http://www.cqc.org.uk/content/regulation-20-duty-candour#guidance

NB: Actual provisions much more complicated.
NB Obligations are also on imposed on individuals
NB Criminal offence punishable by fine up to Level 4 (£2,500).

B.5 Whistle-blowers

To note in passing: Francis III on creating culture in which whistleblowing is welcomed

B6 Required Staffing Levels

To note, in passing: Current debates, links with outcomes, possibly with compassion – space to care?

PART C SOME CONCERNS ABOUT THE ROLE OF REGULATION

Paradoxes of regulation for compassion

C.1 Compassion: Character, Context, Action:

- Is compassion to be assessed in the experience of the person receiving care or the attitude of the care giver?
  - Interest in patient experience has led to the 'family and friends' test
- What is the regulatory target? Being compassionate or doing the right thing?
- Professional agency and corporate regulation
  - Professional discretion v external compliance

C.2 The Liverpool Care Pathway

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

- Model of good practice: 'the LCP entirely reflects the ethical principles that should provide the basis of good quality care in the last days and hours of a person's life.' (p 8)
- But 'implementation of the LCP is not infrequently associated with poor care'.
- Implemented in way the focussed on compliance with process not individual

  'the LCP appears to be being used by some clinicians as a protocol to be followed, rather than as a set of alerts and guidelines for good practice, as it is intended.' (p 26)

NB Moving end of life care from a matter of clinical discretion to regulatory compliance reduced rather than improved individualised compassionate care.

C.3 Cultures of accountability: logics of the Mid-Staffs regulatory responses

- Forced transparency, required apologies, stronger penalties:

  - A positivists' view of the law: commands backed by sanctions, hard to connect with the virtue of compassion
  - Fit and proper persons test provides a vehicle for witch hunts
  - Challenges of triple jeopardy
- Blame, no blame and fair blame cultures

C. 4 Costs of regulation:

Major costs of various sorts are associated with the post Mid-Staffs regulations

- The army of inspectors
- Managerial focus on system compliance (not quality of care: the same was seen in Morecambe Bay)
- Failures of professional leadership (Major feature of Morecambe Bay)
- Professional focus on record keeping (Liverpool Care Pathway)
- Loss of focus on individual care in favour of feeding external regulatory requirements (all Inquiries)

Yet: Little reason to think regulation has reduced the risk that the failures of compassion at Mid-Staffs could be repeated?