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EDITORIALS

Burdensome regulation of the NHS

The insatiable demand for information is part of a wider problem of trust within the service

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Internationally, there is a trend towards increasing regulation of healthcare organisations and professionals, and a less trusting and more bureaucratic approach to overseeing them. The resulting burden of data collection, inspection, and reporting upwards has been the grounds for consistent and growing complaints.

A 2013 review of bureaucracy in the English NHS estimated that the main regulators imposed costs of £300m-£500m (€380m-€630m; $420m-$710m), with perhaps three times more being generated by the rest of the system—for example, commissioners.[1] But reaching any sort of precision—and even more importantly, working out how much can be justified—is fraught with difficulties. Not least of these is the confusing mix of different organisations that carry out regulatory functions or collect information from providers.

The Care Quality Commission (CQC) carries out periodic inspections and requires providers to submit information for an annual review of quality. Recently its remit was extended to include assessing efficiency. Clinical commissioning groups collect a lot of information in their role as commissioners. NHS England does the same, while NHS Improvement—the overseer of providers—looks at a range of measures, including performance, finance, and efficiency. NHS England and NHS Improvement also make frequent ad hoc requests for information and require key staff to join regular conference calls to report on concerns such as performance of emergency departments.

In addition, there are bodies responsible for professional training, professional regulators, and national audits; other statutory regulators; and a variety of voluntary accreditation schemes. Doctors have an additional system of oversight and regulation—with revalidation for GPs only the most recent addition.[2] Over the course of a career, the chair of the General Medical Council has said that he sees investigations by his body as an "occupational hazard."[3] Nurses and other professionals are going down a similar route. On top of all this, there is a substantial amount of internally generated bureaucracy that has a direct and potentially unhelpful effect on front line staff.

Some of this, no doubt, is necessary—but there are good grounds to suspect much is not. The number of regulatory bodies collecting information and asking questions is large, coordination is limited, and despite years of exhortation there remains a reluctance to share information. The result is undoubtedly duplication and wasted effort collecting data that may not be useful or even used. The accountability of the regulators for the burden they create is limited, although work is now underway to deal with some of this between CQC and NHS Improvement.

This problem has been recognised in multiple previous attempts to rationalise information collection and learn from experience in this area. But these have been knocked off path by reorganisations, changes in what is expected of regulators, and a failure to implement the recommendations of well intentioned reviews. The 2013 work, commissioned by the secretary of state, seems to have sunk without trace.

Regulation may have other dangers beyond simply the time and money it demands from providers. Boards and front line professionals may be disempowered or distracted by the requirements of the performance management and regulatory system.

Real responsibility for applying standards rests with frontline professionals and the managers and boards of their organisations. But oversight from so many different bodies creates the potential for confusion and the risk of the "problem of many hands," in which accountability is distributed and it is not clear who is responsible for key actions. Commissioners may still be tempted to take the view that quality is someone else's responsibility. There is a paradoxical chance of ending up with a system that is both burdensome and yet also allows problems to be missed or be seen but not acted upon.[4]

More fundamentally, reliance on external oversight and management can contribute to the low trust and potentially bullying environment that seems to permeate some of the relationships in the NHS.[5] We know this can have unhealthy unintended consequences such as risk aversion, stress for staff, and a culture of hiding problems and shifting blame.[6 7]

There is more to do to sort out data collection and the number of bodies asking similar questions. However, the bigger question is how giving so many roles to external bodies, sometimes poorly coordinated, shapes the way the health service takes responsibility for quality and improvement. Scotland has a coherent quality strategy and institutions that fit together central

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diktats and local initiatives. While the NHS north of the border is not exempt from complaints of burdensome inspection and regulatory burden, there is at least a consistent and aligned approach.[8] The English NHS must examine the same issues if we are to tackle the culture of low trust that is one of its most intractable problems.

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