The year of Francis

How do you change something as resistant to change as the NHS?

The government hit the ground running with the publication of Robert Francis's report into the Mid Staffordshire NHS Foundation Trust on 6 February,[1] and the pace hasn't slackened since. In his accompanying statement to the House of Commons, the prime minister announced several immediate measures—and that was before detailed consideration of Francis's 290 recommendations had begun.

These new measures included the creation of a single failure regime, whereby failures in care (and not just finance) could trigger suspension of a hospital board. Under a new test all patients, carers, and staff members would be given the opportunity to say whether they would recommend their hospital to their friends or family. The Care Quality Commission was asked to create a post of chief inspector of hospitals.

In addition, four new inquiries were announced that day—into patient safety, nursing qualifications, hospitals with the highest mortality rates, and patient complaints. A fifth—on the burden of bureaucracy—was announced a few days later.

Just seven weeks after the publication of the Francis report, the government published its initial response, flagging up its acceptance of most of the 290 recommendations.[2] In addition, it fleshed out the new regulatory regime under the chief inspector of hospitals, which would provide a single clear rating for hospitals, or "a single version of the truth."

Over the past few months the five additional inquiries have reported, and on 19 November came *Hard Truths: The Journey to Putting Patients First*, the government's final response to Francis.[3] It accepted 281 of Francis's 290 recommendations. New requirements for the reporting of ward staffing levels and duties of candour on providers and individuals were announced. Notice was given that "wilful neglect" of patients and the supply of false or misleading information by care providers would be made criminal offences.

Has there ever been a year in the NHS's 65 year history that has witnessed such frenetic activity around patient care? To which the answer might be another question: has there ever been an NHS scandal on the scale of Mid Staffs?

Identifying Mid Staffs culture as the problem, Francis prescribed a "fundamental culture change" for the entire NHS, which would put patients first. The government apparently concurred; the executive summary of *Hard Truths* ends with the desideratum: "hear the patient, speak the truth, and act with compassion."

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St Francis supporting the tilting church

If these words read like something handed out to novices on joining a religious order, they sit incongruously on top of the pile of reports and responses that accumulated this year. Mostly, these provide stricter definitions of old sins alongside a list of new ways of sinning and detecting sin. (For example, the new duties of candour demand that sinners, and their institutions, confess.)

The prescriptiveness of Francis (not 10 commandments, but 290) is likely to be a problem if cultural change is the desired outcome. You can't legislate for goodness. In their *BMJ* article on NHS culture, Huw Davies and Russell Mannion criticised Francis for his limited understanding of cultural change: "research shows more complex and nuanced relations between cultures, practices, and outcomes than Francis implies."[4] And that's despite his inquiry, like the Kennedy inquiry into Bristol paediatric cardiac surgery before it, trying very hard to understand the meaning of culture in a healthcare context.

Mid Staffs *v* Bristol

There's nothing accidental about bracketing these two inquiries together; "Mid Staffs" (or "Francis") has almost supplanted "Bristol" as the exemplar for all the NHS's ills. It is instructive to examine the similarities and differences between the two. Bristol followed higher than expected mortality after complex cardiac surgical procedures in children[5]; Mid Staffs followed some hundreds of extra inpatient deaths and heartrending accounts of abysmal nursing care. But the recommendations for change, and the responses of the government of the day, are remarkably similar.

Top of the Bristol inquiry's list was the need for the patient to be at the centre of everything that the NHS does. The need for openness and transparency, clear and understood systems of responsibility and accountability, enough information to allow patients to make informed choices, and a duty of candour on staff when things go wrong were all listed there a decade before Francis's report.

Far from the medical landscape being "all changed, changed utterly" by Bristol, as this journal predicted,[6] it remains depressingly similar—proof, if any more were needed, that the NHS is adept at absorbing change without greatly changing itself.[7]

So what are the chances that Mid Staffs will change anything? Will it become more than a non-specific term of abuse to smear the NHS and its staff, which is how Bristol mostly functioned for the past decade?

For the record, the specific problem at Mid Staffs was the depletion of its nursing establishment to save money in the run-up to its application for foundation trust status. And, to its credit, the statement of common purpose accompanying the government's response acknowledges that "Blind adherence to targets or finance must never again be allowed to come before the quality of care."

But as this government's aspiration to shrink state spending is likely to make austerity an enduring feature of the NHS, the sheer difficulty of maintaining the quality of care in the face of financial stringency deserves far more attention in the aftermath of Mid Staffs than it has received. The grim determination to examine every element of Mid Staffs other than this one looks increasingly like evasiveness.

Judging by his recent actions,[8] the secretary of state for health has abandoned the goal of culture change and is pinning his hopes on inspections, coupled with naming and shaming of wrongdoers. He seems oblivious that this formula has been tried before and doesn't deliver long term.[9] Similarly, his activism suggests that he's oblivious of the fact that the Health and Social Care Act 2012 was designed to take politicians out of the equation, "liberating" the NHS under the NHS Executive. Perhaps the government has realised that the act cannot be made to work so is behaving as if it were never enacted.

It's odd that the legislation that so dominated our thinking these past few years may end up changing very little. Who knows? The same fate might befall Francis's far worthier efforts.

Full details including references and competing interests are in the version on bmj.com.

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Doctors need to take the lead on poverty's effects on health

Data suggest hard times ahead, especially for increasing numbers of children

For the first time in more than 17 years, child poverty in the United Kingdom increased in absolute terms in 2011-12.[1] This follows a long term reduction in child poverty from among the highest rates in Europe. These were hard won gains resulting from policies to improve the life chances of children in the UK. Now we see worrying signs that these achievements are being undone.

Poverty leading to inadequate nutrition is one of the oldest and most serious global health problems. Although it is assumed not to be a serious issue in rich countries such as the UK, we have highlighted a nearly twofold increase in hospital admissions linked to malnutrition in England—from 3000 cases in 2008-09 to 5500 in 2012-13.[2] People's food purchasing behaviours have changed since the recession. The poorest households have reduced their consumption of fresh fruit, vegetables, and fish, with evidence of substitution by unhealthier foods, especially in families with young children.[2 3] More children are turning up to school hungry in the UK, with teachers reporting that hunger is influencing children's ability to concentrate and learn.[4] Frail elderly people are also at risk of food poverty, with the combination of inadequate heating and nutritional intake over the winter being particularly dangerous.

Christmas is a time for giving. Many people across the country will be gladly donating to food banks, to support the estimated 60 000 people turning to emergency food aid over the festive period.[5] The use of food banks in England has risen dramatically—from 26 000 referrals in 2008-09 to around a third of a million in 2012-13—with many of the recipients being families with children.[2] Furthermore, the public seems to be increasingly worried about the growing social injustice exemplified by food poverty. A recent opinion survey showed that one in six of the British public is worried about poverty and inequality, the highest figure the polling company MORI has ever recorded.[6]

KAREN ROBINSON/PANOS

Hungry to bed

What has caused this increasing reliance on food aid? We know that incomes have fallen considerably during the economic downturn and have continued to fall as other economic indicators improve,[1] and this has occurred alongside a rise in the cost of living. For instance, the prices of fish, fruit, vegetables, bread, and meat have all risen by more than 30% since 2007.[3]

But the policy response to the recession is also to blame. The most common reasons cited for food bank referrals are benefit delays, low income, and benefit changes.[7] Changes to the tax and benefit system are leading to a reduction in the adequacy, eligibility, and access to benefits, especially for some of the poorest families with children.[1] Cuts to the public sector are hitting services on which poor families with children rely, with the largest spending cuts to local authority budgets occurring in the most deprived areas.[8] As a result, cuts are affecting vital children's services such as Sure Start centres, 580 of which have closed since 2010.[9 10] The erosion of these safety nets in the UK is of grave concern, because those European countries that have more adequate social protection experience better health outcomes (see figure on bmj.com).[11]

Being at the receiving end of charity can be stigmatising and disempowering, and food banks do not deal with the root causes of food poverty

This winter's priority

In the short term, a priority must be to get food to those who need it most over winter. The Trussell Trust, Oxfam, and the Red Cross, in collaboration with supermarkets, are leading these efforts. Local government needs to step up to the mark.[12] Local authorities and health services can help to develop joined-up local strategies, to collect better data, and to provide staff and facilities.

But food banks cannot be seen as a viable long term solution. In the context of globally rising food prices and stagnating wages, this problem is not going to go away. Although the charity of people giving food to those who are struggling is commendable, as a basis for a social protection system it is neither sustainable nor appropriate. The rise of food banks is a powerful symbol of failure in our national systems. But being at the receiving end of charity can be stigmatising and disempowering, and food banks do not deal with the root causes of food poverty. Case studies highlight the shame that some people feel when they are forced to resort to emergency food aid. As Nick Saul director of a Toronto based food bank said recently "Most people who have to visit food banks say it is a slow, painful death of the soul."[13]

What can be done? As a start, we call on the royal colleges to take up the challenge of leading doctors against poverty. There is a clear need for better data, improved monitoring, and an increased awareness of the health impacts of poverty that are all too evident at the sharp end of healthcare. The medical profession also has an important role in assessing the adequacy of welfare benefits for supporting health and for maintaining the principles of equity in the NHS. Furthermore, public health professions have a key role in influencing local authority decision making on where the cuts fall in local services. We all need to advocate for more equitable welfare reforms, with the test that they must protect the most vulnerable, particularly children.

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The Cochrane Collaboration at 20

Much has been achieved, but much remains to be done

Just as Archimedes leapt naked from his bath on discovering his principle and August Kekulé dreamt the structure of the benzene ring while sleeping beside a fire, so Iain Chalmers had a vision of the Cochrane Collaboration at 6 am in May 1991 while walking beside a tributary of the Thames in Oxford. The collaboration would fulfil the vision of Archie Cochrane and clean up the Augean stables of medical studies. Specifically it would prepare, maintain, and promote the accessibility of systematic reviews of the effects of health interventions.[1 2] The enterprise would need to be global because it was such a huge task.

Twenty years after it was founded the collaboration has more than 31 000 contributors from 120 countries and has published more than 5000 systematic reviews.[3] Many see Cochrane reviews as the gold standard, and the collaboration has played a major role in promoting evidence based practice. The collaboration is clearly a success. But like any organisation it has problems and challenges, and Chalmers, who gives an annual prize for the best criticism of the collaboration, described some of them at the 21st gathering of the collaboration in Quebec. Challenges included finding more efficient means of preparing and updating reviews and avoiding duplication of reviews.[4]

Arguments for mission creep

Perhaps the main challenge is whether to extend the collaboration's mission. It has mainly covered treatments, but should it be extended to, for example, diagnostic tests, qualitative studies of implementation, and products derived from the systematic reviews that might compete with tools like UpToDate and the *BMJ*'s evidence products.[3] Clearly, extension would be desirable because all elements of healthcare need to be evidence based. In addition, evidence based tools beyond systematic reviews can promote evidence based healthcare and provide additional sources of revenue for the collaboration.

The argument against such a move is that the collaboration has much to do to achieve its current mission. Coverage by the systematic reviews is patchy—some topics are thinly covered and some reviews answer questions that interest only the authors. Some reviews conclude that there is no reliable evidence, which is important to know but not useful to clinicians. This patchiness is not surprising because Cochrane is a bottom-up organisation, with 53 review groups mostly answering the questions that are passively brought to them, and many reviewers are more researchers than clinicians. Some reviews are commissioned, but most are produced by unpaid people who cannot easily be told what to do. There are now attempts to prioritise topics for review and to be more directed. Chalmers's latest creation, the James Lind Alliance, could help because it aims to identify uncertainties in healthcare.

But how many reviews would be needed to answer all questions on just treatment? Jon Brassey, a supporter of evidence based practice, points out that of 358 questions asked in dermatology only three could be answered by a single systematic review.[5] Healthcare is increasingly about people with multiple conditions,[6] yet most randomised trials exclude patients with more than one condition. This is a problem for all of healthcare, not just for the Cochrane Collaboration and evidence based medicine.

Another factor that affects all of healthcare but is a particular problem for systematic reviews is that about half of clinical trials are not published.[7] This was pointed out in a 1992 *BMJ* editorial that described the work of the collaboration,[2] but little progress has been made since then, although a major campaign is now under way.[7] Because published trials are biased towards the positive, systematic reviews probably exaggerate the benefits of interventions. Tom Jefferson, a longstanding reviewer for the collaboration, has struggled to obtain all the data on neuraminidase inhibitors for treating influenza and concluded that "Cochrane reviews based on publications should really be a thing of the past."[5]

The epidemiologist Rod Jackson and others have argued that to be truly useful to clinicians systematic reviews should be based on individual patient data so that patients can be stratified by risk. Such information helps clinicians to know when to treat patients. The limited amount of information on adverse effects also reduces the usefulness of reviews; the lack of information results from poor reporting of adverse effects in trials and trials not being the best way to identify such effects.

Healthcare is increasingly about people with multiple conditions, yet most randomised trials exclude patients with more than one condition

Falling behind

Even with existing reviews there are worries about quality. The "methodological expectations of Cochrane intervention reviews" has 80 standards for conducting and 108 for reporting reviews, and few reviews meet all of these standards.[3] A recent audit showed some basic deficiencies in reviews, particularly in abstracts and plain language summaries.[8] Another worry is that only around a third of reviews have been updated in the past two years.[9] In some cases this doesn't matter—because the evidence hasn't changed or the question is no longer relevant—but in others it renders the review useless. The proportion of reviews that are up to date has fallen over the past three years,[9] and the collaboration may need to find a way of identifying the reviews that need updating the most. No other provider of systematic reviews does better, perhaps because updating can be tiresome and unrewarding, and often arrives at something close to the original conclusion.

Efficiency is a problem because it takes an average of 30 months to complete and publish a Cochrane review.[9] Brassey points out that

Jesuitical

ERIC BRISSAUD/GAMMA-RAPHO VIA GETTY IMAGES

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Cochrane has received something like £150m (€179m; $246m) in funding over its 20 years,[5] around £30 000 a review. And remember that most reviews are conducted by people in their own time.

Both the quality of the reviews and the efficiency of their production urgently need to be raised. Some in the collaboration have begun to produce more rapid reviews, and Chalmers and Paul Glasziou, a longstanding member of the collaboration, have suggested categorising questions into those needing just a rapid review, those that merit a full review, and some that demand a review based on individual patient data.[4] Andy Oxman, who has been in the collaboration since the beginning, has listed 13 ways to improve reviews, starting with "Ensure that any important potential adverse effects of the interventions are addressed (whether the included studies report those outcomes or not)."[3] Brassey suggests that it might be possible to depend simply on the best trial or trials reported in core journals.[5] These strategies are unlikely to be acceptable, not least because if those core journals are the "top" journals, they would be most likely to exaggerate the benefits of treatments.[10]

Open access—realistic goal

Another challenge is to make systematic reviews more useful and accessible. Reviews are currently difficult for clinicians, so the collaboration is exploring more useful "derivative products," although it might struggle against established competitors. The collaboration is committed to achieving open access, which is a more realistic goal. Many people have free access though HINARI and national licences, but at least half of the world does not, and open access is more than free access—it also allows reuse and repurposing. Although institutions in some low income countries have free access, few reviews cover problems relevant to those countries, partly because most research is from the developed world. About a fifth of Cochrane review authors come from developing countries,[9] and the collaboration is keen to increase this proportion and find ways to be more useful in low income countries.

The Cochrane Collaboration is a special organisation, more like a church than a corporation. Muir Gray, one of the founders, says that he saw the Jesuits as a good model. "Cochranites," as they are called, believe passionately in the collaboration's mission, often work for free, and are signed up for life. The passion is palpable at annual colloquiums and has driven many of the collaboration's achievements, but there is room to be more business like. The Cochrane Library got its first editor a few years ago, and the collaboration appointed a new and modernising chief executive just over a year ago. As a consequence, a strategy that has goals and objectives and will soon have targets is being finalised. The collaboration is also considering whether 53 review groups is the best way for it to be structured.

Rightfully proud of its achievements, the collaboration is well prepared to meet its many challenges.

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