

Section G – Contention with NHS England and the Care Quality Commission

Why this separate section?

The nature and closure of St James Surgery in 2016 is described in the *Obituary* in *Section D* of this Home Page. The story of this demise is turning out to be significant far beyond the localised loss to its practitioners, staff and patients.

Although the closure was certainly dramatic, it was exceptional; at the time it could have been dismissed as a small-scale drama of limited interest. Yet around this contentious closure a larger picture has emerged: this larger picture, instead, shows those localised events to be a kind of watershed, a kind of prophetic diorama. It is the importance of this larger picture that merits the detailed argument and documentation that follow here in Section G.

What does this mean? Well, two years later we have clear and increasing losses throughout NHS pastoral healthcare: for staff in morale, recruitment and retention; for patients in service accessibility, let alone personal continuity of care. All of these losses impoverish, then imperil, mental health and primary care services in many ways *because* of the very management regimes that are entrusted with their stewardship.

Included in this section is a long letter titled *General Practice is the Art of the Possible: but we are turning it into a tyranny of the unworkable*. This title alone seems to summarise what is happening – the paradoxical fate of many of our reforms.

And how is this happening? The rise of *REMIC* (remote management, inspection and compliance) brings almost inevitable casualties of its own success and excess. This is because the two are easily conflated: vaunted effectiveness and collateral damage are then often hard to disentangle.

This happens because inspection regimes of REMIC tend to function like our modern, industrial deep-sea trawlers: vast, strong, fine-meshed nets trap not just the desired catch but numerous other species that are then dumped-dead overboard into an ever more lifeless sea. Our expedience is killing our source.

The contents of this section are a kind of biopsy – a tissue sample – from our ailing body politic of governance. Like any biopsy, detail is necessary.

1. A personal foreword and wider views

The latter part of 2016 brought a personal coda: the coerced and sudden closure of my long-established practice. This was the culmination of several years of my conscientious (so highly selective) non-compliance to ever-more NHS regulations. Paradoxically this guillotining served simultaneously as both a personal debacle and an endorsement of my objections: alongside personal loss and trauma there now clearly arose issues of more general interest – after many years writing about the dangers of our increasingly ratcheted and micromanaged healthcare my auguries were now clearly and dramatically illustrated. In particular, I have recurrently urged caution regarding the ever-greater procedural squeezing and corralling of its professionals: we can easily crush or displace much of value.

We are then left wondering: how could this happen?

The following selection of writings first describes the drama of this denouement, and then documents the broader questions and analysis I offered to the relevant authorities.

These writings draw also from my earlier long-term tracking and documentation of the evolving and extensive – if unintentional – damage. So my many years' prophecies of where this would lead have proved mostly accurate: any personal gratification from this instructive wreckage is largely eclipsed by a grim sadness.

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Crucial to understanding these personal and institutional losses is perceiving how we have jettisoned certain principles of professional trust and autonomy. I believe these principles are essential if we are to sustain the kind of healthy professional identity and integrity that lead – mostly – to our better care and judgements: all these depend on individuals' experience, informed intelligence and vocational conscience. *Trust* is a professional cornerstone, but now increasingly mistrusted and so driven out. Unless we are very careful, such over-policed regimes develop perverse forms – institutional power and professional integrity can become inversely related. This is now happening frequently, and with debilitating consequences that enervate our NHS.

I am not suggesting that we should abandon ever-present vigilance and thus discriminating mistrust. But the wisdom and workability of our professions lies in the *balance* (and thus style) we find for ourselves – or command in others – of trust *v* mistrust; of nourishing diversities of competence *v* punishing deviants for non-compliance.

The balance is crucial, yet subtle and delicate. As our current confused and unhappy medley of micromanaging regimes shows, this is not easy.

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Recent management and economic policies have made small GP practices almost extinct. Those few that remain are now, almost always, heroically and perilously vulnerable. This hostile environment, together with my age, boded ill for any lengthy Appeal process. How could I possibly, even eventually, recover and rehabilitate my practice? Even legal redress could not enable me to continue my work.

So, my submission and abdication were coerced, but my thinking and contention remain free. This freedom, now expressed, has aroused a steady stream of fraternalism. For beyond my own story and predicament many professionals throughout our welfare services have communicated to me how my plight and story are redolent of their own increasingly unviable working experiences and predicaments. The [*Centre for Welfare Reform*](#) has also documented many of these.

Clearly the issues raised here are important to many, and widespread.

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No written replies were ever received from NHS England. I made several further informal attempts at contact. Eventually a senior officer said this to me: 'Look, a lot of us at NHS England agree with most of what you say. We hope you keep

writing... This is strictly off the record, you understand...' The voice was wearied, stoic and apologetic.

The CQC at first avoided all invitations for informal discussion. Eventually two warily courteous and lengthily defensive letters were received. These merely reiterated the content and method of the original CQC report, carefully avoiding my seminal questions. I wrote another letter to a newly-appointed and deputising head of the service who, many months later, in August 2018, invited me for a 'face-to-face discussion about these important matters.'

Sections ix, x and xi contain these last exchanges and an account of the meeting.

Will the future be better?

2. Letters and articles challenging our excessive micromanagement and commodification within healthcare

Key points: seminal questions

If you give me six lines written by the hand of the most honest of men, I will find something in them which will hang him.

– Cardinal Richelieu (1585-1642)

Some preliminary questions:

- When we get very different accounts of complex situations in Welfare what do we believe? How do we decide? Which anomalies and discrepancies are tolerable? When do we need official arbitration?

These kind of questions underlie the contentious correspondence with NHS governing authorities over the draconian closure of a popular small General Practice.

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The notions and arguments that develop are complex and are summarised here. Interested readers can then turn to the letters in full.

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- The *mission* of NHS England (NHSE) and the Care Quality Commission (CQC) – to provide competence, safety, kindness and probity (CSKP) in healthcare – excites little debate. In contrast, their *methods* – in defining priorities, rules and truth – are often much more problematic and disputed. This is especially true where important anomalies arise.
- The following detailed accounts and correspondence revolve around one anomalous and then contended example: the procedural guillotining of a long-established and remarkably popular small General Practice.
- The arguments and questions pursued here are not intended to invalidate the many examples of helpful and apposite management practice enacted elsewhere by NHS England and the CQC. Both integrity and discrepancy need recognition.

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- The CQC has developed an increasingly precise and extensive regime of compliance requirements and inspection rules, These are all *assumed* to equate perfectly with CSKP. Yet CSKP is often inseparable from the kind of nuance and vagary that come with context, personal meaning and intelligence: these contextual factors cannot readily be prescribed or formulated accurately by remote edict. Indeed, such a strict regime can bring inadvertent harm through its trappings of rigidity and specious ‘certainty’: a kind of collateral damage.
- So such procedures and formulae are prone to overweening: despite other claims and intent, these reports are often, in fact, *accurate only in assessing compliance to their own protocols*. This means that they may, or may not, accurately reflect the actual desired practice qualities of CSKP. Even if we can pattern general frequent correlation, this must never be assumed universally as a certain equation. Outliers can sometimes be very positive.
- This conundrum is not a mere abstraction: it was evident in this particular practice, where CSKP was rated egregiously *poor* by the CQC, but was *excellent* according to all other real-life sources. An important anomaly, surely?
- In competent science this kind of anomaly is always taken seriously. Such anomaly invalidates, or seriously weakens, any hypothesis based on only one source. Evasion of this principle leads to ‘cherry picking’ – an inexcusable offence in science.
- The following accounts show what happens when this principle is flouted. To compound the problem, rather than explore this gross anomaly, the CQC ignores the discrepant evidence and then destroys its source (the practice).
- Such inspections share the inevitable inconsistencies of many medical screening procedures: false-positives (attributing non-existent pathology) and false-negatives

(missing important problems). Competent medical practice requires intelligent identification and judgement of these exceptions.

- The example here, of a procedurally culled practice, is akin to a false-positive screening automatically mandating major, then fatal, surgery.
- Such errors are most likely when a system becomes hermetic, and thus closed to other incongruous (usually inconvenient) evidence. Draconian defensive procedures – to save the perceived integrity of managing institutions – follow. These defences frequently backfire.

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Some concluding questions:

- How may NHSE and the CQC better understand such significant anomalies, rather than expediently dismiss them?
- How do we best understand the many forms of practitioner CSKP that thrive *outside* rigid and prescribed regimes? And how may we better identify, then understand, the gap that often opens up between strict institutional compliance and *actual* CSKP?
- Our best CSKP in healthcare rarely comes from top-down rules and regulations, or rewards and punishments. How do we now reacquaint ourselves with, and intelligently trust, our more natural human connections, sense and sensibility?
- Avoiding these questions, paradoxically, causes much damage to the very things the CQC and NHSE are briefed to protect. How can we now restore a better and wiser stewardship?

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