Section G – An instructive mausoleum. Contention with NHS England and the Care Quality Commission.

Why this separate section and what is it?

Section G is a kind of archival hub. A synopsis first explains and then introduces recent historical documents that have since become more sharply seminal. So the interested reader can navigate and understand how some apparently small-scale and local events in fact presaged those that have become of much greater and national significance.

The nature and closure of St James Church Surgery in 2016 is described in the *Obituary* in *Section D* of this Home Page and remains here the anchoring example for this collected correspondence. As was anticipated at the time, the story of this demise has turned out to be important far beyond the localised loss to its practitioners, staff and patients, or their immediate era.

This closure was executed with exceptional rarity and rapidity by the authorities' insistence despite substantial (but inevitably) disorganised protest from its staff and patients. At the time this could have been dismissed as a small-scale and anomalous event of limited interest. Yet since this contentious closure a larger picture has emerged: this more comprehensive view, instead, shows those localised disturbances to be a kind of prophetic watershed, a canary in the coalmine. It is the importance of this emergent larger picture that merits the detailed argument and documentation that are collated here in Section G.

Why is this necessary? Well, in the period following this event there have been related, egregious and still 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, of course, impoverish, then imperil, mental health and primary care services. In many ways this happens *because* of the very nature of reforms that, paradoxically, are entrusted with their improvement.

The documents here can help us understand this errant and self-stymying process.

Included in this section is an earlier, 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 does much to summarise what is happening – the unintentional yet absurd antimony of many of our reforms.

So how has this evolved? This compendium shows how the rise of *REMIC* (remote management, inspection and compliance) brings almost inevitable casualties of its own success and excess. There is evidence here, too, to show how this is because the two – success and excess – are easily conflated: vaunted effectiveness then heedlessly overruns to become collateral damage. All-too-easily we overdo our mistrustful regulation and pre-emptive control. The documents here portray the collateral damage.

We can see how this happens: inspection regimes of REMIC are now often functioning 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 administrative expedience is killing our human source: the tighter the management, the more lifeless the workforce.

The contents of this section can be viewed like serial biopsies – tissue samples – from our ailing body politic of governance. Like all biopsies, detail is necessary and several samples are safer.

1. A personal foreword to wider views

A brief narrative will help anchor this analysis.

The latter part of 2016 brought a personal coda: the coerced and sudden closure of a long-established and locally much-loved practice. This was the culmination of several years of conscientious (so highly selective) non-compliance on my part to ever-more often contextually irrelevant and unsustainable NHS regulations.

Paradoxically, this official guillotining served simultaneously as both a personal debacle and an endorsement of previously registered objections. What does that mean? Well, alongside personal loss and trauma there now clearly arose issues of much wider concern – after many years writing about the dangers of our increasingly unbalanced, ratcheted and micromanaged healthcare my predictions were now clearly and dramatically realised. In particular were recurrent cautions to NHS authorities regarding the ever-greater procedural squeezing and corralling of its professionals: we can see how we have since gone on to crush or displace so much of value. And now we are very unsure how to now replace the losses.

Many are perplexed: how could this happen?

The following selection of writings constitute repeated and incremental attempts to answer this very important question. It first describes the drama of this denouement, and then documents the much broader ensuing questions and analysis I offered to the responsible authorities.

Many previous writings, found elsewhere on this Home Page, foretold increasingly clearly the evolving and extensive – if unintentional – damage. So the interested reader can elsewhere track many years of still much earlier prophesies of where this trend would lead, and then assess their accuracy.

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I believe all these documents indicate a common theme: that if we want a good understanding of these personal and institutional losses it is crucial that we perceive

how we have jettisoned certain principles – those of professional trust, responsibility and autonomy. As our serial reforms have overridden these principles, it has become clear just how essential they are to sustain the kind of healthy professional identity and integrity that lead – mostly – to our better care and judgements: all these depend on the experience of individuals, their informed intelligence and vocational conscience. *Trust* is a professional cornerstone, but now increasingly mistrusted and so driven out.

What governing authorities have been resistant to recognise is how we are paying highly for these abandonments: for such over-policed regimes develop perverse forms – institutional power and professional integrity easily become inversely related. Police states produce not only more suspicious, craven demoralisation, but also more corruption. This pattern and its consequences are now very much part of our NHS culture and its sickness.

This is certainly not to suggest that we should eschew a 'police presence': continual vigilance and then *discriminating* mistrust. But the wisdom and workability of our professions lies in the *balance* (and thus form) 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: our wisdom is often lost in the overbearing wish to directly command and control.

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In this Section G we are considering a particular, yet more telling, loss to our Welfare services that eludes deserved discussion: that is how our recent management and economic policies have made small GP practices almost extinct. Those few that remain are now, almost always, heroically and perilously vulnerable. Personally, I could see increasingly clearly that my small practice was on Death Row. When, suddenly, the trap was sprung I was equally clear that this hostile environment, together with my age, boded ill for any lengthy Appeal process. How could I possibly, even eventually, recover and rehabilitate my small community? Similarly, legal redress was most unlikely to realistically enable me to reconstitute my work.

So, my submission and abdication were effectively coerced, but my thinking and contention remained free. This freedom, expressed since, has aroused from others a steady stream of fraternal support. So it is that 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 situations. The *Centre for Welfare Reform*, for several years, has published many of these.

It has become clear, therefore, that the issues raised are important to many, and widespread. Such substantial support provides further anchorage and validation for the compendium that follows here.

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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. It's very important … This is strictly off the record, you understand…'* The voice was wearied, stoic and apologetic.

The CQC at first, similarly, 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 about flawed assumptions and tendentious methodology. 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.'

Items vi, vii and viii contain these last exchanges and an account of this only meeting.

Will the future be better?

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

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)

This section here summarises the complex questions and arguments that emerged in correspondence with governing authorities. The interested reader can find the full

text of these documents at the end of this section. They are listed in chronological order.

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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 or even beneficent? Which are really dangerous? When do we need alternative arbitration?

  These kind of questions underlie the challenge to NHS governing authorities. The contended closure of a popular small General Practice of excellent record here serves as both the focus and the sacrifice.

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Summarised points from the attached documents

- 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, indices and judgements of truth – are often much more problematic and disputed. This is often healthily inevitable and thus not to be parried; especially so where important anomalies arise.

- It is important to acknowledge that the arguments and questions pursued here are not intended to invalidate the many other examples of helpful and apposite management practice enacted elsewhere by NHS England and the CQC. Real achievements may coexist with follies, and the presence of one should not eclipse sight of the other. As with the police or Courts: integrity and competence in some areas does not discount destructive incompetence in others. Both integrity and its failures need continual re-evaluation and recognition. Evasion or avoidance can bring, at best, only short-term respite.
- Like many politicians, governing authorities seem often emphatic and sure in their decrees and judgements, vaunting an Olympian authority and finality. Challenges are often met with such bureaucratic ripostes or defensive evasion. The attached writings represent such challenges and those typical responses.

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- There is a core process to such difficulties, and it is this: these governing authorities have developed, often excessively, an increasingly precise and extensive regime of compliance requirements and inspection rules. These become *assumed* to equate accurately with CSKP (competence, safety, kindness and probity) and this becomes frequently problematic. This is because CSKP is often inseparable from the kind of nuance and vagary that come with context, personal meaning and intelligence. So here is the Achilles Heel of REMIC: these crucial subtleties cannot readily be prescribed, judged or formulated accurately by remote index or edict. Indeed, such a strict regime can itself bring inadvertent harm through, first, a displacement of attention to mere technical compliance, and then to trappings of rigidity and specious 'certainty'. Both of these are kinds

of collateral damage – similar, say, to the damage to ambient life that may come from agri-chemicals. What we plan and what we get become very different.

- So such procedures and formulae are prone to overgrowth and overweening: despite other claims and intent, these official reports are often, in fact, *accurate only in assessing compliance to their own protocols*. Such apparent consistency may then be due to the system becoming 'hermetic'. This means that it may, or may not, accurately reflect the actual desired practice qualities of CSKP. Such are the limitations of 'box-ticking'. Even if we can pattern general frequent correlation, this must never be assumed universally or unconditionally as a certain equation. Even more, the missives that are offered here indicate how outliers can sometimes be very positive.

- This conundrum is not a mere abstraction: the reality is substantially evident in the particular practice exampled here, where CSKP was rated egregiously *poor* by the CQC, but was *excellent* according to all other real-life sources. An important anomaly, surely? Yet one expediently and recurrently ignored.

- In competent science this kind of anomaly is always taken seriously. Such inconsistency of evidence invalidates, or seriously weakens, any hypothesis based on only one source. Evasion of this principle leads to 'cherry picking' – an inexcusable offence in science.

- This discrepancy is particularly notable in a management regime claiming insistence on the submissions and accountability to 'evidence basis'.

- The following accounts show what happens when this principle is flouted. To compound the problem, rather than explore this gross anomaly, the CQC first avoids the discrepant evidence and then destroys its source (the practice).

- Instructively, such inspections often 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 more holistic judgement of these discrepant exceptions.
- The example here, of a procedurally and expediently culled practice, is akin to a false-positive screening automatically mandating major, then fatal, surgery.
- Such errors are most likely when an executive system becomes hermetic, and thus closed to other incongruous (usually inconvenient) evidence. Draconian defensive procedures – to save the perceived reputation or integrity of managing institutions – almost always follow. These defences frequently backfire.
- Here, now, on a national scale, we can see how such inadvertent consequences have accumulated, adding to the current all-too-evident ailment and then decimation of our NHS General Practice.

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Some concluding questions

- How may NHS managing authorities – the major determiners of our healthcare culture – better understand such significant anomalies, rather than expediently discount or dismiss them?
- How do we best understand the many forms of practitioner CSKP that thrive *outside* our current rigid and prescribed regimes? And how may we better identify, then understand, the widening gap that often opens up between strict formulaic institutional compliance and *actual* CSKP?

- Our best CSKP in healthcare rarely comes from top-down rules and regulations, or rewards and punishments. Previous regimes seemed to better respect this principle. How do we now reacquaint ourselves with, and intelligently trust, our more natural human connections, our sense and sensibility?
- Avoiding these questions, paradoxically, causes much damage to the very things these managing authorities are briefed to protect. How can we now restore our better and wiser stewardship?

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Bibliography of submissions to, and correspondence with, NHS England and the Care Quality Commission (CQC)

Note: only very limited and formal responses were ever received from the CQC. These are found at the end of (iv) and (vii).

i. Article 74 *Death by Documentation: The penalty for corporate non-compliance* (2016)
ii. Article 75 *General Practice is the Art of the Possible: but we are turning it into a tyranny of the unworkable. Reflections on our inspections regime* (2016)
iii. Article 76 *CQC Inspection and closure of my NHS General Practice. Farewell from a long career* (2016)
iv. Article 77 *The Proof of the Pudding is in the Eating: Ac tual and virtual realities: how our inspection culture unhinges* (2016)
v. Article 86 *Should All Doctors be Resuscitators? Unfactored costs of prescribed risk management Rhetoric is easier than reality* (2017)

vi. Article 89 *WRONG, WRONG, WRONG … OUT! How can we contain one-size-fits-all policies? Three struggling letters* (2017)

vii. Article 95 *One Small Altercation: a Massive Residuum How do large systems deal with outliers?* (2017)

viii. Article 111 *How may disciplining authorities best be dialogic? Should governance have limits in Welfare?* (2018)

ix. Letter 89 *Collateral damage: the policed industrialisation of healthcare. A personal and professional recent history* (2018)