

Wrong, wrong, WRONG ... OUT!
How can we contain one-size-fits-all policies?
Three struggling letters

David Zigmond

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Our welfare services are increasingly controlled by RMIC (remote management, inspection and compliance) regimes. Evidence of long-term benefits of RMIC are patchy and contentious; evidence of damage or harm is much more substantial, and by many indices.

These problems, and the difficulty engaging authorities, are illustrated by three letters between a coercively 'decommissioned' GP and a governing authority (the Care Quality Commission).

The letters are reversed in chronology: this aids overall readability.

LETTER 1

Dear Professor Field

Alternative Facts

Your CQC inspection and report of my practice.

Thank you for your letter of 2 May 2017. This is the first, and shorter, of two letters I am sending you. It is concerned more with matters of fact. The second letter explores the nature and meaning of the implicated problems and errors.

I am pleased to know that you were 'interested to read of [my] perspectives on the wider policy issues', but sorry that you did not respond to the specific points I had raised. To reiterate some of these:

- 1. The main issue at stake is that the CQC template for assessing GP practices is often a poor basis for assessing outcomes. Even if a clear correlation could be established (which is difficult), there will still be important exceptions. How do we identify and accommodate these?**
2. Your claim that your approach has changed to give 'greater emphasis on outcomes rather than mechanistic compliance' is inconsistent with the contrasting style and content of CQC inspections that evolved in between 2014 and 2016, and the experience of myself and many colleagues. All of these indicate that the reverse is true. The inspection regime has moved in the opposite

direction. This is the most consistent explanation for the many discrepancies I describe.

3. In particular, the CQC scheme is most apposite for very large practices. It easily becomes inappropriate and prohibitively expensive for very small practices. Nevertheless it is important to recognize that small practices are often safe, competent and popular *when assessed by different parameters*. So formalization of such processes is, in many cases, unnecessary and impracticable to implement in small-scale operations, and then often becomes counterproductive to the more fundamental aims of a practice. The Centre for Welfare Reform reports similar predicaments in social services and teaching. It was for these reasons that I very openly did not comply with some elements of the inspection scheme. This, of course, proved to be my undoing.
4. There has been a longstanding drive by the authorities, by stealthy policy rather than through open discussion, to homogenize GP provision into ever-larger practices. There have been two main methods of bringing this about. On the one hand, to introduce ever more demanding requirements of policy, procedure and compliance documentation, and on the other, successively to change details of the GP payments scheme such that provision of such requirements becomes ever more burdensome. In my last few years as a GP I was effectively subsidizing the NHS by paying myself close to the minimum wage for my own hours of work. The few small practices that remain report similar unviability; yet many are very popular. Paying large amounts for certificates of the safety of my fire door or my electric plugs or auriscope batteries, for example, were absurd mandated expenses. In contrast, my actual long-term record of premises safety and

competent clinical and staff management was remarkable in its lack of emergent problems.

5. Standards of cleanliness required by your inspection template are also often both unrealistic and unnecessary. Why should sparse dust on the top of my occasional picture frames and a few cobwebs towards the ceiling of a 20ft high room (neither anywhere near clinical procedure areas) be ranked alongside the inappropriate comparator of a hospital ward, as opposed to the inside of patients' homes where palliative care and district nurses far more frequently administer injections and change wound dressings? For consistency should all housebound patients therefore be sent to hospital for such procedures to be done 'safely'?
6. You suggest that my practice was – similar to others that you have classed as 'inadequate' – 'professionally and practically isolated and not accessing locally available support and advice'. This construction is incorrect. Over many years, I had repeatedly and assiduously approached other parts of our health services, notably NHS England and local Mental Health Services, to discuss ways in which my patients, especially those with largely incurable disorders, could best be supported, guided and contained. I also repeatedly requested discussion about the prescribing patterns which were picked up in your 'intelligence monitoring' reports (although none of those were apparently sufficiently anomalous to warrant 'serious concern'). It was a common and very significant pattern that patients returned to me after having become adrift from those other services. Only shortly after the Hearing at the Magistrates Court did NHS England

acknowledge my series of suggestions and requests, and then informally offer apologies for their failure to respond.

7. The fact that I am very far from professionally isolated is also evident in other ways. My writings on the human problems and failings of the health system in its present form have been widely published in medical and policy journals and are becoming increasingly discussed.
8. The fact that I did not choose to submit a 'satisfactory' but specious professional development plan for myself does not mean that I was out of touch with new approaches or ignorant of the research literature and changes in NICE recommendations. I was clearly cognizant of these. But such activities should not be check-listed heedlessly into formulaic prescriptions that leave no room for professional judgment. Their applicability varies greatly among patients, contexts and scenarios and must depend upon intelligent professional judgment. It is just such discrimination I find now so lacking in our increasingly one-size-fits-all inspection and management regimes.

Your CQC procedures have here ridged NHS healthcare not of hazardous incompetence, but of thoughtful dissent. I know from hundreds of communications that the inadvertent damage done by such over-procedural regimes is now very common, though my tenacity of protest is probably rare.

You may have decided that administratively my case is closed and that no further action or correspondence on your part is needed. However, the many letters and

conversations I have had in recent months indicate that my particular case signifies much wider and deeper problems that certainly remain. They will need much attention.

I will be pleased to hear from you.

Yours sincerely

David Zigmond

LETTER 2

Professor Steve Field
Chief Medical Inspector
Care Quality Commission

Dear Professor Field

Wrong, Wrong, WRONG ... OUT!

Your CQC inspection and report of my practice

Thank you for your letter of 2.5.17. Your long reply does not address the many and very specific points and questions I put to you in *The Proof of the Pudding is in the Eating*. Instead you merely summarise your own earlier report and reiterate your own evidence – yet my familiarity with these must surely have been evident in my detailed challenges and questions.

So I am unclear whether you have read and thought about what I sent you, or whether you wish to simply disregard and dismiss it, if possible with swift discreditation.

Obviously, I would like a careful reading and equally thoughtful response to my earlier missives but here, meanwhile, is a much briefer bullet-pointed list of objections to your last letter. It is necessarily incomplete.

- Your description that the latest CQC inspection regime ‘has a greater emphasis on outcomes rather than mechanistic compliance’ is clearly at variance with my own experience, and many others.
- My *outcomes* (in the real world) were exceptionally good for a very long period. My mechanistic *compliance* (to CQC requirements) was judiciously poor.
- ‘Strong systems and processes’ can easily become rigid and inapposite when lacking intelligent discrimination. Such ‘strong systems’ are not always good.
- I have provided many examples of what I consider intelligent discrimination and why, but you have not commented on these.
- Such discrepancy (where my real-life outcomes were excellent, but my compliance to the CQC’s required systems was poor) is thus widely and clearly evident in: mental illness and chronic disease care; staff probity, competence and relationships; work-environment risk, comfort and acceptability; working colleagueial relationships; infection control; clear instructions and records accessible to all involved professionals; accessible, welcoming and competent care for the homeless and vulnerable.
- I have never been ‘professionally and practically isolated’: I have always been highly engaged and gregariously proactive. However, I have also been increasingly and publicly opposed to many recent reforms. Is this what you are referring to?
- Benzodiazepine prescribing. I have already provided a detailed analysis of this in the *Appendix to The Proof of the Pudding is in the Eating*. Please read it.

* *

The **rest of this letter** offers further explanation and evidence for the above points, together with some thoughts behind the position I am taking.

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Beneath all these contentions I would like to emphasise my accord with the CQC's *mission* of expediting best care, safety and probity. It is the *method* I take issue with. Your claims as to the effectiveness of such methods is much disputed by other investigators (for example by the Centre for Welfare Reform, The Institute of Systemic Leadership and Roy Lilley – all have contacted me about this).

*

Central to much of what I am writing are these two questions: is the best way to safe, competent, best care *necessarily* through strict compliance to ever-increasing regulations? If not, what then?

*

Let me clarify why I am so tenacious in pursuing this correspondence and debate, despite my reluctant acceptance that my long and previously well-respected career has been coercively finished. I pursue this from my long commitment to welfare services and my guidance by a Socratic spirit for public affairs: everything should be open to enquiry. I imagine these may motivate you, too, as a CQC director.

But this means also that the questioners must be open to questions, the nature of evidence itself carefully evaluated. We need this always for the integrity of any kind of judgement of others and – more widely – our public services.

*

One of the soundest and most durable principles guiding the ethics and practice of Medicine is an estimate of the *likely risk: benefit ratio*. Almost all that is meant to help can, possibly, harm. We estimate probabilities and then decide: infallibility is impossible – we exercise our best judgement.

The CQC has not applied this principle in its decision about my practice. The *benefit* is evident in its long real-life record: the *risk* is a theoretical and mooted correlation to your compliance data. It is this important discrepancy I continue to challenge.

*

You mention how I did not pursue either the Appeal process or formally challenge the contents of your report. While this is true, it is important to realise why. First, I was shocked and numbed by events. It also become rapidly clear to me that stopping my small practice in this way effectively killed it. I would never be able to effectively reconvene staff and patients after an Appeal process that might take months.

My age (seventy) made future prospects of recovery seem even less viable.

Realising, too, that the thinking, language and procedure of all formal challenges were tilted in the CQC's favour *and* your massive resources far exceeded mine, I decided that such a route would rapidly become absurdly pathetic – if heroic – theatre.

This informal approach is certainly cheaper, potentially more honest and less polarising. I accept that its leverage depends largely on your reciprocal receptivity and good faith.

*

I can see how managing and evaluating healthcare or healthcarers is a massively complicated task. The rhetoric and intent are easy, the abstraction of models and plans trickier, and any wise practice the most difficult. With much of it we cannot be incontestably right, yet we are easily blamed for getting things wrong. We may aim for perfection yet, in reality, must know when and how to frequently compromise this... No wonder we often retreat behind rules and regulations, projections of crime and punishment.

For several decades I have seen cycles of assault and retreat with derivative policies. None of these can ever resolve these problems, we merely make different kinds of compromise and *modus operandi*.

*

Amidst all this I am not wanting to exchange missiles of rhetoric in adversarial debate about who is right and who is wrong, or mark out guilt, innocence or blame. I am wanting dialogues to better *understand* our problems: the kind of systems we have created that so demoralise, intimidate and (eventually, paradoxically) demotivate practitioners who, with the right milieu, have both the wish and capacity to do good work. Why and how are we creating such secondary problems?

Few seem to thrive with the RMIC culture. Yet as it fails we respond by pushing up the dose: regulations and compliance requirements are tightened.

So, in modern parlance, we have a dysfunctional system – and we are unlikely to rectify that by blame; we will do much better by understanding what is less immediately evident.

*

My own case is, I believe, an excellent example of all this. Here we have two very different accounts of events. They are both ‘true’, but both truths are partial.

The first account says:

1. *‘We have rules and regulations designed to assure good care, safety and probity. We expect evidence of compliance with all these. Failure to demonstrate this, to our satisfaction, thus becomes a definition of errant or outlawed practice. This practice failed to comply, is therefore unsafe, and must be closed forthwith.’*

The second account says:

2. *'This small practice has an exceptionally good and long record of popularity among staff and patients, thoughtful and good personal continuity of care and a remarkable lack of litigation or serious complaints. The GP Principal, though, says that he can only manage this by taking professional responsibility for his practice; his practice cannot manage these things if much of their time and attention are taken up with massive requirements for documented compliance for a governing regulator.'*

Both of these have truth, so what to do? Can we reconcile these differences?

On understanding such complexity a wise CQC might choose* to say:

3. *'This is a small and old fashioned type of Practice that is now very rare. Much of our regulation now is designed to safeguard much commoner and much larger Practices than yours. In some respects your formal compliance to these new regulations is consequently deemed as poor, but this is clearly offset by your wider and longstanding record of outstanding popularity, safety and good practice. This is an anomaly but a positive one: we would like to support your last few years of practice. During this time we would like to understand better the working principles behind your exceptional record, and then discuss how we might apply these to the managed welfare of future practices.'*

In fact, this was part of my earlier missive to you, *The Proof of the Pudding is in the Eating*. Unfortunately you have chosen to respond in a very different spirit. Rather

than consider this third way, you instead chose to return to your own checklist, effectively saying: 'wrong, wrong, WRONG ... OUT!'

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Let us return to the start of your letter where you say:

'I was interested to read some of your perspectives on the wider policy issues.'

Really? What is remarkable here is how the rest of your letter does not engage with my much-considered questions or substantial but alternative evidence. Instead you return to your well-rehearsed mission statements (which I agree with, though clearly not your method) and slightly reworded CQC evidence and narrative (which is what, it is clear, I am questioning).

When you state, as if fact, that:

'[the new CQC inspection regime] has a greater emphasis on outcomes rather than mechanistic compliance'

you do so despite much clear contrary evidence from myself and many others. Your statement may be the CQC's intent, but it is not its effect. Wider evidence means that this objection cannot be easily dismissed as an exception of a small fringe minority.

*

On two pivotal matters you write of (the CQC) having 'no choice' in the ensuing actions and decisions. In my view we humans always have choice in our interactions with others. Such use of language raises not only linguistic and philosophical questions, but important ethical ones, too. We can only touch on this here, though I have above* given an example of how such choice might be expressed rather than denied.

*

A thorough reading of your letter revealed many similar perceived inaccuracies and inconsistencies, but I now fear saturating any reader. I will certainly dissect out further examples if you wish.

*

The first time I read your letter an unbidden image entered my mind: a mist-shrouded, missive-stoned castle vantage astride a craggy hilltop and secluded further by a moat. It commands a vast surrounding swampland. Light can only enter, and the wider world seen, from the small portals through which defensive canons fire.

Subjective reverie? Yes. But it is also representational, so 'evidence' of another kind, albeit singular and oblique.

So, I showed your letter to several erstwhile colleagues, and then described my reverie. Their metacommunication varied: sigh, guffaw, grimace, snort, chuckle. But

all then converged with similar utterances of serious amusement: 'Yes! That's just how it is...!' The shared recognition seemed to offer grim comfort.

*

We can all do better than this, but only if we relinquish pride, competitiveness and certainty.

I shall be happy to hear from you. For your ease of reference I attach my previous missives. I have also included another, addressing CQC blanket policy about GP emergency equipment.

With best wishes

Yours sincerely

David Zigmond

Attachments

- *CQC Inspection and closure of my NHS General Practice. Farewell from a long career*
Letter to Chief Medical Inspector of Care Quality Commission
- *The Proof of the Pudding is in the Eating: Actual and virtual realities: how our inspection culture unhinges,*
- *Should All Doctors be Resuscitators? Unfactored costs of prescribed risk-management.*
Rhetoric is easier than reality

LETTER 3



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2 May 2017

Dear Dr Zigmond

I am writing in response to your email of 17 March 2017. I was interested to read some of your perspectives on the wider policy issues.

In developing the Care Quality Commission's (CQC) programme for the regulation of GP practices, our focus was to make sure that GP practices and other related services in England provide people with safe, effective, compassionate, high-quality care and to encourage services to improve. We developed the programme in partnership with a range of professional bodies and patient groups to ensure that the right balance could be struck between evidence that the necessary processes and policies were in place and being able to assess those other factors of values, ethos, culture and leadership that we know are so important in the delivery of great care to patients and populations. This is significantly different to our previous approach as it has a greater emphasis on outcomes rather than mechanistic compliance and therefore the results of the two methodologies can show significant variation, as they are not assessing the same things.

We have now completed the first phase of our inspection programme, providing the first comprehensive assessment of general practice anywhere in the world. Although we have yet to publish all of the reports, to date we have found that over 70% of practices in England provide safe, effective, caring, responsive and well-led care and have been rated as Good or Outstanding. As part of our aim to encourage improvement, we have analysed the characteristics of outstanding practices and published this on our website. If you haven't already, I would encourage you to read this document as it highlights many of the things that you have also identified – a passion for the delivery of high quality care, a strong team ethos borne from mutual respect, and outstanding service to patients especially those in circumstances that make them vulnerable e.g. the homeless or those with mental health issues. These surgeries are usually at the heart of their communities, practising 'holistic, family-based care' and are able to describe and measure the impact they are having on the patients and families they serve. However they are also able to demonstrate that they have the strong systems and processes in place that enable them to know how well they are doing in caring for their patients, and this almost always pre-dates the CQC as it reflects the values of the practice.

Chairman: Peter Wyman CBE DL Chief Executive Officer: Sir David Behan CBE

Unfortunately we have rated some 4% of practices as Inadequate and these, too, share some common characteristics including the lack of systems to learn from mistakes, poor processes in areas such as infection control, staff recruitment/training required to keep patients safe and poorer clinical outcomes for patients. We also find that they are often professionally and practically isolated and not accessing locally available support and advice. These practices do not always have poor feedback from patients, as we know that whilst patients quite rightly value continuity and relationships, they are not always able to assess - or perhaps have high enough expectations of - the actual clinical care they are receiving.

As you may be aware we have worked with the Royal College of General Practitioners (RCGP) and NHS England to put in place support for those practices rated Inadequate who wish to and have the potential to improve. Our current data shows that 90% of practices we placed into special measures have improved at subsequent re-inspection and we have been able to take these practices out of special measures.

Prior to our inspection of your practice in July 2016, we looked at all the data and intelligence we held, including the views of your patients, and sought insight from NHS England and your local Clinical Commissioning Group – this analysis did highlight a number of areas for discussion including clinical exception reporting especially in COPD and Mental Health, the clinical performance for a number of long term conditions and the practice's approach to the prescription of benzodiazepines. However it was at the actual inspection that our inspectors found a significant number of very serious concerns for the safety of your patients and staff. These included the fact that your practice did not have emergency equipment, or an ability to respond to medical emergencies. Furthermore the practice had not carried out adequate recruitment checks, had not ensured non-medical equipment was safe to use, had not carried out regular monitoring of patients who had long term conditions and repeat medicines, maintained poor clinical records, did not have adequate governance processes in place and did not have appropriate safeguarding processes in place. The team had no choice but to escalate their finding as they had reason to conclude that patients receiving care in such an environment were at significant risk.

After internal discussions it was decided to apply to the magistrates' court for an immediate cancellation of your registration with CQC, which was granted. I appreciate that the decision to take such action, combined with the speed with which things moved, must have come as a shock, but they are there to safeguard patients whilst protecting practitioners by taking the decision away from CQC and asking a court to decide. In these circumstances there is no right for adjournment but there is a right to appeal to the First Tier Tribunal (Care Standards) for an expedited hearing of your case and I know you were advised of this at the time of the hearing. I understand that you chose not to appeal to the Tribunal or to challenge any of the findings in the report itself.

Whilst I do not underestimate how difficult and distressing this has been for you, I must assure you that our conclusions and actions were based solely on the evidence gained both before and during the visit and that the degree of risk identified was such as to leave us with no choice but to act in the best interests

of patients. We rarely take this extreme action but I can assure you that the seriousness of your situation was entirely consistent with other such occasions.

Over the past three years we have learnt a great deal about how to better identify practices that are in difficulty, and to encourage improvement. We are now about to enter the next phase of GP regulation in England but reflecting on the first phase, I believe what we have discovered about the characteristics of outstanding care, together with the action we have taken to protect patients from unacceptable standards of practice, has made a positive contribution not only to patients but to the future of general practice.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Steve Field', written over a horizontal line.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Interested? Many articles exploring similar themes are available via David Zigmond's home page on www.marco-learningssystem.com

David Zigmond would be pleased to receive your **FEEDBACK**