

One Small Altercation: a Massive Residuum

How do large systems deal with outliers?

David Zigmond

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Speaking truth to power may be straightforward in intent but rarely in course. This essayed letter to a health service safeguarding board (NHS Care Quality Commission) illustrates typical difficulties – personal, practical, philosophical and ethical. The questions raised are crucial throughout our tribulated Welfare services.

(For reference, the initial letter, from the corresponding authority, is presented *after* this essayed letter.)

Professor Ursula Gallagher
Deputy Chief Inspector
Care Quality Commission

Dear Professor Gallagher

What to do with outliers? My contention with Care Quality Commission

Key theme: *Substantial conflict of evidence and interest indicates great complexity. Avoidance of this by reduction to increasingly prescriptive management carries grave risks.*

Thank you for your letter on 6 September 2017, on behalf of Professor Steve Field. I appreciate your consideration and courtesy. I understand these are discretionary: you are now under no legal obligation to reply. I will endeavour to indicate why I hope that by continuing such engagement we may serve a greater good.

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This letter is very long, for good reasons. The issues I address are several, subtly complex and so recurrently missed. If this were not so we would not have accrued our current problems. So I want to make my case thoroughly. To mitigate I have attended closely to clarity and order, though depart from the sequence of your letter. To aid readability and interest I have subdivided topics, questions and footnotes.

Sections E and F present the crucial arguments and evidence. Other sections provide buttressing context, history and suggestions.

A. Shared values; different perspectives. Intentions, courtesies and safeguards

First, let me clearly state my internal conflict: a wholehearted agreement with your *mission*, yet frequent doubts and disagreements regarding the *methods* cumulatively systematised by the CQC. This impasse comes at the end of a long career devoted to developing and safeguarding my own professional competence and compassion within a framework of unsullied probity – all key aims of the CQC.

What I now cannot automatically comply with are the ways increasingly mandated and empowered to assess and control such vocational complexity *always* by standardised formulae: our rigid institutional rules. Such rules, by definition, have no place for nuance, intelligent discrimination or positive anomaly.

So while I understand and respect the good initial motives and intentions of the CQC's mission, I unfortunately perceive the methods as having very often become unhinged from this mission. These errant methods account for the much broader, inadvertent waste and damage I have exemplified and described.

My contention is not, therefore, about any respect for your (CQC) values. This assiduous critique is nowhere intended as an attack on what you (and I) are trying to achieve: it is about presenting different types of analysis and understanding, views on the place of compromise, and beliefs about how we may get the best from one another.

The CQC sometimes makes serious misjudgements, yet this is rarely acknowledged: such misjudgements are due to mismatch between the complexity of the brief and

the rigidity of its methods. I pursue this analysis because I believe it is a clear example of much wider difficulties and dangers.

Amidst all this I wish to avoid tendentious generalisation. So it is important that I record here my recognition and appreciation that the CQC *does* often accurately identify remediable problems, then greatly helping individuals and their communities. But, as in good medical practice, *we must also acknowledge exceptions and anomalies*; we must beware that all tests and screenings have false positives and negatives; know that our interventions can harm more than help; know when and how these may happen; be cognisant of likely risk:benefit ratios.

Many discontented NHS staff now describe iatrogenic harm done by our wider NHS REMIC (Remote management, inspection and compliance) culture – more on this later. The CQC is a central part of this. I do not wish to attribute blame – this is fruitless in cultural contexts – so this response aims to explore the nature of this problem; to understand and invite wider dialogue.

B. Some preliminary pickings from your letter

I want here to consider some of your phrases (italicised):

... I fear my responses would not be very different from those you have already had from Professor Field ...

This is telling, and I am sympathetic to your probable predicament. I imagine this: you work in a highly stressed, frequently challenged organisation with a very difficult (impossible?) task addressing vast complexity. You have a near-cessless stream of abstracted documents and data, and so many problems always waiting.

You have no personal experience of me or my (now decommissioned) staff and patients. You are now passed the baton of judgement (suddenly? unexpectedly?) in this long relay run. You choose a grasp of expedience.

If so, I understand. But in my long career (and life) I have learned to be open-mindedly sceptical of documents and what I hear. These are not necessarily untrue, but what other truths are there?

I hope you will here be receptive to several other truths.

... be assured that Professor Field did not mean to offend you..

Thank you. I understand this easily. It is certainly true the other way round. My quarrel is not with individuals; it is with cultural and schematic distortions.

We welcome feedback from practitioners, providers and patients to improve our effectiveness as a regulator; however I am not sure that continuing this dialogue would be helpful to either party.

The first half of this sentence makes for good sense and communication, but is stymied by the second half (which ends your entire letter). How can we 'welcome feedback' if we are already signalling that we doubt its value? How is one ever 'sure' of the outcome of any dialogue? If we are sure, it is not an open dialogue but a signal of determination. In any complex dispute is it not hazardous and tendentious for one party to assume what is 'helpful' for the other?

Thinking about our language can illuminate the webs in which we may be caught. This, here, can be a helpful start.

C. Why do I doggedly contend the CQC's judgement and action? Why don't I just peacefully resign myself to retirement?

Any allegations of my complex grief, wounded vanity or tenacious, conscientious obstinacy are all pointless: I acknowledge them all, but I believe they are mapped and contained.

Beyond these lie matters of much greater public interest: my long-term observations of the damage being done by the REMIC culture. Yes, REMIC does bring some benefits but, like industrial environmental pollution, its damage is insidious, cumulative, often meets with initial official indifference. By the time it is governmentally recognised it is hard to reverse. I was writing of these incipient dangers well before our computerised micromanagement or the subsequent launch of the CQC – a key player in REMIC.

My demise at the hands of REMIC is perhaps a fitting coda and illustration of all that I have long been documenting and prophesying: the triumph of the schematic over the particular, of the strictly procedural over nuanced wisdom.

Nearly fifty years ago I joined a profession with primitive technology but mostly good morale and sense; I leave it with formidable technology but low morale, a craven spirit and little human sense. The evidence for this is all around us, both vernacular and statistical.¹ We are generating massive problems: REMIC is a large part of these.¹

Much of my long career in General Practice was devoted to furthering my own and others' autonomous, fraternal, vocational sense and skills of professional responsibility. I cannot now tolerate seeing these things being exterminated by REMIC micromanagement without my protest.

As I get older and frailer I fear being cared for by a REMIC dominated system: I have a long view of what has happened in the NHS, and the better care that existed earlier (yes, the worst was much worse – that is a necessary counter-acknowledgement).²

D. Why have I not appealed?

It is best to itemise my answer:

- As a small single-handed practice I was effectively finished by suspension by the CQC. Any Appeal (even if successful) could take months. I would not be able to retain my previously very loyal staff during this period: they would need to leave for more secure employment. At my age (then 70) I could not reasonably restart my practice: what high calibre person would commit themselves to such a mortal project?³
- I have much Mojo for personal clinical work, but little appetite for abstracted legal or bureaucratic processes. This is characterological.
- I probably would lose an Appeal. As the Appeal procedure is defined by the CQC/REMIC mindset – and this is the very thing I am contending – how could I possibly succeed? Particularly as I was openly and thoughtfully non-compliant with some of the requirements.
- I could (still) work well with friendly support from management, but not with hostility lurking behind me. Even if I won an Appeal, I feared the Spectre of a waiting and loaded gun pointed in my direction.⁴

- It might be expensive. I prefer my dwindled funds to go to my progeny, not lawyers.
- At age 70 I was afraid the stress might make me ill. Better to go with a healthy bang than an ailing wimper.⁵
- Appeals are legalistic and thus tending to the binary/Manichean: right/wrong, winner/loser, innocent/guilty. That is very much what I am trying to get away from: nobody can have a creative discussion in that process.
- ‘We are all right, and we are all wrong. How so? How do we make the best and creative compromises, for now?’ That has been – generally – my long approach to dealing with most of my encounters with human complexity. Notably, until the REMIC era, it served me very well.⁶
- If I appealed I could never foster that kind of dialogue with the CQC and other REMIC bodies: they instantly become adversarial, defensive-aggressive and – at best – courteously avoidant and opaque.

In my last years I found REMIC officers increasingly impenetrable and inaccessible to dialogue. Now, in retirement, I am out of at least one level of power-play. I might now just manage a kind of genuine – if decommissioned, so ‘unofficial’ – dialogue.

I understand, of course, that any such success takes two (at least).

E. Conflict of evidence

Here we find the crucial, yet recurrently overlooked, anomaly.

The CQC judged my practice to be so egregiously and irredeemably unsafe and poorly managed that it merited *immediate*, legally enforced closure. This was to

protect the public. Such rapid and draconian action is very rare and indicates the severity of the alleged risk.⁷

Yet much evidence from many other sources over a very long period *projected an exactly opposite picture*. Not only did a (very differently conducted) two years previous CQC inspection publish a very positive report, but other real-life indices of enduringly and consistently good, safe and popular practice were legion: remarkably positive patient feedback; staff-stability, loyalty and lack of sickness; *never* any litigation, serious complaints, accidents or deaths requiring a Coroner's further GP probing; and evidently high staff morale with visibly affectionate relationships.⁶

There was no real-life evidence to support the CQC's view. **So we have here very contrasting evidence. The CQC's is based on a measurable grid of compliance regulations. All else is derived from actual events and experiences over a very long period.**

In essence, we are considering a *putative*, projected risk (= poor compliance to a regulator's instructions) having unquestioned pre-eminence over an *actual* risk and quality record from all other sources. The predictive model warns of exceptional damage, yet the reality record is of very high quality and consistency.

What are we to make of this discrepancy?

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In science – as in competent journalism and history – assertions of truth depend upon consistency of evidence from many different sources and contexts. A phenomenon or event accrues truth through convergence of multiple and diverse observations. Use of a single source or method of observation confers only very feeble ‘truth-currency’. Introduction of another, but very different, observation will negate the first, rendering it a redundant notion or – at most – a very partial and tentative truth. So consistency of many and widely distributed observations is an essential to scientific integrity: ‘cherry-picking’ always means invalidity and thus non-truth.

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The CQC’s new procedures and protocols are vaunted as ‘scientific’: standardised, quantified, reproducible, and thus reliably *true*.

But the CQC’s claim to such objectivity and truth is undone by its cherry-picking.⁸ Its ‘evidence’ has the merit of great systemisation but is then equally demerited by excluding forms of evidence that do not comply to its own selection and system. A hermetic system of truth or investigation invalidates itself.

So this kind of inspection and report can provide an accurate account of compliance only to its own rules. Its exclusive and unquestionable claim to any greater truth is untenable.

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How have we managed to construct, and then hegemonise, a system that is sometimes so specious yet so managerially plausible? The answers to this seminal question must draw from many other contemporary currents and are beyond this letter's text.⁹

F. So what can CQC reports tell us?

The reports of the CQC are accurate and substantial *only* in their documentation of compliance to regulations that are *assumed* to guarantee safety and good standards. The conceptual link is putative, abstract and 'virtual'. But often the assumed link is tenuous or non-existent. Even where there is correlation, this is not the same as equation. A link is not necessarily an identity.

In fact (literally) the safety and good standards themselves can *only* be accurately assessed retrospectively by the *real-life record*.

Why this lingering over deconstruction of definitions and methods? Well it has become a central but erroneous assumption of REMIC and the CQC that good practice and safety are assured – can *only* be assured – by compliance to their regulations. So these desirable qualities become not merely predicatively *correlated* with documented compliance, but *equated* with this, by decree.

A more pragmatic truth is that CQC inspections and reports are, in many ways, akin to disease screening. They yield many false-positives and false-negatives. As with the medical equivalents, this does not mean that they are not *sometimes* valid, accurate and crucially helpful. But, equivalently, not all outliers are pathological. We need much care here: simplistic equation can bring much harm.

I return to my case because it is a good example of these dangers. The CQC 'screening' indicated severe sickness, yet my practice was – apart from the testing – in excellent health. Nevertheless an emergency whole-body amputation was mandated in the public interest.

How do we understand this? Particularly in view of the fact that I and my practice certainly *did* have ways of assuring and maintaining good and safe standards, but they were *different* in kind and form from those insisted on by recently introduced regulations.¹⁰

All other evidence supports this last consideration. So the earlier (very good) CQC report extended an intelligent flexibility to understand and evaluate this. The later (fatally bad) CQC report eschewed it.

Mandatory compliance can be a very blunt instrument.

G. A conflict of interests

Official documents now often vaunt 'Patient Choice', 'Public Consultation' and 'Patient Participation' as being key to progressive health reforms. Such terms soundbite our politically correct postures yet are often then disregarded by the actual changes in our insitutions.¹¹

REMIC-tracked industrial-type reforms mostly lead to a sense of disenfranchisement and powerless subjection in both practitioners and patients. This clearly was my experience: the CQC's draconian procedures even effectively denied me timely legal representation.⁷

Such denial of 'public consultation' extended to patients. There was clear, strong and widespread evidence for the popularity of this practice and support for its continuation. The nature and manner of its closure caused immediate chaos, distress and hazard to hundreds of patients that could not be adequately contained by locality managers and practices.¹² Some of this remains active and evident at the time of writing, twelve months later.

Given the actually flimsy, though gravitas-attired, nature of the judgement made against this outlying but very wholesome and popular practice, how can such authoritarian management be in the public interest?

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Politics may be defined as any transaction where one person acts on behalf of another person, claiming the act is for a greater good.

Very often defining any 'greater good' is very complex and needs careful flexible compromises. Failure to respect this leads to yet more serious problems: simplistic political acts pay a high price.

H. A balance of interests

Our difficulties emerge amidst a welter of different interests, analytical schemes and perspectives. Two views of the same situation are expressed.

One account says:

1. *'We have rules and regulations designed to assure good 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 have partial but different truths. A greater truth could be achieved by an interweaving, a synthesis, a compromise. This is often what is meant by 'wisdom'.

So a wise CQC judgement could be:

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 the 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.'*

A historical perspective: Account No 3 is a synopsis of the CQC encounter and report of 2014. Account No 1 is an outline of the disputed report of 2016: in the intervening two years a new chief inspector had reformed, tightened, and standardised inspection procedures.

Certainly this has been achieved. But is this progress? If so, of what kind? And whose interest might it serve?

I. What may best motivate us?

This is another seminal question. Usually there is no satisfactory single or static answer – certainly not one prescribed by authorities. Indeed, the great danger is to be lured into attempting to control or provide one. On the largest scale, the most terrible ideologically-driven calamities of the last century can be explained by intolerance of this uncertainty.

Is the CQC – in its brief to be seen as a strong ‘fixer’ – now speciously avoiding such complexity?

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In 1651 Thomas Hobbes, a political philosopher, published *Leviathan* – a view of human nature and how society should be governed. In essence he saw people as feckless, lazy, stupid, amoral and prone to corruption or violence: our only hope of a good society is to have decisively strong and ever-vigilant government. We must be saved from our own nature.

Law-and-Order lobbies and dictatorships justify and plan their power from such a suspicious and pathology-based view of humanity. Such views tend to regimes that conflate government authority with the judiciary. When government, regulation and inspection are combined, any position of dissent or eccentricity is likely to be quickly judged as some form of ‘bad’, and then eliminated. Non-compliance becomes criminalised. Broader evidence is disallowed. Trials rarely lead to acquittal.

There is an evolutionary thread – albeit unconscious – between Hobbes’ 1651 pessimistic, misanthropic authoritarianism and the CQC’s 2016 forensic and disproportionate mistrust: *we must control people before they do harm.*

Is this the ethos from which we wish to deliver our healthcare?

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Here is an alternative, smaller, more vernacular, guiding notion:

Generally healthcarers want to do a good job. They are, predominantly, motivated by our larger and better senses of humanity: something we used to talk of as ‘vocation’. So if healthcarers work in an intelligent milieu of care, trust and personal understanding they will provide competent, safe and compassionate care.

And the inverse is also true: if the working environment is experienced as mistrustful, alienating and overly controlling, then no amount of management will provide good care and relationships.

Yes, there will be exceptions. Even the most peaceful and stable regimes need some form of government, judiciary and police. But what happens when the authorities are responsible not just for arresting, charging and punishing suspected criminals, but extend those powers to anyone they think might – *possibly* – act criminally?

Historical precedents are extensive and chilling. Yet this is what we are germinating here, in our health service.

I believe that REMIC – and thus the CQC – start with much good effort and intent. But errors of judgement have accumulated beyond such anticipation or intent: so the custodians of care have, increasingly, become mired in defensive-aggressive manoeuvres of justification and survival. This is the common fate of pre-emptive policing.

Like any swampland it is easier to stray into than to get out of.

J. An ending: do we open or close the door?

If you want peace talk to your enemies, not your friends.

– Archbishop Desmond Tutu

Tutu's adage is often our best guide to longer-term wisdom, but is usually quickly dismissed by short-term expedience. Age has taught me its value.

But I would like – in this situation – to add some personal caveats. For I am not an 'enemy' of the CQC. I am not even an antagonist, for I strongly support the mission, though frequently dissent from the method. My position is that of an 'altagonist': my preference is always for analytical dialogue, to find our best compromises and arrangements ... for now.

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Our NHS in its many decades has never previously shown such fractious or fractured malaise, malfunction or discontent. These problems have paralleled the serial reforms intended to make our healthcare increasingly like a competitive manufacturing industry. The idea has been that the market would provide better

motivation, and that command-and-control would ensure safety and quality. REMIC – and thus, latterly, the CQC – have been crucial in this command-and-control.

The gains made by both marketisation and REMIC are certainly debatable.¹ Yet too often, it seems, the virtual eclipses the actual; schemata replace wisdom. The harm:benefit ratio clearly needs more truthful investigation – more antagonism. My own case is, I believe, a good example of our system's inability to deal creatively with anomalies and the negative consequences of this. It can be a good place to start.

And if we do not?

Here are two ancient voices. First, brief advice:

Burn not your house to fright away the mice.

– Thomas Fuller MD (1732), *Gnomologia*

And then a much earlier prophesy:

If you do not change direction, you may end up where you are heading.

– Lao Tsu, 6th century BC

Maybe we can do better than this, in 2018.

I shall be happy to continue a discussion.

With best wishes

Dr David Zigmond

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Footnotes

1. I have written and published extensively on these subjects. In the interests of space and readability I will not make any list here. They can be accessed from the articles and letters sections on my Home Page.
2. I acknowledge that REMIC and the CQC have conferred benefits by preventing, identifying or eliminating some more serious *DSRs* (duffers, slackers and rotters). The problem I identify is the collateral damage that comes from *indiscriminate overuse*. Useful analogies: insecticides in agribusiness; giant-netted deep sea trawling; WWII area bombing – all produce intolerable, unuseful or unsustainable damage initially unanticipated or discounted.
3. My trusty staff had been with me for years. Once disbanded they could not possibly be replaced.
4. Several erstwhile local colleagues have been subject to some kind of ‘Special Measures’ and describe, with much distress, this scenario. They have talked freely confidentially but – for self-preservation – remain otherwise silent.
5. Compliance with REMIC is often stressful; conflict with REMIC can escalate to illness. Reports of this are plentiful. Is anyone conducting quantitative research?
6. I had an exceptionally harmonious, problem-free relationship with patients, staff and colleagues until the hegemony of the REMIC regime. Equally, no one – except REMIC officers – would ever describe me as ‘professionally isolated’ as you document.

I documented the evidence of my actual record in my previous letters to both NHS England and the CQC eg:

- *The Proof of the Pudding is in the Eating* (November 2016)
 - *General Practice is the Art of the Possible: But we are burning it into a tyranny of the unworkable* (October 2016)
7. A description of the CQC’s draconian decisiveness at that time is contained in *Death by Documentation. The penalty for corporate noncompliance* (2016). Again, this is on my Home Page.
 8. In science cherry-picking evidence makes any further exposition a non-starter. In politics, as we have seen, it leads to ‘dodgy dossiers’.

9. Large-scale human maladaptive systems that perpetuate themselves are clearly very complex, so concepts of simple 'cause' are always debatable.

We can see, however, that the evolution of REMIC is contemporaneous with the rise of IT, robotics, corporate markets, codification and packaging of all purchasable objects, commodification and scaling-up of any activity considered 'manageable' ... I hope that sociologists and social economists are studying this vast territory.

10. The CQC's assertion, for example, that the practice did not have adequate management leadership structure, clarity or direction is utterly at variance with longstanding realities: excellent, stable, long-lasting and appreciative staff and close colleague relationships together with remarkably positive and consistent patient feedback. How many practices now manage that? Does the CQC?

This is true, also, of other areas poorly judged. For example, staff appraisal and development programmes, miscellaneous risk audits and preventative procedures. In this very small practice ,with such staff stability, I judged these unnecessary and thus a bureaucratic encumbrance: our practice was very different from a large one with rapid staff turnover. My correctness in this judgement is reflected in the complete absence of serious complaints or accidents, litigation or any type of forensic inquiry. 'Luck' alone cannot account for this. Good professional judgement and responsibility are far more likely.

The fact is that I had very successful ways of running my practice which were different from those now mandated by the CQC. I have always been willing to explain and discuss these.

11. I have exemplified several of these in *Open Democracy* articles.
12. There have been many mutually corroborating reports of the chaos and distress. NHS England and the local MP have been the recipients of many verbal and written complaints.

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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**



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6 September 2017

BY EMAIL

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Dear Dr Zigmund

I am writing in response to your e mail to Professor Field and the related correspondence you sent on 20th June 2017. I was sorry to read you felt Professor Field had dismissed your arguments as he had hoped you would have found his response helpful. I should explain that Professor Field is on leave and so I am responding to your correspondence in both my capacity as his deputy and the Deputy Chief Inspector for the London region.

I will not address each of your points individually as I fear my responses would not be very different from those you have already had from Professor Field, but I will add some reflections to those previously made.

Delivering safe, high quality General Practice is a complex, emotionally demanding and intellectually challenging, but ultimately, when delivered at its best, is intensely rewarding, and can make a real difference. In order to do this it is essential that a number of fundamental elements are in place that are then able to be combined with clinical expertise to create outstanding patient care and a superior patient experience.

Having completed the first England-wide regulation of the system of general practice we were pleased to find that 85% of practices in England were rated either 'good' or 'outstanding'. I believe that this validates our model of assessment of what makes great general practice since it is found in this vast majority of other practices right across the country.

Unfortunately this is not what we found in your practice. A significant number of those fundamentals were not on place. This is not about a tick box but about providing patients with safe care, whether in terms of cleanliness, appropriate staff, or clinical safe care such as the prescribing and monitoring high risk medicines. Whilst we recognize that smaller practices do have particular challenges, the fact that so many have been able to find ways to deliver these important elements means that it is not

acceptable to have patients exposed to unnecessary risk in the way we found in your practice. At your practice you did not demonstrate to us that you had understood these risks and taken any steps to address them – this could have included an assessment of how and why you had prioritized some over others in service of your patients. This was, unfortunately, completely absent.

We believe that one aspect of our work should be to encourage improvement and as part of this we have analysed our inspections to identify any common characteristic found in both 'inadequate' and 'outstanding' practices. Actually size was not a major factor but there is a suggestion that the majority of practices we have rated as 'inadequate' are professionally isolated. This is not simply about whether they work with other agencies but how they seek out professional and practical support - often from colleagues. As with any such finding this is not universal and only you can know the extent, if at all it applies to you and, if this is not the case with you then please be assured that Professor Field did not mean to offend you.

I am concerned that you seem to believe that we are seeking to define a 'one size fits all' approach, aimed at undermining professional judgement. Any close consideration of our methodology will reveal an emphasis on care being planned and delivered in the most effective and responsive way to both individuals and the registered population as a whole. In order to achieve this it is widely recognized as necessary that the practice has systems that ensure that clinicians are kept up to date, are effectively managing care including for things such as high risk medicines and proactively monitoring the outcomes they are achieving for patients. This should mean that were patients require care that varies from the standard that is an explicit decision made by both patient and clinician in an informed way and is monitored to ensure minimum risk and maximum benefit. As you will be aware we found the systems used within your general practice in support of the delivering this sort of high quality, personalized care to be lacking. We did not make any comments or judgement about you as a clinician. That is the role of your professional regulator and not the remit of CQC.

As was discussed previously, although there are mechanisms of appeal built into our processes, you choose not to avail yourself of them, and thus have our judgements of your practice challenged.

We welcome feedback from practitioners, providers and patients to improve our effectiveness as a regulator; however I am not sure that continuing this dialogue would be helpful to either party.

Yours sincerely



Professor Ursula Gallagher
Deputy Chief Inspector PMS (London) and Lead Nurse