

DOVES AND HAWKS

What? Three out of five for 'motivation'? Surely not! I checked the feedback on my latest practice visit once more: a row of fives for communication, expertise, professionalism, and so on, but there it was. The shameful 'three' somehow implied my detachment from the process. I wondered if my time was up.

I first applied to join the ranks of Care Quality Commission (CQC) inspectors (or Specialist Advisers as they are generously styled) from curiosity. I wanted to see how the new organisation worked. I harboured secret aspirations to try and ensure the inspections were formative. Those aspirations were naïve for the purpose of the inspection is plainly summative or judgmental.

I submitted to a thorough training and induction before joining an ex-practice manager for my first visit. The CQC has particular codes of conduct for visitors. Shoes shined, laces tied, fragrant behind the ears, and clutching voluminous checklists I sallied forth. In those early days, one often encountered ill-concealed hostility. The Primary Care department of the CQC got off to a rocky start with flawed data being used as background intelligence. *'Do you not think I've got something better to do than talk to you people?'* the doctor snapped. She had calmed down when I interviewed her later, pouring out the details of her stressed working life. The visit passed off uneventfully as most of them do. We presented our findings with recommendations to attend to minor bureaucratic lapses and the out-of-date emergency glucagon. The doctor rolled her hazel eyes and fixed me with a steely glare. Then, as now, I wondered at the visit's worth.

The CQC has many functions: to register, to monitor, to inspect (and rate), to enforce where necessary, and to advocate independently. The same five questions

are asked of all services visited: are they safe, effective, caring, responsive to people's needs, and well-led? Visitors bear questionnaires ('key lines of enquiry' or KLOEs) designed to explore these domains.

I have little but praise for my fellow inspectors — almost always assiduous, thorough, tactful and understanding. Theirs is a taxing job requiring communication and analytic skills of a high order. They must call out breaches of protocol and, as the whitest of doves, I prefer working with hawks. Nevertheless, I quite often find myself in minor disputes with colleagues over judgements. I well understand that any lapse in documentation constitutes managerial smoke but how truly egregious is the fire from an out-of-date legionella risk assessment or a missing locum pack?

The CQC makes much of its aim to enshrine a single shared view of quality but this is inherently problematic. Quality is multidimensional and different stakeholders (patients, managers, clinicians, politicians) are bound to attach different priorities to different quality criteria. The use of single scores or rankings as a unitary measure of quality is misleadingly reductionist. This was seen with the Quality and Outcomes Framework where single scores were sometimes regarded as reliably reflecting the quality of holistic care.¹

WELL ENOUGH IS GOOD ENOUGH

*'Being inspected by the CQC is like having your least favourite great aunt come to visit and having to helplessly watch her run her finger along the mantelpiece, tut-tutting as the accumulating layer of dust exceeds her expectations by some margin.'*²

Fellow sufferers (and those of Wodehousian sensibilities) will identify with this. The role of the GP is that of 'critical friend': detached and objective but sympathetic to incidental constraints. These often include the challenges of



working for less healthy populations in deprived areas where funding and staff shortages are more likely to occur. The CQC needs to enforce absolute and universally relevant standards but the consequences are predictable. Many practices requiring improvement are serving populations of greater health need where workloads are higher. Unsurprisingly, practices with higher capitation funding per patient obtain higher CQC ratings.³

The most frequent misdemeanours seem to be either in practices that are obviously stressed or, at the other end of the quality distribution, in practices that are in many ways excelling and therefore take their eyes off the drearier, protocol-laden ball. Passing the test is not too difficult if you prepare fully, keep paperwork up-to-date, keep staff in the loop, and avoid defensiveness about any failings (it may come as a surprise but most inspectors are keen to help practice teams over the line).

The GP advisor is usually tasked with assessing safety and effectiveness but KLOEs, asking questions about clinical practice, and superficial perusal of patient records can only take you so far. The preparation, day visit, and follow-up nevertheless provide a deeper dive than

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many staff on the receiving end may appreciate.

I employ my inner 'Friends and Family Test' as a guide. Is this a practice of which I should feel comfortable as a patient? My personal preference lies in favour of practices that are performing 'well enough' in all domains than for practices seeking to impress upon you their excellence in everything. Many practices can point to outstanding work of one kind or another; very few practices are flawless.

I have little but praise also for the practice managers that do the bulk of the heavy lifting in preparation for these visits. They are invariably co-operative with what is the stressful culmination of much work. As a managerial audit and source of reassurance, inspections are of most value to them. Advice to colleagues: don't let it get you down. Use the overwhelmingly positive findings on the day to motivate your managerial and other staff.

In fairness to the CQC itself, large strides have been made to ensure that visits are now 'lighter touch' and more user-friendly. Much was learned from the first round of visits — on both sides. KLOEs have become more focussed. The CQC website provides detailed and doubtless underused guidance (for example, 'mythbusters') on all aspects of running a practice. Over 90% of reports are now delivered on time. The CQC has published its own assessments of impact.⁴

For 2018/2019, the CQC's total annual income was £234 million, 76% of which supported monitoring and inspection. Expenditure was £227 million, of which £25.3 million was devoted to primary care.⁵ The government has required that the CQC recover all of their costs from providers over 4 years. Of the £204.3 million raised in fees, £38.1 million came from practices. Income from practices might therefore be seen as cross-subsidising other activities.

These figures do not include other sizeable costs borne by practices. One survey revealed that almost half of GPs said that their practice spent more than 20 staff

hours preparing for an inspection (with many spending hundreds of hours) and had to cancel an average of 15 appointments on the day of the inspection.⁶ Then there are the emotional and other downsides of possible reputational damage.

Self-evidently, the effectiveness of regulation is hard to measure but the US provides a ghastly reminder of the potential burdens of this 'hidden tax'. The annual costs of healthcare regulation there have been calculated to exceed its benefits by over \$170 billion;⁷ however, estimates of the cost effectiveness of regulation will ever defy anything but speculative modelling and blurry calculus.

As of March 2019, 5% (327) of practices have been ranked as outstanding, 90% (6196) good, 4% (264) required improvement, and 1% (86) were inadequate.⁵ Tautologically, the high proportion of practices doing well is sometimes used as evidence for the benefits of regulation. Reassuring yes but, if anything, it strengthens the sense that many visits are an unwarranted waste of time.

Most of us now accept the necessity for organisational regulation. As the *BMJ's* editor at the time rightly observed after the Bristol Royal Infirmary scandal, 'all changed utterly'.⁸ Many of the same criticisms I encounter, ('box-ticking, time-consuming', 'makes no difference') are also levelled at professional regulation: the processes of appraisal and revalidation. An over-riding concern is that these various different schemes do not 'join up'.

Whether or not the millions required to fund the CQC have yielded remotely comparable gains will remain open to question but, for the time being, I'm withholding my apostasy. Regulatory creep everywhere abounds and doctors need to be closely involved in its application and containment.

At the end of the day following our presentation, the doctor offered me a placatory cup of tea. 'What do you take in it?', she asked. 'Everything but the strychnine';

I said. 'You're in luck,' she smiled. 'That's also out of date.'

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