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

Why this separate section and what is it?

Section G here offers a kind of mini-library devoted to a healthcare campaign: the attempt, over many years, to save our healthcare from the suffocation of harmful over-management and over-regulation.

We start with a synopsis that first explains and then introduces extensive yet evocative correspondence and documents dating from 2016: given the subsequent depopulation and demoralisation of general practice these have since certainly grown in relevance and importance. The purpose of this section is for the interested reader to scrutinise and understand how some apparently small-scale and local events in 2016 in fact presaged those of much greater, and now national, significance.

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The nature and closure of St James Church Surgery in 2016 was the motivating event for the cascading correspondence. That closure is more fully described in the *Obituary* in *Section D* and *Article 74* of this Home Page Archive and remains here the anchoring examplar for this collected correspondence. Much was anticipated at the time; the story of this demise foreshadowed a threat far beyond the localised loss to its practitioners, staff and patients, or their immediate environs: we were witnessing the death-by-design of the personally-known vocational and family doctor. Many more kindred losses would surely follow.

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You will see that this particular closure was executed with exceptional rarity and rapidity. The *coup de (dis)grace* rapidly eliminated the substantial (but inevitably) disorganised protest from its unsuspecting and unprepared staff and patients. At the time this could have

been dismissed as a small-scale and anomalous event of limited interest, like a bewilderingly strange police arrest of an isolated individual. Yet since this contentious closure we can now see a much larger and darker picture: we can see how those localised disturbances were a kind of prophetic watershed, a canary in the coalmine. Smaller, more personally-scaled and responsive practices would soon 'disappear' *en masse*.

It is the importance of this emergent larger picture – now the parlous and perilous state of general practice – that merits the detailed arguments and documents assembled that are collated here in Section G.

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What more needs to be said about this mausoleum and its relationship to our current difficulties? Well, since this event in 2016 the related, egregious losses have increased throughout the NHS particularly in pastoral healthcare: for staff in morale, recruitment and retention; for patients in service accessibility, let alone personal continuity of care. All of these losses first impoverish, then imperil, mental health and primary care services.

It is tragic that, in many ways, this happens *because* of the very nature of successive reforms that, paradoxically, are entrusted with their improvement.

It is hoped that the many documents that follow here can help us understand such errant and self-stymying processes – how it is that the institutions first didactically misapprehend, and then defend against challenges to their misconstructions.

Early on 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 serves as an aphorism for what has happened – the unintentional yet tragically absurd consequences of many of our reforms.

So how did this happen? This compendium shows us, in particular, how the rise of *REMIC* (remote management, inspection and compliance) brings almost inevitable casualties of its

own success, then excess: Pyrrhic victories. There is evidence here, too, to show how this happens, because the two – success and excess – readily conflate: vaunted effectiveness is heedlessly overused to become collateral damage. All-too-easily, therefore, we have overdeveloped our mistrustful regulation and pre-emptive control. Police presence morphs into a Police State.

The documents here detail and track that collateral damage.

Like any country at war, our governments discourage news of such losses to 'friendly fire'.

This institutional-personal dossier is thus like a magnifying glass – showing us exactly how this happens: inspection regimes of REMIC now often 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, then toxic, sea. So it is that our juggernauting administrative expedience is killing our human source: the tighter the management, the more lifeless the workforce.

It is, too, like a pathology museum where we can view serial biopsies – tissue samples – from our ailing body politic of governance. Together our multiple samples indicate a kind of widespread and advancing autoimmune destruction.

1. Post-scripted February 2023: lessons from Covid?

Springtime 2020 saw a strange respite: a healthcare cataclysm that necessitated a change in how our NHS operates and how it is perceived. Covid-19 – a virus – amidst startling and swirling uncertainty, achieved what years of professional campaigning failed to do: restore, at least for a while, much professional human sense to our system.

At the beginning of 2020 – before the Covid-maelstrom – news headlines reported how most NHS healthcarers were then struggling with a very different – now largely eclipsed – crisis: they were buckling under the strain of intense corporate management and

policing. Failures of compliance were then, often intimidatingly, subjected to shame, threat and traducement – sometimes even by the Secretary of State.

In March 2020 Covid struck and the government reeled: they realised they must rapidly compromise or even jettison much of its ideologically anchored systems of commerced management and policed inspections. Thus unshackled if imperilled, our NHS healthcarers were again, at long last, freer to practise largely from their own best judgement, deciding priorities: clinicians were, again, now largely in charge of their own practice – albeit in exhausting and stormy circumstances. These healthcarers consequently were then (in mid-2020) – with shallow expediency – lionised and idealised as 'heroes', sometimes by the same politicians who, only recently, had seemed so determined to discredit them.

In contrast, the government – in its chaotic and conflicted ill-preparedness in the early Covid period – was left looking far less competent and coherent than our NHS staff. What did this tell us?

By 2023 – the Covid crisis now contained – the government has abandoned its eulogization of healthcarers. Conflicts and stalemates about pay, governance and performance are reinstated.

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The fact that the government, in the early pandemic, had (wisely) so rapidly parried its previous fierce insistence on markets and policed practitioner compliance and inspection regimes tells us just how inessential and obstructive such styles of governance often are.

Of particular relevance to the large collection of historic letters that follows here was an additional suspension: that of rigidly formal, increasingly cumbersome practitioner appraisals and inspections. These management devices had, overall, been thought by many, for more than a decade, to be much more harmful than helpful.

In this period of post-Covid concussion it is currently unclear how tightly-ratcheted these compliance-ensuring mandates will now, again, become.

So, this dedicated section documents one practitioner's campaign, over recent years, to establish a dialogue with managing authorities about these issues. Mostly this did not succeed, despite very substantial support that gathered elsewhere.

Yet Covid-19 – the most primitive of life forms – rapidly, if only transiently, changed minds where prolonged human advocacy failed.

Will we return to our pre-Covid folly? Maybe this collection of papers – this pre-Covid mausoleum – will help us re-establish, keep and honour our better human sense.

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2. A personal foreword to wider views

A brief preliminary story is necessary to anchor this compendium.

The latter part of 2016 brought a personal coda for this author: 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 increasing NHS regulations that were found to be ever-more often contextually irrelevant and unsustainable. Paradoxically, this official guillotining served simultaneously as both a personal debacle, yet an endorsement of my previously expressed objections. What does that mean?

Well, alongside personal and private loss and trauma there now clearly arose issues of much wider and public 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 my recurrent warnings to NHS authorities regarding human costs of the ever-greater procedural squeezing and corralling of its professionals: we can see how we have since gone on – as if blind – 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 bring together repeated and incremental attempts to answer this very important question.

In other Sections of this Home Page Archive you will find articles prior to 2016 that describe the extensive – if unintended – damage that was gathering. So the interested reader can elsewhere track many years of incubating difficulties and prophesies.

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I believe all these documents indicate a common lesson to help us understand such personal and institutional losses: we must look at the social and human cost of jettisoning certain principles – those of discriminating professional trust, responsibility and autonomy. Our serial reforms have, again and again, overridden these principles. It is now very 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 largely 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 highly we are paying for these abandonments: for such over-policed regimes develop perverse forms – institutional power and professional integrity easily become not just incompatible but inversely related. What does that mean? Well, Police States produce not only more suspicious, craven demoralisation, but also more corruption. Isn't this pattern and its consequences now very much part of our NHS culture and its sickness? Currently that sickness seems 'critical'.

This is certainly not to suggest that we should utterly 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.

Such 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 to our overbearing and impatient wish to directly command and control.

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In this Section G we are considering a particular, yet very consequential, loss to our Welfare services that has been sidelined from any deserved discussion: that is how our recent management and economic policies have made small GP practices almost extinct. Those very few that remain are now, almost always, heroically and perilously vulnerable. Personally, I could see for several years, with increasing certainty, 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, surrender 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 so similar to their own increasingly unviable working experiences and situations. The *Centre for Welfare Reform* (now *Citizen Network*) has, for several years, published many of these.

Such substantial and widespread support provides further anchorage and validation for the continuing publication of this compendium.

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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, after many months, 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 (found in the later Bibliography) contain these last exchanges and an account of this only meeting.

Will the future be better?

3. Letters and articles challenging our excessive micromanagement and commodification within healthcare: a summary

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)

It may be helpful to summarise here the complex questions and arguments that emerged in the many missives with governing authorities. The more determined and interested reader can, however, find the full text of these documents at the end of this section, where they are listed in chronological order.

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Some seminal 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?

It is such questions that underlie many challenges to our NHS governing and regulating authorities. The contended closure of a popular small General Practice of excellent record here merely serves as both the focus and example.

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Summarised points from the attached documents

- The *mission* of regulating authorities – 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. Such anomalies often have much to teach us.
- It is important to avoid partisanship: the arguments and questions pursued here are not intended to invalidate the many other contrasting 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 (and worse) in others. Both integrity and its failures need continual re-evaluation and recognition. Evasion or avoidance can bring, at best, only short-term and unilateral respite.
- Like many politicians, governing authorities seem often inordinately emphatic and sure in their decrees and judgements, resorting to vaunting an indignant Olympian authority and faux finality. Challenges are then often met with such bureaucratic ripostes or defensive evasion. The attached writings sample these kinds of exchange.

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- There is a core fallacy at the heart of the struggles documented here, and it is this: these governing authorities have developed, often excessively, an increasingly (yet often speciously) precise-looking and extensive regime of compliance requirements and inspection rules. These become *assumed* to equate accurately with CSKP and this then creates many new problems. This is because – in real life – CSKP usually cannot be separated from the myriad kinds 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 and tight regime can itself bring inadvertent harm. It does this, first, by displacing attention to mere technical compliance. This then leads to new cultures of rigid orthodoxy 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 then get become very different.
- Without thoughtful restraint, such procedures and formulae are prone to rapid overgrowth and overweening: despite other claims and intent, these kinds of official reports are so often not what they seem. They are, in fact, *reliably accurate only in assessing compliance to their own protocols*. Such apparent consistency may then be due to the system becoming 'hermetic'. In this case 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 paradox; outliers can sometimes be very positive. This was the case with St James Church Surgery.
- No over-regulated system can accommodate such anomalies.
- This conundrum of discrepancy is therefore not a mere abstraction: how real this is well illustrated by the summary closure of this popular practice – where CSKP was rated dangerously *poor* by the CQC, but was consistently *excellent* according to all other real-life sources. An important anomaly, surely? Yet one obdurately and recurrently ignored.
- In competent science this kind of anomaly is always taken seriously. Such inconsistency of evidence invalidates, or seriously weakens, any hypothesis –

especially if based on only one source. Evasion of this principle leads to 'cherry picking' – an inexcusable offence in science.

- This discrepancy is particularly problematic in any Welfare management regime insistent on rigid governance via a prescribed grid of 'evidence basis'. Such prescribed grids are now almost *de rigueur* throughout many of our Welfare services.
- The following accounts show what happens when such notions are disregarded. To compound the problem, rather than explore these very evident anomalies, the authorities first avoided the discrepant evidence and then destroyed 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 such discrepant exceptions. Few (if any) tests supersede all other considerations. This is the wisest and safest medical practice.
- The example here, of a procedurally and expediently culled practice, is akin to a false-positive screening automatically mandating major, then fatal, surgery.
- These kinds of errors will most likely occur when an executive system becomes hermetic, and thus closed to other incongruous (usually inconvenient) evidence. Draconian defensive procedures – to save the perceived reputation or authority of managing institutions – almost always follow. These defences lead to yet another tranche of problems. In more despotic regimes false charges and rigged courts become the norm…

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- Here, now, on a national scale, we can see how such inadvertent consequences have accreted: NHS general practice has never been so demoralised, depersonalised or dysfunctional.
- We must beware.

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Some concluding questions: back to the future?

- 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 our managing authorities are briefed to protect. So 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: Actual 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)

x. Article 108 *Life After Death? A posthumous dispute* (2018)