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News: Commission will tell doctors they can raise concerns about practice even if they have signed secrecy agreements

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News: Care Quality Commission cuts inspections to meet deadlines for registration

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Is the NHS watchdog fit for purpose?

The Care Quality Commission is under fire from all angles. Can things get better?

They can hardly get worse, says **Nigel Hawkes**

Seldom has any NHS organisation suffered such an unrelieved run of critical comment as the Care Quality Commission, damned from all sides yet its chair and chief executive are still in post.

From the Health Select Committee to the National Audit Office by way of the public inquiry into Mid Staffordshire NHS Foundation Trust, the bad news keeps on coming. A member of the commission's board, Kay Sheldon, has joined the chorus, accusing the commission's chair, Jo Williams, of poor leadership and demanding the removal of the chief executive, Cynthia Bower.

Her allegations were swiftly denied, as were those of one of the commission's inspectors, Amanda Pollard, who said it had "appalling" training standards and a bullying culture. But the health secretary, Andrew Lansley, has ordered a review into the allegations, to be carried out by Gill Rider, president of the Chartered Institute of Personnel and Development.

In its denials the commission is not playing from a position of strength. Its reputation was seriously damaged by its failure to follow up effectively on information from a whistleblower about Winterbourne View, a private hospital for people with learning disabilities in Bristol. It was left to the BBC's *Panorama* to pursue a tip from the same source and expose bad care. To add insult to injury, the *Sunday Times* recently reported that Ms Bower—"one of the best-paid quango bosses in Britain"—received £435 000 (£510 000; \$680 000) last year for presiding over this. (The figures, available in the CQC's annual report, are made up of a salary of £195 000 and a pension uplift of £240 000.)

Can things get better? They can hardly get worse. Still, the commission can look on the bright side: Mr Lansley has expressed confidence in its leadership. Whether Ms Rider's report will change his view remains to be seen.

Unpromising start

The CQC was the product of an arranged marriage attended by many prophecies of doom. It

brought together the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission to create a "super regulator" for the whole of health and social care. These organisations had different approaches and cultures, and binding them together was never going to be straightforward or swift. The chair of the Healthcare Commission, Ian Kennedy, questioned publicly whether even trying to do so made any sense.

Since the merger was designed to save money, funding was cut and the commission was formed just as the economy turned sour. Less money, wider and more demanding duties such as the registration of all health and social care providers, and the resignation of its first chair, Barbara Young, for reasons never fully explained dealt the commission a tricky hand. A ban on recruitment as part of the coalition government's economies made that hand even harder to play.

The commission's response might have been to seek changes to what had become an impossible mandate. Instead, it concentrated its efforts on meeting the registration targets. It had been given a timetable; missing it would be a black mark. So it focused efforts on registering providers rather than inspecting them, diverting experienced inspectors into the role in order to meet its targets.

Had this worked, and Winterbourne View not intervened, the commission might have got away with it. But the processes it used were "cumbersome, bureaucratic, poorly administered and subject to significant delays," according to the NHS Confederation. The British Dental Association described them more vividly as "shambolic." The registration process was not properly tested and could have been much simpler and swifter had the commission adapted it to different providers, the Health Select Committee concluded, adding: "It is astonishing that it could ever have been considered sensible for

small dental practices to work through the same process as a large hospital."

Wrong focus

Mrs Pollard, an inspector with experience of healthcare related infections, was one of those pulled off inspection work at short notice in August 2010. She told the Mid Staffs inquiry that since then she believed there had been no routine inspections of cleanliness and infection prevention and control at acute hospital trusts. The commission does not deny this but says it came about because the Department of Health had concluded that the task of controlling infections was complete.

Mrs Pollard says she was given no training and was told there was no clinical or specialist skill needed to complete the registration. "The process seemed nothing more than a tick box exercise," she said. "Our quota was to complete one registration a week. It sounds ridiculous now that it would take so long, but it did as it was such a complicated and difficult process.

"People would be in tears in regional meetings as the process was difficult, and we were then told at the meetings that management would 'name and shame' those that were not meeting their quota of registrations, although this ultimately did not happen. The situation was deplorable."

Not true, counters the commission, How could it be a tick box exercise if it took a week?

But its explanation of the process

confirms that if a provider declared compliance with its standards, and there were no other grounds for concern, its application would be approved. To that extent it was a matter of ticking boxes, albeit rather a lot of them.

While the commission was tussling with this bureaucratic nightmare, inspections fell off a cliff. The select committee found they had fallen by 70% in the second half of 2010-11, which it said was "unacceptable" and evidence of "a

"The Care Quality Commission was the product of an arranged marriage attended by many prophecies of doom"



TERI PENGILLEY/THE GUARDIAN

Cynthia Bower, chief executive of the CQC, has faced calls to step down and media questions about her salary



Mid Staffordshire NHS Trust: the inquiry has heard stiff criticisms against the CQC



TIM IRELAND/PA

Winterbourne View, a private hospital in Bristol. The CQC failed to properly follow up on whistleblower information



GRAHAM TURNER/THE GUARDIAN

Dame Jo Williams, chairwoman of the CQC board, has been accused of "poor leadership"

failure to manage resource and activity in line with the main statutory objectives of the CQC." The National Audit Office concluded: "With the exception of NHS trusts, the commission did not meet its deadlines set for registering providers; at the same time, levels of compliance and inspection activity fell significantly . . . We therefore conclude that although regulation is being delivered more cheaply, the commission has not so far achieved value for money in regulating the quality and safety of health and adult social care."

The audit office does not acquit the Department of Health of all responsibility for the debacle. It suggests the recruitment ban made it hard to fill vacancies. But even after the department relented and gave permission in October 2010 to recruit an extra 70 inspectors, it took eight months for the commission to do it. Dame Jo told the select committee that recruitment was hindered by the need to give preference to people made redundant by the merger, but the committee was unimpressed. The commission should have been pressing the government to recruit outside the initial pool much sooner, it said; the delays "indicate a failure to react with urgency to a problem that was severely undermining the organisation's compliance function."

Or, as Stephen Dorrell MP, chairman of the select committee, put it: "Any adult regulator shouldn't take on responsibilities if it hasn't got the resources it needs."

Leadership questions

Could some, at least, of these blunders have been avoided? If Mrs Sheldon is a credible witness, the answer is yes. She portrays the commission as lacking clarity of governance, with a chair beholden to the executives and a board used to rubber stamp decisions already reached.

She does not lack experience, having served for five years on the board of the Mental Health Act Commission and as a trustee of the mental health charity Mind for a similar period. It was on the strength of this background that she was asked to apply to become a member of CQC's

board, and she was appointed as one of five non-executive members.

Among her more remarkable claims to the Mid Staffs inquiry is that as a board member she has never seen details of the budget or how the money is spent, that the board was never properly informed of the deliberations of its own audit and risk committee, and that the first they knew of an important change of policy—a commitment to conduct annual inspections of all providers—was when they read it in *Health Service Journal (HSJ)*.

"I do not have concerns about introducing annual inspections per se, but I was very concerned that I should find out about this decision via the *HSJ*, without an understanding of whether this was achievable. I believe the decision to conduct annual inspections was made to pre-empt any criticism that might be levelled by the Mid Staffs inquiry," she said.

In a lengthy response to the inquiry, the commission says that the board does in fact get budget information every December, but it admits that the board was not informed in time of the change in the inspection regime, a delay for which Ms Bower apologised. It denies the change had anything to do with the Mid Staffs inquiry. It also denies that the board has not been informed of the deliberations of the audit and risk committee but adds that these reports have recently been expanded.

Mrs Sheldon's evidence to the inquiry followed a series of emails to the chair, the chief executive, and other non-executives detailing her anxieties. She does not seem to have gained much support from the other non-executives on the board, three of whom—Deirdre Kelly, Martin Marshall, and John Harwood—issued a statement dissociating themselves and unreservedly supporting Dame Jo's chairmanship.

Mrs Sheldon further claimed that figures on inspection rates were presented at the November board meeting and the board was asked to reduce the expected performance figures so as to suggest the commission was still on target to achieve them. Inspections for adult social care and independent hospital care for the second

quarter of 2011-12 stood at 26.7% of the target, a figure backed by a copy of the "scorecard" she gave to the Mid Staffs inquiry.

"During the meeting the executive told us we needed to agree to 're-baseline' these figures so that the organisation was seen as being on target," she said. "This to me is unacceptable."

The commission denies this allegation: "What actually occurred was a resetting of the targets, in a transparent way, in order to reflect what the organisation could realistically be held accountable against, prior to the move to the annual inspection regime commencing on 1 April 2012."

The commission also denies the charges made by both Mrs Pollard and Mrs Sheldon that it has a bullying culture. It says it does expect changes to be delivered, "and there are a few people in every organisation who resist change, but dealing with this does not amount to bullying."

In addition to Ms Rider's review, the Department of Health is currently carrying out a capability review into the commission, as one of a series of such reviews into "arm's length" bodies. It is due to report in mid-January. Mr Lansley has said that he believes the commission is now running a proactive and tough inspection regime and does not plan any further reorganisation of regulation. "I have no plans for changes to the CQC," he told *HSJ* in November. The department has approved the recruitment of a further 230 inspectors for 2012-13, an increase of nearly a third on present numbers.

So is the commission and its present management safe? Maybe, but it certainly can't afford another Winterbourne View, never mind another Mid Staffs. Ultimately all regulators are judged by the results they achieve, not the elegance of their risk models or the rhetoric of their strategy documents. And events have a nasty way of intervening when least expected.

Nigel Hawkes freelance journalist, London, UK
nigel.hawkes1@btinternet.com

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Reality of the NHS budget squeeze

Constraints on NHS budgets are forcing providers to re-examine the way that they deliver care.

Richard Vize looks at how two areas, Devon and Newcastle, are responding

Drastic reform of clinical services is the only way the NHS can avoid being overwhelmed by falls in real funding and rising demand. According to the Department of Health, this means finding £20bn (€23bn; \$31bn) of productivity gains by 2015.

What became known as the Nicholson challenge was first articulated in the 2008-9 annual report of NHS chief executive, David Nicholson. It was already clear that the banking crisis would trigger sharp cuts in public spending, and Sir David knew he had to get the NHS to confront the reality that it would have to make huge changes to the way it worked if it was to avoid its second financial crisis in a decade and cope with rising demand from an ageing population.

So he called on the NHS to prepare for “unprecedented” efficiency savings of £15-20bn between 2011 and 2014, since stretched to 2015. Quality, innovation, productivity, and prevention (QIPP) were to be the levers.

The £20bn is a slippery concept. It is not a cash cut but an estimate of the additional value the NHS needs to squeeze out of its resources if it is to continue to meet demand as spending flatlines. As the Commons’ health select committee pointed out last December in a report on spending, exactly how this is supposed to translate into practical changes has never been made clear. “We do not believe that the government is providing a clear enough narrative on its vision of how these savings are to be made,” the committee said.

Sir David told the committee that about £8bn would come through cuts in administration and management costs.

Another £8bn is coming from cuts to tariff payments. For example, hospitals are being paid less for many operations, forcing them to carry out the procedures more efficiently if they are to avoid working at a loss.

The final £4bn will come from redesigning services. This includes high profile and contentious changes such as reducing the number of trusts providing children’s heart surgery.

The government says the £20bn amounts to 4% savings each year up to 2014-15, although the Commons’ health select committee heard in October that many organisations needed to deliver 6% to stay out of trouble. The health secretary, Andrew Lansley, has admitted that hospital trusts generally need to save more than 4%. No

health system in the world has achieved productivity increases of that magnitude for that many years.

Slow to change

The NHS is unsuited to rapid change. Its huge fixed costs tied up in hospitals are difficult to liberate, professional boundaries are entrenched, there is intense public and political opposition to major changes in local services, and acute care is often poorly aligned with primary and social care.

The pressures of all this are starting to show. The number of organisations failing to meet their referral to treatment target has jumped, with orthopaedics a particular concern. The four hour wait targets are slipping in some emergency departments. The regulator, Monitor, has raised its financial risk ratings on several foundation trusts. Add in the legacy of private finance initiatives and other pressures such as fuel costs, and around 20 acute trusts are now seen as unviable. And all this with at least three years of “efficiency gains” to go.

According to the NHS Confederation, 82% of its members are confident of maintaining financial stability this year, often supported by using reserves, but there are widespread concerns about future years. In a survey published in July, most said they believe access to care will decline while local authority budget cuts will lead to more people needing NHS services. Forty

two per cent said the financial situation was “the worst they had ever experienced.” Over half were cutting staff.

The pace of service reconfigurations is slow but acceptance of the need for them is growing. Even some politicians—including Mr Lansley—are reluctantly falling into line. One striking example of how what the public often sees as “cuts” can improve services is the merging of the Burnley and Blackburn emergency departments on the Blackburn site with the creation of a cardiac centre; outcomes from heart attacks have improved by 15%.¹

The Department of Health gives the impression it can accurately monitor productivity. It has assured the health select committee the QIPP programme is “on track.” In truth it has no accurate way of measuring overall productivity or what this really means in terms of services provided for patients. This can only be judged locally. So to assess how the Nicholson challenge is affecting clinical services, let’s examine two areas—Devon and Newcastle.

Devon’s response

Two of the biggest aims of the productivity drive have been to move care from hospitals into the community and to curb emergency admissions. The NHS operating framework for 2010-11 stamped on the escalating cost of emergency care by paying hospitals only 30% of the tariff for emergency activity above their 2008-9 levels. Healthcare trusts in Devon have responded in different ways.

The North Devon Healthcare NHS Trust, which is applying to become a foundation, is an unusual hybrid of an acute hospital (in Barnstaple) plus 17 community hospitals across Exeter and east and mid-Devon; 12 were acquired this April under the transforming community services programme, which separated primary care trusts from the provision of services. Almost half its 4400 staff work in the community hospitals. There are 340 beds at Barnstaple and a similar number in the community. Over the next five years it needs to save £55m—about 5% a year—to get into surplus to survive as a foundation trust. It aims to do this without any cuts to services or clinical staff.

Central to its drive to keep patients out of hospital is the “virtual ward.” As medi-



cal director, Alison Diamond, explains: “It is led by primary care but the multidisciplinary team is employed by the hospital. It identifies patients at high risk of being admitted to hospital and then looks at what options there are across health, voluntary sector and social care, and allied health professionals—physiotherapists, occupational therapists, community matrons—to keep them in the community.”

Patients are identified by obvious indicators such as multiple medical conditions. “We provide a list for GPs of the top 100 patients who are at risk of admission. From those they pick the ones who would benefit from the multidisciplinary team approach. Once they are referred to the virtual ward a case management plan is put together and while that plan is active they are in the ward. Once they are stabilised or need less input they might be moved into ‘outpatient,’ which means they might have a phone call every so often to check how they are, or they are discharged back to the normal care of the GP.”

The virtual ward has been running for three years and three practices that were in from the beginning have been benchmarked against three outside the scheme. While there has been no significant rise in emergency admissions for the participating practices, admissions for those outside rose 13%, according to a preliminary evaluation. As well as preventing admissions, the virtual ward aims to cut length of stay. It is reducing bed days for those who are admitted by around 200 a month.

A second change at North Devon to cut emergency admissions is how it responds to GPs who are unsure if they have a surgical emergency. Instead of patients going to the emergency department GPs can now refer them to an emergency surgery clinic for an immediate consultant opinion.

The handling of patients who do arrive in the emergency department is being standardised and speeded up. They have adopted an emergency hub approach, with a range of senior specialists on call. “That is a real challenge to the way not that the emergency department has worked but the way the other specialties have worked,” says Dr Diamond.

Outpatient visits are being cut through GPs emailing consultants for an opinion. Consultants reply within three to five days. The potential savings in cost and patient and consultant time are huge. It is being piloted in paediatrics as well as urology, where, Dr Diamond explains, “there was a lot of concern that there were people drifting through the system who didn’t really need to be seen.”

All these changes depend on the skills, mix, time management, and attitudes of the consultants. There is no money to recruit more, so posts

NEWCASTLE

As in Devon, some Newcastle services are cutting while others are maintaining headcount. Northumberland Tyne and Wear NHS Trust has told the Royal College of Nursing it is looking at cutting 300 posts over the next two years. Newcastle Hospitals NHS Foundation Trust is not looking at either voluntary severance or a vacancy freeze.

Guy Pilkington, GP chair of the Newcastle Bridges clinical commissioning group, says “people have been thrown together” through a combination of the Nicholson challenge and the health service reforms.

“We are attempting to work with the hospital management. There is going to be less activity in hospitals so nobody thinks it will be easy. We do know that fewer people are going in with emergencies in Newcastle so you are at the beginning of an impact there.”

The Freeman Hospital, part of the Newcastle Hospitals trust, is adopting similar tactics to North Devon. GPs can get consultant advice by a dedicated phonenumber 8 am to 8 pm weekdays, and rapid access clinics have been established for diabetic foot care, heart failure, and ear, nose, and throat to cut emergency admissions.

Musculoskeletal services are now the biggest outpatient operation; nine GP clinics are offering services in an intermediate clinic with the focus on physiotherapists but backed up by an outreach consultant. Whitley Bay GP George Rae says: “A lot of the weight is taken off the hospital admissions system. About 95% of patients are seen within two weeks and a huge number within 48 hours.”

Is quality slipping under the pressure to save money? Dr Pilkington says: “To date it would be difficult to find evidence that services have declined. There is huge potential in saving resources with long term conditions and avoiding unplanned hospital care. It should be OK.”



OWEN HUMPHREYS/PA/AP

are being examined as consultants retire to ensure the replacement complements the new arrangements. Part of this will involve strengthening the emergency team.

“A lot of consultants’ work is based on the number of beds they have, and I can see that is changing,” says Dr Diamond. “Take care of the elderly—consultants are potentially a very ambulatory resource who can give care closer to the patient. And that will be the challenge—identifying the specialties where it is appropriate to change the way they work.”

The largest hospital trust in the south west is Plymouth Hospitals, a teaching trust which includes a Ministry of Defence unit. It is having a

tougher time than North Devon. Its application for foundation status was put on hold in 2009 with problems including breaches of the hygiene code. Then in February the Care Quality Commission made a series of safety recommendations after six “never events” within six months in its operating theatres.

It has recently closed 45 beds, leaving it with around 900, and has had 53 compulsory redundancies since April among 6000 staff. It says the bed closures follow productivity improvements such as cutting average length of stay 6% last year and getting bed days for electives down 11%.

Its consultants are doing more weekend working, and diabetes and respiratory consultants are moving many of their services into the community. Discharge support has also been expanded.

The primary care trust, NHS Devon, has been working with GPs to cut hospital referrals by using two referral management centres. Such centres are not universally popular with GPs, who can resent the perceived weakening of relationships with both patients and specialists and the loss of clinical autonomy.

According to Andrew Sant, vice chairman of the Devon Local Medical Committee and a Plymouth GP, the one in his city is “OK without being fabulous.” It has cut outpatient referrals by 12%, and he believes most of this is for the right reasons.

The GPs are also pushing for changes in the way the county’s four acute hospitals handle cases, Dr Sant says, notably by trying to cut consultant to consultant referrals that sideline GPs’ skills.

Devon is best known in NHS circles for Torbay Care Trust, an integrated health and adult social care organisation serving 140 000 people.

Medical director, John Lowes, cites overhauling the community management of diabetes as one of its successes with fewer amputations.

The trust has cut bank nurses, managers, and administrators and closed a 28 bed ward. Dr Lowes admits the administration cuts are “starting to hurt.” But he has no doubt about the need to change. “If you don’t face up to this challenge the NHS is going nowhere.”

Richard Vize freelance journalist, London, UK
richard.vize@gmail.com

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¹ House of Commons Health Select Committee. Oral evidence to hearing on public expenditure from NHS Confederation chief executive Mike Farrar, 13 September 2011.

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