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Regulation of the NHS – is it working?

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In this issue of *Clinical Medicine,* Nick Bishop describes the development of new methodology at the Care Quality Commission (CQC), the statutory independent regulator of quality in the NHS in England (Wales, Northern Ireland and Scotland have their own regulators) (pp 529–31). There have, however, been recent criticisms of the regulator from a number of sources.

The Health Select Committee published a highly critical report about the priorities and performance of the CQC in September 2011.[1] The exposure of abuse of people with learning disabilities at Winterbourne View, despite a satisfactory review by CQC and the failure of CQC and its predecessor body, the Healthcare Commission to expose poor care at Mid Staffordshire Trust has also fuelled criticism. So what has happened?

The history of regulation in the last decade has been one of disruption, reorganisation and change of emphasis and policy direction. In 1998, the Labour government published *A first class service* when it laid out the framework for promoting and assuring quality in the NHS in England and Wales.[2] A new body, the Commission for Health Improvement (CHI), was set up to check on the quality of the NHS. This was the first time there had been a statutory regulator of quality to cover the whole NHS. The legislation was framed initially in terms of clinical governance – the framework through which NHS organisations and their staff are accountable for the quality of patient care[3] – and the ability to carry out investigations into serious service failure. Seven domains of clinical governance were examined: clinical audit, clinical risk management, patient and public involvement, education, training and personal development of staff, clinical effectiveness, staffing and staff management and use of clinical information. The theory was that if good clinical governance systems were in place, on the ground as well as led strategically by the board, then the quality of care to patients would be assured. The results were put into the public domain, which was another lever for improvement.

All acute trusts, ambulance trusts, mental health trusts and primary care trusts were visited for a week, with plans for a five-year rolling cycle. The visiting teams were composed of a professional lead manager of the process, a lay member, a doctor, a nurse and an NHS manager. These team members were drawn from the NHS and so there was an element of peer review. The emphasis was on assessment for improvement – with action plans being drawn up post-review by the trusts to deliver better systems in the future. The difficulty of the boundary between the regulator and the NHS as to who is responsible for improvement is an ongoing debate.

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The regulator also collected data about performance which were used to collate the star ratings which were, of course, used by the press to compile league tables. An overall report of the quality of the NHS in England and Wales was compiled annually.

The clinical governance reviews were labour intensive and time consuming, with gathering of information before the visit and analysis and report writing afterwards. There was criticism from the NHS that staff on the review teams were not senior enough. There was also a move from government that a reduction in all regulation was needed, that regulation was a 'burden' and should be 'targeted and proportionate'.

In 2004, CHI was reorganised into the Healthcare Commission (HCC) to take on further functions to regulate quality in private sector provision as well as the NHS in England (Wales set up its own health regulator). Clinical governance processes were no longer directly measured. The Department of Health set standards for care which organisations had to meet.[4] This raises the question of whether meeting minimum standards means that those who meet them become complacent, rather than striving for ongoing and further improvement – continuous improvement means that the 'quality curve' is constantly being pulled to the right and even the excellent can get better.

There was a move to risk profiling to make regulation 'targeted and proportionate', based on collection of data, to monitor the performance in trusts and private providers and then to decide which organisations should be visited. The team was no longer drawn from the NHS but based on professional inspectors, with some lay input. The HCC was given powers of enforcement if standards were not met. It also commentated on the overall quality of the NHS in an annual report.

In 2009, the HCC was abolished and the new regulator, the CQC, was formed to cover social, as well as health, care providers and also to have some responsibility towards those people detained under the Mental Health Act 2007. Again, the methodology changed. Regulation is now about compliance with essential and minimum standards in order to be registered as a provider and to have a licence.[5] Registration now also applies to all dental practices and, from 2013, to all GP practices.

Registration has been a huge task, covering all health providers (both NHS and independent sector) and social care providers. The CQC has been criticised for putting all its resources into this process, and doing fewer visits to providers.[1] It has now said that it will return to doing annual visits to all providers – the public and patients want more regular inspections on the ground to assure them about the quality of care. The CQC also undertake themed reviews, such as dignity and nutrition for patients,[5] but it no longer commentates on the

overall quality of the NHS. It also leaves improvement to the providers, though recognising the debate about how far the regulator should be involved in quality improvement.

This brief (and incomplete) history of regulation raises a number of other questions. Nick Bishop's article on risk profiling explains that regulation will still be targeted, to pay attention to 'poorer' providers and leave the 'good' ones with less attention. Is this the right approach, given that the public wants assurance about all providers? What is the relationship between Monitor, the economic regulator of foundation trusts, and the CQC? This will be played out as the new Health and Social Care Bill is implemented. Is the CQC too big, bringing together health and social care? Probably, especially with an overdependence on social care inspectors to undertake the health work. Is it being asked to do too much with the resources it has, so is doomed to fail? This is a very real risk and one which is more important than ever with the current NHS reforms. If there is less central control of provision, and services can be commissioned from any qualified provider, then setting tight contracts and robust external regulation are essential to protect the quality of service. Is there sufficient clinical engagement in the processes? Probably not, with few clinicians engaged on inspection visits. The CQC does not have a medical director or nursing director on the executive team. Few clinicians are involved in the local process of their trusts returns on the essential standards, and those standards are rarely being used clinically to drive up local improvement at patient care level.

Can regulation ever completely assure the public that the quality of care is good enough and prevent further scandals of poor care? The view of the Royal College of Physicians (RCP) is, not on its own. There are pockets of good and poor care in all organisations and no system will have sufficient granularity to pick up those differences. Perhaps the development of service accreditation could begin to address this issue. The RCP is developing an accreditation unit to look at extending service accreditation.[6] Other levers for quality include professionalism,[7,8] national clinical audits, system improvement and more involvement of patients, as discussed in the recently published RCP quality strategy.[9]

The RCP is building closer links with the CQC, to give more professional input into the regulator's processes and to share information as appropriate. A strong regulator of the NHS is in everyone's interests, not least the patients, and it is to be hoped that the CQC will weather the current storms, make the necessary improvements and be allowed to perform to its optimum, without another untimely reorganisation.

(Dr Patterson was the medical director of the Commission for Health Improvement 2000–4.)

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