

All change on the road to better health care

The Healthcare Commission disappears this year, after only four years.

Nigel Hawkes talks to its chairman, Ian Kennedy, about what it has achieved



In Nikolai Gogol's comedy *The Government Inspector*, the Lord Provost of a small town in the Russian backwoods conjures up a brilliant scene. "The first place any inspector worth his salt will want to have a gander at is the charity wing of the cottage hospital at the foot of the road yonder," he tells the manager.

"It's a disgrace! Filthy hammocks hung from the rafters with even filthier patients hanging out of them roaring drunk, regaling all and sundry with bawdy songs from the trenches, may be your idea of a hygienic and recuperative environment, but it certainly isn't mine, Sir!"

The dread of dirt and squalor in public wards survives, even if the inspection methods have changed. The biggest splash made by the Healthcare Commission in its four year life was a damning report on Tonbridge and Maidstone NHS Trust, estimating that 90 patients had died in two outbreaks of *Clostridium difficile* infection. Among much that the commission has achieved, this single case with its graphic descriptions of unsatisfactory care will for most people be its lasting epitaph.

For Ian Kennedy, who stands down as

chairman when the commission is subsumed into the Care Quality Commission in April, that would be a pity. He never saw himself as a heavy handed enforcer and rejects what he calls the old fashioned view of regulation—"that it took the form of police action, based on targets established by central government, pursued through inspection, and that it was punitive, designed to catch you out."

The commission, born in the days before "light touch" regulation had shown its limitations in the banking meltdown, aimed to reduce the burden on the inspected without losing the ability to finger miscreants. Its tools were information, gathered from many sources, backed up by a limited number of inspections. Its battle was to escape from the rigid set of standards it inherited from the "star ratings" era and to measure things that matter to doctors and patients, not civil servants.

"You can't inspect just by wandering the land," Sir Ian says. "The NHS has lots of

information, and so do lots of other bodies, too. To bring it together and analyse it was the way to do it.

"We then used the information to produce benchmarks of risk—at what stage does something become a hazard to patients, and when do we have to go and have a look? Our visits were targeted, and only when the data suggested a risk.

"We also did some random visits—the mystery shopper approach. Managers were most opposed to that because they argued that we might catch them on a bad day. But patients also risk catching them on a bad day, and doctors do as well."

In the haphazard way that Britain is governed, the commission was

doomed within less than a year of its formation, when plans were hatched to merge it into a super-regulator, the Care Quality Commission (CQC) covering both health and social care. "We were struggling for three years against the demise of the organisation," Sir Ian admits. The CQC formally came into existence in October last year,

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Ian Kennedy: “Government saw the need for the regulator but . . . felt uncomfortable about it”

and will take over from April. Neither Sir Ian nor his highly regarded chief executive, Anna Walker, will be part of it.

Lasting legacy?

So now is a good moment to assess what the Healthcare Commission achieved, and what its legacy may be. Sir Ian says that the idea of “information led, risk based inspection” is definitely embedded. He also believes that his commission “persuaded clinicians and patients that we wanted desperately to say things they recognised as being important.”

He adds: “We are now in a place with clinical professionals which is extraordinarily good. They are all piling in and wishing to help—the penny has dropped. For the 2008 health check, we added a theme of clinical quality to all sectors of healthcare and asked clinicians for advice. We were bowled over by the amount of help we got—more than 70 possible indicators of clinical quality were lobbied at us. I think that’s a clear validation of our approach.

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but it’s now up to others. Is the approach embedded enough? Others will do what others will do, but the CQC intends to carry on our approach in 2009-10 and perhaps beyond.”

One burden laid at the door of the commission, that of dealing with patient complaints not resolved locally, will not be passed on to the CQC. Other Whitehall regulators think the Healthcare Commission should never have been given this task, which proved overwhelming. The volume of complaints soared—an acknowledgment that patients saw the commission as independent—but dealing with them was a problem. A backlog built up, more staff needed to be recruited; it was not a triumph. But it was no worse than what went before, and may be no worse than what is to follow.

Relations between the commission and the Department of Health were prickly at times, but so they should be. Over Maidstone and Tonbridge, Alan Johnson felt he had been left out of the picture until too late, but Sir Ian retorted that the department would be better informed if it stopped sending junior staff to meetings with the commission. Relations are since said to have improved, but Sir Ian revealed in an article in an internal commission newsletter that he would have liked a warmer and more collegiate relationship. “Regulation was sometimes seen as part of the problem rather than part of the solution,” he wrote. “Government saw the need for the regulator but at the same time felt uncomfortable about it.”

The commission’s principal product, the annual health check, has turned the old star ratings into a more rounded product, less easy to fiddle, which has shown year on year improvements in adherence to standards and financial control. But Sir Ian admits there is a huge unsolved challenge in getting data about the quality of general practice. “I would like to have had a better handle on safety in primary care—misdiagnosis, late diagnosis, non-diagnosis, poor medical management,” he says. “We couldn’t look at general practitioners, only at primary care trusts, which are a poor proxy. The average patient doesn’t know what a trust is.”

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The commission’s final report, published last October, suggests that general practitioners are making 600 mistakes a day, one in five causing harm to patients—but of nearly a million incidents reported to the National Patient Safety Agency in 2007-8 in which patients were put at risk, only 0.3% were reported by general practitioners. “We are a long way from an NHS that hungrily and systematically examines its own performance, gathers in and learns from mistakes, reinforces good practice, and does things differently for the future,” he says.

Asked to identify areas of unfinished business, Sir Ian offers three. “First, at the strategic level, government needs to understand that regulation is an ally, not interference. Particularly in commissioning, we need to ensure that people are up to the job.

“Second, public health, and the need to keep it at the forefront. And third, a plea for a neglected area, adolescent mental health. We have a generation of young people whose health is at considerable risk, from unemployment, crime, and drugs. We don’t hear enough about it.”

Sir Ian will look for new challenges when the commission disappears on 31 March. He is to chair the international panel to select the new academic health science centres promised by the Darzi review, but this will not occupy him full time. “Have briefcase, will travel,” he jokes. “I need to work.” He ruefully acknowledges that despite his years of service to the NHS—first the inquiry into heart surgery deaths at Bristol, then at the commission—he is not a civil servant with a bulging pension pot.

He will leave a legacy of independence, fairness, and sound investigation to be inherited by the CQC. In the regulator’s seat, you can’t please everybody, all the time. But as Gogol put it: “If your face is crooked, don’t blame the mirror.” In Sir Ian’s mirror, the NHS is reflected as honestly as the circumstances allow—and he leaves it, by his own measures, a little better than he found it.

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