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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: The CQC, hierarchies, and hospital safety

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Last month Ted Baker, chief inspector of hospitals at the Care Quality Commission, said that safety in many NHS hospitals wasn't improving quickly enough.[1] Although performance had improved in recent years, 40% of services still received ratings of "requires improvement" or "inadequate" for safety.

In the same speech he compared hospitals with other sectors, including the aviation industry. I'm sure he was right to say that a focus on safety first, as an overarching priority and mission, isn't so well ingrained in the NHS. But he also mentioned pilots not leaving the stand if a flight wasn't safe, however much trouble they got into for missing schedules, and an "elastic attitude to safety" among NHS staff under pressure. It's not that healthcare has nothing to learn from aviation, but a detailed thematic review by Kapur and colleagues showed the problems with such comparisons.[2]

Commercial flights are planned and largely predictable, and there's no absolute need for them to take off unless fully staffed, with every check in place. In the acute hospital NHS, we have to provide responsive services, 24 hours a day and 365 days a year, to all comers. We have no option but to keep going even with rota gaps or staff sickness, when we've run out of beds, when a scanner is broken or our electronic prescribing has shut down, or when ambulances are stacked outside the emergency department. Downing tools in those circumstances will put patients at risk, just as surely as muddling through.

We're in an inherently risky business, dealing with patients often already at high risk of poor outcomes. Our job involves hard human choices that can't all be protocolised by prioritising the needs, risks, and wishes of each patient against those of all others. As Emma Cannon, a core trainee, and Mark Davies, a consultant in anaesthesia and perioperative medicine, said in a recent *BMJ* rapid response, "keeping the plates spinning" requires "leeway, ad libs, and workarounds" which, far from being unprofessional, are necessary.[3]

Baker went on to say that hierarchies and deference in healthcare can worsen safety and that staff should feel confident and empowered in challenging unsafe practice or stopping the line if patients are at risk. He'd find wide support and a body of literature backing this view.[4-6] And if his inspectors have, as he said, often found cultures where less powerful or senior staff were afraid to challenge things, this certainly must change.

But if hierarchies and fear are harming patient safety, surely the Care Quality Commission is as much part of the problem as the solution, given just how much store it sets by inspections and rankings—and given how much worry or reputational damage these can induce. And its definition of improvement is inherently circular, meaning "improvement against our own inspection standards and processes."

An independent evaluation in 2018 suggested that the commission's own effectiveness in improving quality required improvement.[7] And a recent study by the University of York found that hospitals spent £160 000 (€180 000; $200 000) to £420 000 preparing for inspections and that care worsened during these.[8] In a centrally funded, politically accountable system, organisational and professional regulation are both required in some form. But the way to improve or sustain safety and quality in health systems[9] is not by a system of heavily centralised inspection and regulation.

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1 Carding N. NHS hierarchies put patients at risk says CQC chief. *Health Serv J* 2019 Apr https://www.hsj.co.uk/patient-safety/nhs-hierarchies-put-patients-at-risk-says-cqc-chief/7024867.article. (Login needed.)
2 Kapur N, Parand A, Soukup T, Reader T, Sevdalis N. Aviation and healthcare: a comparative review with implications for patient safety. *JRSM Open* 2015;7:2054270415616548. https://www.ncbi.nlm.nih.gov/pubmed/26770817.26770817
3 Cannon E, Davies M. Electronic response to Rimmer A, How can the NHS offer fulfilling, lifelong careers? *BMJ* 2019. https://www.bmj.com/content/364/bmj.l1100/rapid-responses.
4 Ham C. Reforming the NHS from within: beyond hierarchy, inspection and markets. King's Fund. 11 Jun 2014. https://www.kingsfund.org.uk/publications/reforming-nhs-within.
5 Green B, Oeppen RS, Smith DW, Brennan PA. Challenging hierarchy in healthcare teams - ways to flatten gradients to improve teamwork and patient care. *Br J Oral Maxillofac Surg* 2017;55:449-53. https://www.ncbi.nlm.nih.gov/pubmed/28343734. 10.1016/j.bjoms.2017.02.010 28343734
6 Brennan P, Davidson M. Improving patient safety: we need to reduce hierarchy and empower junior doctors to speak up. *BMJ Opinion* 2019 May 3. https://blogs.bmj.com/bmj/2019/05/03/improving-patient-safety-we-need-to-reduce-hierarchy-and-empower-junior-doctors-to-speak-up/.
7 King's Fund. CQC inspection regime having an impact but there is room for improvement, landmark report finds. 27 Sep 2018. https://www.kingsfund.org.uk/press/press-releases/cqc-inspection-room-for-improvement.
8 Bodkin H. Hospital inspections "bad for patients." *Telegraph* 2019 Apr 12. https://www.telegraph.co.uk/news/2019/04/11/hospital-inspections-bad-patients/.
9 Bohmer RMJ. The hard work of health care transformation. *N Engl J Med* 2016;375:709-11. https://www.nejm.org/doi/full/10.1056/NEJMp1606458. 10.1056/NEJMp1606458 27557297

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