**Inspecting the inspectors – does external review of health services provide value for money?**

Health and social care providers internationally are heavily scrutinised by external regulators as part of accreditation, inspection and external review processes. The aims are generally to identify poor performance and/or to improve performance, and in particular to ensure the delivery of good quality services. This can result in a complex, costly and overlapping network of oversight arrangements.1

The growth of inspection over the last 25 years reflects a number of converging themes such as the rise of new public management,2 the desire for more public accountability, and the decline of trust in health professionals. This has been further stimulated in the United Kingdom by a series of high profile failures of care,3 subsequent public inquiries, and at times exaggerated political responses aimed at reassuring the public that services are safe.

In England, the Care Quality Commission (CQC) is one of the regulators which, among other things*,* inspects health and social care providers to assess whether they are: safe, effective, caring, responsive to people's needs and well-led. The CQC has undertaken a comprehensive programme of inspection and ratings in health and social care in England, producing a huge volume of reports. When it finds inadequate care, this can have consequences including the departure of senior managers or even prosecution. In other health care systems, similar approaches are used, often involving expensive accreditation schemes.4 Given the significant resources used as part of inspections, it is important to ask to what extent all this effort has had positive (or negative) effects and represents value for money.

There has been little research evaluating inspections. The regulatory organizations have not invested in robust research and when they have examined their impact, it is often methodologically flawed and, in the case of CQC, can appear rather self-congratulatory.5 In this issue of the Journal, a sophisticated quasi-experimental evaluation of the impact of CQC inspections on two nursing sensitive measures of care found no positive effect.6 Another recent quantitative analysis of the effect of CQC inspections (although the methods are less clear) found small and mixed effects on other key performance indicators.7 These disappointing results reinforce the findings of previous studies of other similar schemes. A Cochrane systematic review assessing whether external inspection of compliance with standards can improve health care found a distinct paucity of high quality evaluations of effectiveness and cost-effectiveness; the studies they did find were generally low quality and with equivocal results.8 Similarly, a review of external accreditation did not show clear evidence that it improves patient safety or quality of care, although it did increase costs by up to 1.7%.9 More recently, a large observational study found that US hospital accreditation was not associated with improved patient outcomes.10

It is not surprising that the results of the few studies to date do not seem to justify the regulatory superstructures that have developed internationally. It is hard to develop a regulatory system that drives improvement; quality cannot be ‘inspected-in’, it has to be built in. No system of external measurement and regulation will be able to substitute for the relations of trust and professionalism that can help promote quality,11 nor will it be able to foster a quality improvement culture.

Shifting to a system reliant on formal external inspection and regulation can have unintended negative consequences. These include the crowding out of local quality improvement activity, voluntary cooperation and informal peer-based actions to deal with poorly performing staff, the bruising and draining effect on people and organizations, the encouragement of short term performance, and ‘playing to the test’ which undermines long term planning.3 Excessive external quality policing can weaken internal regulation within organisations, so that the net positive effect on quality is limited. Regulatory inspections regimes are also expensive, not only in terms of the direct costs, but also due to the substantial opportunity costs that organizations incur in preparing for visits, consuming considerable staff time and energy, which gets diverted from more productive activities.

Inspection and accreditation regimes tend to be insufficiently reliable or consistent; they are likely to have low sensitivity and specificity and so will falsely reassure (and reprimand) and ultimately fail to satisfy stakeholders.3 Failings in inspection will eventually result in more scandals, panicking politicians and senior managers “into more initiatives which create an even more bloated and invasive regulatory structure of uncertain effect and cost”.12

We must of course recognise the responsibility and indeed fear that politicians and service leaders must feel for failures of care on their watch. The pressure to (be seen to) do something – or to shift the responsibility – can be overwhelming, and more regulation is often the easiest response. Thus, even in the absence of robust supportive evidence, regulatory bodies find it difficult to scale down activities. The CQC’s new risk-based approach to inspection, for example, appears to have led to more, not fewer, inspections.7

The key lesson for us is not that regulation, or more specifically inspection, should be abandoned, but that we need a creative combination of oversight, self-regulation and improvement activities.11 Resources need to be redistributed away from costly, undervaluated regulatory regimes to build capacity for more national and bottom-up improvement approaches, using improvement science as a guide, and to develop a stronger evidence base to inform us how we best do that. Evidence of how to apply quality improvement approaches effectively and efficiently remains mixed,13 and there is a significant lack of high quality improvement practice and research capacity in health and social care which urgently needs to be addressed.

Inspection is a complex intervention and should be developed and evaluated carefully. If it were considered as a screening programme (looking to detect poor practice) or drug (to improve the quality of care), on the evidence we have to date, inspection would not be licensed, and most certainly not be funded in the UK at current levels. Its growth, along with the regulatory organizations established to promote quality reflects the hubris of politicians and those who lead national health services or direct the inspectorates. At a time when health services are struggling with high patient demand and very tight budgets, we should hold the regulators to account and demand a more evidence-informed approach to inspection.

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