HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Work of the Care Quality Commission, HC 562

Wednesday 15 January 2025

Ordered by the House of Commons to be published on 15 January 2025.

Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Deirdre Costigan; Jen Craft; Andrew George; Paulette Hamilton; Joe Robertson; and Gregory Stafford.

Questions 1 to 87

Witnesses

I: Ian Dilks, Outgoing Chair, Care Quality Commission, and Sir Julian Hartley, Chief Executive, Care Quality Commission.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Ian Dilks and Sir Julian Hartley.

Q1 **Chair:** Welcome to today's session of the Health and Social Care Select Committee on the work of the Care Quality Commission. Today's session is about accountability for providers, patients and families who rely on the CQC for assurance about the quality of care provided.

Following the publication of the Dash review, we want to understand what went wrong to land the CQC in this situation and what steps its leaders are taking to address the review's findings and restore credibility in the eyes of those it regulates and serves. Before us we have the outgoing chair, Ian Dilks—thank you for joining us—and the new chief executive, Sir Julian Hartley.

Ian, in your pre-appointment hearing, you told the Committee that you did not think it was up to the CQC to sit in an ivory tower and dream up what it thinks good care looks like. At the moment, we are in a situation where it seems the regulator itself is not clear what good care looks like. As a result of the organisation's failures detailed in the Dash review, and as a Committee, we are keen to hold the regulatory community to account. Given the breadth and importance of the services of the CQC, we are starting here.

Ian Dilks, given the failings of the Dash review, are you sorry?

Ian Dilks: Obviously, we are sorry for the poor performance on that bit of our activities covered by the Dash review. I am sure we will explore some of that in more detail. The CQC has not done what it should have been doing over a period of time, but most particularly over the last year to 18 months. I and everyone else in the organisation are sorry for that.

Q2 **Chair:** What personal responsibility do you take as the chair for those failings?

Ian Dilks: We may want to explore in more detail later what went wrong. I chair the board. The board is ultimately responsible for the conduct of the organisation, albeit working with other parties. It has become clear over the last 18 months or so—and particularly the last nine months—that a lot of what was happening was not delivering what was expected.

I believe the board did take a number of appropriate actions about nine months ago. I would love to be sitting here and saying as the outgoing chair that the organisation is in much better shape than everybody thought it was when I arrived, but I cannot say that, for which I am personally very sorry. But equally, I do think that I and other board colleagues have behaved appropriately in very difficult circumstances over the last nine months and have taken actions that at the time were very difficult to take. I am happy to expand on that, but let me leave it there for now.

Q3 **Chair:** You have been in place for longer than nine months. Some of this will have been under what happened before. Why was it only nine months ago that you started to take action for these failings? Did you not know about them until nine months ago?

Ian Dilks: If I may, I will give you a little historical perspective—I will try to do it quickly because it is complex, but I am sure you will come back in more detail if you want. On the historical perspective, CQC was formed in 2012 and in about 2018, it decided it had to change. There were two key drivers for that. The world was changing, and it needed to change. Also, a lot of its systems were getting to the end of their life. There was a risk that they just could not continue.

In 2018, 2019, 2020, they embarked upon a transformation, and a number of changes that would have required some major systems changes as well. Consultants were engaged in 2020 and the work was flowing. In 2021, the board approved, with everyone's support, a much more ambitious strategy, which required a significant number of changes to the pre-agreed transformation programme, both in terms of ways of working with people and in terms of the complexity of the systems. It also had to take account of new requirements being imposed upon us in integrated care systems and local authority work, which, again, you may want to come back to. That was the context.

So if that was started in 2020 and amended in 2021, what went wrong? We have of course looked at that. I would highlight four things—and I do have the benefit of hindsight; none of the current board was there in 2020 or 2021. First, some of the strategic decisions were, with the benefit of hindsight, not the right decisions, primarily around the operational model. I can expand on that, and I am sure that Julian will later want to talk about the changes that will be made in that area.

Secondly, there was the pressure to get things done quickly. The programme was hugely ambitious—I would say too ambitious—and was a major transformation. It was going to cost tens of millions, and it has—we will come back to the numbers later, I am sure. I can sympathise with why people wanted it quickly. We can see lessons. Probably the big surprise was that the technology did not deliver—it was specified, signed off and approved, and reputable contractors were hired, but it simply has not delivered. There are some quite unbelievable problems with the technology we have got, and again, we can give you examples, should you wish.

Last but by no means least, I just do not think that the organisation listened well enough to a series of stakeholders or, most particularly, to our staff internally. Probably, it did not engage well enough at the outset. Transformation should be led by the people, but this was more a technology-led transformation, and when staff started to raise concerns, it was not listening closely enough or hearing what was being said.

Some of that is just history, and we cannot do anything about it. I would also say that I think the risk management framework and the governance

were not good. Of importance to this Committee are the questions, "What have we done?" and "What is changing?" I would highlight two things, and then I shall pause. First, we have continued to improve both the governance and the risk management framework. We have made quite big changes, but to be clear, quite a lot of improvements are still required. I do not want to mislead—

Q4 **Chair:** That is at board level—you have changed how the board is structured?

Ian Dilks: In the board and within the organisation—perhaps more in the organisation, but at board level as well.

One of the key missions for Julian, and I am sure he will expand on this, is how we get our people who stuck with the organisation through a very difficult period—they do deserve credit for the way they spoke up—on board and find a way of working that better engages them. I do not want to steal Julian's thunder, however.

Perhaps the bit that I did not address was timing. Again, I will skip a few things in the interests of simplicity. Although our staff were raising concerns, it was towards the back end of 2023 and into '24, as the transformation was coming to an end and the technology was being deployed, that the scale of the problems became obvious. The technology roll-out ended in March 2024, and the next board meeting after that was May—

Q5 **Chair:** How often does the board meet?

Ian Dilks: Every two months. At the May meeting, the board leaned in—the phrase I have used—and demanded some significant changes. A number of things followed from that, but let me pause there, as I have talked for a long time.

Chair: Thank you. I appreciate you setting out the timeline. You are saying that strategic decisions were made—that is quite passive language—but, presumably, those strategic decisions were brought to the board for sign-off.

Ian Dilks: They would have been, yes.

Q6 **Chair:** Right. So you sanctioned—as the board.

Ian Dilks: As a board, it sanctioned.

Q7 **Chair:** So do you feel that the oversight by the board was strong enough during the time between when those strategic decisions were made and all the problems that ensued?

Ian Dilks: It is impossible to say it was, given the problems that we are now facing, but to give you a personal perspective, you will appreciate that the board is almost entirely new, and that—

Q8 **Chair:** You keep saying that. Was the board almost entirely new when the strategy was brought to it, or was the strategy brought and then there

was a big change in the board make-up?

Ian Dilks: The original plans and then the new strategy were signed off by a board, but none of the members of that board is still with me on the board today.

Q9 **Chair:** What happened?

Ian Dilks: A combination of natural retirement and considerable difficulty in replacing people. When I arrived, one of my first acts was to work with the Department to put out a specification for three new non-executives. That would have been in May 2022. We interviewed in September 2022, but they were not appointed until June 2023, so it was quite a thin board. On the executive side, again, there were some natural changes. Probably the biggest loss was that our chief inspector of hospitals had a catastrophic illness towards the end of 2023. We are just about to kick off recruitment to replace them.

I do not want to throw everything back to a previous board, although I did say at the outset that I have the benefit of hindsight, which the people on the board at that stage did not. The question is, could we or should we have seen this before? I wish we had, but from a personal perspective, when I was considering applying for this role three or four years ago, I made extensive inquiries. Nobody highlighted any concerns to me at that stage about what had been approved or adopted.

In the first few months there, although there were things that I wanted to see done differently—I highlighted shortcomings in governance on the risk management framework, for example—for the most part, with the possible exception of comments made by staff, we were not getting evidence coming up to the board that there were problems. Indeed, as late as spring 2022, around the time the transformation was completed, the reporting coming up to the board from the executive line was suggesting that everything was going to be working.

Why did we change in May last year? What created that? Effectively, the board had three sources of information. It had what was coming up through the form of reporting lines, what our staff were telling us, and what we were hearing from the market. Obviously, the staff were easier to hear in a way, but I spent a lot of my time speaking to others outside the organisation. We found, as a board, that the feedback from our staff and what we were hearing externally was coalescing around one version of the truth, which was different from what we were—

Q10 **Chair:** Were you lied to?

Ian Dilks: I think that would be unfair. There is a limit to how much we can look back in history, but I think people's understanding of what was being delivered was different. On technology, for example—

Q11 **Chair:** Was it incompetence or was it on purpose?

Ian Dilks: There is no evidence that was the case and that is not what I am suggesting. I think people who were delivering things genuinely thought it was working, and it was not.

Q12 **Chair:** That is extraordinary. The head of the organisation presumably hearing the same thing from the sector and from the staff—you must assume they would have heard that—has one version of the truth, and you as a board are finding another. What do you call that? If it is not incompetence or lying, what word would you use for that?

Ian Dilks: There was clearly a failing in the information that the executive team had to understand what was going on that they were bringing to the board.

Q13 **Chair:** I think people will have their own words for what that might be. I will give Ian a break for a moment, but I am sure we will come back to much of what he said. Julian, where are we now with the organisation? No doubt it is very bruised—perhaps relieved. What did you find on day one when you stepped in as chief exec?

Sir Julian Hartley: I started in the job on 2 December, but about two weeks before that, I wrote to all 3,000 staff to introduce myself and to ask them what they thought the top three priorities for the organisation should be, because I felt that it was important, before I set foot in the organisation, to have a sense of where the staff were. I was very clear about where stakeholders were, given my previous role as chief executive of NHS Providers.

What I found was unambiguous. The feedback, which I have subsequently shared with all staff, was that the No. 1 issue was all about the problems that the new regulatory platform—this system that was implemented—have caused staff. There was deep distress and a real sense that it is stopping them from being able to do their jobs. That was highlighted in the Dash review, but what has become really clear to me through spending a lot of time with staff in the organisation and hearing their concerns is the depth and scale of that distress.

We got a lot of qualitative feedback, in terms of comments. Here is one that illustrates this issue: "The regulatory platform and the IT systems—this is far and away the No. 1 reason for low productivity, staff stress, low staff morale and poor staff wellbeing. The regulatory platform is not fit for purpose and is preventing us from doing our job." That was No.1 by some distance—by about a factor of three—from the next key issue, which was workforce. And then, there were concerns about the structure changes. Also, in relation to that top priority, a lot of people talked about the problems that the single assessment framework had caused, and I am sure we will return to that particular issue.

Q14 **Chair:** Yes—soon.

Sir Julian Hartley: I have made it a priority to ensure that, if you like, we have that moment of truth and reconciliation—that sense of catharsis—about where people are at, because I believe that it is vital to make sure

that we rebuild the sense of trust, and the sense of engagement and empowerment, of our 3,000 valuable staff, so that they in turn can ensure that we keep people who use services safe and we can support improvement across the sector.

That has been a very important part of my early time in the organisation, and together—I can say more about this when you wish me to—we have set out the priorities to address the challenges that we face.

Q15 **Chair:** We will certainly come to that. I just want to come back to the governance point. What specific changes have been made at the board level—given that that is what you would have been responsible for, Mr Dilks—that help to address this moving forward? Has the structure of the board changed? Does it meet more frequently? Has it changed its approach? There is an element of this that is a board failing, is it not? What have you done to change it, in preparation for the incoming chief executive?

Ian Dilks: Two or three things. Until about three years ago, the overview from a board perspective of the transformation was done by a sub-committee of the audit committee.

Q16 **Chair:** Okay. How many sub-committees do you have on the board?

Ian Dilks: A sub-committee of the CQC's audit committee was providing oversight—

Q17 **Chair:** What other committees are there? People and culture, presumably—

Ian Dilks: There was an audit and corporate governance committee. We have changed that to an audit and risk assurance committee, to give it a much greater focus on risk and risk assurance. There is a regulatory governance committee, which looks at the effectiveness of the operations of the way we go about regulating—the evidence suggests whether or not we are discharging our regulatory responsibilities. And then there is a relatively straightforward remuneration committee, which does the things you would expect for an arm's length body.

To go back to your question, later in 2022, the feedback I had was that the sub-committee of the audit committee was not the right level—I totally agreed with this—to be overseeing the transformation, so we moved reporting for that to the main board.

Q18 **Chair:** Hold on. So that enormous transformation that affects the whole of the organisation was not being directly overseen by the board at main board meetings? It was being done by a sub-committee of a committee. Am I understanding that correctly?

Ian Dilks: Correct. Clearly, reporting was going up to the board, but it was being handled by a committee of the audit committee. So we moved that to the main board.

I was always very keen that we have a much greater focus on risk in the organisation. From a board perspective, we changed the remit, or amended the remit, of the audit and corporate governance committee to audit and risk assurance. We had an audit committee chair at the time who was well able to do that. Unfortunately, she was required to stand down because of another role that she had taken on. That was in November 2022, and regrettably, it took until February 2024 to make a new appointment. So we did not have a board chair—

Q19 **Chair:** There is a lot of churn going on—that is what I am hearing. But you were a constant in all of this.

Ian Dilks: Yes, that is correct.

Q20 **Chair:** But you did not have a sense of what was going on? Did you step in, so you got more involved and could see what was going on? Was all of that happening?

Ian Dilks: Yes, of course I did, particularly in the last nine months, as we have had a change in chief executive.

Q21 **Chair:** And before that?

Ian Dilks: But even before that. It has been a very different role.

Q22 **Chair:** When did you personally start getting involved in the transformation?

Ian Dilks: Not in the delivery of it, but as part of the board. As I said, the board has changed, but as part of the board, we got involved in looking at the progress on the transformation. The indicators and the information we were being given in ’22 and ’23, at which stage a lot of the problems that have now emerged, particularly on technology, which had been developed—it was being delivered against a specification. There was no evidence to me or to the board, and it would have been very difficult to see that what was being built was not going to deliver what was required. It was only when it started to be rolled out that that became evident.

Q23 **Chair:** Do you feel that the board and its structures, with what it has learned, is better now? We are going to have the pre-appointment hearing of your replacement, but that is not the entire board, and the structures remain. With the benefit of hindsight, would it have picked up these problems sooner, or does work need to be done on the governance structures within the board itself?

Ian Dilks: It is conjecture, but if I was staying, I wouldn’t say, looking back, that I would change the structures beyond what we are doing. We have been considering some changes, but I am not sure they are particularly relevant to this Committee. We have been looking at monitoring performance differently.

What I would say is that it would be nice to have greater consistency on the board and the approvals from the Department that allow that. I have indicated that, depending on the definition of dates, it took between nine and 12 months to replace those retiring in 2022. It took 14 months to

replace the audit committee chair. We have two NEDs standing down now. One has had to resign because he had an executive role and changed jobs; he has a conflict. Another person is going at the end of January. They both have to be replaced and it would be very nice if that could be done as quickly as possible.

Q24 **Chair:** We will certainly come back to the role of the Department. I have one final question, and then we will start diving into some of these issues more specifically.

Mr Dilks and Sir Julian, you have quite understandably talked a lot about the organisation and the workforce, but ultimately it is patients and families who you regulate that have potentially been failed by this. What would you say to them? Can they be sure that the care home their mother is in, the hospital where their child is being treated or the results of your inspections that have been done in recent years are safe?

Ian Dilks: In the vast majority of cases, yes. We gave a self-assessment when the Penny Dash review started, so what is in her report reflects what we had largely come to realise ourselves. It shows that we are simply not doing enough inspections. That has been a growing problem over two or three years. We have questions to come back to about some of the assessment work. But at the same time, it is important to say that we have a lot of very good people who try very hard day to day and do a good job.

Q25 **Chair:** They are not here; you are. We are here to understand how they can be better served as well.

Ian Dilks: Yes, but your question was about the organisation and whether people are being kept safe. I am saying that there are clearly significant improvements we need to make to get to the standard we wish to, but I would not want it to be thought that most of our staff on most of the days are not doing a good job—they are. We need to give our people the tools to do the job that we want them to do. The systems and tools are a significant part of the problem. We are in the process of changing those and will have to change them further.

Sir Julian Hartley: The main objective of the CQC is, as you say, Chair, to protect and promote the health, safety and welfare of people using health and care services. The Dash review was very clear that poor operational performance is impacting on our ability to ensure that health and social care services provide people with safe, effective, compassionate and high-quality care. Six weeks in, I am hugely focused on addressing those shortcomings in order to improve where we stand right now.

I am sure that we can come on to the specifics, but in terms of the number of assessments that we have done—2,500 so far in the past year, which is significantly less than in any previous year—and backlogs in terms of registrations and notifications of concern, there are multiple issues that need urgent resolution. That is what I am focused on and working hard with the teams and, indeed, the board to get right. That must be the guiding principle for us—to ensure that we are delivering against our core

purpose and the expectations of communities, families and people who use services as well as—

Q26 **Chair:** I am concerned that you cannot just answer that with a "yes" or "no".

Sir Julian Hartley: Sorry—forgive me. We are not delivering for people. I am sorry that I went round the houses on that.

Q27 **Jen Craft:** I will pick up on the last point you made, and then we will move on to talk about the single assessment framework in more detail. You mentioned the backlogs that you currently have, and you have expressed that you recognise there is a need to change the way in which the CQC operates. Are you confident that you have the capacity to address the backlog while implementing the changes that are necessary?

Sir Julian Hartley: I am confident that we have a plan to go at it. The first job is to ensure that we have the ability to ensure that with the regulatory platform, which has caused so much difficulty for staff, there is a way for inspectors and staff to actually be able to do their job in order to increase the number of assessments.

One of the key priorities that we have agreed is to do more assessments, and we are tracking that. We have put in place a workaround, because the problem with the system was that inspectors literally could not get reports published because of the problems with the regulatory platform. Since the start of December, we have had an approach that should enable us to do more assessments in order to get more of those done.

Backlogs of registration currently stand at around 29% over the 10-week target, and that is another key focus. I am sure that the Committee is aware of the concerns expressed by the Care Provider Alliance, Care England and other stakeholders that their members are finding it incredibly difficult to get services registered; so the second priority is around reducing that backlog of registration.

We have increased the number of staff involved in registration, and we have had to move off that regulatory platform, because that was one of the elements that just wasn't working. There is now a different means by which people can make their registration application, which hopefully will start to move things through. I will be in a better position to judge how effective that action is over the coming weeks, obviously, given that we have just started implementing some of these improvements.

Addressing the backlog of what we call notifications and information of concern that goes into the national contact centre is another key priority for us. Again, we have put additional resource in for that. I have brought in some expertise from the NHS in terms of clinical team, because we need more clinical expertise in the CQC to tackle that. Those three areas of backlogs and problems created by the platform are key immediate priorities, which we have talked about across the whole organisation.

Q28 **Jen Craft:** To pick up on backlogs of notifications and information of

concern, are providers not being notified that you have concerns around the way in which they have been operating following an inspection?

Sir Julian Hartley: These are both a requirement for providers to notify us of major issues, incidents and changes, and also the opportunity for people to contact the CQC with major issues of concern.

Q29 **Jen Craft:** So there is potential there for quite significant safeguarding issues around people flagging things early on.

Sir Julian Hartley: Exactly.

Q30 **Jen Craft:** Do you have an idea of the numbers in that backlog?

Sir Julian Hartley: Yes. We have about 5,000 of those, and we receive around 800,000 a year. There is around 5,000 in that backlog that need working through that have not been responded to in the 10-day timeframe. Those need to be fast-tracked. They are categorised into different priority levels according to their urgency, and we are getting weekly updates on how quickly we are able to work through those. I have brought in additional resource to tackle that issue.

Q31 **Jen Craft:** What is the longest that people are having to wait, outside of that 10-day timeframe? Do you track that?

Sir Julian Hartley: I have, and it is in my notes. May I come back you when I find that? It depends on the priority, but some of these go back months.

Ian Dilks: May I clarify? We don't necessarily need to or have to respond to people who have raised the point. The significance of this is that we need to look at it, and that informs our ability to see what further action is required. For example, if you had several pieces coalescing, that might trigger an inspection of a care home. They are not necessarily things that we need to respond to people about, but we have a very good triaging system to make sure that, when queries or points come in, the most urgent are dealt with more quickly, such as those that would affect safeguarding. Those are policies that we have refined over the last couple of years.

Q32 **Jen Craft:** That is the concern, isn't it—that the triaging system is effective? If you have reported something that you have a concern around, it may need further action, or it may not. You need to know that someone has seen that who knows how to make an appropriate decision. It feels like, at the moment, there is a potential for that to go very badly wrong for individuals and for their families. It is about an assurance that that is heading in the right direction, and that the backlog is being prioritised.

Sir Julian Hartley: Absolutely. As I say, that is a top priority for us to tackle. We have got to get that backlog down, and we have brought in additional resources to do that, including clinical expertise, on that very point about triage and making sure that we are dealing with the most urgent safeguarding and whistleblowing cases earliest.

Jen Craft: Thank you. To move slightly on into the single assessment framework in general—

Q33 **Chair:** Just before, have you found those figures?

Sir Julian Hartley: Yes. The oldest cases with no review—the first stage is a risk review—are from 30 November 2023. The oldest cases with no action are from 19 August 2024.

Q34 **Jen Craft:** Would that mean someone has made a report of a concern and they have not received a response since August?

Sir Julian Hartley: I believe so. We will write to clarify exactly where we are with that.

Chair: That would be very helpful. Thank you.

Q35 **Jen Craft:** You can appreciate the level of shock that we felt on that. Without understanding what that particular case entails, there could be a significant issue behind that.

I will just move slightly on from this to the single assessment framework. The development and implementation of the single assessment framework appears to have been a failure. It is muddled and confusing, providers do not understand what good looks like, and inspectors do not necessarily understand what they are looking for. Who was responsible for the development of the single assessment framework and how did it come to be such a mess?

Ian Dilks: I will pick up the first part of that. The single assessment framework was all part of the transformation programme that I referred to earlier. The design principles were reviewed and signed off at the time the programme was initiated.

I will try not to repeat what I have said previously, but as things were being rolled out in the early part of last year, we were getting the feedback that you have described, both externally and internally. That was why the organisation as a whole, but it particularly came from the board, commissioned the work from Mike Richards to gather an understanding of what the problems were and what needed to be done about it. I personally got involved in meeting Mike and splitting it up, and Mike came to talk to the board. We now have some useful feedback from him.

It is important to say that Mike has tended to focus mainly on health. We have a separate piece of work going on—well, not separate, but adjoined with his. Vic Rayner is working with the team to look at the implications for adult social care. That work is ongoing. I cannot give you an exact timing, but I am rather hoping that they will be able to report their findings and what needs to change to the next board meeting, which is in February.

We made some changes almost immediately as a result of Mike Richards's feedback, but the other things require a bit more thought. The single assessment framework was developed for a purpose, and we want to

make sure that, in any redesign that is done, we don't throw out the baby with the bathwater, but capture what needs to change and what we need to continue. We are doing that at this time. Obviously, our people have been trained and supported to a newer way of working. This isn't just something that you can just switch off; we have to make a decision and provide some consistency for our people, and it is one of Julian's priorities to deal with that.

Q36 **Jen Craft:** I am trying to understand what went wrong in the design and development of it. Clearly, Sir Mike Richards's report and the Dash report have commented that it does not work. It does not do what it is supposed to do; it does not provide a single assessment framework.

You have 34 different quality statements, so it is pick 'n' mix, depending on the provider. That is not a single framework by any means. What went wrong in the development? When you are looking at changing the system and not coming up with something entirely new but modifying what is there, what lessons have been learned from when the system was designed and developed? What lessons can you take forward?

Ian Dilks: I will answer that first, and then Julian may wish to add something. It may sound odd to say this, given the way you phrased the question, but my understanding is that quite a lot of co-design work was done with providers. We certainly did go and talk to providers as part of the development.

What we have realised, particularly in adult social care, is that there is a broad array: it ranges from big international groups to much smaller providers. Something like 80% or 85% of providers have fewer than 50 people, and what works in one may not work in another. Without going into the detail, the concept of a single assessment framework that is exactly the same in health and social care was well-meaning—

Q37 **Chair:** Whose brainchild was it? Was it an individual? Was it a committee?

Ian Dilks: The principle of trying to align the way we look at different types of provider was entirely laudable. Certainly, when I arrived, the way it was explained seemed sensible, but it was too ambitious.

Chair: Whose idea was it?

Ian Dilks: I am sorry; I am not quite sure I understand the question.

Q38 **Chair:** Whose idea was the single assessment framework? Was it the board's idea, the chief exec's idea, the head of a department's idea? Whose idea was it?

Ian Dilks: It was the executive team, particularly the chief executive, but we have a strategy team—risk, strategy and regulatory people—who did a lot of the more detailed design work. A significant part of the organisation was involved in the design. Given the problems that you now find, maybe this is surprising, but the changes were made for a good reason, and some of the changes are probably still valid.

Q39 **Jen Craft:** I understand that they were made for a good reason. There is

definitely something in making sure that people have an idea of how their health provider is assessed so they can make those kinds of judgments themselves, but it clearly doesn't work. Something clearly went wrong in the design and development.

You are now looking to potentially redesign the system. What went wrong, and how do you ensure that you don't do it again? You mentioned that you spoke to providers and other people, but what specifically did you do or not do that you are not going to do again, or that you are going to do this time?

Ian Dilks: Sorry; I digressed in answering your other question. The key question is: what have we learned and what are we going to do differently? Again, Julian should talk about what he plans to do. Some of the ambition—the idea of a single assessment programme that is exactly the same in health and adult social care—was probably wrong. Frankly, there were different views on how much it was ever intended to be single, but it won't be; we have to cater for the different approaches.

Some of the core principles are the same. Ultimately, this is driven by the need of the users of services: the core purpose is to assess whether they will be safe and have the right quality of care. Those objectives are consistent across health and adult social care. To have more consistency, perhaps, than existed many years ago is what I would therefore describe as a laudable objective, but the systems are different, so we are not going to have complete consistency.

Perhaps, too, it was overengineered by the assessments' being made at too low a level, which was one of Mike Richards's clear recommendations. I think the main learning from all that is that there has to be very much better working with the provider community, learning what works for them. That is partly around methodology, but it also has to be something that works for them.

I stress that, ultimately, we are there to make an assessment on behalf of the users of systems; we are not there to provide a service specifically to providers. But you cannot be an effective regulator if you are doing your job in a way that causes friction with, confuses or creates difficulty for users. We have to listen more in the next design phase, and come up with something that keeps those very core principles, but is workable and can be done at a level that enables providers to get on with their job.

Q40 **Jen Craft:** What are those core principles? On the one hand, you said that having a single assessment framework is laudable, but on the other hand you said that you cannot unite the health and the social care sectors, because clearly you cannot have consistency across both in a single framework. What are the core principles that you are driving at that will modify the way things go?

Sir Julian Hartley: I do not think it is possible to have a single assessment framework for all the different sectors that we regulate. A care home or GP practice is very different from a major teaching hospital. The learning from this—and picking up what Professor Sir Mike Richards wrote

about as well—is that it was over-complicated not only with the five key areas that people are used to, such as safe, effective, caring, responsive, but also 34 quality statements, six evidence categories and then scoring, at each evidence category, of each quality statement. That is incredibly complicated and hard to penetrate.

A lot of our inspectors—people I have spoken to—say that the scoring does not work for them. It removes too much professional judgment. It speaks to the point made about not having enough clinical expertise within the organisation—inspectors who understand the areas they are going into and inspecting. So on your question about key principles looking ahead, I would say the system needs to be clearly understood by the sectors we regulate. It needs to ensure that it is clear about what the CQC is looking for. Quite a lot of care organisations said to me, when I met a group of them: "We don't know what your inspectors are after, because there are all these quality statements and all these evidence categories. Just give us a clear sense of what you are looking for and what good looks like."

We are doing work to get to that point, but there is also the point about engaging with the sector to make sure that there is a level of co-production, and with people who use services, so that when they look at a CQC rating, they understand what sits behind it. Those are key principles behind what we do next.

Q41 **Jen Craft:** Do you think single-word assessments are fit for purpose? When people look at a CQC rating, will they understand that the provider they are looking at will give the care for themselves or their loved one?

Sir Julian Hartley: That varies by sector and by size of institution. We have moved away from aggregating ratings for individual services up to an overall rating for an NHS trust, but, again, a major teaching hospital is very different from, say, a GP practice or a care home. Single-word ratings offer a level of clarity and simplicity for the public, which is certainly something we have to factor in. I think the single-word judgment currently in use for bigger organisations like hospitals on "well led" is important in giving a view of the leadership of the organisation.

Our priority is to put our house in order on some of the key basics and then to keep under review the idea of how we give a single-word or two-word judgment. But the first-order priorities are to make sure that those in the sector, and indeed patients and the public, believe that we are offering a quality, and reliable, assessment of those institutions.

Q42 **Joe Robertson:** The reviews have found a fundamental problem with both CQC staff and service providers being able to understand what good care looks like. How do we deal with that? Do we have a problem? I suggest that this might exist in throughout the regulatory world in this country: "good" becomes a very technical thing, disconnected from what service users feel is good and what we mean by good in everyday English. Can you address that for us?

Sir Julian Hartley: Yes, certainly. That is an important question about the confidence people feel they can have in what we say. If we go back to

first principles and look at the measures that most global health systems will use to assess themselves, we go back to the Institute for Healthcare Improvement's triple aim, the first of which is the importance of patient experience and outcomes—how patients or people who use services experience things, and the outcomes that they get from their treatment. Second is the way in which those health services deliver for broader populations and communities, and third is how efficient they are, because one of the original parts of the CQC's role was to look at efficiency and at having regard to the use of resources. That is an area.

Given the pressure on health and care budgets right now, it is important that providers are offering the best care—the most effective and efficient care possible—as well as excellent patient experience, with due regard to population health and health inequalities. If we work back from those principles, we get to a set of things that some of the quality statements cover, but the problem with the quality statements is that they do not translate into what we call key lines of inquiry, which are crisp ways of describing what good looks like, breaking the categories down.

One of my colleagues who goes to inspect emergency departments has actually done that: he has taken some of the quality statements that make sense for emergency departments, turned them into key lines of inquiry, been clear with those he is going to inspect what they are, and put together the good practice and the evidence that supports those. That gives people a much clearer sense of what good looks like.

You are absolutely right that some of that becomes quite technical when we get into the detail of the clinical processes, but in overall terms we need to be better at having a clear statement behind each area. What is it we are looking for from a public-facing perspective?

Q43 **Joe Robertson:** I would suggest that a well-intentioned measurement system assessment framework with scoring, no matter how well intentioned, runs the risk of becoming detached from what people think of and feel is good when they receive care. That is going to be a challenge.

Sir Julian Hartley: To add to my answer, the current inspections take account of a lot of patient feedback, but that is an area that we need to develop and to build further, because the direct feedback from patient service users is a vital part of your point about what good looks like.

Q44 **Joe Robertson:** On the problems with implementing new technology, at the beginning you made that assertion yourself, Ian Dilks, and acknowledged that there had been difficulties implementing new technology. I think you suggested later that you could give an example. I invite you to give an example of the difficulties faced and of the problem with implementing new technology.

Ian Dilks: Julian may wish to add to my answer, in view of the review we have commissioned. Without being too technical, the decision to use the underpinning technology of Microsoft Dynamics was sensible; time has shown that that has worked. We have been using that technology to

specify things that should be done to deliver a portal externally and the regulatory platform internally.

To give an example of how almost unbelievable some of this is—Julian started to touch on this—it is possible for staff to start work on a report, put it inside the system and then it gets stuck. We now have reports, going back some months, that are stuck in systems—people cannot get them back out. There is no way on earth that anyone would have designed a system to say, "Do you know what? We are going to lose a report in the middle of it," but that is what—

Q45 **Joe Robertson:** Sorry, but when you say stuck, do you mean the reports are somewhere in the system but people cannot find them?

Ian Dilks: Yes, people have started their work, they have all the evidence, they have done their job and they have started to draft a report. At that stage, there is probably more information needed and the report has to go for quality assurance, but they cannot get the report back out of the system. It is unbelievable—you raised your eyebrows, Chair.

Chair: It's extraordinary.

Ian Dilks: I cannot tell you exactly how that has happened; I am just giving an illustration of the sort of difficulty we have.

Before Julian arrived, we had already started work with providers to see how some of this happened. There would never have been a design principle, but was it a feature of design, build or implementation? We need to know the answer to that. When Julian arrived—he may wish to expand on this—he commissioned an independent IT expert to look at it. We have literally just had the findings, so it is too early to comment on that, but we need to take account of how we progress from here.

One point that I am sure will come out, which would absolutely be a yes from me, is to keep it simple. The CQC cannot change absolutely everything at once, so we will have to choose how to do things in a logical and sensible way. Clearly, as part of that there has to be a much greater attention to working with users to make sure we do not have a repeat of these quite extraordinary systems failures.

Sir Julian Hartley: It was clear to me that we needed an urgent review of what had gone wrong and what we could salvage from the platform. Looking ahead, as a board we will consider the independent review that I commissioned next month, but the key issues were over-reliance on external consultants, not building up enough in-house expertise and a moving target model, because this was happening simultaneously with the introduction of a single assessment framework and a major organisational restructure. The stability of the organisation was thrown by those three major things happening simultaneously, which created a huge amount of destabilisation.

The health and safety review of the process found that 33% of staff experienced physical and mental distress as a consequence of the

implementation, so the engagement of frontline teams in any technological change is important. The implementation of new technology is not just about a new system: it is about a change of culture, approach and ways of working, and everyone needs to be involved in that. When we look ahead and learn lessons from that, I am clear that we have got to work closely with those at the frontline to ensure they are involved in any revisions to try to mend the system.

Ian Dilks: May I add one quick point? One other observation I would make is that this work was kicked off as we were coming out of covid, in a virtual world—I would never advise anybody to undertake a major transformation over Teams.

Over the last couple of years we have started to bring people together in conferences and get much more engaged, but more can be done. I applaud the approach Julian has taken since he arrived to engage with people right at the outset, and to get our people on board, supportive of and giving input into whatever changes we now deem to be necessary.

Chair: Danny Beales, would you like to come in on this point?

Q46 **Danny Beales:** You have touched on a number of points. I was going to ask about technological change, which the NHS is grappling with more broadly. There might be interesting lessons here on how not to implement technological change successfully.

I want to ask about over-reliance on a contractor. It seems that you were quite reliant on the contractor, rather than on in-house resources. I am specifically interested in the involvement of staff in the design and roll-out. You touched on this slightly, Julian, but perhaps you could expand more generally. To what extent were staff involved in the design of the new technological solution, and in the active roll-out, the ongoing assessment of its success in meeting what it was designed to do, and any further changes needed as it was implemented on the ground?

Sir Julian Hartley: I caveat my answer by saying I was not involved in the roll-out, but I can tell you about the review that I commissioned. That independent consultant spoke to around 100 staff, who gave accounts of their experience. It was clear that there was just not enough engagement with staff. There was also no willingness to listen to staff who reported the problems they experienced.

Because of the deadline and the rush to get it done, there was insufficient testing of the system to make sure that it worked and delivered. Consequently, when it went live, it just did not deliver anywhere near the benefits that were originally conceived. The report I commissioned will set out chapter and verse, and I am happy to share the findings with the Committee, Chair.

Chair: We will be very grateful for that.

Q47 **Danny Beales:** You told quite a damning story about this technological solution not meeting in any way what it was required to do. That seems a

major failing by the contractor who was asked to create this technological platform and solution. What contractual management is there of the contractor involved? What contractual mechanisms are there? There has clearly been a lot of waste and disruption to productivity; what effect has that had on the contractor in terms of your contractual management?

Ian Dilks: If you will forgive me, I will not say too much about that at present. I hate to say that this pre-dates me—I was not involved in the selection specification—but in many ways the right things were done. Looking back, we had very extensive involvement with the external contractor.

Julian and I both share the view that doing more in-house would be good, if we could. There is an important caveat to that: like many public sector bodies, we have pay scale issues. Recruiting people on board is difficult, which means the system has tended to use contractors. I am not saying that what was done was either good or bad; I am just saying the context is that the use of contractors is often because it is very difficult to bring people on site at our salaries. An awful lot of use is made of contingent labour, again paying a multiple of what it would pay—

Q48 **Danny Beales:** Sorry to interrupt but time is brief, and this is supplementary to someone else's question. I appreciate that it sounds like you lack in-house resource.

I want to return to a specific point about recourse for the contract. You have been clear that you were given something that was not asked for and that did not perform as promised. The contract, in a sense, was not delivered to the specification. What recourse have you taken or are you taking against the contractor? What mechanisms do you have in the contract to enforce non-performance?

Ian Dilks: Sorry, I should have been clear earlier. That is ongoing at the present time. We can start to conduct part of the review anyway, supplemented by the work Julian has commissioned, to look at what was asked for and what contractors delivered against that.

Danny Beales: Perhaps you could write to the Committee with the specifics.

Sir Julian Hartley: Indeed. If I may add briefly, it is also about the ability to specify and make sure the scope is clear of what external contractors can deliver, as you said. That is another skill set that is very important in the context of making these things work.

Chair: Thank you. We would be grateful if you could write to us in more detail on that point.

Q49 **Paulette Hamilton:** Good morning. I want to concentrate on the concerns of the providers and the staff. The Dash report talked particularly about the increase in the time taken to carry out a reinspection of a provider after an inadequate rating, going from 87 days in 2015 to 136 days in 2024. For providers with a "requires improvement" rating, it went from 142 days to 360 days.

Mr Dilks, while those figures were going up, and providers were shouting from the rooftops because it meant that people were not being discharged from hospitals and there were blockages in the system, what was the board doing to address the problem?

Ian Dilks: I will make two quick points. The first is that the most significant driver of the statistics you have been quoting is difficulties caused by the transformation, particularly when systems start to deliver, and before that, as people were moving to new ways of working. If you look at the number of inspections we deliver, historically, pre-covid, it was about 17,000. It never recovered after covid—it dropped to about 10,000—but at the moment we are delivering a fraction of that level.

The question is, was the board aware, and then what did we do about it? Progressively, the board became aware, supplemented by feedback from staff and people outside the organisation. Knowing there is a problem and knowing what to do about it are two slightly different things. The board had requested a series of actions in order to speed up the number of inspections we are doing, to reduce the unfortunate statistics that you quoted, but the organisation found it very difficult to respond to that at a time when it was attempting to complete a transformation and roll out new technology, which, as it then turned out, compounded the problems rather than made them easier.

Q50 **Paulette Hamilton:** Thank you. I am going to move to you, Sir Julian. Now that you are in post, what are the two quick things that you would like to see happen to address the system backlog in registering, inspecting and reinspecting services? What are the two or three quick things you think you need to do as an organisation to start getting some wins in this area?

Sir Julian Hartley: First of all, do more assessments. The average age of our assessments currently is around four years. That is the highest it has been. We have got to get back to doing more assessments. We are currently at 2,500. That is the worst it has been since we started. To do that, we need to sort out the issues with inspectors having the tools to do the job. That is No. 1.

No. 2—and it is such an important issue—is what I was talking about earlier about backlogs in relation to information of concern notifications. That is very important in terms of making sure we are dealing with key issues, key risks and so on. If you will allow me, I have two more.

Q51 **Paulette Hamilton:** Go on then!

Sir Julian Hartley: We have to get those 500 stuck assessments that Ian referred to out, and we have to speed up registrations. You referred to the views of providers. I had a very, very challenging session with groups of colleagues representing care homes and social care organisations about their frustrations in relation to the time it takes to get services registered. Those are the four immediate things we have to sort if we are going to rebuild our credibility with the sectors.

Q52 **Paulette Hamilton:** I would like to add that the CQC has been a

respected regulator for many years, and people have loved what you have been trying to do, but in the last few years that has slipped. When you are looking at work with patients, service providers and staff, how do you plan to build that trust going forward?

Sir Julian Hartley: That is a great question—thank you. First, we have to build relationships. We have to make sure that we get out there, talk about what we are doing to try to solve the problems and talk to patient groups, people who use services—get their feedback as well as providers'. I am doing that.

Over the last six weeks, I have met dozens of representative organisations in the NHS and social care. On that point about rebuilding trust and getting engagement with the sector, I have had meetings with Martin Green at Care England, Carers UK, the National Care Association, Independent Healthcare Provider Network, Care Provider Alliance, ADASS, the LGA, organisations that represent people with learning disabilities and autism and of course the NHS Confederation and NHS Providers, which I formerly led.

All those conversations are important in being clear about what the people that we regulate require from us, and there is a lot of feedback as well from patient and service user groups. One of the things we will be doing in the coming months is reintroducing chief inspectors of hospitals, of mental health, of primary and community care and of adult social care: four chief inspectors, with a view to bringing back the operational delivery under each of those areas, to have the right expertise in the organisation to relate to those different sectors, so that people understand the issues and the detail in each of them.

As part of that, we want to bring more colleagues in those sectors to be part of our work, so that they can add value in inspections and so on. When I used to run a trust, I got involved with CQC as an exec reviewer. You learn a lot. You learn a lot by going on a CQC inspection and that transfer of knowledge, expertise and good practice is very much part of our role to promote improvement.

Q53 **Paulette Hamilton:** Finally, because I am out of time, you talked about bringing in chief inspectors. How are you going to benchmark this? The CQC did not go downhill overnight; it went down over a period of years. Covid and lockdown just exacerbated it. How will you benchmark that?

Sir Julian Hartley: We want to get the best people, so we have agreed the benchmarking of salary levels with the Department of Health and Social Care. We want to make sure that these are people who are respected in their sectors.

Given the fact the CQC is at such a low ebb with where we find ourselves, there is a real opportunity for people to come in and support the work. I think everyone believes in the importance of regulation in health and care. We have not had any feedback to say the CQC should be completely abolished; it plays a key role. The fact is that we need to renew, reset and

get people in who can really take us forward in building those key relationships.

Q54 **Paulette Hamilton:** So as part of that you will be prioritising, with your benchmarking, things around backlog?

Sir Julian Hartley: Yes. To be clear: four immediate priorities I have set out, and alongside that are what I am calling a series of foundational improvements. Those include the things we have been discussing as well as, crucially, the development of a much more positive culture within the organisation: where we empower frontline teams, where they feel proud to be part of the CQC and, crucially, where they feel free and open to speak up. We ask providers to have good speak-up mechanisms in place; we should be an example of best practice ourselves in relation to that. At the moment, the staff survey reveals that a much lower percentage of staff feel able to speak up.

Chair: That is a very good segue to Deirdre Costigan's questions.

Q55 **Deirdre Costigan:** Thank you very much, Sir Julian and Ian. I want to focus on exactly those issues around staffing and workforce. I know that some of the changes made to how you employ people in the CQC have led to some of the issues we have spoken about today. It is no wonder there has been a loss of credibility from the public and providers when the Dash review found that there were people inspecting hospitals who apparently had never been to a hospital before and people inspecting care homes who had never met somebody with dementia. That seems almost unbelievable.

How will you look to rebuild that expertise in teams to address concerns about this lack of knowledge—not just in-depth sectoral knowledge, but to make sure that people have actually met someone with dementia or been to a hospital before?

Sir Julian Hartley: That is fundamental point, and something we would all expect from those regulating us. Having myself experienced several CQC inspections in the past, it is fundamental to have the quality of expertise coming into your organisation that can stand in comparison with those you have got in the organisation, and the people must understand the issues. The first step is to make sure that we focus on ensuring we have a positive culture in the organisation, so that people feel clear about their roles and purpose and can work not in silos but with a shared purpose across the whole organisation.

We need to make some changes, because changes were made to the structure of the organisation leading to a loss of specialist expertise. The Dash review talks about the loss of specialist expertise that is able to go in and understand exactly what is happening. Instead, more generalists went in with a kind of scoring mechanism based on the single assessment framework, and that simply did not deliver what was needed.

We need to have chief inspectors in place. I am hoping that we will be able to make some appointments in the course of the next few months and have a team of four chief inspectors in role, each of whom will have teams

that can specialise in their sector areas. That means having in-depth subject matter knowledge in social care, mental health, primary care and so on, rather than a generalist approach.

At the same time, we must address the problems we discussed earlier about the single assessment framework, so that teams feel equipped to do the job and focus on the key lines of inquiry they will be going into those areas to manage.

The other thing I would like to do, which I want to make some progress on, is bring expertise in from those sectors. Plenty of people in the NHS and social care and so on have told me that they want to support the work of the CQC. Over recent years, we have not had enough people joining inspections from the sector, both in terms of staff and service users and patients. We do have experts by experience. A number of them do join, but I think we can do more of that.

Making big changes around chief inspector roles, aligning the organisation around those, drawing more people in from the sectors we regulate and making sure we have good-quality perspectives from the patients and people who use the services should give us much better credibility and quality of output from inspections we do.

Q56 **Deirdre Costigan:** I am delighted to hear that you are moving forward with the four chief inspectors. I know that the Richards report said that one of the issues was that there was a sort of divorce between strategy and operations. Hopefully that might go some way to bridging that gap. How will you make sure that you do not recreate silo working but in a different way—a kind of sectoral silo working? How will you ensure that there is a strategic overview a step above those four inspectors?

Sir Julian Hartley: That is a key point. Given the 10-year plan, the importance of integration, and health and care working much closer together it is vital we do that. I would see that group working as a team, making sure that we are regularly sharing insights and experience. We have a data and insight function in the CQC that pulls information from many different sources. I think we need to use more outcome data.

For example, there are many crossover areas where people with mental health challenges can often end up in emergency departments, so you have to look at these things across the piece. We were asked to inspect integrated care systems, but we have paused that work because of the travails that we have been dealing with.

Q57 **Chair:** We will come to that point in a later question.

Sir Julian Hartley: Okay. On that point about integrated care, one of the most successful or effective experiences that I had at the CQC a number of years ago was a thematic review of frailty across the whole of the lead system. That looked at primary, social care, acute care, voluntary sector, in the round. If we look at things through a thematic lens, you can make those joins in terms of the point you are making about guarding against silos.

Increasingly, people's experience of healthcare is all about trying to find a way of it being seamless, and not having to retell the story each time they go to a different part of the system. That is an important part of our work.

Q58 **Deirdre Costigan:** What is your assessment of what staff morale is like at the moment at the CQC? You can imagine that people will feel sort of bashed a little bit. What specific steps are you going to take to ensure you do not lose what I am sure are very experienced people still there in the CQC who want to do a good job and be part of the future?

Sir Julian Hartley: Absolutely. I have had the privilege of meeting a large number of really good colleagues—fantastic people who are dedicated and committed to the CQC and want to see it radically improve. They have been deeply distressed by the position it finds itself in. Many of them have talked to me about how their concerns were not taken on board.

Step 1 is to make sure that we have a positive, open culture that learns the lessons from the past; that work has started, by the way. We are running a dedicated programme on strengthening the engagement of all 3,000 colleagues. What is our shared purpose? What is our vision? What are our values and behaviours and how do we work with our sectors? That is critical because frontline staff need to know that myself and the board are absolutely with them in terms of supporting their work.

The staff survey last year revealed that only 27% of staff believed that leaders in the organisation shared the values of the organisation, so we have work to do there. That is a huge priority for me and I have always believed—the evidence and the work of Michael West and others support this—that if you do not engage frontline staff and you do not have a sense across the organisation of that clarity of mission purpose and engagement, you will not deliver for the people that use the services and make the regulation work effectively.

Q59 **Chair:** When the survey says "the leaders", who do they mean?

Sir Julian Hartley: Senior leaders.

Chair: Senior leaders—the executive team.

Sir Julian Hartley: The staff survey from last year makes for difficult reading. On your question about where staff are, they are deeply distressed and deeply concerned. But I have to say—on my first day I spoke to 3,000 staff over a Teams call—they are really clear and, I believe, open with me about where they are.

It is our job to build a way of working that gives them the confidence that they have a leadership they can trust and that they can be open with, and also that we are building our strength in terms of the point I made about chief inspectors and clinical expertise and so on. Crucially, they want to see and they are watching that we address those immediate priorities that I spoke about to make sure that they see some improvements.

Q60 **Deirdre Costigan:** It is good to hear that you are rolling out this

programme of engagement but, as you said, many staff could see the issues clearly and raised them at the time. Do you have a whistleblowing procedure and are you confident that it works? Do any changes need to be made? Will people be listened to this time?

Sir Julian Hartley: Again, that is a crucial point. I studied a report that had been done prior to me joining, which was a major review of listening, learning and responding to concerns. That report was done in May 2023 and set out some key issues and recommendations for the CQC. The Government internal audit agency concluded, through an internal review in December, that it provided limited assurance on the adequacy and effectiveness of our arrangements. Again, we have work to do there.

There are still a number of recommendations outstanding. I am planning to use the work on culture and engagement to ensure that we cover the issues around openness and whistleblowing concerns. Having read that lengthy document, it is important for me to understand that we have a number of areas in terms of how we listen to whistleblowing concerns, freedom to speak up, learning from employment tribunals, listening to our staff, expectations and experiences of people who raise concerns with us, and cross-organisational recommendations. Those key areas, all of which have a series of recommendations, need to be addressed as quickly as we can.

Q61 **Deirdre Costigan:** That is a lot of concerns. Do you have a clear timetable for that?

Sir Julian Hartley: Yes. We have a plan around the work on culture, to take us to the spring. I am happy to update the Committee on where we get to by that stage, in relation to those recommendations from the LLRC report, but it has to be a key priority for us.

Chair: Back to ICS inspections with Ben Coleman.

Q62 **Ben Coleman:** It is good to see you here, Sir Julian and Mr Dilks. You just touched on the suspension of the ICS assessment programme. What needs to be in place for you to restart that programme, and what timetable are you working towards?

Sir Julian Hartley: The first thing I would say is that what has to be in place is improvement on our current performance. The reason why the ICS programme was suspended was simply because trying to do that at the same time as dealing with the current issues in front of us would have been too much of a stretch for the organisation. We have repurposed the staff who were recruited to do those ICS inspections on the key priorities that I described, because we need that capacity to deliver against the things that are, if you like, the fires that are burning that we need to put out. I agree with the point about pausing those.

In terms of the timeline around restarting them, we first need to be clear about how we are going to do ICS assessments and what we are going to be looking at in relation to ICSs. We have already had conversations with Matthew Taylor at the NHS Confederation, and other stakeholders, about

how we do this. Ian might want to comment on previous pilots that were done on ICSs.

For me, the issue about getting this right is that integrated care systems and boards sit above a kind of geography: there are 42 of them across the NHS, of different sizes. They have an overview of the connections between health and social care, of health inequalities, of population health and so on. They are not directly delivering the services—they are overseeing them—so we have to be thoughtful about how our inspection approach, once it starts, looks at their particular role.

In an earlier answer, I talked about a thematic review around particular areas of care. That might be an interesting way of thinking about this. We have not worked this through in detail, but if you look across an ICS area at, say, frailty, or the care of older people, maternity, children and so on, it might be that a thematic approach gives us more insight than just a review of a structure that sits above a series of providers.

Q63 **Ben Coleman:** That is helpful. What about the timing within which you hope to be able to achieve this?

Sir Julian Hartley: That depends on the speed at which we tackle the issues that I have outlined. I hope to be in a better position—and I am happy to inform the Committee of exactly when we think we would be likely to recommence that. We are in conversations with the Department about this. We are in discussion with member organisations, so that we are not wasting time. We are talking about this, but in terms of actually getting people out there into those areas—leave that with me.

Ian Dilks: A quick point of clarification: there is a difference in the ICS and local authority work we do, compared to everything else, regarding the role of Government and Ministers here. We actually require specific approval from our Ministers or the Department for the work we do on local authorities, which has been continuing, and on ICSs.

As Julian said, we did some pilots last year, but we never actually had approval from Government to commence. I thought we were close, but then an election was called. Everything Julian said is right about us internally but, at the end of the day, the other crucial thing is that we have to get approval from the Department.

Q64 **Ben Coleman:** Interesting. That is helpful. Just a declaration: I used to sit as the local authority representative on an ICB. It is fascinating; the NHS part does not integrate; all the mental health hospitals, primary care and all those bits do not integrate well—and the other side with the local authorities is a challenge.

I note that neither of you has a background in local authorities, and yet we are not going to sort out the health system unless we sort out social care. I appreciate that you are going to appoint an inspector who is going to look particularly at adult social care. How will either of you know, seeing as neither of you have backgrounds working with local authorities, whether they know their stuff, and how will you be able to hold them to

account effectively at a senior level?

Sir Julian Hartley: Although I have not worked as an employee in local government or social care, I have worked with social care and local government for many years. I spent a decade working very closely with Tom Riordan, in Leeds, who is now second permanent secretary in the Department, and with Cath Roth, director of adult social services at Leeds council.

I learned enormous lessons about the importance of social care in the context of what we were doing not only in the hospital, but across the wider community as anchor institutions and supporting people at home, in care settings and in the care sector.

The Secretary of State has talked about the work we did to move resources from the NHS into social care to support more activity in social care. I have a keen appreciation of the role and importance of social care in the context of health and care delivery across the country.

We did a lot of work together to ensure that we understood each other's roles, that social workers were regularly in the hospital and that our teams were out there. I think that is a vital part of how we tackle some of the challenges we currently have across the NHS and social care, particularly with the number of patients in hospital wards who would be better served in care homes, healthcare communities or home care.

We have a major challenge with the scale of staffing and funding in relation to social care. I take your point about my background, but I would say that the work I have done and what I have experienced in relation to social care has given me a strong sense of its value, importance and crucial nature in relation to this work.

Ben Coleman: Forgive me—I will look forward, rather than backwards, on this, because there is a huge amount to do and to make better. What sort of background would you expect your chief inspector for adult social care to have?

Sir Julian Hartley: I would expect them to be a director of adult social care.

Q65 **Ben Coleman:** Can I just come back to what my colleague Jen Craft said about one-word assessments? The Association of Directors of Adult Social Services, the Local Government Association and others have said you should look at what Ofsted has done and stop going for the overly simplistic one-word assessments. Will you do that?

Sir Julian Hartley: I think I said earlier that we are reviewing our position in relation to—

Ben Coleman: Does that mean that you are considering it as one of the options?

Sir Julian Hartley: We are considering it, but I should say that it is ultimately not our call; it is for the Secretary of State, in terms of both local authority and ICS assessments.

Ben Coleman: But you are going to be making a recommendation to the Secretary of State.

Sir Julian Hartley: Indeed.

Q66 **Ben Coleman:** Will that be one of the options that you will consider in making a recommendation?

Sir Julian Hartley: Right now, we are having lots of conversations, and we talk to ADASS and the LGA a lot. We are about halfway through the local authority programme, so we are getting lots of feedback. There have been 16 published assessments so far and lots of feedback from the sector about how it is going and how it is feeling. The key thing is to come at this from the perspective of how we as an organisation can support the improvement within local authorities' social care and across other sectors. How does the way that we describe services support that, and how do we account to the public?

There are quite a few factors to think about, so I apologise for not giving you a straight answer on this one. We are thoughtful about it, and we will be taking on board views and opinions. We will be reviewing the evidence and thinking about where we go with it. I come back to my earlier point: we have to sort out the basics to ensure the assessments we do are credible and high quality.

Q67 **Ben Coleman:** I appreciate that. I was just seeking clarity on whether the possibility of a one-word assessment is on the table for discussion at the moment as part of the process that is taking place. I am still not quite clear whether it is.

Sir Julian Hartley: The possibility is, certainly, as part of the review. We committed to review the feedback on the process, and that will inevitably be part of it.

Q68 **Ben Coleman:** Thank you very much. That is very helpful. You have slightly distracted me from the final question that I was going to ask. I want to go back to the ICSs. There are many, many differences, and the different parts of the NHS do not work well together, but there is a fundamental difference of governance between the way local authorities operate and the way the NHS operates—bottom up, top down, and lots of other things.

Do you think the staff you have in place are equipped to understand that and make an assessment, based on a proper understanding of that difference? The Dash report notes that local authorities are fundamentally different. Do you think you have people who really get that in place at the moment?

Sir Julian Hartley: I do, because I have met a lot of them. We have a lot of people who have worked in local authorities' social care. We also have

people who have worked in the NHS and primary care—in a range of settings. Part of what I was saying earlier to your colleague is that our organisation needs to be permeable. We need to make sure there is learning from colleagues who are going into social care settings, care homes and NHS settings and that, thanks to the different backgrounds that our inspectors have, there is a clear understanding and an appreciation of the merits and importance of those other sectors. We expect those we regulate to have close working between health and social care.

In terms of the body of people within the organisation, I believe we have good experience and talent to do that. What we lack is, in broad terms, those at the chief inspector level, bringing the operational delivery under each of them. That is the bit that we need to get right.

Ben Coleman: Thank you. By the way, I think your thematic approach is a good one, based on experience.

Q69 **Gregory Stafford:** Do you believe that the CQC's current budget is sufficient to fulfil its statutory duties and respond to the failings outlined in the Dash report?

Sir Julian Hartley: In short, I am clear that I have to work within the budget that I have.

Gregory Stafford: That is not quite an answer to my question.

Sir Julian Hartley: Okay. Fee income constitutes £220 million of our core income, and this year we have agreed that we are not putting fees up. I am sure colleagues will agree that, given where we are, it wouldn't be right to ask those we regulate for more. There is more we can do internally to make sure we are working efficiently and effectively. I am sure that, from what you have heard today, you will get a sense that there is a lot to do within the organisation itself to ensure we have the right use of resources, particularly given what you have heard about the deployment of the computer system, the regulatory platform and so on.

Originally, that was planned to save considerable sums, but of course those benefits have not been realised. That gives us something of a challenge around what was forecast. Right now I am working with my team and with the finance director to project where we think we will need to be over the coming years. Next year, we are planning to do a zero-based budgeting exercise to make sure that we are clear where the resources lie.

I am sorry that I hesitated initially, but you will understand that I am making a detailed assessment of our existing resource. I am conscious of the challenges that our regulated sector faces in terms of financial squeeze. I am not proposing that we ask for more through fee income. We are talking to the Department about specific areas where grant in aid supports some of the potential work with ICSs, and so on.

That is where we are and where we are planning to go. It is important to recognise that we will need to increase staffing in things such as registration in order to get the backlogs down and repurpose staff on other priorities. It is a moving picture at the moment; I am making a clear assessment of that. Six weeks in, that is as much as I can say to you about that.

Q70 **Gregory Stafford:** In terms of the allocation of resource, where do you see the split between doing the day job and putting in the reforms that you have been talking about?

Sir Julian Hartley: In a sense, the changes that we need to make will be the day job. Sorting out the four immediate key priorities I discussed with your colleague; reviewing and strengthening the single assessment framework, although it will not be a single assessment framework because I do not think that works; building a culture of the organisation; ensuring that we have the right operational arrangements—I anticipate that we can go at all of those without asking for a significant additional resource.

There may be some things we will need support with if we are asked to do more. For example, we see demand for registrations and the number of concerns that come in rising. We have to keep pace with demand, but we also have to look to ourselves to maximise the resource we have.

Q71 **Gregory Stafford:** When you put in this extra resource to deal with the reforms, the day job and so on, how do you ensure that, once you have hopefully overcome those issues and are on a more secure footing, you keep that expertise and do not lose it because you go back to a point where things are running "as they should be"?

Sir Julian Hartley: You make a really important point about the expertise that we need. One of the peculiarities of the Care Quality Commission is that the pay levels are different from the NHS; it has more of a civil service-based approach.

Over time, that has had an impact on the differentials between Agenda for Change in the NHS and where we are. That can be a challenge for recruiting at a level that is commensurate with what we need. We are having to work through that and are working closely with the Department to make sure that we can get the right people in at the right level, particularly at chief inspector level.

I would hope that my earlier point about bringing in expertise to work with us on inspections and spend time with the CQC, not necessarily as permanent staff, but to support some of the work periodically as part of people's development and as part of what people can do from other sectors, will help with that point about expertise.

Q72 **Gregory Stafford:** Going back to the funding itself, you said that you want to transition to a new, simpler fee scheme. Can you outline what you mean by that? You were clear that you were not looking to raise the registered providers fee this year, but does that simpler system mean you will be doing so in future?

Ian Dilks: I will answer that. To be fair, the comment was made before Julian arrived, so I will take responsibility for it. We have a total sum that covers a number of activities. It is easier to focus on inspections, but we have 55,000 locations that we have to register; 65,000 new pieces of information that come in every year; 800,000 notifications and information of concern, and so on.

All of that is a big infrastructure, and then you say, "How do we split that total fee out among people?" That has not been looked at for some years; it does need looking at. I was chair of the board when we decided, at that time, that it was not a good time to be telling providers that we would like to look again at the way fees are allocated. That is a separate issue from the total quantum, which was your first question, but we felt—this decision was made a long while ago—that with everything else going on, it was not a good time. It will be up to Julian, but I would have thought that we will need to look again at the basis of charging in the next year or so.

Apart from anything else, the world has moved on; the areas where we are putting our activity are now different from what they were. The intention was to be far more data-informed in what we do. We haven't really achieved that, because of some of the problems we have outlined, but if we do that, it will impact the relative effort between adult social care and health in particular, as well as the emerging and fast-growing independent sector. Sorry—that was a bit of a long answer. It does need to be looked at, but now is not the time. Next year or so.

Q73 **Gregory Stafford:** Thank you, Mr Dilks, for taking ownership of that. Following on from that, Sir Julian, where do you see it?

Sir Julian Hartley: I remember well signing off the fees that we paid as a trust for the CQC, and they were not insignificant. If we think about the perspective of our providers—those we regulate—it is a non-negotiable part of what they have to do, but we want to be able to demonstrate that we are adding value.

I want the focus to be on what providers feel they get from us, not just in terms of summative judgments, but in the sense of what we do to support improvement; how our work helps to inform what good looks like, sharing best practice and bringing people together; as well as fulfilling the core functions. That is where I want the focus to be, so that people feel that it is fair. We have to deliver what we need to deliver. We have 3,000 staff. We need to make sure that we have the right resources to do the job well, but we also want to make sure that people feel they are getting a fair deal in terms of the fees they are paying for the work that we do.

Q74 **Gregory Stafford:** You have been very clear. Can I push you for a simple answer on whether you feel fees will go up in the next few years—yes, no, or don't know yet?

Sir Julian Hartley: My understanding is that they have remained the same for the last six years. I cannot give a guarantee that they won't go up; I think we are going to have to look at the prevailing conditions. As I said to you earlier, we are going to do a zero-based budgeting exercise

next year. I am sure that, when I come to see you next time, I will have a clearer perspective on that for you.

Chair: It sounds like "Don't know yet".

Q75 **Andrew George:** Sir Julian, you described the one-word assessment system as at least having the advantage of being more publicly comprehensible. In the light of that, would it be fair to deem the CQC as you arrive inadequate, in a one-word judgment?

Sir Julian Hartley: I would say—and I will explain why—that because of what I have seen in terms of the teams I have met and the people in the organisation, in whom I have great faith and confidence, I might have said that previously, but I would say "requires improvement". Because I think there is the capacity to improve, with the people we have and with the desire, willingness and commitment to address the key challenges.

I absolutely understand your proposition, but I am giving you my sense of where we are right now in relation to where I think we can go, given the people that I have met and am working with, and the clarity of purpose that I think we will bring to trying to improve the whole situation.

Q76 **Andrew George:** So you have gone native in the new organisation and are taking their view. Do you think it would be not unreasonable for someone external who was looking at the state of the organisation to perhaps preface it with the word "shockingly", considering the IT debacle?

Sir Julian Hartley: I would not disagree with that. I think that when you look at the deployment of the so-called transformation programme, with those three things that were prosecuted at the same time, the difficulties that we have explored around the regulatory platform, the impact that has had on staff and the psychological and physical impact of that, there is no doubt that that has caused significant damage, and your characterisation in relation to that would be fair.

Q77 **Andrew George:** We will move on, you will be pleased to hear, to the nature of the inspections that you undertake. A lot of it seems to be kind of forensic, and understandably needs to be forensic in nature, but to what extent are you sensitive to the whistleblowers when pursuing inspections on the basis of that kind of intelligence-led approach?

Sir Julian Hartley: That is very important, and there is already an approach, which is described as a risk-based approach to inspection, where whistleblowers can trigger a response—an inspection—on a collection of issues.

Given what I said earlier to your colleague about the backlog regarding information of concern notifications, that is something we have to sort out quickly in order to make sure we are on top of that. That then informs the speed at which we are able to go into organisations. One of the other problems with the fact that we are only at 2,500 assessments is that we are not moving fast enough to go back to places that have been rated inadequate—that have problems. So, your point is key.

One of the other foundational improvements we are looking at is on data and insight. How do we make sure that we are smart at gathering all of the data, including all of that feedback from people who use services, and staff in provider organisations, who are flagging this, so that there is a consistent and rapid response to that?

Q78 **Andrew George:** In terms of trying to extract some benefit from the difficulties that the CQC has experienced, and following from Danny's line of questioning in relation to the IT contract that you have undertaken, there will be lessons to be learned that I think the wider public sector could really learn from. I would hope that the CQC could produce a report to say, "This is where we went wrong, and this is where, given another opportunity, we would put it right."

I am not an IT sceptic, but I live in a "quill, pen and parchment" kind of world to a certain extent, and it seems to me that, by having an overdependence on technology—if you are not, if you like, doing the mental arithmetic alongside the calculator, and you are not sense-checking what the technology is telling you—you are going to start believing material that is extremely unreliable. It would be really helpful to have a statement from you so that the wider public sector could benefit from your experience.

Sir Julian Hartley: We would be very happy to do that. The report that I commissioned is detailed in relation to those lessons, and indeed on what benefits have and have not been delivered by this. As I said earlier, I am very happy to provide the Committee with that, and hopefully those key findings will serve the purpose that you describe.

My reflections would be that any major IT project cannot just be the preserve of either contractors or people with IT knowledge; it has to engage everyone, and it has to be a whole change programme, rather than just seen as a sort of implementation of technology.

Q79 **Andrew George:** Yes. Learning that you have reports that you cannot get out of your system, and that you have not even kept paper copies, let alone Word copies on laptops or whatever, is just remarkable. I think people will be shocked. I mean, we were all shocked; jaws were on the floor when we heard this.

Sir Julian Hartley: I don't disagree, and that is exactly why, when I heard from colleagues—when I sent out the email and got all of that feedback—I immediately commissioned a review to understand for myself exactly what had gone wrong and why.

Q80 **Dr Cooper:** Thank you, Sir Julian and Mr Dilks, for being here. I would like to ask you both about the Department of Health and Social Care as a sponsoring body for the CQC. Mr Dilks, I will come to you first. Could you tell us how that support has been for the CQC and for yourself, and perhaps any areas in which you would like to see improvements moving forward?

Ian Dilks: That is an interesting question. Clearly the last few years have been challenging, with changes of Government or personnel. The

Department just at the moment has been very supportive. We have taken advantage of a new chief executive coming in and have held a number of discussions; we meet every couple of weeks.

However, if I am completely honest, I am a little surprised by the extent of contact I have had with the Department, particularly at ministerial level. You may know that I chaired another public body before, for seven years, and I was used to seeing the sponsoring Minister periodically and I did also meet the Secretary of State on a number of occasions. That has not happened in the last few years. That is over two Governments. I had six Secretaries of State and I think three sponsoring Ministers.

Q81 **Dr Cooper:** Just to be clear: under the previous two Governments you have not had regular interaction with the Minister or the Secretary of State?

Ian Dilks: No. One of the reports, I think Penny Dash's report, did refer to this. There is oversight and there is sponsorship. They are related because you have the same meetings. I don't wish to be overly critical, but having been used to chairing another body where I had those regular meetings, I am a little surprised that I have not had the same engagement with Ministers here. I think that would have been helpful.

Q82 **Dr Cooper:** Have you got any sense as to why that was the case?

Ian Dilks: No. I could speculate but I won't.

The other point I would make, and have already touched on, is about speed of response. We know that is an issue across Government. This is not about us or our sponsoring team; I am sure you have all seen the NAO Report about the speed of reporting and directors. We were in danger of not being quorate as a board at a pretty critical time. Was waiting nine months for a cohort of NEDs and 14 months for a chair of the audit committee the cause of the problem? Absolutely not, to be clear, but it would have been helpful. If you assume that having a good board is a good thing, then it would have been helpful for it to have been in place.

The same applies on approval for pay scales. We have a huge degree of independence, but one thing we do need to do is get approval for posts of a certain level. The Department was very helpful in giving me approval for the salary level we felt appropriate to recruit Julian. We got that by the beginning of September and were able to run a process that ended in four weeks. That was great.

However, I can give you other examples where we have been waiting for a very long period of time. The chief inspector of hospitals would be the obvious one. We have had a vacancy there for over a year now and we are just beginning recruitment. As the outgoing chair, I think speed of response on key issues would be very helpful.

Q83 **Dr Cooper:** Before I move to Sir Julian and ask a similar question, to clarify: were you seeking meetings during this time that you needed? Were you seeking responses and simply not receiving them?

Ian Dilks: Correct.

Q84 **Dr Cooper:** Sir Julian, I am sure none of this is coming as a surprise to you. With your incoming appointment, what are your reflections on the current relationship with the Department and what do you hope for going forward?

Sir Julian Hartley: In starting in the role, my experience of engagement with the Department of Health and Social Care has been very positive—quarterly accountability reviews, budget and assurance meetings, fortnightly recovery meetings with senior colleagues in the Department, fortnightly policy and engagement meetings, regular one to ones, and the opportunity to speak to the Secretary of State.

I feel I have a positive and engaged relationship with the Department. Their expectations of me and of what we as a CQC do are clear to me. They are very clear about the need to address the issues we have discussed today and are in my view having the appropriate conversations about those issues, and indeed looking to support the chief inspector appointments that we want to make.

Ian Dilks: I think you phrased the question slightly differently. Let me be clear: I have a very good relationship with the people I deal with day to day in the Department and as I have already indicated I am extremely grateful for the speed with which they responded to approval for recruitment with Julian. We gave slightly different answers, but I was asking a question about what else could be done.

Dr Cooper: That is very clear. Thank you, Mr Dilks.

Q85 **Danny Beales:** This is the final question, which I am sure you are pleased to hear—a bit of a marathon, so thank you for bearing with us. We have heard in depth about what has gone wrong, the lessons that have been learned, the unfortunate impacts on the system of those failures and what your priorities are—Sir Julian, your four priorities for putting it right.

Looking forward to the successful implementation of those four priorities, what does success look like for you in six months? Perhaps at the end of your tenure at the organisation, how should this Committee judge whether that tenure and your priorities have been a success?

Sir Julian Hartley: That is an important question; thank you. First, restoring the operational effectiveness of the organisation, addressing the problems that are highlighted in both the Penny Dash report and the work that we saw from Mike Richards.

Secondly, restoring confidence in the sectors that we regulate, so that the CQC is recognised as a regulator that is there not only to make sure that patients, service users and people who use all of our range of services are protected, but to support the improvement of the delivery of services by sharing best practice, by being clear what "good" looks like, by bringing people together, by involving people in those services in those sectors in the work of the organisation and—crucially, I would say—by holding up the mirror in our annual "State of Care" report and the other reports and

things we do on the progress we are making collectively across health and care as a nation, with the key themes and issues that we are able to highlight and reflect on, ensuring that they are given focus and priority where needed.

I would hope that we are a regulator that is seen as fair, reasonable, good to work with and, crucially, independent and absolutely clear about shining a light on the areas where service users and patients need to see improvements happen.

Q86 **Danny Beales:** That is an ambitious agenda. I hope you succeed. Were the Committee to have contact with you—written, or perhaps back before us—in six months, what practical indications will we see on movement and direction? How can we judge whether the organisation has moved forward towards those goals?

Sir Julian Hartley: That is fair. I would say, judge me on those four operational, immediate priorities I set out, and where we have got to with key appointments in those chief inspector roles, where we are with the feedback from staff internally about how they feel about the leadership of the organisation and—although six months is probably not long enough—what sectors say about how they experience us. We have metrics to judge performance—we have a metric for each of those four immediate priorities—and we do regular staff sentiment surveys to give us a view as well.

Danny Beales: Thank you. Perhaps you will share that survey and the four metrics with the Committee in the follow-up.

Q87 **Chair:** Ian Dilks, we have the pre-appointment hearing for your successor. What advice would you give them?

Ian Dilks: To answer with a link to qualities, first I think is independence. I know Committees are always focused on that, but I have chaired different bodies now for 10 years and independence—and being seen to be independent—is hugely important. Independence and, as a matter of fact, the way you act being seen to be independent, are important. That is particularly true for a regulator, and we cover such a broad array—we are not just NHS or adult social care, but the lot.

The second point—I will make three—is to make sure that in selection of the board, in its agenda and, indeed, in looking at things, one works with the quality of care received as a north star. We have to work with providers. I have been regulated all my life, and I have been a provider in a different environment, but although we have to work with the providers—that relationship has to be good—at the end of the day our purpose is not to regulate; our purpose is to have the right quality of care for people. We need to do that, and in a way that introduces the right balance between health and adult social care.

This Committee asked questions about my experience of adult social care, and I assure you that I have tried very hard—in the board, its construct

and the operation—to get that balance. That is not always easy with the pressures in the environment.

My third point to some extent comes from the feedback I had when it was announced that I did not wish to be reappointed, because I spent a lot of my time talking to others—as an ambassador, if you like, or a link point with others. The words "openness" and "transparency" came up a lot. I sincerely hope that my successor will not be in the position that I have been in. It has been a very difficult couple of years.

I would like to think that being straight with people, being open and transparent about our problems, and making it clear that the board recognises and is dealing with that has been helpful. I would commend both your selection and my successor, whoever that is, to continue with that approach. Those are my three points.

Chair: With that, I thank you. The bell has rung. I thank you both for the time you have spent with us. It has been a very useful session. The providers, I am certain, will have been tuning in, and perhaps the patients. We will certainly be keeping in conversation with you, Sir Julian, and thank you, Ian Dilks, for coming to give evidence.