HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Pre-appointment hearing - Chair of the Care Quality Commission - HC 1091

Tuesday 22 February 2022

Ordered by the House of Commons to be published on 22 February 2022.

Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Dr Luke Evans; Barbara Keeley; Taiwo Owatemi.

Questions 1-34

Witness

I: Ian Dilks OBE, the Government's preferred candidate for Chair of the Care Quality Commission.

Examination of witness

Witness: Ian Dilks.

Q1 **Chair:** Good morning and welcome to the Health and Social Care Select Committee's pre-appointment hearing with the Government's preferred candidate to be the new chair of the Care Quality Commission, Ian Dilks. Thank you very much for being with us this morning, Ian. I think you are the first ever witness to give evidence when they actually have covid, although you do not look too bad on it. We appreciate your joining us. Can you start by explaining why you applied for the role, and what particularly you want to bring to that very important position?

Ian Dilks: Thank you for inviting me and agreeing to do this on video given that I have covid.

There are two parts to your question, Chair—why do I want to do it and why I think that I would be a suitable candidate. Let me take the questions separately.

Without making too long a story of this, on why I want to do it you will have seen from the background papers that what I call my first career was in the private sector. I worked in PwC, initially in a variety of roles, and I was there until 2013. I tried to take a year out, and looked around for what to do. I was keen generally to find things where I could add value and use the benefit of my experience, but at the same time I enjoy a challenge, and I wanted a new one. To be honest, initially I was not thinking of the public sector, but somebody suggested to me that I really ought to consider it. If you don't mind, I will repeat what they said to me, which sounds a little bit pompous in a way. They pointed out that I am part of the golden generation; I do not come from a wealthy background, but I received a first-class education at the cost of the state, I went to a first-class university at the cost of the state, I have been lucky enough to have a career that has left me financially independent, and as the individual put it, "It's time to pay back and why don't you consider public service?", which I did. It was one of the better decisions I have made.

Chair, as you will probably recall, I applied for the chairmanship of what was then the NHS Litigation Authority, now NHS Resolution. I thoroughly enjoyed that role for a whole bunch of reasons, but including meeting that giving-back criteria—I hope you will accept that comment in the spirit in which it is intended. I finished there 14 months ago, so then the question was, "What do I do next?" Having enjoyed public service, I was quite keen to continue in that vein. I was looking for chair roles, and it made sense to me to see if I could find something suitable in the health sector. I had spent the best part of seven years enjoying my time in the NHS, enjoying what it stands for and accumulating knowledge. Frankly, it seemed a real shame from my point of view not to find a way of using that knowledge for the benefit of society more generally.

I noticed that the CQC chair role was vacant—I can say more about that later if you wish—and in truth I did think very carefully about whether to apply. I took soundings from a number of people who knew me and knew the CQC and the health and care systems. I sought their views and got very positive feedback that it was something to which my skills were well suited and that I should apply. I hope that that gives you a feel for why I chose to apply.

As to what I would bring, I have sort of touched on that, but I believe that my experience before NHS Resolution, and particularly since, has given me an understanding of the workings of the health and care systems. I understand what an ALB is, and I know how to work with other bodies, the Department of Health and Social Care and Ministers. I believe that I did that successfully at NHS Resolution, and I am keen to have the opportunity to use that experience and skills with a new challenge. Does that answer your question?

Q2 **Chair:** Yes. One of the most important changes that you made while I was Health Secretary, and I think with some encouragement from me, was to focus NHS Resolution on patient safety, and to focus the litigation authority, as it was originally, on the fundamental point that the best way to reduce the cost to the state of compensation was to reduce the incidence of harm in the first place. I think NHS Resolution made some very important steps in that direction, but the CQC is also central to improving patient safety, particularly through the transparency that it brings. What lessons have you learned from your time at NHS Resolution, in dealing with some of the terrible injustices that occur when things go wrong in the NHS, that you can bring to the CQC?

Ian Dilks: First, I just want to confirm the premise of your question, Chairman. One of the key changes we tried to bring about at what is now NHS Resolution was that focus on patient safety—something that you championed continually when you were the Secretary of State. One of the reasons I was interested in the CQC role was that I could see there were certain parallels between starting off with one role, whether paying claims or regulation, but then seeking to use that knowledge to improve the experience for patients and service users, which is key.

To your question specifically, it is difficult to point to one specific thing, but I am not sure, and this is my personal opinion, that the system is good at learning. One might say, "Why does Resolution"—or indeed the CQC—"have to do some of the things it is doing?" but the system needs some help and encouragement to understand what has gone wrong when you have an outcome that is not correct and how to encourage or support the system to do things better next time. At NHS Resolution, as you probably know, we sought first to identify, through a series of means, what was causing the problems. We worked with others in the system to share that knowledge and to try to work up collective solutions.

A chief executive of a hospital once said to me, "Ian, you need to understand that one of the problems with my job is that patient safety is a very crowded field", in that there are lots of people with views on it. We

really did not think that NHS Resolution coming up with its own ideas of what should be done was helpful, so we worked closely with bodies like the GMC on the one hand, and NHS Improvement and NHS England on the other, to refine our views and thinking, and worked with them to put that information back into the system. We also used our soft power—if I can use that phrase—where we could, to encourage different behaviour. Again, you will know that in maternity, we tried to provide incentives, provided the board formally reviewed and signed off on their adherence to the national safety standards that were being developed. That is what we did at Resolution. I think there are parallels here with the CQC.

The CQC is in a unique position to form a view, not just at an entity level but across the system, on what may or may not be working. I think it is therefore able to identify good practice. It would be important to collaborate with others in the system, particularly at this time of significant change— such as the mergers that are going on—to work out the best things that could be done, and then to collaborate with others so that people in the field get, as I call it, "one version of the truth" in what should be done.

The soft power available may be slightly different in the CQC. That is something I am not currently close to, but I hope that if the CQC has a respected voice on what works, that would be listened to. All of that will be particularly important with the new ICSs, given that these are new and inevitably some, when established, will work better than others.

Q3 **Chair:** Let me ask you about that, and then I will hand over to some of my colleagues. When you became chair of the then NHS Litigation Authority in 2014, that was the year that the CQC, or we, became the first healthcare system in the world to Ofsted-rate our hospitals with "outstanding", "good", "requires improvement" and "inadequate". That proved to be a big change, which I think most people would say has stood the test of time.

Under your leadership—assuming you take up this role—the CQC, or we, will become the first healthcare system in the world to do the same thing for entire geographical regions of health systems. What lessons have you learned, in terms of your background reading around this subject and your earlier experience, to make the Ofsted rating of ICSs a success?

Ian Dilks: Obviously, it is early days. The CQC does not currently have a method of rating ISCs. That is one of the things I identified that I would make a key priority for the CQC over the next year or so, were I to be appointed.

If there is one key lesson it is that it is necessary to work with others, in collaboration, in the development of what good looks like and the standards. That does not mean to say that you should not ultimately be the expert and have the courage of your convictions to rate as you see fit, but I do not think it is up to the CQC to sit in an ivory tower and dream up what it thinks good looks like.

It is really important to listen to others and get the experience of others. That will have two objectives. One is to inform what good outcomes for patients and users are, because, ultimately, that is what we are talking about. It is not an internal metric; it is what is good for patients and users. It would result in a better quality system and, crucially, work towards gaining the support of users when ratings are actually given. It will not be in anybody's interests if the CQC comes up with a whole bunch of ratings, and ICSs say, "Well, I don't know how you got there. Why did you do it that way?" Involving all the relevant parties in the development process, so that what emerges has a high degree of acceptance as an appropriate way to rate, will be quite important to the success.

As I mentioned a moment ago, I think the CQC has an important role in identifying good practice, helping to share that and helping these new bodies to develop. Obviously, there will be greater acceptance of what good looks like if it is obvious that the CQC is engaged with people in the development of those new standards.

Q4 **Chair:** One last question on that point, because it is very important. If you asked Mike Richards, who was the first chief inspector of hospitals, what was the most important reason for the success of the programme he set up he would probably say—I don't want to put words in his mouth—that when he rated a hospital as "outstanding" or "inadequate" he was generally making comments that the users of that hospital—the patients who used that hospital—recognised as truthful and accurate; that there wasn't a disconnect between what the public felt and what he was saying as the country's first chief inspector of hospitals.

To do that, he had to set up the system and the weighting of the system so that it reflected what the public really cared about—how long they had to wait to get care, whether the care was safe, of high quality and compassionate, and all those things. Will you be willing to resist pressure from NHS England and the Department of Health and Social Care to weight the way you rate ICSs on the basis of their internal targets, which are the things that matter most to them, and make sure sufficient weighting is given to what the public really care about, which is the safety and quality of care?

Ian Dilks: The short answer is yes, but you probably expect me to elaborate, Chair.

I think that is why bodies are set up as ALBs. It is important that the chair, in particular, and the board of those bodies take that responsibility seriously, so it is established under laws set by Parliament, to whom it is ultimately accountable, but with a clear remit to do the right thing for the patients and users of the system.

In my limited engagement with CQC so far—you will appreciate it is very limited—I get the impression that they take that responsibility seriously. Certainly, as chair of the board, I would see getting that balance right as one of the most important responsibilities of the board over the next year

or so. It is an important responsibility now to rate existing providers, but it will be crucially important in rating the new ICSs.

Apart from the matter of technical responsibilities, why wouldn't we do that? Well, however ICSs are rated, if in a couple of years' time people simply do not recognise or believe the ratings that are given, I do not think that would be in anybody's interests. I think it is important that an outcome of this is that people recognise and respect the ratings that are given.

Q5 **Lucy Allan:** I declare an interest, in that I worked at PricewaterhouseCoopers for 10 years during the period in which Mr Dilks was a partner.

Good morning, and thank you for coming to speak to us today. One of the key criteria in this role is about leading reform and transformation, and in the NHS cultural change is clearly something that is very difficult to deliver. I wonder if you could tell us a bit more about your experience of effecting cultural change and, in particular, if you could reference how you would hope to make the NHS more accountable to the people it serves.

Ian Dilks: It is an excellent—and very big—question. Multiple books have been written on cultural change, and I can only give you some personal views or experience here. A critical part, or an important starting platform, is to make sure that people understand what it is that you are trying to do. It is great if people agree with what you are trying to do, but when effecting cultural change, not everybody will agree with the direction of travel—that is inevitable. However, if people understand the vision and what you are trying to do, that is important: it is probably a prerequisite for successful change thereafter.

In order then to implement it, a number of things are really quite important. Good communications are essential, so that people know what is going on. Consistency is important. If you are trying to effect change, nothing is worse than people perceiving that you are chopping and changing in what you are trying to do. It is also important to develop a clear message that people understand—and hopefully agree with, but even if they do not, that they understand—and articulate that in a way that people understand, in the sense of "What does this mean for me?" Not just, "How am I going to shuffle the deckchairs in an organisation?" but "What will life look like for me if we bring about this change?"

As I say, consistency of purpose and communication to people so that they understand are all pretty key. I also think, if we are talking about change inside the CQC, that the board plays an important role—particularly the chair, who is more visible than the others—but it is important that people walk the talk. If you are going to make commitments to do things, they have to be done in such a way that people can see that the leadership has embraced them, as opposed to merely introducing something that has an impact on everyone else.

I suppose the last thing I would say —trying to keep the answer brief—is that it is quite important to have good feedback mechanisms, so that you know whether or not your aims are being achieved. I put those into two categories: the right governance in the organisation would be essential, and by that, I particularly mean that the executive should have methods to do the measurement, and the board should have oversight and the NEDs should hold the executive to account to make sure that is happening properly. Personally, I have always been a big fan of informal techniques as well, by which I mean as much personal contact as possible with people at all levels, so that you hear things first hand rather than just through the formal channels. However, that is just a matter of personal style.

I have focused mainly on change inside the organisation there. Does that answer your question?

Q6 **Lucy Allan:** Yes, absolutely. The only point I could press you on is around accountability, and how you would bring your private sector experience to the role to ensure increased accountability to patients—to people who are served—rather than to some obscure body somewhere else in Whitehall.

Ian Dilks: I believe that in my response to the pre-application questionnaire, I used the term "governance" a few times. I do think it is important that governance is right in an organisation. I think that is about making sure that the governance in a changing organisation, sitting in a changing environment, is correct. That would be something to look at. The key point about governance, for me, is that people understand what it is they are accountable for, so you don't have gaps in accountability and, as far as possible, there is a single point of accountability to get something done. Single-point accountability isn't always possible, but it has the benefit that, when somebody wakes up in the morning, they know that they have to do something, as opposed to, "Well, maybe I could rely on my colleague to do something."

From the point of view of the board, to pick up the last bit of your question, I think that if one is looking to effect change, one will want information at the board level—performance indicators, or whatever you want to call them—to measure what is happening. However, it is important that, wherever possible, those are externally focused, as opposed to internally focused.

That picks up your point about why we are doing this: it is to produce a better outcome for patients and users of the system, not merely to be able to say that we've just implemented this new system or sent so many people on a training course, or whatever. Those may be indicators that we're doing the right sort of thing but, ultimately, what you want to measure is the impact on people outside.

My background is in professional services, as you said, and that impact had to be bread and butter to us because, at the end of the week, month or year, we got paid what clients paid us. Therefore, there was an unremitting focus on clients—what they said, and how they valued us. If they didn't value us, they went somewhere else. My whole history—much

of my work was on the markets angle, if you like, of the firm—was being very conscious of how others viewed us and whether we were delivering what they wanted. I am sure that if my colleagues in NHS Resolution were here, they would say that they often heard me use the phrase, "Put yourself in the other person's shoes"—so what does it look like to the person outside the organisation?

Lucy Allan: Thank you. The key point that I am picking up here is that patients are clients of the NHS. I am very pleased to hear you say that.

Ian Dilks: Patients and service users in social care, yes.

Q7 **Barbara Keeley:** You said in your response to the questionnaire that you are familiar with the health provider landscape but less familiar with the social care provider landscape. What is your knowledge of social care?

Ian Dilks: Well, it is pretty much as I said. I have not worked in the social care system, but that said, it is a very fragmented system in any event. The healthcare is dominated by the public sector—the NHS—and it has a framework and a number of bodies that I am used to working with, which I can relate to get things done.

One of the challenges of social care is that it is fragmented. The provision is largely dominated by private enterprise. Indeed, I believe that roughly 50% of the spend on social care actually comes from private money rather than the state, so the whole dynamics are very different.

Of course, like everybody, I know people who have used social care. I certainly wouldn't want to claim a whole load of knowledge from my family, but I think you do absorb that knowledge. As I said in the document, I have a daughter who is a social worker, and another who deals with children with learning difficulties, particularly autism—I may wish to come back to that, depending on questions. Even just through talking to them, I think I have a pretty good feel for what—certainly to the disadvantaged in society—the users of social care can look like.

In addition to saying that social care is fragmented, I would also pick up on the point that the bulk of it is provided by private enterprise. That is my background; I am used to working with it, and I do understand the way that private organisations do things. I've been lucky enough not to have personally been in need of social care, but I think that, just as a member of society, I have a sense of what it is like to be a user, and I also think I have a good understanding of the dynamics affecting the bulk of the providers of social care.

Q8 **Barbara Keeley:** Let me mention a couple of things that I think are issues for the CQC in social care. One intractable issue in social care is the scandalous issue of the detention of over 2,000 autistic people and people with learning difficulties in hospital in-patient units, many of which become ranked as "inadequate" or "requiring improvement". We see scandals in the press from time to time about these issues.

Another issue is the persistence of care quality issues in care providers

that are ranked "inadequate". Currently 284 services are ranked "inadequate" and 3,271—14% of the total—are ranked as "requires improvement". There has been an issue over the last number of years of those providers just not improving.

Given that the role of the chair of the CQC is to envisage and rank key political and strategic priorities for discussion, are you concerned as we discuss this about that lack of knowledge of social care, given what a large part of the work of the CQC it represents?

Ian Dilks: I identified in my earlier response that, in terms of areas where I would need to invest my time to learn more, this would be one of them. I would not have done that if felt I had absolutely nothing to learn. But I do not believe that, given the nature of the social care system that I described earlier, a lack of knowledge is an impediment to doing the role. At the end of the day, the board's role and the chair's role is one of governance and oversight. The board has bright people on it. They can learn very quickly the dynamics from the executive, who do understand the detail on the ground, so I don't perceive it as a critical gap.

To your point on ranking strategic priorities, again, I have to say I am not in post and it is up to you whether I am, but I absolutely would see that addressing society's concern about some of these things is very important. One of the things I look forward to learning more about is the role of ICSs in all this. If you will bear with me, can I give a one-minute anecdote about why I think the role of ICSs is important, based on the experience of one of my daughters?

Chair: Why what is important?

Ian Dilks: I want to give the example of what one of my daughters does to illustrate why I think ICSs can be so important to solving some of these problems.

Chair: By all means, can I let Barbara finish on social care first and then we will come to that, because I think both are important.

Q9 **Barbara Keeley:** I don't think discussing here the role of ICSs in response to the questions I have just put is very helpful, because there is still concern about how the social care sector will be represented on ICSs.

I wanted to make a final point. You said in your responses on the reputation of the CQC that you felt it was generally good, particularly among those who are more familiar with what it does. I picked up the sense from what you said that you could see that there had been high-profile perceived failings in the past, but that the organisation had changed. It was almost as if it had swept past that.

In my experience a small but significant group do not believe that about the CQC. They tend to be the families of those with experience of detention in those failing units. I think it is important to see that there is still an issue and that we have not swept past it. I think it is very important for the chair of the CQC to be understanding of the fact that, where there have been those issues, we do not just assume that we are

past them and that there is no problem. There are persistent issues that will need addressing from time to time.

I know that this is a detailed matter, but it is important for the chair role to understand that. I hope that will be something that plays out, because it would not be good for us to accept that the CQC's reputation is generally good among those who are familiar with what it does. Some people are familiar with what CQC does and do not accept at all that its reputation is good, and I think that the chair will have a role in changing that.

Ian Dilks: I note the point. Thank you very much for making it.

Q10 **Chair:** Thank you. Ian, did you want to come in with the point that you were going to make about ICSs and your daughter's work?

Ian Dilks: It was meant to be relevant to the last point, but if I may I will make it anyway. I think it is an interesting story. My eldest daughter specialises in dealing with children with autism. She is no longer, but she was, a doctor in the NHS, and although her role was technically dealing with children, the real measure of success was enabling the families to understand the challenges and how to deal them, and for the children to live with their families. It cost the NHS to do that, but it was a good outcome. In the event of a failure, children go into local authority care, which as you know can cost thousands of pounds a week. The area that she worked in, a borough in west London, had the wisdom to say, "If we paid for this unit"—which my daughter was involved in—"it would save us a huge amount of money because we would no longer have to take these children into care."

So the local authority social care people and the NHS team co-located, worked closely together, and it was a win-win-win. It didn't cost extra money; it actually saved money, but more children ended up staying at home. The local authority saved money, and the NHS costs of running the unit were reimbursed by the local authority. I know that is only one example, but I think it is a great example of how the ICSs have the opportunity, through better collaboration and working together, to have a considerable benefit on some of the vulnerable in society, and not at additional cost but actually saving money.

Q11 **Chair:** I am going to bring in my colleague Luke Evans and, if she wants to come in, Taiwo Owatemi, but first I want to, if I may, go back briefly to the point that Barbara made. I would perhaps put it slightly differently to Barbara, but she makes a very important point. With the new inspection systems that are being set up for hospitals, GP surgeries and adult social care, they fared slightly differently, I think it is fair to say, and I would say the one that has been the most obvious success has been the hospitals inspection regime. The main reason was that it was very thorough; the CQC sends 50 inspectors for three days, and they do a more thorough inspection, certainly than any country that I have come across. The GP one, and the care home side, was more difficult because you are sending perhaps one inspector for one day, and it is very hard to get a very accurate picture of what is going on.

One of the things we hope you would come back to when you come before the Committee in the future is the consistency across what the CQC offers and how you would deal with some of those issues. Sometimes an inspector can go for a short period of time and can make a snap judgment that does not have the widespread respect that I think generally the hospital inspections have had. Do you understand why I make that point?

Ian Dilks: I do entirely. I don't want to go into too much detail, because I could sound defensive when I don't have the facts, but I can see that there are something like 26,000 individual care homes and some of those are very small, so there is a limit to what one can do quite so quickly, but that is not to say that one doesn't try. That is a challenge, and one either finds a better way of doing things or at least identifies what some of those challenges are and sees what can be done about them.

Clearly, one of the major thrusts of the new strategy of the CQC is to be much more risk-based in its approach, and if there are parts of the system that are perpetually failing—which is the point that your colleague made a moment ago—then it would seem to me that common sense would say that the risk systems would flag those up as things that need dealing with as a matter of priority.

The other thing that I have picked up in my very early discussions so far—I touched on this earlier—is that in the NHS there is a framework that does mean that you can call on resources to fix a problem if there is one, and clearly we don't have that sort of framework in this very diverse care landscape.

Q12 **Chair:** I understand that, but I think I have a concern about the changes that the CQC is proposing. In fact, yesterday, there was a story in the *Health Service Journal* that one in five CQC employees are unhappy about the changes that are being made at the moment, and it really relates to the history. The current inspection regime was set up to replace what the CQC did before, which was a largely paper-based system. People used to complain, for example, with care homes that the CQC inspector would arrive at a care home and would just sit in the office at the back, going through paperwork for 24 hours.

The new system that was set up was explicitly designed to use people's judgment and to ask inspectors to walk around a care home, to use what the first inspector of adult social care called the smell test—you know, "Is this somewhere I would like my mum and dad to go?" I hope you will guard against moving away from using human judgment as to whether a place is working or not, because when people talk about moving to targeted inspections, it sounds very logical, but what you can end up with is a tick-box exercise. I do not have the knowledge either as to whether that is actually what is happening or not, but I would hope that, with your fresh pair of eyes, you will guard vigorously against that.

Ian Dilks: I also believe that that is not the intention, but I have taken note of the comments. Thank you.

Q13 **Dr Evans:** Ian, to follow up from Lucy's questions, do you see yourself as a continuity leader or as a disruptor and an agitator leader, given your role in the CQC?

Ian Dilks: Gosh, that is a very good question. This is going to sound like hedging bets: I would say elements of both. In many of the roles I have had over the last 20 years, I have brought about change—that has been the attraction of the roles—and clearly, when I went into NHSLA, there was an expectation that change was needed. What I oversaw may not have been quite what was expected, but that was required, and in my career search, as I said right at the outset, I have been interested in new challenges—I think, by nature, more of a disruptor than continuity.

On the other hand, the CQC has already put forward an ambitious new strategy that will be a challenge to implement in any event, but particularly over a period when everything is being disrupted by covid. I certainly would not want the Committee or anyone to think that "disruption" means that I would see myself coming in, throwing out a strategy and starting all over again—far from it. I saw this role as associating with an ambitious new strategy that will mean a lot of change—that was the attraction of the role—but recognising that for something that ambitious, life will never be as simple as one might wish it to be when the strategy was approved.

At the same time, though, I think there are benefits—and it gives a platform to do that—from the fact that I do not have to go through the learning curve of understanding the workings of a big chunk of the system: what an ALB means, how to work with the Department. I think I have a good understanding of how to do that, so to that extent, it would be something of a continuity.

Q14 **Dr Evans:** Can I pick that up, then? This role is an independent regulator. How do you see that interaction? Do you feel that you have the ability to stand up to Government and the Department, but also, given the fact that you have worked for years in the NHS, how are you going to guard against groupthink?

Ian Dilks: On your first point, I said in my pre-responses that one of the strengths of the system that seems to have evolved is choosing people who have a background of working at senior levels, but are not dependent upon the role or the support of Ministers for anything they wish to do in the future, automatically gives a degree of independence. Certainly, the feedback I got from my previous role is that I demonstrated an appropriate degree of independence: where it was essential that we did things as we saw right, we did, but at the same time working in a collaborative way. We are all on the same side here, ultimately. We all want to see better-quality care for the populace of the UK, or specifically England. I believe that my background and my experience demonstrate an ability to operate independently. I am not beholden to anybody.

Q15 **Dr Evans:** Can I pick up on your CV? It says you worked for NHS Resolution from 2014 to December 2020. What have you been doing this

past year?

Ian Dilks: My main other commitment is that I am on the board of Royal London insurance. That was a role I took on about six months after I joined NHS Resolution. Under the City code, that is a nine-year term, so that runs until November 2023.

Q16 **Dr Evans:** Do you see that as a conflict of interest in the role you are doing, given the fact that you are presiding over the reviews and standards within the NHS and the care system when there is an insurance base behind it?

Ian Dilks: The short answer is no, I don't. I obviously did consider that, and it wasn't a conflict before. I can honestly say that there wasn't a single example of something that appeared to be a conflict. Having talked about it with colleagues at Royal London and with the Department of Health and Social Care, we couldn't see why it would be a conflict. There really isn't insurance sitting behind the system as a whole, and certainly with this role as an independent regulator there is currently no contact between the activities of Royal London and the NHS or the CQC.

Q17 **Dr Evans:** Thank you. One final question. We have talked a little bit about the Government, the Department, and we have talked about the patients. One thing we haven't talked about is the staff and organisations that go through CQC. What would you expect them to feel when they go through CQC?

I appreciate that it's not your role to determine exactly what that looks like, but generally, as leadership—when CQC first came in, it was a very scary, laborious thing for clinicians on the ground. I think that has somewhat worn away, but we have also heard from my colleague Barbara that there are some concerns about what the perception of being reviewed is.

What would you like staff to be able to go away and deal with when one of your inspectors walks in to look at that GP surgery, care home or hospital?

Ian Dilks: The situation you have described with regulators is not unique to the CQC. I have been regulated the whole of my career, both as an individual and within a firm, and continue to be regulated at Royal London. Without wishing to be flippant, I don't think there are many people in the world who get up in the morning and say, "Yippee, I'm being visited by my regulator today!" That's just the way it is.

Specifically to your question, it touches on the point I made earlier on. I think that if there was an understanding of what the inspection involves and what it is trying to achieve, that should go some way toward alleviating individuals' concern or anxiety. It is not easy or perfect, but we did have this to some extent in NHS Resolution—often part of the problem in dealing with clinical staff was that they had a misunderstanding of what our role was and how, in practice, we were much more there to help them as individuals to get to the bottom of things, not to be difficult.

I think a lot can be done to better understanding as to what we are trying to achieve. We all know that clinical staff, NHS staff, go to work wanting to do the right thing by their customers, clients, or whoever. If they are not doing it, it is usually a systems issue rather than the motivation of individuals. If the outcome of a good inspection is to enable the participants in a care provider to get better care, then, providing you can explain that clearly, that ought to help people see the benefit of something being done.

So I think there are steps that can be taken. Good communication and education is a big chunk of it, but I think one has to accept that, at the end of the day, the human nature of not finding being regulated attractive is going to persist.

Q18 **Taiwo Owatemi:** To follow up on the Chair's question, can you provide reassurances that patient advocacy groups and families' input will be better listened to and acknowledged, particularly with regard to GP surgeries and care home inspections?

Ian Dilks: It's difficult to say much more than "yes", to be honest. I am not in post, I don't have the details, so I don't know the full implications of the answer I have given you, but I think it's the only right answer that I can give to that question the way you posed it.

Q19 **Taiwo Owatemi:** Thank you. Once you are in post, if approved, you will be able to come back to the Committee and tell us about the work you are doing to ensure that patients and families are at the centre of CQC inspections.

Moving on to staff morale, a recent CQC report showed that ethnic minority GPs felt that the CQC does not understand or appreciate the unique challenges that minority-led practices face. If you were to be approved today, how would you support CQC work to ensure inspections are carried out in a fair and equal way?

Ian Dilks: At this stage, I could only say that it clearly has been identified as an area of concern. You have rightly raised it, but it is out there as an issue now. It has to be addressed. I can think of a number of reasons why certain practices may feel that way. I suspect that, in practice, the situation will vary from one practice to another. There probably is not one simple answer that says, "Ah, the issue is always X or Y." Clearly, it is an issue that has to be addressed.

A couple of times during this discussion, we have touched on the CQC being respected for what it does—it is part of its licence to operate, if you like. If people continually say that there is something that is not necessarily being done right, I think that has to be looked at, and I would expect the board to ask the management what the issues are. That does not mean to say there are very simply solutions.

One of the challenges, it seems to me from the outside of the CQC, is how to reflect that balance of having a consistent method of rating. I do not think the public wants people to say, "This hospital or this GP surgery is

really good and this one is nothing like as good, but in the circumstances it is quite good." That is not right; there has to be a consistent way of saying that it is very good, good or whatever method of grading we are talking about.

What I think is essential is that where a care developer—a GP or whatever—is falling short of the standards one would like, there is an ability to understand why and to do whatever can be done to feed back into the system to support that care provider to improve or do better. In some cases, it may be specific individual things, and in other cases it may be more a question of particular local circumstance. I would have thought, intuitively, that this is a role that the ICSs have to play as well, because part of their remit is to operate at a much more local level and to design structures that deliver care to the right standard for the local community they are based in.

Q20 **Taiwo Owatemi:** On the subject of equality, are you able to share with the Committee an example from your own professional experience where you have worked to improve equality within an organisation?

Ian Dilks: Off the top of my head, I cannot think of situation where I have been involved in something where there has been gross inequality, so it is a difficult question to answer. The closest I can say to you is that, within NHS Resolution, while I do not think we had major inequalities, we did work very hard at board level to make sure that we gave equal opportunities to all our people. I was very proud of the fact that the proportion of BAME in the organisation was about 40%, which is much higher than many other public bodies or companies, and was pretty much on a par with the ethnic make-up of the communities in which we were based—basically London, and increasingly we were recruiting up in Leeds.

To some extent we did the same thing with people with disabilities. That did not come from a major problem that we started off with, but we recognised the fundamental importance, particularly bearing in mind who our customers were—people who had brought claims against the organisation—of being able to demonstrate to people that our own staff reflected the make-up of the community more widely.

Q21 **Chair:** I do not think we have any more questions. Did you have any final comments you want to make, Ian, before we conclude?

Ian Dilks: Only to say briefly, Chair, that obviously I am here because I would like you to ratify the appointment. The more I look at it and get close to it, I think the CQC will be hugely important over the next year or so. It does not deliver the changes, but as an expert commentator on what is happening, it can provide great insights to Parliament and support to the system. I am keen to do it. I have taken note of some of the comments I have heard. Were you to appoint me, I look forward to coming back, and I will undertake to try to respond to the points that have been made.

Chair: Thank you very much for your time this morning, and good luck with your recovery from covid. We will look forward to being in touch.