



Health Committee

Oral evidence: [Complaints and raising concerns](#),
HC 350

Tuesday 17 June 2014

Ordered by the House of Commons to be published on Tuesday 17 June 2014

Written evidence from witnesses:

- [Care Quality Commission](#)
- [General Medical Council](#)
- [Nursing and Midwifery Council](#)

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Members present: David Tredinnick (Chair); Rosie Cooper; Andrew George; Charlotte Leslie; Grahame M. Morris; Andrew Percy; Mr Virendra Sharma; Valerie Vaz; Dr Sarah Wollaston

Questions 263-394

Witnesses: **David Behan CBE**, Chief Executive, Care Quality Commission; **Professor Sir Mike Richards**, Chief Inspector of Hospitals, Care Quality Commission and **James Titcombe**, National Advisor on patient safety, culture and quality, Care Quality Commission gave evidence.

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Q263 Chair: I would like to welcome you this afternoon. Before I ask you to introduce yourselves, I am David Tredinnick, acting Chair of this Committee in the interregnum before the election for a new Chair tomorrow, Stephen Dorrell having given up the post a couple of weeks ago. We thanked him very much last week for his great work.

The other point is that there is a film crew coming in this afternoon, by permission of Mr Speaker, who are making a documentary about activities in the House. So you will be on film.

David, would you like to introduce yourself first, then Professor Sir Mike and then James Titcombe?

David Behan: Thank you, Chair. My name is David Behan. I am the chief executive of the Care Quality Commission. Good afternoon.

Professor Sir Mike Richards: I am Mike Richards. I am chief inspector of hospitals at the Care Quality Commission. I am responsible for inspecting acute hospitals, mental health services, community health services and ambulance services.

James Titcombe: My name is James Titcombe. I am the national advisor for patient safety for the Care Quality Commission.

Q264 Chair: In your memorandum you say that, as part of the Care Quality Commission's new strategy, you want to encourage feedback on care services to understand the quality of care and to identify risks of poor quality. What effect do you think this new approach is having on your work in regulating the quality of health and care services?

David Behan: I will start, Chair, and then Mike will probably add to this. To set a more general context—and I will be very brief in doing this—in 2013 we published our three-year strategy, which set out that we were going to undertake a root-and-branch reform of the way that we regulate and inspect health and care services in this country. From April of this year we changed our organisation, so now all inspections will be led by three chief inspectors—Mike, Steve Field and Andrea Sutcliffe—for adult social care. They will lead directorates of inspectors who will specialise and work with other specialists in the way that they undertake their inspections. This reform will take us another two years—the remainder of this year and next year—to bring about the changes that we want to see. We will ask five key questions on all of our inspections. How safe are services and the people who are using them? How effective are those services? How caring are those services? How responsive are those services to the needs of people whom they serve? Fifthly, how well led are those services?

The reason we are asking that fifth question is that we know the culture in organisations is set by the leadership—the board, the executive team. We will ask our questions around how those organisations listen to concerns from people using those services—in the case of health trusts, patients and their families—and we will arrive at a judgment about how well led those services are based on how those organisations listen to complaints and listen to people who blow the whistle. I think Mike might want to add about how we are taking that forward.

Professor Sir Mike Richards: If I set out the general framework for how we go about our new inspection programme, I think how feedback comes into that will become apparent. Effectively, for any acute trust—but this could also be a mental health trust or community health service—it is a three-phase process. We start by getting a whole lot of information in. Do you want me to pause?

Q265 Chair: Order. We have a Division. I am sorry to do this to you when you are in mid-flow, but we have to adjourn now for 10 minutes. Then we will be back.

Professor Sir Mike Richards: I will pick it up from there.

Sitting suspended for Divisions in the House.

On resuming—

Q266 Chair: I am sorry about those two Divisions. Part of life in the House of Commons is that we are often called away to vote in the middle of other things.

Professor Sir Mike Richards, you were in mid-flow. Would you like to remind us of where you were and answer the first question?

Professor Sir Mike Richards: I will set out very briefly what it is we are doing around the new hospital inspection programme. The same approach applies to mental health, to community health services and will apply to ambulances as well. Effectively, there are three phases to our approach.

There is a very important pre-inspection phase, where we gather as much information as we possibly can about an organisation. We gather that from all the datasets that we have plus going to the trust itself to ask them for information, asking colleagues at the GMC, NMC, the Royal Colleges, and so on. So we gather in all that information. We then plan the inspection knowing what we might be going to find when we get there. It is very important to say that whistleblowing incidents are one of the main sources of information that we would use, and any complaints and concerns we have heard from patient groups would also come into that.

Q267 Chair: That sounds very sensible, but do you have any evidence of how the new arrangements have improved or not improved outcomes?

Professor Sir Mike Richards: It really is early to say about that, but with the inspections we rate each of the services against the five key questions that David mentioned of safe, effective, caring, responsive and well led. We have already seen that giving a rating that something is inadequate mobilises action very quickly. In fact, those same trusts want us to go back quite soon to show us the improvement that they have made. So, to that extent, we hear from them of the improvements they have made and we go back and look at it.

Q268 Chair: You have said that you want the Care Quality Commission to become a role model. You have only just got this new mechanism going. Do you not think that is—shall we say—a slightly aggressive approach? You have hardly even bedded in the new arrangements and yet you want to be a role model across health and social care.

Professor Sir Mike Richards: Yes, I think we want to be a role model both in terms of how we treat our own staff and also then in showing people how we expect staff—and indeed other complainants—to be handled in NHS services. What we are expecting of NHS services we would expect to do ourselves. We know that in the past we have not always done that, which is why we are changing the culture very rapidly within the CQC so that we can genuinely be a role model.

Q269 Chair: How actually are you assessing progress, apart from word of mouth? Do you have any formal process?

Professor Sir Mike Richards: Do you mean assessing progress within the NHS?

Q270 Chair: No, within your operation of the Care Quality Commission.

Professor Sir Mike Richards: Within our own operation there are a number of different ways in which we can assess our own progress. One is that, in terms of our own staff, we run staff surveys. In the same way as we run staff surveys in the NHS, we run staff surveys in the CQC and I am very—

Q271 Chair: What are they telling you, please?

Professor Sir Mike Richards: They are telling us that things are improving. There is still further to go by a long way, but there is absolutely no doubt that we are seeing major improvements in quite a number of the questions that we are asking. I think we can point to that as very positive progress.

David Behan: May I add, Chair, we know that complaints generally in the NHS are increasing and we know that referrals to ourselves about concerns in the NHS are increasing? Yesterday I met Katherine Murphy of the Patients Association, and she described an increase in referrals to the Patients Association but also an increase in requests from trusts for the Patients Association to help those trusts deal with complainants. I asked Katherine what she thought that might be driven by, and her answer to that was, in part, it is driven by the fact that the CQC is now asking all trusts, as part of their inspections, how they manage and handle complaints. The fact that we are paying attention to this is driving changes in the way that trusts are behaving in relation to complaints.

The second point that you were exploring with Mike, Chair, is that we want to be a role model in being open and transparent. It strikes us that, if we are to hold others to account for how they are open and transparent, then we must be meeting those standards as well. We are not there yet, but I think the way we dealt with the Orchid View case a couple of weeks ago, where we knew we got that wrong—we carried out a root-cause analysis on that and then published the findings—is an example of how we held up our hand where we were found wanting and then described what we were going to do to put that right. I would like to think that that was a demonstration of us reaching to be a much more open organisation.

Q272 Chair: So you agree that sunlight is the best disinfectant, do you?

David Behan: It is one of the disinfectants.

Q273 Chair: Making people aware.

David Behan: Yes. Being open is absolutely key, yes.

Q274 Andrew Percy: Just to continue this issue with regard to public perception, in your written evidence you state that, first, people still find the system and processes for complaining about health and care services overly complex and confusing and would prefer the system to be simplified. What are you actually doing in that regard in terms of trying to force trusts, when you go in and do your inspections, to simplify the system? When we had you at the accountability hearing, I think it was, I questioned you on the same issue about public awareness of how and who to complain to, and what they can expect from that process. What are you doing via the inspections to deal with this problem that you have identified in your evidence?

David Behan: I will deal with what we are doing as an organisation and then let Mike pick up what they do in the inspections. As an organisation—and you are going to explore with my colleague Niall, from the GMC, and my NMC colleagues what they are doing—a key part of what we have been doing over the last 12 months is developing our relationships with our key partners in relation to complaints, particularly the professional regulators. We have with the GMC quite a detailed practical guidance for what our staff and NMC staff need to do if there is a complaint made to them. We are developing the same with the NMC, and we have a programme of work with the parliamentary and health service ombudsman and the local government ombudsman because these are the key organisations into which complaints are going to come.

Previous criticisms of the CQC have been that we do not do enough to work with those bodies. I think, together, we have invested quite a lot of time in what we do. Just last week there was a meeting that brought all the professional regulators together with Monitor and ourselves over in our building where we looked at, “Are we getting the best fit from the complaints systems that exist and how can we work together to remove some of this confusion for people?” We have had quite an active approach to that. I think we have made some progress, but there is more to do. But if Mike just says what—

Q275 Andrew Percy: Just on that—because you have mentioned the GMC, NMC and the local government ombudsman—there are all these different organisations that are part of the complaints process. Obviously you don’t deal with individual complaints. Do you think there is an argument for saying that there should be a single point of access for complaints across the whole of health and social care? If I am a member of the public, I don’t know who to go to when I am unhappy about my care home. Do I go to the local government ombudsman because they are paying for my granny’s care or should I be going elsewhere if she has gone into hospital? It is just terribly confused. Do you think there should be this single point?

David Behan: We would agree with you, and one of the top lines in our submission to you is that this is still a confused landscape and needs to be simplified. Having a single point of contact which is then triaged is one way to do that. But it is also important that people can complain to their local services. If it is for the regulators to sort out a complaint, it has got rather too developed. One of the issues that we are challenging trusts and care homes on is, “How good are your systems for resolving concerns when they are raised so people don’t have to make complaints and then have to blow the whistle?” I am certainly very

clear that whistleblowing procedures are a symptom that an organisation has failed to listen to the concerns of its staff. Therefore, what we should be working towards is making sure those concerns are picked up and dealt with, working with other regulators and simplifying the system.

Since you last explored this question with us, we have done sentiment tracking of the public, and unprompted awareness of the CQC has increased since this time last year. It was just 4% last year; it is 9% now. Prompted awareness has gone up to about 55%, it being greater for older people. Those figures are still too low about who and where we are, so we need to do more work to make sure that people are aware of us, and we will continue to do that. But we think the challenge, whether there is one point of contact or not, is that we need to work with our colleagues, and an awful amount of our effort and resource has gone into making sure we can do that.

Q276 Andrew George: Where are you on the interpretation—I mean how you see complaints—and particularly if you have had conversations with the Patients Association, because you are the Care Quality Commission? The impression that a lot of MPs get, who receive complaints about failings in the health system, is not that people wish to pursue them for litigious reasons but that they do not want others to experience what they have experienced and that lessons are learned. Actually, the word “complain,” in terms of complaining purely for the sake of it, is possibly even the wrong term. We need to find another term. If you are saying that complaints are going up, which they clearly are, would you say—and this is kind of a devil’s advocate question—that it is a function of a change in society or a reflection of a failing in systems? If you are there to address care quality, you have to take into account perhaps societal attitudes to the NHS as well as standards. Is that not fair?

David Behan: Quite so, and I think that is a big question as well, Andrew. We think that the increase in activity we are seeing is as a result of greater awareness around poor standards and, going back to Andrew’s question, greater awareness among people about where they can go to press their cases. Healthwatch locally is helping in this as they signpost people. The rate of development of Healthwatch is very different across the country, but those organisations are now coming up to their first year. They are reaching some degree of maturity and are able to represent and signpost people. We know from the Litigation Authority’s figures that litigation is going up, so I think both things can be true. I think more people can be aware, and certainly, in our experience, when we have spoken to people who have complained—families, individuals and whistleblowers—when they began their journey through this system what they wanted was some satisfaction to understand what had happened and why. They were not thinking of litigation or anything else. They just wanted to understand what had happened.

Professor Sir Mike Richards: We see this at individual hospital level where the best hospitals are making people aware of how to complain. They are giving them a single point of contact at the hospital. They are trying to pre-empt the complaints and deal with them before they ever become a complaint. That will bring the number down, but at the same time they are making people more aware of how to do it, and, of course, the best hospitals are also the ones that then have a good process for dealing with it but subsequently learn from it as well. As we go into trusts, we are asking them about all those

steps and we itemise them all so that we can assess whether they have a good complaints handling process and whether they are a learning organisation.

Q277 Andrew George: I have a final question on that. Is it possible to disaggregate between what we might understand as a genuine complaint, where they wish to see some kind of reparation to themselves, or feedback, where they believe that there is some constructive feedback which the organisation needs in order to improve, and, if it is possible, to put what we still place under this umbrella term “complaints” into those two silos of activity?

Professor Sir Mike Richards: I think it is a spectrum, to be honest, and we often talk about people being able to raise concerns. That may be members of the public, patients or members of staff who are able to raise concerns. That concern may be a formal complaint and may go to a negligence action and litigation, but many of them do want to know what happened and want to make sure, if they possibly can, that the same things won’t happen to others.

Q278 Dr Wollaston: This is to follow on from some comments you were making earlier and is a question for Professor Sir Mike. Ann Clwyd in her evidence to us described you as her “champion for complaints reform” and told us that this was going to be right at the top of your shopping list. Could you set out, first, is that correct—that you see this as being the key challenge for you—and, if so, what do you see as the priorities? You have touched on one of them, but what do you see as the key thing as being the real game changer in complaints reform?

Professor Sir Mike Richards: I can confirm that it is very high on our priority list. There is absolutely no doubt about that. As we have been doing our initial inspections, we have been trying to build our concerns handling, if you like—how we look at concerns, whether they are staff concerns or patient and public concerns—into every step of our process. I mentioned what we did before, going on an inspection and getting the whistleblowing events, and so on, but on the inspection we are listening. A lot of it is listening: it is listening to patients at public listening events; it is listening to our staff through focus groups; it is having drop-in sessions. The trusts that worry me are the trusts where we get a lot of people coming singly to drop-in sessions because they feel that they cannot speak up in any other way. That is a signal to me that this is a trust that I might worry about.

Q279 Dr Wollaston: Are you specifically seeking out junior doctors? I know there has been—

Professor Sir Mike Richards: Yes. We always hold focus groups for junior doctors, senior doctors, junior nurses and senior nurses, admin staff and allied health professionals so that they can come in their professional groups. I often go to the junior doctor focus groups if I am on an inspection, and they are very revealing. They tell it as it is, in my view. They are sometimes extremely good and positive about a trust, but sometimes less so; you can get down to the level of the individual department and we also have information from the GMC training survey, and the two do very often match.

Q280 Dr Wollaston: Thank you. Can I follow on from that? The other point that Ann Clwyd told us was that you were going to be injecting proper independence into the complaints process because there is often felt to be some kind of capture in the way this happens. How do you see that happening?

Professor Sir Mike Richards: Our assessment of the complaints process will clearly be independent, but what we are effectively doing—and James can describe this more in terms of what we have done with the Patients Association—is trying to build our approach partly through listening and focus groups, but also by having an interview with the complaints manager so that we can see what they are doing at a trust. It may also involve looking through some complaints files to see how well they have been handled. We are not just looking at the timeliness of complaints, which is what tended to be looked at in the past; we are looking at the whole complaints process.

Q281 Dr Wollaston: There has been concern in the past that PALS get too close to the system. What is your view on that?

Professor Sir Mike Richards: That may be so in some cases. I think we are in a very different position and we are going in independently to each of these trusts and assessing, as part of our domain of how responsive the service is to the patients they are seeing, how the complaints are being handled. We are not just looking at it at a trust level. We are also asking about it within each of the eight core services. So we look at how they are doing it in A and E, on the medical wards and the surgical wards. For each of the different departments we are asking those questions about the complaints and, importantly, whether they make any difference and do they change as a result of it. One of the most important questions I often ask a chief executive is, “Tell me of a change you have made as a result of a complaint?”, and the best ones can.

Q282 Valerie Vaz: My question follows on from that, before I move on to something else. Where do you disseminate that information?

Professor Sir Mike Richards: The first step is that we publish a report for each of the inspections we do. Those are in the public domain. It takes us around two months after the inspection itself to publish a report. We go back for an unannounced visit after the announced visit; we bring all the evidence together; we write the report; we check it through; we quality assure it; and we give the trust the opportunity to comment. Then we publish it. In addition to that, we will also publish thematic reports of what we are finding. We published a report at the end of our first wave of 18 inspections that gave some key themes. I have committed to publishing a report on what we are seeing about complaints and we will do that later this year.

Q283 Valerie Vaz: Is there anything that you can offer us by way of themes that are coming out of these trusts?

Professor Sir Mike Richards: I suppose the theme is one that we are seeing in lots of other aspects of what we are seeing in trusts, which is that there is variation. Some places are doing this well, some are doing it less well, and most have room for improvement in how they are managing complaints. I do not think you will be surprised about that, but that is

certainly what we are finding. But through that we will also be able to say, “This is what we see as good practice,” and there will hopefully be some places that we will be able to say are outstanding in how they manage complaints.

Q284 Valerie Vaz: I would like you to expand on that and give us examples of exactly what you are seeing.

Professor Sir Mike Richards: For example, there is one trust I can think of where a year earlier we had issued a warning notice because we thought that the complaints handling was very poor, but when we went back into it early this year we saw major changes. They had appointed somebody much more senior to take charge of it and had got their process sorted out. When I went to interview that person, he could tell me exactly not only the number of complaints but what the things were and what they had done about it. It was not yet perfect but it was getting a lot better than it had been before.

Q285 Valerie Vaz: I am sorry to interrupt, but what I am trying to get from you is what the themes or the general areas are that people are complaining about. I listened to a lot of what you were saying before about the various organisations and lots of meetings, with lots of words being spoken, but, at the end of the day, I suppose when constituents come to me I would like to see if the Manor Hospital has had lots of elderly people falling down that it is published somewhere, either on your website or on the Manor Hospital’s website, and there is an obligation to provide that kind of information so that different people are not complaining about the same thing and that things are getting done, rather than lots of reports being made.

Professor Sir Mike Richards: I can certainly give you some broad categories that things fall into.

Q286 Valerie Vaz: That would be great—on the trusts you have inspected, obviously—yes.

Professor Sir Mike Richards: Sometimes it is about the care and treatment they have received. Quite often it is about staff attitudes. Sometimes it is about administrative failings. Very often it is about car parking, let’s be honest; that comes through quite a lot. But one of the things that I think is also important is to be able to ask a trust, “Is it the same now as it was a year ago?”, seeing if they have moved on. In one trust I remember a lot of complaints had been about ward 12, and, actually, those complaints had now ceased. Why? It was because they had really taken them on board and had sorted out the problems that there were on ward 12.

Q287 Chair: Thank you. Before I go to Charlotte, I want to ask James Titcombe, as an independent advisor, what is your assessment of change in the Care Quality Commission?

James Titcombe: I have seen a huge amount of change since joining the CQC. The focus that everyone asks about all the time now is what this means for people; what does it mean for patients? There has been a huge transformation in the approach that we are taking,

putting people at the heart of it. We obviously have some distance to go before we get everything right, but the approaches, the work we are doing on complaints and whistleblowing, is going to make a big difference. We now need to turn those ideas and embed them into what we do.

Q288 Chair: Do you think they are adequately funded? I can't believe you are going to say yes.

James Titcombe: Look, more funding, obviously, and resources is always something that helps, but—

Q289 Chair: I do not get the feeling there is a crisis from what you are saying.

David Behan: You have put James in a difficult position. He is a fully paid-up member of staff, rather than an independent member of staff, and, therefore, I think the questions about funding—

Q290 Andrew Percy: Of course he will want more money.

David Behan:—for which the settlement has been set for this year—

Q291 Chair: So he is independent but on the payroll.

David Behan: Yes.

Q292 Chair: Okay. Is that because—

David Behan: Why is James with us? James can speak for himself about this, but I was keen that we had somebody right at the heart of the CQC with access to the board, to me, to Mike and to our basic staff, someone who had experience of the system and the way the system didn't work in the interests of people, but also somebody who understood systems and safety from his experience in the nuclear industry. That is why James has come to join us. It is a permanent appointment. It is funded for that duration.

As to the adequacy of our funding, we have had discussions with the Department of Health and we have been given an additional £40 million for this year to allow us to discharge our responsibilities. I expect for this year that that sum will be adequate for what we need to do.

Q293 Chair: I will ask James what recommendations for change you are making.

James Titcombe: As David has said, I have daily meetings in the strategy team with him, so a lot of the input I have had is already shaping what we are doing. As to the plans, in terms of taking Ann Clwyd's recommendations about standards in complaint handling forward, I have had a big say and am very involved with the work. As to the culture of the organisation, I think it is very important that we continue to listen to people and bring

them in. Together with Mike and David, I have met with many patients about their experiences. So I think a lot of the recommendations I have made are happening and I will continue to have that input.

Chair: Thank you very much.

Q294 Charlotte Leslie: I want to take two things that we have covered very briefly—Sarah’s question about junior doctors and also whether really the CQC has teeth. I remember there was a system in the hospital recognition committee where medical training was examined by medics from Royal Colleges, and if they felt that the medical training was not sufficient, which would impact of course on patient safety and care, they had the ability to take away training status from that hospital, which seemed to me to be a very powerful tool—for teeth—in terms of focusing minds on change. You say that you have seen significant change in the trusts you have inspected. Do you think the CQC has sufficient teeth to really get change in those stubborn trusts where change might be difficult?

Professor Sir Mike Richards: I have said earlier that I think it is early days in seeing what impact we have, but it is worth remembering that we have a range of different powers. I think the power just to publish a report, and with that the ratings, which is new, will show up where in a trust the problems lie and will focus attention. I think most trusts do mind a lot about their reputation, and that in itself will make them make changes in the relevant areas. Also, in our reports we will say, “These are some ‘must dos’ and these are some ‘should dos’.” When we hold the quality summit at the end of this process, where we get in the room with the trust, the CCGs, Monitor, the TDA and others, we go through all those “must dos” and out of that comes an action plan. We can issue compliance actions and, under current legislation, warning notices as well, but we can also take more rapid action. In two or three cases that I can think of already we have said, “We do not think a high-dependency unit is well enough staffed. We ask you to close beds today,” and they have always done that. So we can have very fast action where we think care is unsafe.

Q295 Charlotte Leslie: So you do have ability for urgent action. In education, if you are replicating Ofsted, schools have dragged on in special measures, in some cases for 13 years. I think action plans are not the same as action. Can the public be reassured that there is action and not just the plan?

Professor Sir Mike Richards: We are at an early stage with special measures in health, as you know, and last summer 11 trusts were put into special measures as a result of the review that Sir Bruce Keogh did. We are currently re-inspecting those same sites, and later this summer we are planning to publish a report setting out what the progress has or has not been—I won’t pre-empt that at this stage—in those trusts that we have re-inspected.

Q296 Charlotte Leslie: How do you inspect a complaints system? Again, in the worst hospitals, often the problem is that they can tell a very good story about why everything is fine and it is very difficult for those saying that it is not fine to get their voice heard. How do you know you are hearing the truth?

Professor Sir Mike Richards: How do we know that they are telling us the truth? We can see what complaints they are getting, we can ask them about their complaints process and

we can look at their complaints files, as we have done in a pilot study already, to see whether they are doing that well.

Q297 Charlotte Leslie: Can I intervene? How do you know that the complaints files you get to see are all the complaints files there are and how do you know the information you are being given is all the information? In cases that I have seen, the whole point is that what the regulatory bodies get to see is nothing like the extent of the truth. How do you know what you don't know?

Professor Sir Mike Richards: We can ask to see where their files are and choose the files at random, and also it is worth remembering that there is now a duty of candour on the NHS, so if we found that they were not divulging things that we asked for we would take that very seriously.

Q298 Charlotte Leslie: How would you find that they were not?

Professor Sir Mike Richards: Through whistleblowing is the simple answer. How did problems at Colchester come to light? It was during Bruce Keogh's inspection that a whistleblower came forward and said, "I think you may want to look in detail at cancer waiting times." So then the CQC took over and did do that, in conjunction with the police. We cannot possibly look at every single bit of data from every trust and say, "Is this correct?" But where people know that it is not, they can inform us.

James Titcombe: Is it just worth bringing in the trial we have done with the Patients Association?

Charlotte Leslie: Yes, please.

James Titcombe: Ann Clwyd made a recommendation that the CQC should develop standards in complaint handling. We looked around, and the Patients Association had the 12 standards and we have done a trial at 10 trusts recently, taking members of the Patients Association with us. That trial process involved some quite new things. One of the things we did was send a survey out to all the people who had made a complaint in the previous year. That survey asked key questions about their experience, whether they felt they had had honesty in the response and also whether we could contact them, asking for a contact number. We would follow up the surveys we got back having conversations with the people who had been through the complaints process. As to your question about "How would we know?", you do not know and you have to speak to the people who have been through the process. We have taken some really useful learning from that trial and are now adapting that. By October, in all our inspections we will have a set of standards and an approach that incorporates what we have learned from that trial.

Q299 Charlotte Leslie: We are talking about complaints, but do you think there is a need for investigations to be triggered without a complaint being made?

James Titcombe: Absolutely. One of my frustrations is that, in my experience, if something serious goes wrong, it should never become a complaint. The mechanism for having a serious incident investigated should not be a complaint. The systems that the

trusts have for investigating serious incidents should be there. We are also doing work to set standards in how incident investigations should be done, and, in pre-inspection, we are going to look at doing an audit of how serious incidents are investigated. It is massively important. Often, we have conversations with people who come to us and tell us about their experience when something serious has gone wrong, and they have become the detective and have to fight for the answers; and that is wrong. I really believe that we need proper, robust incident investigations with human factors. That should be an absolute standard and a requirement.

Q300 Charlotte Leslie: Can you explain “human factors” to us?

James Titcombe: There is a concordat on human factors, and, basically, health is one of the few safety-critical sectors where this is not currently embedded into the way we work. Human factors are very much about understanding, when something goes wrong, “Why did people behave in that way?” Often, it is that the systems were counterintuitive; there were poor systems. This is a way of thinking about things, not just about looking at how things go wrong, but planning work from a human-factors perspective is really important.

Q301 Charlotte Leslie: It is how systems will affect people’s behaviour, essentially.

James Titcombe: Absolutely. Systems need to be resilient to the errors that people make.

Q302 Charlotte Leslie: What do you need to do—or is there anything Government need to do—to ensure that investigations can be triggered without a complaint being made?

James Titcombe: I think we need to set standards, with a clear message to providers, “This is how we expect complaints to be investigated,” that we use as part of our inspections. I suppose setting standards is one thing. The other thing is, “Do people have the right training? Do they have the right resources? Is the investment in providers there to make sure that this can happen?” At the moment there is probably a gap in skills and training. In industry there are qualifications people have in how to do incident investigations; there is robust training. I think there is a need for that in healthcare.

Q303 Charlotte Leslie: My final question—and I realise I have taken too much time—might be beyond your remit, but often if a system is wrong and something has gone wrong, you said that you have an ability to close down a high-dependency unit if need be. Sometimes there are various individuals within trusts who are making it very difficult for the system to operate as it should. Are you able in any way to hold those individuals to account for perhaps perpetuating a very bad and possibly dangerous system? It strikes me that you are not going to get change in the health service unless individuals are held to account for their actions?

Professor Sir Mike Richards: As part of our inspection programme, we are looking at this well-led domain that is partly about individuals, partly about the governance processes and whether they have a vision and a strategy for the trust. But we do look at individuals and we are looking at “well-led,” at the trust, chief executive and board level. We are also looking at it at service level. The time that we are on site is quite restricted, so our ability

to say that it is specifically an individual is quite limited, but quite often the trusts may know where that problem is. We can point out that a particular service is not well led and then it is up to them to take action.

Q304 Charlotte Leslie: How many trusts have you known that have held that individual to account, or has the individual just moved on to another well-paid job?

Professor Sir Mike Richards: I do not have figures for that, I have to say. Actually, I can give examples. I can give examples of trusts where they have taken action, and, let's be honest, in the past more action has probably been taken about nurses than has been taken about doctors. A trust that we have recently declared to be good is one where they did take action against poor behaviour among some doctors.

Q305 Charlotte Leslie: What about managers?

Professor Sir Mike Richards: This happened to be about doctors in the trust I am thinking about, but I think, where they did find poor behaviour among managers, that trust would undoubtedly have taken action there too.

Q306 Charlotte Leslie: Even though they do not have a GMC equivalent to instigate it.

Professor Sir Mike Richards: I think they would have taken the action. This was not about the GMC on this occasion; it was about poor behaviour and they tackled it themselves.

David Behan: There are three things I would build on what Mike has said. The Care Act, which you and your colleagues took through the Houses and gave Royal Assent to in April this year, introduces the fit and proper person test, which is one of the levers that is new that we will have to inspect against as we go through. It will effectively say, "Are all people at the senior level in this trust, at the board level, fit and proper people?" The chair of the trust has to satisfy him or herself that that is the case. The second thing I would say, Charlotte, is that where Mike makes a decision to put a hospital trust into special measures, then options are open to either Monitor or the Trust Development Authority to change personnel at either board or executive level. That is a sanction that is available.

Going back, Colchester is a good example of where a criminal inquiry will run alongside the civil work we do, or indeed some of the criminal powers we have now been given under the Care Act to allow us to take that action. It is not that we are without teeth. I think previously the CQC has been criticised for not using the full range of its powers rather than needing new powers. That said, the Care Act has introduced new powers, and I expect that we will need to demonstrate to you and to others that those powers are being used and used appropriately.

Chair: I know, Valerie, you have something you want to come back on and then we will move on fairly quickly.

Q307 Valerie Vaz: I have a series of little questions on some things that are coming out of the evidence. Could you describe what you mean for the lay public when you say “special measures”? What is actually happening in the hospital? What are you doing?

Professor Sir Mike Richards: I would recommend putting a trust into special measures when I believe that the leadership of that trust is not capable at this stage on its own of lifting the trust in terms of the quality of care it gives. We look at our quality domains of safe, effective, caring and responsive. If they are poor and we judge that the leadership is not sufficiently strong to do it on its own, I will then recommend to either Monitor or the TDA that they put the trust into special measures. That then leads to a range of actions which are tailored to the individual trust. They will all get an improvement director to work alongside them. They will usually now get a buddy trust from another part of the country to support them, and that would be a trust that is performing well, obviously, that can support them in their development. Alongside that, there may be changes to members of the board. Monitor and the TDA have the powers to change the members of the board, and they may do a further detailed look at where those changes are needed.

Q308 Valerie Vaz: Would it help you as an organisation if you had some of the powers of Monitor, if they had come to you, rather than have a separate organisation?

Professor Sir Mike Richards: Over the last 10 months we have worked closely with Monitor, and I have to say, when I have made recommendations on special measures, both Monitor and the TDA have, so far, always taken my recommendation.

Q309 Valerie Vaz: I think Francis said that he thought there are too many organisations. I am getting the feeling that there are lots of meetings going on and too many people talking about it. I think there might be too much bureaucracy.

Professor Sir Mike Richards: Certainly over the last year we have worked a great deal better together and I think we are now working out how to do that, particularly with the struggling trusts.

Q310 Valerie Vaz: But you could do it as part of one organisation at some stage, could you?

Professor Sir Mike Richards: There are always changes that can be made.

David Behan: On this, Valerie, there are a couple of occasions where we will undertake joint inspections with Monitor and so remove the duplication, which I think is at the root of your question, and do some things jointly. We have made a huge amount of progress with Monitor over the past 12 months to make sure that that is exactly the approach we are taking. The challenge about duplication is a good one, so we need to respond to that by removing duplication, not perpetuating it.

Q311 Valerie Vaz: Just quickly, given that you were put in this position as chief inspector and there is a lot of publicity around it—and I am not sure I was one of the fans of

having another layer of bureaucracy at the top level rather than, “Let’s have more doctors and nurses, and district nurses even,” which we are seeing the effect of now—people see you as a paragon of someone to complain to. When individuals contact you, what is your next step?

Professor Sir Mike Richards: To give an example, a whistleblowing complaint came directly to me at the end of last week about a mental health organisation. My deputy Paul Elliott, who leads on mental health with me, and I have arranged to meet the whistleblowers in that particular case, but I cannot say I will do that in every single case. What we can say is that every single case will be investigated. We will look at those whistleblowing cases as we hear about them, or other patient concerns, and say, “Who is the most appropriate person to be dealing with that?” It may be one of our inspectors or it may be one of our managers, one of our heads of hospital inspection, but we will take it seriously every time.

Q312 Valerie Vaz: Yes, and you do something that can trigger an inspection, a serious inspection or a—

Professor Sir Mike Richards: We have already had examples of that happening where in one trust there were concerns about what was happening in the operating theatre. That led us to do a focused inspection of the operating theatres in that trust and we have subsequently also done a comprehensive inspection of that trust. In another one, there were concerns about the culture within the trust and about whether there was racism within the trust. We immediately did a listening event at that trust to try and find out more about what was going on so that we could plan our comprehensive inspection, which came a few months later.

Q313 Valerie Vaz: Can I turn to the written evidence you put in? I know it is difficult for an organisation to keep putting in written evidence, but it is dated February 2014. I wondered why that was so early.

David Behan: I think that is when you asked for it. That is when your inquiry began. You have had previous witnesses and this is just where we are in the queue.

Q314 Valerie Vaz: I think maybe we could encourage you to put in a more up-to-date one. I was looking at paragraph 23 where you say, “Over 3,000 completed whistleblowing enquiries in both of the years presented here did not have an outcome recorded.” You then said you would have this data available at the end of March. Is that now available?

David Behan: Your numbered paragraphs are probably different from mine, but don’t worry. For whistleblowing, the up-to-date figures we have in relation to that, during this year 2014-15—so to date—are that we have had a total of 1,573 which have come in. That compares with figures for the whole of last year, which were at 9,492, and the previous year we had 7,800, and was behind my comments to the Chair about us seeing an increase in activity coming forward to us. They come in to our helpline, so once we have triaged them they are not all whistleblowing cases. I would not want to give you the impression that there were 9,000 whistleblowing cases last year, but there are 9,000 calls to the dedicated helpline that we have that people can respond to. They will come in by

telephone call, e-mail or letter. The important thing about that number is that we then track those. We have been criticised historically for not tracking them. We track them so that we know where they are at any particular point in time through to resolution. It is a system that we have had to tighten up as we go through and operate it. But, effectively, that is the system that we have for people who come in on our “whistleblowing” helpline.

We also take cases to our “Tell us about your care” helpline. We take cases from the Patients Association, the Relatives & Residents Association, Carers UK and Mind, and we will take them from July—next month—from Action against Medical Accidents. If they get calls to their helpline that they think are for us, they will refer them through as part of that.

Q315 Valerie Vaz: I know the GMC also have a helpline. Are there lots of helplines and people phoning in, and is it the same thing coming through? I know you track it, but does anyone co-ordinate that information, and do you need extra personnel to do that?

David Behan: Niall and Jackie will talk about what they do, but we have the protocols I referred to earlier that are designed to ensure that, if there are issues that are common between us, we are communicating and they exchange information with us. There are also occasions, if we think we have relevant information, when we can exchange information back the other way, where we will find individual cases that we think might need to be referred to the professional regulators. Similarly, professional regulators’ investigations of cases might throw up more generic systemic issues around quality and safety. So the exchange of information is important.

Q316 Valerie Vaz: Do you have sufficient staff to deal with all that?

David Behan: It goes back to the Chair’s question. For this year we have been given additional money by the Department of Health to the tune of £40 million. We are currently in a recruitment campaign where we anticipate bringing in 500 additional staff during the course of this year. Those staff have not arrived yet, so we are still under pressure as an organisation where we have a high volume of work but a fixed number of people.

Q317 Chair: When are they coming?

David Behan: That recruitment campaign is under way. They start arriving next month, in July, and will also arrive during August, September and October. Once they have arrived with us, if they are brand new staff to us, we need to train them so they are good to go. They will start being “productive” in September/October and beyond. Then we will run a recruitment campaign later in the autumn to get the additional numbers in.

Valerie Vaz: Thank you very much.

Q318 Dr Wollaston: Can I ask David Behan about the terminology you used about compassionately listening to those who raise complaints? Given that you have no role in investigating individual complaints, is there a danger that individuals will feel that you are

the complaints handling process when you are not? Are you very specific with people that you are not going to be investigating their complaints, so there can be no confusion?

David Behan: That is a very good question and I think it is one of the issues that give us quite a lot of very practical difficulties when we are dealing with individuals. In answering your question, we are a complaints body for people who are detained under the Mental Health Act and who wish to complain about the way they are detained under the Mental Health Act. There is not another body apart from the CQC that they can come to outside the body that is detaining them, in that sense, so we do perform an important role, but you are right that we do not have the ability to adjudicate complaints and work towards resolving them. But as Mike, I think, has already shared with you, the intelligence that we gather from people who raise concerns is absolutely essential to us so that we can assess whether their complaint is something that has affected just them or whether there is a pattern of complaints coming from, say, maternity care, and if there was that would then inform our inspection plans. Would we bring forward our inspection? Would it help us to focus what our inspection is?

Q319 Dr Wollaston: So it is background intelligence that might trigger an investigation.

David Behan: Yes.

Q320 Dr Wollaston: But are you always very clear with that individual that you are not going to be investigating their individual complaint and supporting them in what mechanism to use?

David Behan: Yes. What we need to do as well, Sarah—and we do this in letters to you and your colleagues where you write in about your individual constituency work—is make sure that we signpost people to the appropriate body, if that is the parliamentary and health service ombudsman or the local government ombudsman; we will try and signpost people. The compassionate bit is that we do understand that people want some satisfaction and want some resolution to their concern, and that just being cold, bureaucratic and clinical about this is not what people are looking for—so signposting appropriately.

The other thing that we have made some real progress on this year is putting the names of inspectors and inspector managers certainly in letters to MPs, saying, “If you want to discuss our responses in more detail,” and that should be available to all MPs and indeed to people, members of the public, who are making complaints as well. I think, in doing that, we want to present a more humane face to people, albeit we can’t provide them with that individual satisfaction.

Q321 Dr Wollaston: Can I follow up something briefly with Sir Mike? What do you do, for example, if somebody makes a complaint to you about a mental health service and there is nothing that the system can respond with because they might be under a financial constraint and they simply don’t have the staff to respond to it? What kind of action is the CQC in a position to take where it is not an issue where people are behaving badly—it is simply that they can’t provide the service?

Professor Sir Mike Richards: Clearly, our responsibility is to inspect the organisation, the provider of care. But if the provider of care is not providing a particular service and we think that is essential to the mental health service—it might be a psychiatric intensive care unit, for example—we will make that comment on the report because what we will observe is that the patients are having to travel outside the territory of that trust to get that service. So we will undoubtedly comment on that. But then, remember, when we come to the quality summit at the end of this process, the commissioners are in the room as well. So we will say, “We observed here that there is no psychiatric intensive care unit.”

Q322 Dr Wollaston: Just to take one very specific point, in Devon and Cornwall we have children as young as 12 being detained overnight in the cells for mental health assessments under section 136. Would you be in a position to say, “That is so unacceptable, I am going to close that service down”? I would have thought that would be a service that you would close down immediately—or one might think you could—assessing an acutely psychiatrically unwell child in a police cell overnight.

Professor Sir Mike Richards: I have not assessed those services so I am not going to make a specific comment about that service, but—

Q323 Dr Wollaston: But if somebody complained about it and came to you and you inspected it, could you close it down?

Charlotte Leslie: Is that a complaint, Sarah, that you have just made?

Dr Wollaston: Yes, I am making a complaint about that, but I am just wondering whether the CQC could close that down and say it is unacceptable.

Professor Sir Mike Richards: We can and will follow up on that. In fact we have been assessing mental health services in that part of the country fairly recently, and I think we will certainly make those comments. I hope that the commissioners will then also take note of this because we can close the service; yes, we can close the service, but in—

Q324 Dr Wollaston: I am saying that you cannot assess a 12-year-old in a cell overnight. Would you be in a position to go in and say that to them?

Professor Sir Mike Richards: We would have to think what the impact is of us closing a particular service. Would that mean that that 12-year-old had to travel further for care? We can certainly say, “We think this is inadequate service.” We can certainly issue them with a warning notice, and we can certainly say, “This must be changed,” but we have to make a decision as to whether closing that service that day is in the interests of the population or not. That is a balance that we are constantly, obviously, thinking about when asking, “Should we close a service?” Going back to the example I gave of beds on the high-dependency unit, we did not close the whole high-dependency unit. We believed it was sufficiently safe and would have enough staff if it was looking after—I think it was—four rather than six beds. Those are the judgments that we are making, frankly, all the time. But in the particular instance that you give, it may be that, with just one place of

safety, we would have to make a decision as to whether it is in the interests of others who may need that service to close it completely immediately.

David Behan: If I might add, as to the issue about whether they have resources or not, there are two things where I would want us to be absolutely clear that something is not acceptable: juveniles in police cells is one and the other is inappropriate use of restraint. The position we need to take there is that this is not acceptable, that it needs to stop, not, “Please stop it if you have the money to stop it.” People have to find a way to stop it because it is inappropriate, and if we do not call that we cannot claim to be on the side of people using the services because that is inappropriate.

I did an inspection on Friday not a million miles away from there where they do have section 136 suites, and the upshot of that is that there aren’t any people in police stations. Within our inspections we know that there are some places with a similar resource package that are providing this service—this is Mike’s point about variation—and other places that are not providing this service. So if place A can do it, why can’t place B?

Dr Wollaston: Thank you.

Chair: Thank you. I think Charlotte Leslie wants to come in on this.

Q325 Charlotte Leslie: You have touched on the cracks that previously people fell through whereby someone would go to the CQC and the CQC would say, “Oh no, no, no, it is the ombudsman,” and the ombudsman would say, “Oh no, no, no, it is the CQC.” Previously in years gone by that was a problem. Now that seems to be a bit more clarified. Because the public would see your roles as still very similar and connected, your reputation is going to depend very much on the performance of the ombudsman. Given that the ombudsman itself has had some significant issues to overcome in recent years, I am going to ask David and Sir Mike what is your view—and I am sorry if this is a difficult question for you—of the progress that the ombudsman has made, given that you signpost people you compassionately listen to to that very ombudsman?

David Behan: I am not sure, ultimately, that our destiny is with the ombudsman. We need to look after our own destiny and sort out the CQC, and that is what we have been trying to do. As I tried to say earlier, Charlotte, we have taken to heart the criticisms of this Committee over a number of years that we have not worked effectively with other organisations—my colleagues who are going to follow us, but also the ombudsman. We have set ourselves the task of working with the parliamentary and health service ombudsman, being clear about what they do and being clear about what we do, and where we have individual cases, if necessary, having the conversations about who is going to do what in relation to each case.

I meet the parliamentary and health service ombudsman on a regular basis, and in the work that we are doing to review our approach to inspection, and indeed our own processes, because we have a dual relationship with the ombudsman—we deal with complaints that people are making about the system, but also people can complain to the ombudsman about us, so of the 500 or so complaints that were made against us last year, 24 went to the ombudsman where they were not satisfied with the way that we dealt with them—within that, I am satisfied with the progress that we are making.

I know the ombudsman has been making significant changes in relation to the way that they operate, that they are going to investigate far more cases than they have investigated hitherto, and, again, coming back to Dr Wollaston's question, the ombudsman provides us with valuable information and intelligence about what complaints are telling us about the quality of services. So there is a lot more to do. I am not for one minute pretending that this is sorted, and I am not for one minute pretending that everybody who is complaining to either us or the ombudsman is satisfied. But we are setting out a way of responding to complainants that means we will work more closely with the ombudsman and ensure that we have the appropriate protocols in place at a senior level, and that that is working its way through the way individual cases are dealt with between the CQC and the ombudsman's investigators.

Q326 Charlotte Leslie: James, I am going to ask you to take your CQC hat off now and as a layman—because it is important to ask a member of the public—ask what you think the progress of the ombudsman has been?

James Titcombe: This is a difficult one for me to answer, Charlotte, and the reason is that I have the long history of Morecambe Bay and what happened to my son. I have a long-running dispute with them at the moment, and my personal experience—I have to be honest—has been very poor and it really couldn't have been any worse. That is my own personal view, and I think I have to dissociate that from the CQC.

Q327 Charlotte Leslie: That is not a CQC view.

James Titcombe: It is not a CQC view, and I have to be honest about that.

Charlotte Leslie: Thank you.

Q328 Dr Wollaston: On that point, we have had some people approach the Committee saying that they think there should be a national inquiry into the ombudsman. Do you have a view on that?

James Titcombe: Taking off my CQC hat, I very much think that there should be. As I say, my personal experience has been very poor. The most worrying aspect of it is that I have not had the answers and I have raised serious issues about the decisions they made. It is the lack of transparency about how they answer those questions. That, to me, is the more worrying part of this. So, of course, from a personal perspective I would welcome that.

David Behan: Can I just add, Chair, that when James came to work with us I was keen, as was James, that in no way should coming to take a formal role with the CQC inhibit him in any way in pursuing his own individual case in relation to the death of his son, and that has been a really important principle in our working relationship? As I have said, James has access to the chair, to me, to Mike and other senior colleagues, as well as inspectors who are out on the front line doing this work on a day-to-day basis. We would not want to change that, and I would not want anybody to construe that taking James on was a way of stopping him criticising the CQC—because he had his criticisms about us—or indeed a way of preventing him speaking out about his own personal circumstances in relation to the ombudsman. I have to say I think he has dealt with that with immense integrity and

respected that, and I think that is reflected in the way he has just answered what is a difficult question.

Q329 Andrew Percy: Moving on now to complaints from staff members—
David Behan: CQC staff members?

Andrew Percy: No, no, no.

David Behan: From staff in the NHS.

Andrew Percy: Yes, staff in the NHS, so trust staff or elsewhere. You clearly do not have a role in this, do you? You do not deal with staff complaints about particular trusts or any whistleblowers from trusts. In your evidence you state that all too often people who have raised concerns with employers “find themselves going through HR processes and disciplinary procedures, when they had the best interests of patients at the heart of their concerns. The detail of the concerns themselves can then end up being ignored.” I have had experience of this with constituents who have come to me who are former employees and they say, “I raised these concerns and all of a sudden I lost my job.” They will say to me, quite openly, “I have a beef with the trust. I will honestly say to you I have a problem with the trust, but I also have these genuine concerns.” Unfortunately, when you try to raise these, sometimes they are dismissed as, “Oh, well, but they just had a problem with the trust and we had HR issues,” and all the rest of it, “and that is why they are pursuing opportunities not available with us.”

I suppose the question really would be to respond to that and to answer, I guess, how big of a problem you think it is that whistleblowers are put through HR procedures. Is it a big problem? We well know there have been some examples of it, and nationally they have been well reported. Is this a big problem and how should we be looking to address this?

David Behan: We will probably all three say something about this in answer to your question, if we may, Chair. These are some of the most difficult, complicated cases that are around at the minute, particularly a number which are historical and have been going on for a long time. With this enmeshing of quality and safety issues with HR issues, and, as Mike said, in one or two cases, with issues to do with race, it means that some of these are very difficult cases. One of the things that we have tried to do over the past 12 months in particular is to meet with people who are blowing the whistle, both people who are doing it now as well as historical cases. David Prior has met a significant number of whistleblowers, as have Mike and myself, James and myself, Mike and James, and we have really tried to open ourselves up to listen to what it is that people are saying about these cases and that informed the way that we have inspected some services. Mike gave an example of how six theatre nurses had concerns about theatre safety, and that led to us carrying out an inspection of theatre services.

So, for the current contemporary cases, I think we are able to pick up issues, but we are not an adjudication authority. It is related to Sarah’s question about complaints, and on whistleblowers, we are not an adjudication authority. We have no power over any other organisation as an employer, but what we should be and are doing is listening to the concerns people have about quality and safety. Also, we think there is something in there,

going back to the culture of an organisation. Is this organisation open to learning from the concerns that are being raised and is that culture—

Q330 Andrew Percy: But in your inspections you do not comment on how trusts deal with complaints from staff, though, do you? You do not comment on the processes.

David Behan: No. This is why I think all three of us will provide an answer.

Professor Sir Mike Richards: I agree with David that this is a very difficult and challenging area. Our first role is to listen, and I think that listening can give us clues into two different areas. What is the specific concern? Is there poor practice in the operating theatre—to give it as an example—or in a radiology department, or wherever it may be? If there is poor practice there, we may need to go in and get on top of that. But also we need to listen as to why it was that the whistleblower felt that they were not being heard internally or were being bullied or harassed about it, because that will tell us about the culture; and when we listen to that bit of it we are trying to find out whether that was at middle management level or senior management level. So we can ask questions about how they raised the concern and what the response was, because that may tell us a lot about the leadership of this trust, either locally or at the top of the trust, and that in itself may occasion us to go in and look at a trust if we feel that it is not being well led. This is one of the areas where we may do that jointly with Monitor, for example. We might go in and look specifically at that domain. So we can use the information from whistleblowers in a focused way to decide what we need to do about the trust.

James Titcombe: I will just bring in some of the work we are doing with Kim Holt, who is an adviser to us at the moment on whistleblowing. In February this year, we had an event and we called it “A conversation with whistleblowers” where we invited a number of whistleblowers to the CQC and had a conversation and listened to their stories. Exactly as you have said, so often the typical pattern is that they raise a concern and then suddenly the focus goes away from what they have raised and becomes a focus on them, and it is an employment issue and you get into this terrible situation. So we have listened to those people. We now have a panel of people that we can carry on engaging with, and the work I am involved in with Kim is very much saying, “What does a good trust do to stop this happening?” Just as a trust should have a good complaints system for patients, what is their system for listening, responding and encouraging staff to raise concerns? It should be normal. This term “whistleblowing” is not used in the nuclear industry; I had never heard of it. It should just be a normal part of what you are expected to do in your job, and the trust should have systems that support that. How can we develop a framework for what that looks like and how can we assess that? We are developing that with Kim at the moment and that is going to be incorporated into our inspections by the end of this year.

Q331 Andrew Percy: Do you think there is a culture of trying to shut up whistleblowers? Is it an institutional problem?

Professor Sir Mike Richards: It is very variable. There are undoubtedly trusts that have an open culture where, if there are concerns, they genuinely want to hear about it because they want to act on it and they want to put things right. We come across those in different parts of the country. We come across ones where it is very much more a closed culture

and, “Let’s try and stamp things down,” and I know which one I would like to be treated in.

Chair: Thank you very much.

Q332 Grahame M. Morris: Just on this issue about raising concerns, but this time within the CQC rather than within other organisations—perhaps I should direct this question just to Mr Behan out of awareness of the fact that the other two gentlemen are employees of the organisation, though I suppose you are too—what steps have you taken to try and ensure, within the CQC itself, that someone who is a whistleblower who has legitimate concerns can make those known?

David Behan: I think it is a really important question, Grahame, and of course anyone familiar with the history of the CQC will know that we have had a board member and a member of staff give evidence to the Mid Staffs inquiry about their concerns, and we have taken those seriously. I think it is not just me but Mike and our other senior colleagues are pretty determined to work towards creating an open and transparent culture in the CQC. It goes back to the answer to the Chair’s question earlier about us being a role model on openness and transparency. What are we doing about this? We are reviewing our own processes whereby people can make complaints against us but staff can raise concerns. That process is being overseen by Michael Mire, who is a senior independent non-executive director of the CQC, and he is chairing a committee of the board of the CQC that is providing oversight to this, so there is a degree of independence from our senior non-independent director.

We regularly survey our staff. We ask those staff about the culture of openness, whether they are feeling bullied or supported. We do that twice a year, once in July to every single member of staff, and once in January/February to one in four staff. We publish those results. We have a public meeting of our board tomorrow, and the reports on the staff survey will be published so that they are there to see. We have put in place a whole raft of changes around creating a more open organisation. I personally write to every member of staff every Friday about the work we are doing. I frequently get responses from people who are saying they are not happy with this or they don’t like that. I know that I have a number of disappointed staff who have applied for promotional posts and not got them, and they have let me know that; and we deal with those issues through that culture of openness. We have instituted regular meetings with senior leaders, managers and staff in the organisation. So I think we are working very hard, Grahame, to create an organisation where people feel it is safe to raise their concerns.

Q333 Grahame M. Morris: I know time is short, but just very quickly, to develop that, if someone within the organisation—I am not thinking of anyone in particular—felt under pressure to produce a critical report about a particular trust and did not, and then they thought their career would suffer, there had been some detriment, and despite all the processes that you have put in place was still unhappy about that, what would they do then? How would they seek resolution in relation to their perception that their advancement in the organisation had been harmed?

David Behan: If people cannot come to the organisation, to me or to the board, then they can go to external organisations. The *Health Service Journal* covered a note about workloads that had been “leaked” to them the other week. Interestingly, coming over here, we bumped into the editor of the *Health Service Journal*, who commented on how differently we had responded to that by not being defensive about it. That had gone out. It is an issue. We are talking to staff about the workloads; we know it is an issue; we have acknowledged it and we are not trying to cover it up. So I think that was an example of how we were trying to be more open, but you all know as MPs that members of staff from organisations will come to you and share with you their concerns if they are not happy and you will raise it directly yourselves. So there are lots of checks and balances. We have the joy of an annual accountability meeting where you will ask us these questions when we come in front of you.

Q334 Grahame M. Morris: You mentioned, finally, that particular case from 2010-11 where a staff member claimed constructive dismissal—you kind of alluded to it—and they lost their claim in fact. What has the organisation of the CQC learned from that experience?

David Behan: The original complaint to the Mid Staffordshire inquiry was that we were asking staff to undertake new duties and new roles and not supporting them through training. One of the key offers that we are making as part of the changes that we are currently introducing in the CQC is what we have called the Academy. It is a vehicle by which we will train and support our current staff in the new methodologies, and new staff that we are employing will get up to 30 days’ training in our new approach and our methodologies to make sure they understand the law. That is new; that is in the process of being established and set up. But we have really listened to the criticism that came through and are setting up the Academy so we can support staff. This year we expect to spend about £5 million on training and supporting staff in the new methodologies.

Coming back to some of the issues that you have asked us about, we have a whole new raft of regulations that will need introducing and staff will need training in those new regulations. So we are developing a programme for the year and for next year which will allow staff to understand, “What does the duty of candour mean when it comes to an inspection? How are we going to inspect a fit and proper person test? What will the new regulations mean for what we need to do?” These are the questions that Charlotte was pursuing us on in relation to, “Are we taking the appropriate enforcement action?”, which effectively means, “Are our staff, when they are out on an inspection, collecting the evidence so that we can make a prosecution such that the prosecution won’t be thrown out because we have collected the evidence inappropriately?” The training investment in staff is absolutely critical. That has been a big lesson learned from the whistleblower at the Mid Staffs inquiry.

Q335 Chair: Finally, David, before I thank you all for coming, I think you have appeared in front of the Commons Health Committee four times.

David Behan: It feels like more than that, Chair.

Q336 Chair: It probably does. I think your organisation has appeared in front of us six times. You touched on the impact of these annual accountability hearings twice in the discussions we have been having. Could you elaborate a little bit on what you think we have contributed to the change process, please? I am thinking actually—

David Behan: Is there an election on?

Andrew Percy: Massage our egos a bit for the record.

Q337 Chair: That is not the objective. It is fair to say that in fact it was our former Chair, Stephen Dorrell, who has now left the Committee, who put to the Committee in the first place that we should have these accountability hearings. So I think it is an appropriate moment to ask you candidly to tell us a little bit about what you think it has done to contribute, or not, to your organisation.

David Behan: I think it is a really good question, if I may say, and Stephen Dorrell was right to ask us to come here as part of an annual accountability process. I think it is right in terms of our accountabilities, and I think the CQC has multiple accountabilities. I have accountability to the board, I feel we have accountabilities to the people who are using health and care services, but I think the accountability to you in Parliament is a really important accountability. Therefore, while these meetings have not always been comfortable, I have seen it as being an absolutely essential and fundamental part of a parliamentary democracy operating to oversee public services in this country. So I come at this from a slightly ideological position. I spent my earlier career in local government. I am used to elected politicians scrutinising senior officers and see that as a legitimate activity to take place. You have all been voted to sit there: we have been appointed to sit here. Therefore, I think your legitimacy to challenge us on behalf of the people you represent is real and significant. So I begin my answer with respecting the role of the Committee and the legitimacy of you asking people like us to come and account to you and represent the people who have voted for you.

What are the differences that you have made? I have experienced the Committee during the time I have had this job as being challenging. You have asked questions that have made me feel uncomfortable, but nevertheless I think they have been legitimate questions. That has made us go away and think about how we are doing the job. It concentrates the mind to know we will be back in 12 months' time and that you will ask us, "What have you done over the past 12 months?"

What are some of the things that we have put in place? I think our approach to transparency, which was Grahame's question but has been a theme through all of your questions, has been a key part of it. How we respond to complainants and whistleblowers has been a key part of it, and I think we have done our own bit on that, not just because you have asked us. We have invited James to join us and Kim Holt has come to join us. We have opened ourselves up to the people who have been blowing the whistle. You have made recommendations in all your inquiry reports, as part of our hearings, which have set objectives for us to deliver on. I do not mean this to be sycophantic, but the good way that you have done that is to make those recommendations consistent with what Robert Francis, Ann Clwyd and Trish Hart were saying around complaints. That has meant we have not been trying to serve too many different people on too diverse an agenda. I think it has acted to focus our attention and drive improvements in the way that we operate.

Q338 Chair: From what you have just said, I am sure we will ask you back.
David Behan: Good. Thank you for that and I will look forward to it.

Chair: We are running a bit over now. David Behan, Professor Sir Mike Richards and James Titcombe, on behalf of the Committee, thank you for coming. We will move on to our next session.

Witnesses: **Niall Dickson**, Chief Executive, General Medical Council; **Anthony Omo**, Director of Fitness to Practise, General Medical Council; **Jackie Smith**, Chief Executive, Nursing and Midwifery Council and Sarah Page, Director of Fitness to Practise, Nursing and Midwifery Council, gave evidence.

Q339 Chair: Thank you very much for coming. Would you like to introduce yourselves, please, starting with Anthony?

Anthony Omo: I am Anthony Omo, the director of fitness to practise at the GMC.

Niall Dickson: I am Niall Dickson, chief executive of the GMC.

Jackie Smith: I am Jackie Smith, chief executive of the NMC.

Sarah Page: I am Sarah Page, director of fitness to practise at the NMC.

Q340 Chair: Thank you very much. I am going to address the first question to Niall Dickson and Anthony Omo. You made various undertakings to the Clwyd/Hart review of the hospital complaint system about the way the GMC would operate in the future to support the complaints process and those seeking to raise concerns. What changes can we expect to see in the GMC's method of operation as a result of implementing these pledges, please?

Niall Dickson: I hope a fairly significant step change. I suppose one of the key areas that we highlighted in the pledge to the Clwyd/Hart review was about how we support complainants through our process. Traditionally, it has to be said that the GMC—and I suspect all other professional regulators—historically have dealt with complainants by writing them letters, often fairly legalistic letters, which are sometimes difficult for complainants to understand, and then the only time that they would see the complainant would be when they turned up for a hearing, if there was a hearing in that particular case. So we have started a process—we are piloting this at the moment and we will produce an independent report on it later this year—whereby we actually meet complainants, which is new for us, as it were, at the start of the process and—

Q341 Chair: So that is new, yes.

Niall Dickson: This gives us an opportunity first of all to set expectations, because sometimes complainants have unrealistic expectations of what our processes can do, but also to listen to them, what is really concerning them and what they wish addressed. There is that initial meeting and then there is somebody there to whom they can go during the process. We are also meeting them at the end of the process, when the process is concluded, to explain what has happened during the process and why the decisions, whatever the decisions are, have been made in that. That process of face-to-face meetings is, as I say, obviously at a very early stage—it is a pilot—but the early signs are that patients and relatives really welcome this. Inevitably, you will get more positive at the beginning than at the end because, in our business, inevitably, some people are disappointed at the end of the process, whether they are the doctor or indeed the patient who is complaining. So that is one area. I can happily go through some of the other pledges if you would like.

Q342 Chair: You pledged to act to support patients through the fitness to practise cases brought against medical professionals. What do you think was deficient in the way the General Medical Council treated patients in the past?

Niall Dickson: Pretty much as I have just indicated. I think in the past we have seen our process as legalistic and we have not supported patients sufficiently through that process or explained perhaps clearly enough how to engage with us and what they can expect. The other thing we have recently done is to introduce a new online complaint form. I know that is boring and bureaucratic, but it is really important in terms of how easily accessible it is to anybody who wants to complain, whether they understand the process going through, and also, if it is not the GMC they want to go to, that they end up in the right place. That is part of our function too.

Q343 Chair: The GMC was quite a stuffy organisation, was it, and now it is more open?

Niall Dickson: Interestingly enough, an awful lot of the organisations that you will have in front of you will be new organisations with new names. You have just had one. I think various Governments managed to change the letters for the system regulator in the first 10 years innumerable times. The GMC and some other organisations—

Q344 Chair: It happens with Government Departments.

Niall Dickson: Indeed, with great regularity. The GMC has been around a long time and I think it is a mistake to think that behind the letters the organisation is the same, because it is not. If you asked any of our staff who have been around for a while, they would say it is like working for a different organisation.

Q345 Dr Wollaston: Can I ask you to comment a bit further on instant patient feedback, which you have said you are going to bring in more? Could you explain to anyone

following this session what that involves and how far you will be encouraging new registrants to use it?

Niall Dickson: Did you say “instant patient feedback”?

Q346 Dr Wollaston: Yes, instant patient feedback on your registrants. You have committed to increasing the use of it. Could you comment on what you mean by that?

Niall Dickson: The first point on where we are at with patient feedback, which is some way from instant patient feedback in relation to our processes, is that we introduced, as you know, this system of checking on doctors—annual checking through revalidation; all doctors are required to go through that. As part of that process, as part of that annual check, doctors are required to bring both complaints and compliments. We certainly had discussions with groups like “iWantGreatCare.com” about how they could contribute towards that, and doctors who are subscribed to them, or indeed other services, I hasten to add, could bring those instant feedbacks into that checking.

Q347 Dr Wollaston: So this would not be led by the GMC. You are encouraging doctors to use outside bodies that help them to access instant feedback on their performance; am I right?

Niall Dickson: That is right, but what I am trying to say is that it becomes part of the revalidation process; it is part of that checking process. At the moment, the formal bit of revalidation has two elements to it in terms of patient feedback. One is that you, as a doctor, are required to bring all compliments and complaints to your annual process. That would include, of course, something like “iWantGreatCare.com,” if you were doing that as well, but it might be more routine complaints and compliments that you happen to have received in that process, and you are required to reflect on that in your appraisal. In addition, we have a requirement that once every revalidation cycle you have an objective questionnaire, which is independently administered, which does both patient and colleague feedback. The vast majority of organisations which have to organise it for the doctor will be able to both compare doctors within their institution but also with other organisations as well, which enables the doctor themselves to see whether they, for example, might have some issues around their communication with patients. Those are the things we are doing at the moment.

As I say, we are encouraging instant feedback in the sense that we are not requiring it—we are not yet at that point—and we have not even begun to evaluate the model that we have just set in place, but over the longer term I think the role of instant feedback will become more important; I am sure it will. We are at the very early stages of this and we have to work it through. We absolutely want to encourage doctors to think about how they use feedback, whether positive or negative, in developing their practice. We already see quite a lot of positives around the system, anecdotally, from the use of patient feedback, as indeed there was before revalidation came in, because quite a lot of hospitals and other places already had started to use it.

Q348 Grahame M. Morris: Just on this point about whether the GMC had expressed concerns about, potentially, problems arising from deficiencies in education and training, if I can put it that way, in terms of the impact upon patients and the introduction of the enhanced monitoring, can you tell us a little bit about that for the record, please?

Niall Dickson: Enhanced monitoring is a system which we will introduce almost always alongside the local Deanery which is responsible for overseeing medical education. It is where we have concerns about some aspect of the quality of education and training. That can be supervision of doctors in training; it could be about handover; it could be about the degree of autonomy they are being given that is not appropriate; or it may be that these doctors are not being given proper time in order to do their training. So it is a whole range of things. Many of those might have patient safety implications; not all of them necessarily will have those. By enhanced monitoring, we mean that we will work with the local organisation; we will expect the hospital—and it is usually a part of a hospital, so it is one area or department that we have concerns about—to respond to the series of actions that we and the local Deanery require them to take. If they do not do that, just going back to some earlier questions and so on, we will remove trainees from post; we have already done that this year. We have taken trainees out of a hospital as a result of the hospital being unable to satisfy us and the local Deanery that the quality of care was adequate.

Q349 Grahame M. Morris: Just before you finish, as a matter of routine, do you identify those trusts that are involved, or is it a matter for the GMC? Do you publish that?

Niall Dickson: Yes, we do. We now publish all enhanced concerns on our website, and we are committed, as the CQC obviously are as well, to transparency. In fact our fitness to practise referral data is also now going in the public domain. Data used to be something that I think was a by-product of our operational activity. Today, it has to be the way in which we start to develop a more risk-based model of regulation.

Q350 Grahame M. Morris: Finally, has the enhanced monitoring had a positive effect? You have said you have taken trainees away, but, generally, has it been a stick that has had a positive effect to address these deficiencies in education and training?

Niall Dickson: In some ways it is hard to say. In one sense it is a change of terminology. It was called “concerns” that we had and it is now called enhanced monitoring. The difference now is that we are publishing it. As I think people have said, publishing it makes a real difference. I think that people in the system know that that thing is being published. Our view is that publishing it concentrates the minds, and we certainly hope that, for example, we don’t have situations where action plans are running on indefinitely. Indeed, we will not tolerate action plans running on indefinitely. They have to end, and if they have not delivered what is required then we would expect ourselves and the local Deanery to take the necessary action.

Q351 Chair: Before I go to Andrew George, I have a point on communication. The NMC has committed to having a new operational protocol and data-sharing agreement with the CQC in place to share, where appropriate, complaints information and feedback. Are you

confident that your operational protocols for sharing data with the CQC and other regulators are adequate to protect the public?

Niall Dickson: Yes. We have this document “Operational Protocol a practical guide for staff,” which, as you can see, is from the CQC and the GMC. In the past, organisations like our own did sign memorandums of understanding with other organisations, and they were well meaning and signed by chief executives, but I think the challenge would have been as to what actual impact they had on the behaviour of the organisation. We believe this document is starting to have an effect. We jointly train our staff in it. We have identified individuals who are expected to share information with each other down the organisation. So I think we would say it is adequate.

Q352 Chair: Is your software compatible? Are the systems actually operating? We have had plenty of examples in Government in the past where different organisations simply cannot interface because one is using ICL and the other IBM, or whatever it is. I just want to know from a technical point of view, having worked in the industry once in another incarnation.

Niall Dickson: At the level that we are exchanging information now, it works.

Q353 Chair: There are no problems.

Niall Dickson: It works, but that is not because the CQC can dive into the GMC’s files because they can’t. It is up to us to—

Q354 Chair: There are protocols, but there are communication systems running.

Niall Dickson: Yes.

Q355 Andrew George: In relation to the NMC’s new arrangements, giving support to patients in cases where it is evident that it is a fitness to practise complaint that is being made, in those cases where patients are interfacing with what they consider to be a rather daunting and complex system, what assistance are you able to give them, to handhold them where you think it is appropriate, to ensure that you get the best out of their complaints, so that they can articulate themselves in a way that is useful?

Jackie Smith: Part of the answer to that Sarah can touch upon in relation to witness experience, but I will come back to some of the stuff we are doing at the moment for patients and public. We are consulting on a code review at the moment, which takes account of the Clwyd/Hart recommendations. Where individual registrants have responsibility to deal with complaints we have the witness experience work, which Sarah can talk about, and we have just launched a public-facing leaflet for members of the public on how to make a complaint about a nurse or a midwife. We engage with 92 organisations through our patient and public engagement forum to try and get their input into how we can make it easier for people to make complaints to us, but then, if they do, “What is that experience like?” As I say, Sarah can touch upon that.

Sarah Page: Dealing specifically with the witness experience, during last year we spoke to a number of witnesses who had been involved in our hearings and asked them about their experience, from making the referral or the complaint to us in the first place through the process up to the point of attending one of our hearing centres. Using that information, we identified some of the things that we needed to improve. One of them was around having, for example, a single point of contact for a witness through the proceedings. Another was about just making sure we kept people informed at the various stages as things progressed. Witnesses also told us that the actual environment where they had to attend to give evidence was very important to them, and we have made a number of improvements based on that—to make the hearing centre a place that is more comfortable to wait in so that witnesses feel more relaxed when they are called upon to give evidence and various other changes of that type, including providing better training to our staff and our panel members so that they are all aware of how difficult it is to carry through a complaint to the end. What we are intending to do later on this year is to go back and do the evaluation of that by asking another group of witnesses whether or not the changes we have made have brought about improvements.

Q356 Andrew George: In doing that, do you make sure that they understand what is relevant to what will be a technical and medical hearing, using terminology which they will not necessarily be comfortable with, and also that they properly understand what the role of the registered nurse or midwife is and what it clearly is not?

Sarah Page: Yes; that is a very good question. One of the things that is important for us to address right at the beginning is managing the expectation of the person who is complaining to us in terms of what we can do—what changes we can effect. As you have touched upon, we are a regulator that regulates individuals. We can take action to protect the public. We can't necessarily resolve all the issues that the witness may have brought to the table, so part of what we do at the beginning is making sure that the witness understands the part they are playing in the process and what the possible outcomes may be. Also, in terms of demystifying the process, we offer an opportunity to witnesses to come and have a look at a hearing centre, sit in the place where they are going to give evidence and also understand some of the jargon and some of the questions they may be asked, to try and help people through that process.

Q357 Andrew Percy: Obviously, the new code and the education standards place duties and burdens on nurses and midwives. What have you done thus far to raise awareness around that, and how have you evaluated how embedded these new standards and this code have become across the professions?

Jackie Smith: The standards for pre-registration nursing and midwifery were launched in 2009-10. We are about to embark on an evaluation of the pre-registration nursing standards. We will do that later this year. It is really important that we do that because, as you will know, there is much comment and debate about care and compassion. We would say that we think we cover those really important qualities in our standards, but we need to test that. So we are doing that piece of work.

We are also working with Health Education England now on the “Shape of Caring Review,” which is looking at the future nurse and midwife. Actually, it is going to focus

on nurses. What is it that the public want from a nurse? What is the expectation that we are trying to meet? That is an important piece of work which we hope to finish next February.

Then, of course, there is the code review, which is out to consultation at the moment, and we are embarking on revalidation, which this Committee will know about. So there is plenty that we are focusing on. It is all in its infancy, so in terms of evaluation and outcome it is difficult for us to say at the moment.

Q358 Andrew Percy: Specifically in relation to complaints, how would you assess where we are in terms of nurses and midwives understanding their duties when it comes to complaints with patients?

Jackie Smith: We have had in place for some time our raising concerns guidance. We first introduced that back in 2010. We were very lucky to use Helene Donnelly last year and her experience at Mid Staffordshire to relaunch raising concerns. That sets out the duties upon a nurse and midwife: if you see an issue, you need to deal with it; you need to flag it. That is being embedded in the code. We are making it absolutely clear what the expectation is. We have also included in the draft code the duty of candour, which is the need to be open and honest. Again, that was in the current version of the code. It says pretty clearly, “You need to be open and honest.” We are taking a lead from the GMC in suggesting that individuals should reflect on the fact that they should apologise when things go wrong, because this is all about reflecting on your practice, meeting the demands of your patient and acknowledging when things do go wrong and responding to that. Our view is that by the time it gets to the regulator it is too late. We need to be part of the system that makes the culture better at the beginning.

Q359 Chair: Thank you very much. What measures do you have in place in your different organisations to assess the policies of trusts and other providers to support your registrants in raising concerns?

Niall Dickson: I am happy to start on that one. I think it is very important—and it is a difficult distinction—to understand the difference between a system regulator and a regulator that is responsible for individuals. Our focus is on individuals, not on the hospitals themselves. That does not mean, of course, that we are not concerned with or do not seek to influence the culture within organisations, nor does it mean we do not have to rely on—which we do—the recommendations, for example, for revalidation, which are based on clinical governance arrangements within these institutions. But we have neither the statutory powers, nor the resources, frankly, to start second guessing and inspecting the clinical governance arrangements, including the culture of safety. That is the job of the gentleman you saw earlier this afternoon and it is very important that we both understand that. I think the new leadership of the CQC does understand that and it is one of the reasons why we are working very closely together, so that they feed information back to us when there are individuals or, when we come across things where we think there may be a systemic problem, we pass that information to them. Secondly, we have assurance from them that there are systems in place to assure the clinical governance arrangements, for example, that the responsible officers’ recommendations to us are based on a proper system of appraisal, that that is quality assured, that they select and train their people for appraisal and all those things. That is a clear division of responsibilities.

Just to take that point further, we will look at the recommendations and the patterns of the recommendations, and we will be trying to understand if there are any patterns that raise concerns for us, but the underlying clinical governance arrangements have to be a matter both for the organisation itself and the boards of that organisation. We strongly stress that, and we are about to write a letter to all the chairs of boards throughout the country with the regulators, with David Behan, the head of Monitor and the head of the Trust Development Authority, making it absolutely clear about boards' responsibilities in relation to the performance, the management of their doctors and understanding the culture that they create around that that supports revalidation.

Q360 Chair: What about confidential helpline issues? You indicated that your confidential helpline for your registrants to raise concerns has received over 1,000 calls since it was launched in 2012. It has led to 71 fitness to practise cases being opened. Is that correct?

Niall Dickson: That is right.

Q361 Chair: How would you split those calls up? What proportion have raised concerns about safe operating?

Niall Dickson: I do not know the breakdown of all the calls at the moment. They vary enormously.

Q362 Chair: Can you write to me?

Niall Dickson: Absolutely. We will provide you with that information. They vary enormously, from people who simply want to understand who they should go to within their organisation to ones where there are very serious concerns about something that they have just witnessed.

Q363 Chair: What sort of advice are you giving to those who raise concerns on your helpline?

Niall Dickson: Our guidance is very clear. First of all, if there is something immediate that needs to be done, the doctor needs to take immediate action at that point.

Q364 Chair: So would you take it up with trust management? I am sorry to interrupt you, if I may.

Niall Dickson: Step 1 is that you take immediate action. The next thing is you find the next nearest responsible person who is responsible for that area of care. Often, in the kind of whistleblower issue you are getting people who have raised concerns and do not feel that those concerns have been answered. Again, we give advice about organisations they can go to if they want to explore that further or, if we think there is an issue about an individual doctor, whether that is a matter that we should be investigating; and the 71 cases that you have referred to would be examples where we think there is an individual doctor.

Q365 Chair: What about the NMC? Do you have similar procedures?

Jackie Smith: No, we do not. We are obviously very interested in the GMC's experience and we are watching it closely, but we have had our own difficulties, as you know, and our own caseload to get on top of. We certainly do not want to launch new initiatives until we are in the right place to be able to do so.

Q366 Chair: So you are not ruling it out.

Jackie Smith: We are absolutely not ruling it out.

Q367 Chair: Is this where you would like to get to? You would like to have a similar system to the GMC.

Jackie Smith: I would like to have a conversation with Niall first before we make that decision.

Q368 Dr Wollaston: What proportion of people contact the confidential helpline anonymously? That must also be a concern. If people raise a complaint anonymously, it is never going to be as easy to investigate it as if people are prepared to give their names, and, therefore, by definition, if people are not prepared to give their names they themselves are turning their own backs on their duty to provide every assistance. It is difficult.

Niall Dickson: Our general guidance says, setting aside the confidential helpline, that you can phone the GMC anonymously and raise a concern. So we absolutely do not want to stop anybody raising a concern. My understanding—Anthony may be able to expand on this—with the confidential helpline is that the vast majority of people do say who they are, and, of course, if we open an investigation, then again not always but we would generally know who the complainant is.

Anthony Omo: That is correct. We can get you precise figures on how many are anonymous and how many are named, and you are right in the point you make that if we do not have details to go back to—and in some we don't—that makes it difficult to track down. But we do use our employer liaison advisers who are meeting regularly with responsible officers. So if they have named a trust or something, we will send them out to have a conversation with the responsible officer, saying, "This is what we have heard. Do you know anything about this? Can you look at this and give us some assurance that you are on top of it?" In most cases they are aware of an issue and they pick it up.

Q369 Dr Wollaston: Do you raise the point, though, with somebody who wants to make an anonymous complaint that they themselves may need to reflect on their own responsibilities to patient care?

Anthony Omo: It depends on which stage of the process it is at. If they are making the call, we will simply take the call, try and get their details and get on to whether there is something we need to do immediately or not. Within the process, if we decide to take a

case, then, yes, we will be talking to them about their responsibilities, what we expect from them and what we will do to support them.

Q370 Chair: Before I turn to Charlotte, what sanctions, if any, can both of your organisations impose on trusts that are managing medical or nursing midwifery services who are not GMC or NMC registrants?

Niall Dickson: We have no powers beyond those powers for individuals. The only other powers we have—the ones we have sort of touched on already—are in our role as having responsibility for postgraduate education and training; we have powers in relation to those trainees. That can have a massive impact on the service that is provided within a particular trust.

Jackie Smith: Yes, and, equally, we can remove students.

Q371 Chair: We are publishing a report tonight on the accountability hearing with the Health and Care Professions Council. If you have not given it to us already, do you have a view on regulation of registrants who would not fall within your scope, for example? Do you think that there are bodies out there that should have some oversight that do not? Have you identified any?

Jackie Smith: Healthcare assistants.

Chair: Thank you.

Jackie Smith: I think you have asked us about this before.

Q372 Chair: I cannot tell you what is in the report; it is embargoed—not for very long.

Jackie Smith: Our view on this has been that the NMC has not been in a position to take on regulation of one and a half million healthcare assistants, and I think that is still our position. There is also something to say about whether regulation is the answer, bearing in mind the lessons that we have all learned post-Francis: is it the normal, natural response to a work force and are there better ways of delivering this?

Chair: Thank you very much.

Q373 Charlotte Leslie: Briefly, do you place a lot of stress on the importance of a registrant raising a concern about patient safety within the trust as soon as possible?

Anthony Omo: Yes.

Q374 Charlotte Leslie: There are cases where registrants who have not raised an issue of patient safety as soon as possible, for whatever reason, have themselves become

subject to a fitness to practise case. How do you treat those kinds of cases? What context do you have to take into account?

Niall Dickson: I will get Anthony to expand on this, but the basic principle is—and I do not think we should depart from this—that we should treat everybody the same in the sense of looking at the circumstances of their case, taking into account the context within which they have been working and then assessing the evidence to the best of our ability. The fact that somebody has complained about somebody else and then gets referred themselves—either way round—means we need to look at the circumstances of each case and examine its strengths and merits.

Anthony Omo: I think that is correct. We would need to understand the reasons why it was not raised earlier. It may be they were trying to do so in their own way in the trust or they had done so but had not been listened to, and we would take that into account if we were investigating. The basic point is that, if something is referred to us, we need to look at it and we will try to do so as quickly and thoroughly as possible, but you cannot get at the answer without looking at it.

Q375 Charlotte Leslie: How confident are you in your ability to ascertain the context effectively—out of 10?

Niall Dickson: Anthony gives the number and I will do the qualitative bit. I think the answer is that it is extremely difficult. This is a complex and difficult area. I do not think we have any magic wand in order to do that. We simply have to look at the evidence that is presented to us. I would hope that in the vast majority of cases we get it right, but it is difficult, and of course it may be that somebody says something and somebody else says something, and there is no way of resolving it because they were the only two people who were in the room at the time. It becomes quite difficult.

Anthony Omo: I think it is difficult. I am reasonably confident that we do what we can. We cast a wide net, which is sometimes a criticism. We delve as deeply as we can, but ultimately, as you recognise, we are dealing with individuals, and if someone is determined to hide something it is very difficult to get behind it. But we have extensive powers to require people to produce things and often we can take them to court to get them to produce the documents or whatever it is, and we use those powers to get at as much detail as we can. If someone raised a concern, we would ask them who or where else we could go to. We go to the trust and broaden it as much as we can, and we get our lawyers involved very early to make sure we can build as good a case as possible.

Q376 Chair: I want to develop this theme a bit. You both stress the importance of finding a local resolution to problems. How do you go about deciding whether to go for local resolution? Is there a bar of ghastly behaviour that has to be crossed to take it up to your level? Can you explain a bit about that?

Niall Dickson: There are two ways of looking at this. If you look at a complaint, how do we think, if we had a fully functioning and good system, a complaint would normally work? Then I guess our view would be that it would be good if that complaint was raised locally and it was dealt with effectively at local level. But if there were concerns about a doctor's fitness to practise, then the responsible officer within that organisation would make a referral to us. That may have originated from a patient complaint, a series of

patient complaints, concerns raised by other staff or concerns raised by the clinical managers of that doctor, or whoever, whatever the source. Then that complaint would come up to us and be dealt with. Of course the world is not as tidy as that. Sometimes patient complaints come directly to us. and that is fine and we have a system for that.

We then have to assess those patient complaints, assess where they are in seriousness, and, exactly as you are describing, there is a bar which has been set by Parliament about when we have to investigate and when we do not. As to the ones that are below, some of them are clearly not for us. It may be that somebody is complaining about their doctor as a landlord or their doctor as a tenant, or things that are not relevant, or it may be, “The doctor prescribed me this drug and I wanted that drug.” These are clearly things that are not going to reach our threshold. It may have been, “The doctor picked up a mobile phone and started talking during the middle of our consultation.” As a one-off, that absolutely would not engage our processes and it would be ludicrous for us to do that. So we have a system there for dealing with those ones which are not absolute nonsense and we put out the door but which may be something that the doctor ought to reflect on and perhaps the responsible officer ought to know about. Anthony might just explain that new process.

Q377 Chair: Can I interrupt? What duties are there on a responsible officer to communicate with a complainant?

Niall Dickson: They are under statute. This is NHS complaints procedures, not the GMC, because it is not part of a GMC process in terms of them communicating with patients. We do not govern NHS complaints procedures; that is a matter for the NHS. If they are within our procedures, I have explained how we would go about that.

Q378 Andrew Percy: Just on that, I am confused. Is that on the local resolution issue? That is your procedure, is it not, for the local resolution?

Niall Dickson: The procedure is that the first set of things we may get are absolutely not for us and we will close those initially. There is another set where we will close them because they do not meet us and we will send them to the responsible officer and say to him, “This does not reach our threshold, but you may wish to look at this and reflect,” and we will also say to the doctor that we are referring it to the responsible officer. That is how we deal with those that are worth them having a look at, as it were, and reflecting on but absolutely do not reach our—

Q379 Andrew Percy: Who is the responsible officer?

Niall Dickson: The responsible officer is a statutory function. It is largely medical directors within the health service who perform that role and they are creatures of statute. They have a set of responsibilities that are spelt out within that statute.

Q380 Chair: Fine. You will be aware of cases where a trust’s management has sought to open fitness to practise proceedings against a GMC registrant. What investigation do you undertake in those circumstances?

Niall Dickson: I am sorry?

Chair: You have a situation where a trust's management has sought to open fitness to practise proceedings against a GMC registrant. What investigations do you undertake?

Niall Dickson: That would happen all the time—constantly. As Anthony explained, we now have employment liaison advisers who deal on a daily basis with the responsible officers, who will make the referrals, as you have described, into our proceedings. Often, now, that would be as a result of a discussion they would have with us where they would say, “We have these concerns about this doctor. We think this should be referred in,” and we would discuss that and have support. Occasionally our employment liaison adviser might say, “We do think you should refer this case because it requires that level of seriousness.”

Q381 Chair: Do you not think there is a risk that a trust's management may seek to use a GMC referral as a means of punishing a GMC registrant who has raised very legitimate concerns?

Niall Dickson: Yes. This is an issue that we have discussed before and there is history around this of individuals who are classic whistleblowers. We were discussing earlier how you differentiate between a genuine whistleblower and somebody about whom there are genuine concerns, and I think we all—

Q382 Chair: Don't the lawyers call them vexatious litigants—the people who come back?

Niall Dickson: We have those as well, yes. But trying to sort this out, as it were, is part of what our investigations have to do. We have to try and establish where the truth lies. We should not automatically accept, because it is a trust's management, as you put it, putting in the complaint, that they are right and that the individual is wrong. You have to take it on the basis of the evidence that we are presented with.

Chair: We are getting very close to the end of this session. I will ask Charlotte Leslie to ask a couple of questions and then Sarah Wollaston wants to come in with another question.

Q383 Charlotte Leslie: If you go to the whistleblower community—and these are whistleblowers who have had their concerns borne out and were proven to be correct, many of whom now do not have jobs—and you say “GMC,” why do you think they roll their eyes and say, “Oh, they always stick up for the bad guys”? Why do you think that is—because it is certainly the case that they do?

Niall Dickson: We have had quite a lot of conversations with Kim Holt and with some, as you put it, within the whistleblower community. I am absolutely prepared to accept there are things that we can learn from this process. What I will not accept is, “This is all dead easy, and here are the good guys and here are the bad guys,” because it is not as simple as that. One of the things we are prepared to do is to review how we handle the

whistleblowing area and how we manage to deal with people who are saying they are whistleblowers. We want to get this right. We stand by our basic procedure, which is that we try and investigate. I know that Anthony's staff don't walk into work in the morning saying, "I am going to shut down—I am going to do something nasty—because that person is a whistleblower," or, "I have a natural affinity with this hospital trust's management." That is not the mindset that we work with. But if there are things that we can learn, we will learn, and we will get somebody external to come and look at how we handle that process of where people identify themselves as whistleblowers.

My only wider point is that I think this is very important; I accept it is very important, and we need to deal with it. The bigger and underlying issue is: how do you change the culture within these institutions so that the whistleblower, as somebody said earlier, is a sign that the thing has failed? It is about creating cultures in which people can raise small, medium and big concerns, and they are dealt with and answered. You will always have fallings out and you will have dysfunctional teams; you will have all those aspects of human behaviour. Especially having listened to a lot of the whistleblowers, it is easy for us to say, "We have our procedures and they work," and so on, and, inevitably, somebody is going to dislike them, but there are lessons that we have to learn and we will reflect on them, conduct an external review and publish the results.

Q384 Charlotte Leslie: Do you have any idea of a time frame for that external review and results?

Niall Dickson: We are still in the process of drawing up both terms of reference and who we might ask, but the short answer is that it will not be at three years and it will not be hundreds and hundreds of recommendations—I sincerely hope. It will be a limited piece of work, but we will set a time frame for it.

Q385 Charlotte Leslie: Could you keep the Committee updated on your progress on that?

Niall Dickson: We will, absolutely.

Jackie Smith: Can I come in here? We are doing a piece of work with Patients First at the moment looking at how we can engage them and their ideas just on this issue. I completely agree with Niall that this is not easy, but there are lessons for the professional regulators to learn here.

Q386 Charlotte Leslie: It is encouraging to hear that people accept there are lessons. Both the GMC and the NMC have registrants who are not so much in clinical positions but in managerial positions, and, often, ironically, it is only because they are registrants with you that they are able to be held to account for their managerial decisions or able to be referred to you to be held to account. To what extent and how do you judge people in managerial positions and hold them to account on their duty for patient safety even though they are not clinically practising but are in a managerial position? Do you have a code or a guideline for that?

Jackie Smith: Yes. I think we can provide a very good example of a recent case that we dealt with at Mid Staffordshire of a nurse in the most senior managerial position. We are quite confident that our code applies to all nurses and midwives regardless of the position that they hold, and I think that case demonstrates the fact that our panel members understand how the code works and can apply it to those individuals.

Q387 Charlotte Leslie: Given the ability you are able to exercise with accountability for registrants who are in managerial positions—this may be slightly outside your remit—would you be in favour of a similar kind of body as a GMC or an NMC for managerial positions for people who had not perhaps got clinical qualifications first?

Jackie Smith: I am not sure about this, I have to say. As we have already described this afternoon, the process, the landscape, is very complex, and what additional value does it add to an individual if they are dealing with somebody through a professional regulator and then through another organisation which is for managers? I think we need to ensure that we help to change culture so that things are dealt with at the appropriate time. I am not sure of the value added of another body, another organisation, for those individuals.

Q388 Charlotte Leslie: Everyone wants the culture to change, everyone wants whistleblowing not to exist—it is kind of a given—and, in reality, we can all have warm words and learn lessons, but in many cases, if the incentive is for a manager to bury bad news and problems, they are incentivised to do that because there is not a major penalty in not doing so. If there is a major penalty and they might never be able to work again if they are found to have buried concerns because they are accountable to a regulatory body, they might find that, even though it is difficult not to bury bad news, it is far less difficult than being struck off and never being able to work as a manager again. Do you think there is a lack of equity or equality in the system whereby if you are a clinically qualified manager you can be held accountable, but if you are not a clinically qualified manager off you go to another well paid job, which has happened? How do you square that in equity in the accountability system for managers if you do not feel there should be an organisation to hold managers to account?

Jackie Smith: Do you want to have a go, Niall?

Q389 Charlotte Leslie: I am sorry to press this, but you can see how important it is in terms of changing the culture.

Jackie Smith: There is sometimes inequality there, and that is the case. I suppose what I am saying to you is that it needs to be clear where the value added is, and another regulatory body that can do these things might be the answer; it may not be. I just think that regulation seems to be the response every time there is an issue, and, as Francis demonstrated, the regulators did not exactly cover themselves in glory in respect of Mid Staffs. Are there alternative ways of dealing with this? I accept your point that there is inequality there but I am not sure of the value added. Niall, do you want to add anything?

Niall Dickson: I will try, and I have had this debate with this Committee before. If the answer to a more transparent and open culture and raising concerns was the likes of Anthony and me walking round wards with great sticks on our backs, then I have to say that is the wrong answer. The idea that people will become more transparent and open because there is more threat on them I don't think works. I think we have to use another

set of levers, more difficult and more complicated levers. I am not saying, “Let people off”; that is not what I am arguing. But in terms of what message we are trying to transmit in terms of changing culture, I think fear is absolutely not the one that we need to try to encourage people to create the kind of culture that, as you say, we all want.

I am sure you are right that there are managers who have moved around and skipped off from one job to another. It is also true that lots of managers have been sacked and have been held to account in that sense. So I don’t know that they always get away with it. The turnover at the top of the NHS is not a matter for us, but it is a matter of concern. What is of concern to us is, of course, the responsible officer level, the medical directors, who are, I think, beginning to take on the role of revalidation. We will absolutely hold them to account for what they do, but we also absolutely want to support them in doing what I think is a really difficult job. If, of course, they suppress whistleblowers, fail to refer cases, don’t run a robust appraisal system or whatever, we will absolutely hold them to account. But I have to say the early signs are that the calibre, the enthusiasm and the drive among that cohort of people is much better than it was, say, five or 10 years ago when an awful lot of clinical management at the top were “Buggins’ turn” or nobody else wanted to do the job and so on. So we have some way to go, but professionalising that and supporting these people in helping us to create the open culture that you have talked about, encouraging concerns and producing all this fabulous guidance—the question is, “How real is it?”—is what we need to do more of.

Q390 Charlotte Leslie: The final question is a very quick answer one. Patients First have recommended and want a truth commission to look at cases of whistleblowers, particularly those where people say they have raised concerns as clinicians and their reward has been to be struck off, never to find work at any organisation again. Do you think there is merit in a truth and reconciliation commission to get to the bottom of some of these historic cases, to learn lessons for the future, and perhaps to have some accountability where there has so far been none, to set a precedent of the right rewards for the right behaviours?

Niall Dickson: I have not reflected on this. I will come back to you and answer. It would be foolish to give an immediate answer. I have not really thought about that. It has some appeal.

Jackie Smith: I think something is required, absolutely. Whether it is in that form or not, I think something is needed.

Q391 Dr Wollaston: As you all know, the draft Law Commission Bill on the regulation of health and care professionals was not taken forward in the Queen’s Speech. In referring to our current inquiry about complaints and raising concerns—and I know the Government have said they will bring forward some secondary legislation to deal with the most pressing issues—is there anything relating to our current inquiry that the GMC or the NMC would like to put on record as requesting the Government to prioritise?

Jackie Smith: I think the NMC has been most vocal about this, so perhaps I ought to put it on record. The problem that we have quite simply is that we have just experienced a 14% increase in complaints, so complaints continue to rise to the NMC. Our ability to be able to deal with those in the most effective way is hampered by our legislation. We are deeply

disappointed that there was no parliamentary time for the Law Commission Bill. That is the fundamental problem that the NMC has.

Q392 Dr Wollaston: Given that there has been a commitment to bring forward some secondary legislation, are you currently in conversation with the Department of Health about what avenues of secondary legislation could help with that particular issue, and are you satisfied with the response? Are there points that you would like us to raise in our report about that?

Jackie Smith: Yes. I could say I want something but we are unlikely to get it. The secondary legislation that we are going through at the moment is in relation to the decision to review “no case to answer” by our investigating committee and replacing the investigating committee with case examiners. These are creatures that the GMC have had for a number of years. The fundamental problem we have, though, is that most of our cases end up in a hearing and we do not have quick ways of disposing of them. That takes a long time. It is very expensive. It means that we spend 80% of the NMC budget in fitness to practise. That has a direct impact on our registrants in relation to the registration fee. The Law Commission Bill, particularly in relation to fitness to practise, which would give us something similar to what the GMC has, is what we most need.

Niall Dickson: We would endorse all of that. We have some legislation that is a bit more advanced, as it were, or more modern than the NMC have, but we face the same issue of rising numbers of cases and pressure on our system, and we regard our current system, even though it has some aspects that are better, as still cumbersome and not flexible enough. The Law Commission Bill offered a real opportunity to take forward innovation, to create a piece of legislation that would allow further innovation, not to fix it in the aspect of 2014 but allow something that would evolve and encourage innovation over time in this area. So, like the NMC, we are bitterly disappointed.

We are getting secondary legislation. The Government are—I am glad to say—progressing this. This is particularly around an area which the Committee has constantly asked us about, and indeed I remember the first hearing where we were quizzed about why we did not have this. We set up an independent adjudication service. This would be putting it into statute, but it would also give us a right of appeal, which we regard as extremely important, so that we can challenge decisions that we do not believe protect the public sufficiently.

Q393 Dr Wollaston: Chair, with permission, may I have one second more? Given that your evidence submitted to the inquiry was written at a time when it was thought that the full Bill might go through, are you able to update your evidence so that we can make sure we reflect in our inquiry on anything that you feel is most pressing that could be brought forward under secondary legislation?

Jackie Smith: We would happily do that.

Q394 Chair: Having actually chaired the Joint Committee on Statutory Instruments for the whole of the 1997 Parliament and 2001 as well, with Martyn Atkins as the clerk, I do

have a recollection of the 1997 Health Act, section 60, which provides simply for a lot of this work to be done on statutory instruments. Part of the problem is you have the SI, positive or negative, but once you actually have it, then there is a whole cumbersome process beyond that to do anything. So it is not just a case of whipping it through the Committee on a Monday afternoon at five.

Niall Dickson: No. Section 60s have provided a degree of flexibility around this but not sufficient flexibility. They have driven the Department of Health mad themselves, I think.

Jackie Smith: Insane, yes.

Niall Dickson: They certainly have caused huge amounts of frustration, and of course we have had an element of planning blight because we were dangled the prospect of “Don’t worry. The Law Commission is doing this work. It will produce legislation. It will free you.” And of course now we have been told that we are still in the cage; we have not been let out.

Chair: What a lovely phrase to leave it on. Thank you so much, everybody, for coming.

