



## Health Committee

### Oral evidence: Appointment of the Chair of the Care Quality Commission, HC 641 Tuesday 1 December 2015

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Members present: Dr Sarah Wollaston (Chair); Dr James Davies; Andrea Jenkyns; Andrew Percy; Paula Sherriff; Maggie Throup; Helen Whately; Dr Philippa Whitford.

Questions 1-56

Witness: **Peter Wyman CBE**, gave evidence.

**Q1 Chair:** Good afternoon. Welcome, everyone, and welcome, Mr Wyman. Thank you for coming this afternoon. Could you begin by introducing yourself to the panel and to everyone following this hearing?

**Peter Wyman:** I am Peter Wyman. I am currently chairman of Yeovil district hospital and I am here today to talk about the Care Quality Commission.

**Chair:** I will hand over straight away to Dr Whitford.

**Q2 Dr Whitford:** Can you tell me why you applied for this position in the first place?

**Peter Wyman:** Yes. It is quite a long story and I will try and be fairly brief. I come from a medical family. My father was a doctor and my mother was a nurse. I kind of grew up in the NHS but then fate conspired that I became an accountant, not a doctor.

Fast forward 40 years, I was leaving PwC and starting a non-executive portfolio and was very keen—it may sound a bit trite to say this—that the majority of my effort would be in both public and voluntary service having had a very fortunate life up until then. Because of my previous association, if that is not too strong a word, with the NHS I particularly wanted to do something in healthcare if the opportunity arose, so I jumped at the opportunity of Yeovil hospital when it came along. I would have expected to have stayed there for at least another 18 months, but the headhunters called and started to talk about the Care Quality Commission. Fortunately, for the first call I was in a meeting or something and they left a message on my voicemail, which gave me a chance to think about whether I really could walk away from Yeovil at this particular juncture. I came to the conclusion that the management team and board we had established at Yeovil were sufficiently good, and the momentum behind what we were trying to achieve in new

models of care and other things was so great, that if I walked away now everything would carry on anyway. That made me think seriously about the CQC and whether that was not where I could make a bigger contribution to the NHS. I concluded it was, and so here I am.

**Q3 Dr Whitford:** In what way do you think your past career, in that, as you say, you were an accountant rather than someone within the clinical field—much as you have lived with your parents, though I am not sure that quite counts—prepares you specifically for what is going to be a challenging role?

**Peter Wyman:** Everything I have ever done in my career has built on what has gone before. I started by qualifying as an accountant. Not only does that teach you a lot of basics of finance and management and so on, but more particularly it gives you a lot of the key professional and ethical values—integrity, independence and so on, very much in fact the Nolan principles for public life, which I was taught right from the start. I then spent 20 years or so working quite closely with companies—big and small, good and bad—and learned a lot about what makes organisations successful and what does not. I had a really interesting role for the Cabinet Office in the mid-1990s looking at the customer-facing side of national insurance and PAYE. There was a lot of evidence that people who set up businesses often did not make the next big step, which was to take on an employee, because it was too difficult to fathom out how to comply with all the legislation. I was doing some work on trying to make the customer-focused bit of it more aligned and simpler to access. If you substitute the word “patient” for the word “taxpayer”, there is a lot that I have seen, certainly since being involved in the NHS, where, unintentionally, people in hospitals and other parts of the health services inadvertently put their organisation ahead of the patient, in terms of convenience and organisation. That was relevant experience.

I was very fortunate to do a lot of work on governance, working in particular with people like Sir Adrian Cadbury, who sadly recently died. Adrian Cadbury was the doyen of corporate governance. He was the Cadbury behind the Cadbury Code, which became the Combined Code and then the City Code, and, although that applies to the City, almost every other governance code, including that for foundation trusts, higher education, charities and so on, is based on that. I have a lot of understanding about governance and leadership. That is a really important ingredient in the NHS today. I set up, along with the Financial Reporting Council and people from the Department of Trade and Industry—as it then was, BIS as it is today—a new regulatory structure for the accounting profession. That was an important insight into thinking about regulation. I have had 20 years of board experience, an executive career and in the last five in a non-executive capacity. You are absolutely right that growing up with a doctor and a nurse as parents does not equate me to being a clinician, but a lot of the other things I have done are really relevant.

**Q4 Dr Whitford:** I can see they are very useful from the point of view of looking at the financial structure and stability of trusts of organisations, but obviously the Care Quality Commission is predominantly there to look at care. Do you not think a complete lack of clinical experience makes it difficult for you to get to the heart of what the CQC has to go in and look at in an organisation?

**Peter Wyman:** If I was here today as an applicant to be one of the three chief inspectors, clearly, I would not be remotely qualified as I am not qualified to make those judgments, but that is not the role of the chair—that is the role of the chief inspector. The role of the chair and the board is to make sure that the processes we use are appropriate and fit for purpose, that we have the staff with the expertise, that we use our resources effectively and have systems that enable the right judgments to be made. Ultimately, those judgments—and this goes to your point about me not being a clinician—are made by people with deep expert clinical judgment and it is clear that those decisions are made by the chief inspectors, not by me.

**Q5 Dr Whitford:** You would see that as two completely different roles within the CQC: yours is the financial and organisational governance of the CQC, and the chief inspector would be entirely responsible for, if you like, the clinical judgments.

**Peter Wyman:** That is for the judgments, but the board has to have responsibility for how the inspections are carried out and their frequency. We may talk later about where the next round of inspections has to go, but these huge inspections that have been taking place, giving a great depth of knowledge, at some considerable cost, are unlikely to be what we need in the next round. Working out what we do next and how we use information and data to better inform where the effort should be are the sorts of decisions that the board will make, and a lot of my experience will be very valuable—at least I hope it will be—working with the clinicians, but it is a different set of expertise.

**Q6 Dr Whitford:** I assume, therefore, that there would be other board members who would be able to support the impact the CQC has. Some of the complaints about the CQC have been about the impact on the services being inspected and, obviously, again it is the requirement for that clinical input.

**Peter Wyman:** You are absolutely right that there has been some quite deep concern about the impact on the providers of services. We need to think first of all about how we can carry out inspections in ways that are less burdensome on the people being inspected. I am hugely conscious that every pound we spend on inspection—and I do think the process is very important, by the way—is a pound that is not being spent on the front line. Getting this proportionate and right is important. I am not saying that the chief inspectors would say this for a minute, but there is always a tendency that they will want to do more because that is what their job is about. The job of the rest of the board—and I will come back to the board in a moment, if I may—will be to test, push and say, “Is this really proportionate?” One of the jobs of any chair, to answer the other part of your question, is to make sure that the board has the right mix of skills. There are, I think, already some vacancies on the board that have not been filled, so that would be an opportunity to sit and look, if I am appointed, at where the skills gaps are and then find the right people to supplement what I believe is already a very able board.

**Q7 Dr Whitford:** The Department of Health has said that during the interview you were asked what you saw as the challenges for the CQC in the coming five years. Can you share with us what you answered?

**Peter Wyman:** I divided it into three parts. There was a part around the environment in which we are all operating, a part about how the CQC responds to that environment and

then a part about what I called the internal challenges within the CQC at the moment. I think everybody in the room will be very familiar with the external environment, an ageing population, a growing population, a shortage of nurses, a shortage of doctors in many specialties, a shortage of care workers and financial constraints. All of that is going to drive new models of care. It is the only way that you can square the circle. That provides quite a lot of challenges for the CQC. In particular, it needs to work out how it is going to inspect new models of care. It is going to have to think quite carefully about how it reports in a way that absolutely fearlessly points out anything it finds that is wrong. I am not trying to duck any issues, but it needs to do it in a way that encourages people who are working in the health and care services to respond. Most of those people are proud to be doing the job they are doing, and if somebody told them that the next-door hospital is doing a better job than they are in this area they will want to be competitive and up their game. That sort of reporting can go the other way and just demoralise everybody. We have to be careful that that does not happen. There is a lot of thought around how to respond to the situation.

**Q8 Dr Whitford:** In Scotland, just on that very issue, that is a reason why we have never used things like league tables but use standards so that everyone can aspire to pass them, rather than things that mean, no matter how good you are, you may still be at the bottom of the league. That is really important. There are many areas of staff that have ended up quite demoralised depending on how they are handling it. How would you envisage dealing with that? Some people did tend to feel, particularly in primary care units, that they had had a hard time from the visits.

**Peter Wyman:** There are undoubtedly some people who feel that, possibly through no fault of their own, and it may be the organisation's fault for not providing good care. We cannot duck that issue, but there are ways of reporting so that you emphasise the good things that are going on. If you read the CQC reports—and I have not read them all, but I have read quite a number—even those that they have found to be the worst performers have lots of areas where they are performing very well, so you need to emphasise that and point the way to encouragement. Your point about league tables is interesting. I would define success for the CQC as being that, in due course, without altering the standard, everybody that is inspected is good, if not outstanding. That would be success because you have moved the whole thing along. It is about thinking of it like that.

Coming back to the challenges I gave to the interview panel, that was one set of challenges. The second set was how to manage to do the job we have been asked to do with a smaller budget in the future. The answer I gave was that if the world was standing still it would not be too difficult. It is never easy to reduce your budget by 25%, or whatever the number turns out to be at the end of the day, but, going back to what I said earlier, these huge inspections and so on should not need to be replicated in the future. You ought to be able to right-size what you do to the budget that is available. Unfortunately, the world is not standing still, and not only do we have new models of care to think our way through but, sooner or later, the NHS is going to catch up with the 21st century when it comes to using technology. It is a long way off most of the rest of the world, but it is changing and it is changing at different speeds. Some are already using technology in quite advanced and very interesting ways; others have not started yet. There is a real challenge for the CQC. Regulators of all sorts tend to be behind the people they are regulating, always trying to catch up. It is an opportunity for the CQC to think its way

through quite carefully what this future technology is going to enable it to do and try, if not to get ahead of the curve, at least to catch up with everybody else. That will require, in my view, an investment, and I have no idea of the quantum of that investment at this stage because I suspect we need people who have different experience and skills and the time to be thinking about this new world while everybody else is getting on with managing the old world.

The final set of challenges I gave are what I call the internal challenges. If you look at the CQC's staff survey, morale is very low. It is better than it was 12 months before the last survey, so the trend is in the right direction, but it is not good. That worries me a lot, because if you do not have a well-motivated workforce your chances of delivering high-quality work are quite low. I need to understand, and I do not at the moment, what is causing that low morale and what can be done about it. Those are some of the challenges that are there.

**Q9 Dr Whitford:** What was the most difficult question in the final section interview if it was other than the one you have just answered and how you answered it? What made you feel most exercised?

**Peter Wyman:** I was not exercised, but I was asked what I would do if I was asked to do something that was not in the patient's interest. I struggled with that because it is hypothetical and there is a scale between trying to negotiate and do your best but carrying on and the other extreme where you resign. I struggled to answer that question very coherently. There are things where I argue—with my Yeovil hat on—with our commissioners because we are being commissioned to do things that we could do in a different way that is better for the patients, but I do not resign: I argue, and I win some and lose some. Were I asked to do something that demonstrably was going to damage a patient—and I cannot believe I would ever be in that position because, as you rightly pointed out, I am not a clinician—there is a point at which I would say, “If you make me do this, I have no option but to resign.” I have never had to resign from anything in my life to date, but I struggled with the answer and in the end I gave up because it was hypothetical.

**Dr Whitford:** Thank you very much.

**Q10 Andrea Jenkyns:** A lot of what you have said so far has been focused on systems and processes, which is obviously important in a leadership role. What about patients? Surely that should be at the forefront. How have you demonstrated your commitment to better quality care for patients?

**Peter Wyman:** Everything we do, ultimately, is for the patients.

**Q11 Andrea Jenkyns:** Everything you do as an organisation, but how have you demonstrated your commitment to this?

**Peter Wyman:** I am sorry—I understood the question—but that was just to emphasise why I am here and that is why we are all here. If I can talk about Yeovil for a minute—because that is my experience so far—there we have been very actively developing new models of care to make both patient outcomes better and the patient's experience much better.



**Q12 Andrea Jenkyns:** Can I pause you there? That is talking about the past with Yeovil. I would like to know how you would demonstrate your commitment going forward. What are you going to do going forward regarding patients?

**Peter Wyman:** Going forward, this is about giving patients reassurance, first, that the quality of the services they are going to receive is good, and I think there are some things that the CQC could do differently to give clearer signposting to patients—

**Q13 Andrea Jenkyns:** Can you give an example?

**Peter Wyman:** One is that it is quite difficult, unless you start hunting around, to find out what the CQC said, and anyway there is a long lag time—several months—between an inspection and any sort of report, and people are worried. There is no doubt that people are worried, particularly with care homes more than hospitals and hospitals more than with primary care, but there are a lot of people who are worried about whether the quality of care they are getting is good enough. A very visible early way of signposting that we have been to this organisation, have inspected it and are saying that, overall, it was safe, effective, caring and compassionate, or whatever, is really important.

Going on from that, if shortcomings are found with the practice, the hospital trust, or whatever it is, there needs to be a way of communicating with patients that this has been found, that it is not good but is being addressed. On the one hand it is about giving that reassurance, and on the other it is making sure fundamentally that the services are good. Also, one of the problems with the NHS is that over time it has become incredibly siloed: nothing is joined up. That does two things: one is that it does not always lead to good patient outcomes, so we end up admitting far more patients than we should; the other is that we make it really difficult.

Coming back to my earlier answer about the work I was doing for the Cabinet Office, how can you make this journey much easier for patients? There is quite a lot the CQC should be doing looking at these new models of care and inspecting not just the individual silos but inspecting the patient pathway. So much of what is not working well at the moment is the breakdown between different bits of the system.

**Q14 Andrea Jenkyns:** Going deeper into patient issues, patient safety is an important thing for me. I chair the APPG on patient safety. I would like to understand what your plans are to ensure that patient safety is at the forefront of what you do as an organisation—the safety aspects. What are your plans, for example, if you find a place where it is not giving good quality care? How are you going to ensure there is in place a consequence for these places?

**Peter Wyman:** I need to preface this by saying that I am not yet the chair of the CQC.

**Q15 Andrea Jenkyns:** I realise that, yes, but you must have some ideas and plans on it, though.

**Peter Wyman:** Absolutely. I will give you ideas, but I would not want to suggest this is the CQC's plan—I have not discussed it with anybody there—because I will get told off later on.

**Andrea Jenkyns:** That is no problem.

**Peter Wyman:** It is absolutely essential that, if something is unsafe, action is taken very quickly. It is not good enough to write a report and let things hang around. If it is really unsafe, there has to be immediate action. If we are talking about a care home, then it is about working with local authorities to find alternative provision. It is those sorts of things, but it has to be done quickly. You have to be really sure that that is in the individual's best interest because you have to move them from the home they are in and so on, but if it is really unsafe it is what you have to do. If you find an unsafe practice in a hospital, you are clearly not going to close the hospital, but there are resources that are available to come in to manage whatever is unsafe in the event that the hospital management cannot sort it themselves. It is really important to find it quickly and deal with it if it is unsafe.

**Q16 Andrea Jenkyns:** That is obviously where you find things are wrong. Is there anything you can do as chair to ensure that you have a culture where people are not afraid to come forward when they spot things—changing the culture of the organisation and of care in general—so that they are not afraid to whistleblow and come to you when they suspect something is happening?

**Peter Wyman:** It is important that that is the culture. The evidence that I have seen from where I have been in the NHS is that that culture exists now, but I keep reading that in other places it does not. I need to understand properly whether there really is a problem and, if there is a problem, what else we can do beyond the things I know the CQC is doing to make it easy. It comes back again to my point about looking at everything through the patients' eyes. How can you make it easy for patients to raise points? I know you do not want me to talk about Yeovil, but one thing we have done, which I think is brilliant, is to have a bit of software that enables patients, their families and carers to make comments in real time. The system works so that, if there is a negative comment such as, "I am on ward 6 and I do not think I am being fed properly," that flashes up and you can respond to that immediately. That works for staff as well: staff can say that there is a problem; that they do not have enough staff. That is brilliant because it is a complaint, but if there is a complaint you can deal with it immediately rather than somebody suffering and then eventually there being a much more difficult complaint after the event. There are lots of things that the NHS generally can do, but the culture of openness, transparency and people not being afraid to raise issues are important.

The other vital thing—and I think the CQC is focused on this—is leadership. In my judgment, almost all failings of all organisations, other than just individual things that go wrong, are down to poor leadership. One of the things I know the CQC focuses on is leadership. If you have good leadership, that leadership is out and about, talking to staff at all levels, both clinical and non-clinical, talking to patients, visitors, relatives and volunteers, and it picks up issues. I go round my hospital and people stop in the lift or the coffee shop, or whatever, and you have a conversation that you would not have through any formal channel. It is brilliant and they know they can raise issues. It is that sort of culture that we have to have right across the system.

**Q17 Andrea Jenkyns:** Thank you. My final question is: what lessons do you think the CQC needs to learn from the past regarding patient safety? What lessons have you observed? What would you like to see change?

**Peter Wyman:** One thing that struck me from reading the most recent report the CQC put out, which was a summary of where we are today, was this huge variability. The good are excellent, the poor are not very good and the really bad are awful. How can that be? How can you have two GP practices five miles apart where one is absolutely brilliant and one is terrible but both have patients going to them? There is the lesson of trying to understand—and I think the CQC is beginning to get a lot of data—what is good and what is bad.

Coming back to your earlier point, it is then about how you make the public aware. At the end of the day, if people do have a choice—with hospitals they have less choice, but in primary care, care homes and in lots of other things they have a lot of choice—it is not about league tables but about making people aware that this is outstanding and good, that is rubbish, and, therefore, as a consumer of care services, I will go to the good rather than the bad.

**Andrea Jenkyns:** Thank you very much.

**Chair:** Philippa, you have a quick supplementary.

**Q18 Dr Whitford:** Being from the Scottish system, I am not aware of all the details. Within our system, we have a set-up called Datix—I do not know whether it is the same here—which encourages staff to report even very minor, if you like, non-standard issues, which we have certainly felt has worn down that barrier to whistleblowing. If you have got used to reporting all the tiny little things, of course you are going to report that something awful is emerging. Those are reviewed on a regular basis and they will be minor, moderate, major and near misses. The near misses particularly are often very helpful. Is it the same system or just something very similar?

**Peter Wyman:** It is certainly similar. I do not know enough about the Scottish system to say whether it is identical, but it is certainly very similar. It comes back to the point about culture, because if the culture is one of fear, even though the system is there to report, the risk is that people will not.

**Q19 Dr Whitford:** But there is a system because, obviously, anecdotally meeting people in the corridor is not really quite enough.

**Peter Wyman:** No. I was not suggesting that was the only thing; I was trying to suggest that in addition to all the other processes. It is about leadership, being open and giving people the confidence to report on everything. Often, they are quite small things, but they need to be reported. If they are major things, there is even more need for them to be reported.

**Q20 Paula Sherriff:** I have a few questions largely around declarations of interests. I am sure you will appreciate and understand the need for a great degree of transparency. Do you have any connections to any political party or significant individuals in a political party that you feel we should know about in the context of this hearing?



**Peter Wyman:** I have no declarable interest. I have never been involved in canvassing or in being a member of a local political party organisation. Nobody has ever asked me this before, but, to be totally transparent, I am a member of the Conservative party and always have been—not always, but for many years—but that is a private matter as far as I am concerned. It has had no bearing ever on anything I have done in public life. Up until this moment I do not think that anybody outside my immediate family, which I think is probably just my wife, and obviously the party that takes my membership, has been aware of that. It is not an issue as far as I am concerned.

**Q21 Paula Sherriff:** Thank you for your candour. Following on from that—and I hope this does not make you feel uncomfortable, but it is incredibly important that we are aware of any potential conflicts, although I am not suggesting that would necessarily be so—have you ever made a donation to a political party other than your subscription or been involved in a decision to make a corporate donation to a political party, perhaps from a previous life, or maybe not, as the case may be?

**Peter Wyman:** I chair a company now called Sir Richard Sutton Ltd. If you look at my CV, it was called then Sir Richard Sutton Estates Ltd. It is a family business. The company has made donations, again to the Conservative party. It is a unitary board and I chair the board. There are three members of the family who sit on the board as non-executive directors. There are two areas involving the independent non-executives, and I leave it to the family's judgment. One is around charitable donations—they give quite a lot to charities—and the other is around political donations. So, yes, I have sat on a board that has made that decision and, of course, legally it was a board decision, but the background was entirely that this is what the family chose to do.

**Q22 Paula Sherriff:** How recent were those donations, so that we can have an idea of what sort of timeframe we are looking at?

**Peter Wyman:** Since I have been on the board, there was one donation and it was made about a year ago.

**Q23 Paula Sherriff:** Thank you very much. Do you have any further financial interests that might be relevant to this position as chair of the CQC?

**Peter Wyman:** I do not think so. The only thing that you will have seen—at least I think you probably saw—from my application letter was that until very recently I was a senior adviser, or that was the title, to a Washington DC-based consultancy, Albright Stonebridge. I resigned from that a couple of weeks ago. I do not think there is any conflict at the moment, but it is not impossible that they would find themselves advising a care organisation, for example, or a private hospital group. Rather than manage the conflict when it arose, I thought it better to resign now so that it cannot arise.

**Q24 Paula Sherriff:** Thank you for sharing that with us. Can you talk to us about your involvement in the work of PricewaterhouseCoopers as external contributors to the CQC's internal audit service? What was your involvement in terms of that contract?

**Peter Wyman:** None at all. I have never in my involvement with PwC had anything to do with healthcare.

**Q25 Paula Sherriff:** Thank you. I have a supplementary question. How would your appointment affect PwC's future involvement in work with, or for, the CQC? Would that conflict you?

**Peter Wyman:** I do not think so. It is five and a half years since I left PwC. As I said, I had no involvement whatsoever in healthcare. If there was a decision to use PwC to do something for the CQC, and that was a recommendation from the executive—it would not be a recommendation from me but from the executive because that is how it works—and the executive says, “We need this piece of work,” and if for some reason PwC were the preferred provider, I do not think I would have a problem with that. It is a little like I was saying earlier about the hypothetical question being difficult to answer.

**Paula Sherriff:** I understand.

**Peter Wyman:** I certainly would not want to be in a position where I personally was wholly reliant on some advice from PwC if that could be portrayed or perceived as being a conflict. But in regard to the sorts of things for which I would imagine the CQC would be using a firm like PwC—and I have no idea if it does at the moment, but if it does—I do not think I would have a problem.

**Q26 Paula Sherriff:** Thank you. Chair, may I ask one further question on the issue around the expenditure, while recognising that Mr Wyman is not currently working for the CQC? I want to change tack slightly, if I may, and ask a question around something I read. I am conscious that everything you read in newspapers is not true—in fact, much of it may not be true—

**Peter Wyman:** You disillusion me.

**Q27 Paula Sherriff:** I would like to garner your opinion on an article and understand how you would address this issue. There was a recent newspaper article, as recent as last month, November, which talked about how the CQC had spent four times their £1.1 million budget for travelling and meals—subsistence, if you like—including an £80,000 hotel bill for 18 officials at one single inspection. Clearly, it is absolutely imperative that the CQC is seen to be providing value for money and value to the taxpayer while carrying out what is clearly a very crucial role. How would you address this if you were the chair? I am not apportioning any responsibility for what has happened previously on you.

**Peter Wyman:** This is where having a chair who is an accountant could be a good thing. I read the article as well and I clearly thought about it quite a bit. I guess, but I do not know, that this was to a community provider. Certainly in Somerset, for example, the community provider has—I forget the exact numbers—seven or eight community hospitals as well as a number of other places it operates out of, treatment rooms and so on. So if you are going to inspect all of those in one go, you are going to have quite a large number of people. Ditto for a big hospital: you are going to have people on different wards with different specialties and so on. If you are going to have those sorts of inspections and if you are going to have expert, trained people, they are going to have to travel and it will be more efficient for them to stay in hotels than to be trying to travel daily from wherever they live.

**Q28 Paula Sherriff:** Absolutely. I do not think anybody would resent them staying in hotels. When you look at the details, some of these hotels have been £300 a night and it is a case of whether that is appropriate expenditure.

**Peter Wyman:** Absolutely. First off, I do not have a problem that there are hotel bills and I think the four times over the original budget is probably a reflection of the fact that these inspections are bigger than originally planned. The second question—and I think probably where you are trying to get to—is whether this is properly controlled: are they, as an organisation, buying hotel rooms at the most effective price? Are they using their purchasing power, or the Government’s purchasing power, because I think there are arrangements across government? Are the people organising individual inspections controlling it? Is there a proper budget? Are the places they are staying appropriate, because if they are £300 a night there has to be a very good reason why they are there. To be fair, there could be, although I cannot readily think what that would be.

**Paula Sherriff:** Possibly.

**Peter Wyman:** One thing I would be looking at—and there are many other areas of expenditure, though, as you say, this is the one that hit the newspapers recently—is the audit committee, the internal audit, to look at the efficiency of the organisation. Where is it spending its money? Is it spending it effectively? I come back to two points: one, it is going to have less money in the future to spend; and, secondly, every pound it spends is not a pound being spent on the front line. These sorts of things are very important. They are also important because they undermine people’s confidence in the organisation.

**Paula Sherriff:** Absolutely, yes.

**Peter Wyman:** It is a money thing, but it is a broader thing as well.

**Paula Sherriff:** Thank you very much.

**Q29 Andrew Percy:** I am still recovering from the bombshell that not everything I read in the newspapers is true. I do not know if I can get over this fact. You will be aware of your predecessor’s approach to the job. Do you have any comment on where you think your approach will differ from his and which of his priorities you will be carrying forward?

**Peter Wyman:** I am not sure how different it would be if David were chair for the next three or four years. It would be very different from the time when he became chair and the organisation was, in his own words, not fit for purpose. There was a massive turnaround that he had to oversee and, fundamentally, rebuild the whole organisation. That journey is not complete—there is still more work to do—but it is substantially done. The challenges for the next few years, as I was saying earlier, are more about completing that task but then asking what the future is—future models of care, use of technology and new types of inspection. That is where a lot of my focus will be.

I come back to the silos. A different set of silos are Monitor, TDA—now NHS Improvement—NHS England and the CQC. How can those bodies work much more effectively together? One other point about cost—and people always think about the cost of the CQC—is that there is at least as great a cost, and actually perhaps a greater cost, in the organisations that we are inspecting. I know that for Monitor we in Yeovil—Yeovil is quite a small district hospital, not a mega teaching hospital—employ the equivalent of a

senior financial manager in just transcribing financial data into spreadsheets for Monitor. It is actually spread over two or three people, but it is the equivalent of one. That is expensive. Then we will be doing the same for NHS England and something slightly different for the CQC. That is not the modern world. That is not how data should be accessed. That is something for the three organisations to work together on, with the provider community, to say, “How do we arrive at a common set of data that each organisation can access that does not require masses of manual manipulation so we can reduce the burden that we put on the provider community?” That is quite a big priority going forward and working across the other organisations to share intelligence better.

In recent years, the CQC has just hit everything. I know there are some intelligent monitoring processes going on, but essentially the approach has been to go in and blitz everything. I do not think that is sustainable in the future. Even if money were no object—and clearly there are financial constraints—that is not what should be happening. How can those organisations work together to make sure that the effort is put where it is needed, to go back to the earlier question about how, therefore, you can guarantee patient safety by sharing that information?

**Q30 Andrew Percy:** I was going to ask you what you thought the biggest priorities were, but it sounds, from your answer to that and your previous answer, as if there is not one single priority but a range of priorities. Something we have not talked of a great deal—and when we had the pre-appointment hearing with David Prior this was something we pushed him quite hard on and on which he was very open with us about the way he thought the CQC had been failing—is public engagement and public understanding of the work of the CQC and post an inspection, what that means. What is your view on where we are at now and what improvements do you think are still required on that front?

**Peter Wyman:** I am not sure the public really do understand. Coming back to not believing everything you read in the newspapers, there was an inspection a little while ago at my local community provider, not my hospital. When the CQC does an inspection, it has an open meeting so that people from the public can come along. There was a big thing in the local newspaper saying, “Come to this open meeting,” but the picture was of the local acute hospital, which is run by a completely different organisation. Not even the local newspaper understood what was going on. So there is an education job to be done.

**Q31 Andrew Percy:** How are you going to do that? The CQC said it was one of its priorities three or four years ago and not much has changed. I do not think public understanding in my constituency is any better now about what the CQC does. It is probably slightly better, if I am fair, because people do seem to understand there is an inspection regime, but I do not think they know how to access it or even what the outcomes are following it.

**Peter Wyman:** One thing I would like to do is make sure there is a much earlier indication of the findings so that when people are aware there is an inspection, pretty soon after that, there is an indication of what was found. Clearly, there has to be a moderation process and you have to make sure that every comment that is made is justifiable and accepted by the people you are commenting on, but it should be possible to come to an overall conclusion—a traffic-light system, you know, with maybe not the full ratings but whether it is red, amber or green, or something like that. I need to talk to the CQC inspectors and

others to see what we could do, but I would like something to be out very quickly—a matter of weeks after the inspection, if not even quicker than that—so that you start to build up a head of steam: we are going to have an inspection, everybody knows that, and comes to the public meeting, and very quickly after that there is an indication of whether it is a good or bad outcome.

There is a danger in what I am about to say, but, in principle, I would like to make sure that things are very visibly displayed within a surgery waiting room, a care home or in different parts of the hospital. The danger is simply that there are an awful lot of other things that people require to be displayed so there could be an information overload. But again, coming back to technology, why is there not a smart screen that just has information revolving around—some hospitals have this, though lots do not—with one of the things that revolves saying, “We were inspected by the CQC and this was the outcome”? If you said you were inspected in 2015 that could still be being played in 2017, but at least it reminds people there was an inspection and that these were the outcomes. There is a lot around that.

**Q32 Andrew Percy:** What about other inspection regimes elsewhere in the public services? I hate to say this, as a school teacher, but Ofsted is pretty effective in terms of public understanding, with schools knowing what it is about, and the local media and everybody else know what the inspection regime is. We raised this a few years ago. Is there value in pursuing that?

**Peter Wyman:** The parallel is that people are aware of how a school has been rated by Ofsted when they are thinking of sending their children to the school. I would guess that most constituents who do not have school-aged children will not be familiar. They will be in the newspapers and there will be some—

**Andrew Percy:** I disagree on that.

**Peter Wyman:** As a sample of one, when my children were at school I was very aware; when I was chairing the governing body of the school, I was very aware; I could not tell you today which are the really good schools and the less good schools around where I live because I do not have children of school age. My point was—you are obviously not agreeing with me—that if it is the case that the people most likely to know the ratings are the people who are thinking of sending their children to school, transfer that into hospitals, care homes or GPs. It is about the people who are accessing the services. If you can make it very visible to them, you have gone a long way there. I am not overly worrying about the rest of the population who seldom, if ever, access those services.

**Andrew Percy:** We will look forward to hearing about your progress on that when you come before us for an accountability hearing.

**Peter Wyman:** Noted.

**Q33 Andrew Percy:** My final question, if you are appointed—I am pre-empting everything—is around care homes, which again was another issue we raised with David Prior. It is not only care homes, but where you are dealing with a patient base that may not have full capacity it is more difficult for users to understand the results of your inspection.



Particularly with friends and family, or where people have no family, what is going to be your approach to how we improve what we have seen with a lot of inspection? I get them flagged up in my patch and it is always care homes where there are failings that seem to be coming out; the emails sent to us are always very useful as local MPs because it allows us to pursue them further. What is going to be your approach on care homes? Something clearly is not working here. David Prior, in his pre-appointment hearing, accepted that, and I would say, a few years down the line, things still are not working in care homes in terms of inspection and people understanding what is to be done afterwards.

**Peter Wyman:** Again, I have not been inside the CQC so I have a level of knowledge at the moment that is no more than my reading, but my understanding is that the approach to the inspection has improved but it is quite difficult. What needs to happen much more is the communication of the outcome of the inspection. Your point about a lot of the people not having full capacity is about writing, I think, to family, carers, children, or whoever it is—the immediate family members. It is also about having clarity as you go in through the front door. There needs to be a sign, “We were inspected by the CQC. These were the findings.” It is much more difficult just because of the small nature of the organisation. It is quite hard in a big hospital to hide things; there are just so many people. In a small home with six or eight rooms, we know from some of the inspection reports that I have read that it was all fine on the day of the inspection, the rooms were properly heated, everybody got water, everybody was smiling, and the next day it was completely different. So I think it is quite challenging. As to how we tackle that beyond what has already been done, I am going to have to come back to you at a future date.

**Q34 Andrew Percy:** That will be something you will prioritise.

**Peter Wyman:** It is really important. The risk in the care home world is an economic risk now as well. If the organisers try and pare back on what they spend, the risks of poor care will be greater than ever. It absolutely is a priority area.

**Q35 Chair:** Could I ask a question now about how you are going to ensure your independence from government and ensure that that is transparent to everybody looking in from the outside?

**Peter Wyman:** I had a meeting with the Secretary of State as the final part of my process before coming to you today. He and I had never properly met and he was obviously trying to suss whether I was up to the job, but my absolute question to him was, “Can I have your assurance that you regard the CQC as being independent of government in terms of the outcomes?” I got exactly the response I was hoping for. Obviously, Secretaries of State can change and things can happen, but that was the starting point. Secondly, my whole professional upbringing has been about independent reporting. I have had one conversation with each of the three inspectors since I was the Secretary of State’s preferred candidate—I think that is the language—and they are all totally focused on this independent reporting without fear or favour. Quite honestly, if there was ever to be any attempt to change the independence of the reporting, the whole of the CQC process would be invalid. It is something that I hope is another hypothetical, but were it ever to happen you can be absolutely assured that I would resist it. That would be a line in the sand. It is fundamental that we must be able to report what we find.

**Q36 Chair:** You can assure us that you would speak without fear or favour if you found fault. Can I take you back then to that difficult question: what would you do if you were asked to do something that you did not want to do? To give you an example, there has been some concern expressed that it is very difficult for care homes to fulfil their obligations because of a lack of funding. If you felt, as the chair of the CQC, that it was impossible for care homes to carry out their duties because of funding, would that be the kind of thing you would be prepared to comment on?

**Peter Wyman:** It is absolutely one of the things. If it got to a point where it was impossible to provide care of an appropriate quality because of the funding, that is something the CQC should be prepared to say. I would certainly be prepared to say it. It is quite interesting when you read the reports of the CQC—and particularly this recent state of the nation report—that they make clear that funding is an issue, but it is not the only issue, and some organisations seem to cope very well with the funding that is available and others are failing with the funding that is available. It does make the point—and I made it right at the start—that funding is an issue for providers of all services at the moment and there is no getting away from that, but it is not the only issue.

**Chair:** Thank you.

**Peter Wyman:** I will say it and I have said it.

**Q37 Chair:** How big a priority for you is governance? You talked about governance and your experience within governance in your opening remarks. How far do you think that is going to be a priority for you if you are taking up the post?

**Peter Wyman:** Governance of the CQC is paramount. This is about allowing the chief inspectors the independence that they have but managing it within a system, which is the board of the CQC. So the governance of the CQC is really important, how it spends, how it invests, how it deals with all the issues that we have talked about this afternoon—all really important—but then there is governance of the bodies that we are inspecting, which is also very important.

**Chair:** Thank you. You will be relieved to hear that everyone gets a chance to stretch their legs now because there is a Division in the House. We will be resuming shortly.

*Sitting suspended for a Division in the House.*

*On resuming—*

**Chair:** We will press on and resume. A couple of other colleagues may join us shortly. We are going to resume with James's question.

**Q38 Dr Davies:** What would you describe as the Care Quality Commission's core purpose?

**Peter Wyman:** It has two related purposes. Its absolute fundamental purpose is to ensure high quality, safe, effective, caring and compassionate care. The secondary purpose, which is linked to that, is to encourage improvement. It is not an improvement organisation, as such, in that it is not going to go in and do the improvement, but it is very important, as I was saying earlier, that the style of reporting encourages organisations to try and better

themselves. That is an important element. I do not see this as being a static world where you are good, bad or indifferent to care and that is where you stay. Everybody has to get better and the CQC has a role in trying to achieve that.

**Q39 Dr Davies:** How successful do you think the CQC has been, or currently is, in doing that, in achieving its objectives?

**Peter Wyman:** It has not had the greatest start to life, shall we say, but it is getting better. Certainly, in my trust we worry a great deal about what the CQC is going to say. Although there is a ton of bureaucracy, which we rather resent—and one of the things I would like to do is try and reduce that bureaucracy, as I was saying earlier—the things we are being measured against by the CQC are not things that we should not be doing anyway. The encouragement to make sure that there are locks on medicine cupboards, or whatever it might be, is something we should be doing anyway, and if we were not doing it and the CQC comes and encourages us to do that, or the threat of them coming encourages us to do that, that is an improvement process in its own right. The direction of travel is much better. It has quite a long way to go. I hope that, if I am appointed, at the end of my tenure we will have seen a lot of progress. People will not be asking whether this is a good use of money or is effective but will be having discussions about where it goes next, but on a much stronger footing than perhaps today.

**Q40 Dr Davies:** Do you think the CQC's response to the Francis inquiry in the wake of Mid Staffordshire has been successful so far?

**Peter Wyman:** You could say that what it has done is overkill, but it is overkill to arrive at a huge amount of really valuable information. When it has completed its round of new-style inspections, which for hospital trusts will be Easter and for everything else later next year, it has this marvellous starting point. It then needs to be intelligent about how it uses those data to inform where it goes next and how it goes about that. So, yes, it has reacted well and it has a moral influence, if that is the right phrase. We are, as I say in the trust, very mindful that the CQC can come at any time. We are an ambitious trust, our ambition is to be outstanding and I would be mortified if we were anything less than good right across the piece, and so would my staff. That is a driver to ever-improvement of quality. It is doing a lot of things right, but it certainly has a long way to go before we will all be saying, "This is a really effective organisation and it is great."

**Q41 Dr Davies:** I appreciate that you may have touched on some of these already, but what further steps might you take in your position to come to make sure that the CQC is fully delivering on its remit?

**Peter Wyman:** Perhaps I will go back and expand a bit on what I was saying about technology. I talked a little bit about my father earlier on. My father retired from practice—he was a consultant at the old Westminster hospital—35 years ago. If he walked round most hospitals today, most of what he would see he would recognise. Thirty-five years ago, we did not have Amazon, Google, easyJet and we did not have smart phones. The world was completely different, but if you go into most hospitals you see people trundling around with trolleys with loads of patient records on them—lots of things. It is changing, and, as I said earlier, different providers are at different stages of that change. Think about the potential for what all of us can do with the sort of data that should become

available—commissioners understanding the outcomes of what they are commissioning and people like the CQC being able to interrogate systems to understand where, again, outcomes are not as effective.

A lot of regulators across the piece, not just in health, tend to look at inputs. If you have all the inputs right, there is a built-in assumption that the output is okay, and probably that is a reasonable assumption, but a much better and more economic way of looking at things is outputs—outcomes. Because of the disjointed nature of the NHS, you can look at all the inputs in the hospital, in community care and in primary care, and then tick all the boxes and actually the patient is getting a lousy deal because the bits are not joined up. If you looked at the outcomes for patients that would be great, and technology is a big driver of how you achieve that in a cost-effective and proportionate way. There is no one single thing, as I said earlier, but if there was one thing I would very much be concentrating on, it would be the technology piece and how you use that intelligently over the next few years.

**Q42 Dr Davies:** So you are saying there should be a focus on outcomes using technology to gather data that are perhaps difficult to gather currently or have been in the past.

**Peter Wyman:** Yes, and outcomes for patients. Let me be absolutely clear about that: this is not financial outcomes but outcomes for patients. That is where there is a real potential.

**Q43 Helen Whately:** How do you think the CQC could and should evolve in the coming years? You were giving a steer on that in your response to technology and a focus on outcomes. Is there anything further you would like to say about the evolution of the CQC as you would like to see it?

**Peter Wyman:** I am in danger of repeating things I have said in answer to different questions, but there does need to be a much more integrated approach by the three bodies: NHS England, NHS Improvement and the CQC. That is important. Looking at pathways, looking at system-wide activity, rather than just units, is going to be important. Coming into the CQC itself, it is quite a demoralised organisation. An awful lot of people say what some of you were saying earlier: it has not had a great start in life. It cannot succeed unless it is staffed by people who are enthusiastic about what they are doing. The good thing about the staff survey is that almost everybody who works for the CQC thinks that the CQC does an important job. That is a good starting point. If they all thought they were doing an unimportant job, then you have no hope. They think the CQC has an important role, but then, individually, it is only about 35% who feel satisfied in the job that they are doing. So a big focus for me—and again I know there is already a lot of work under way—would be to make sure that over time we have a highly motivated group of people working for the CQC because then you can start to deliver the sort of results that you want from people who are working for you, whereas if they are all demoralised you just get a really bad set of outcomes from those people. That is a big driver for me.

**Q44 Helen Whately:** As the potential technology develops and there is more of a focus on outcomes, do you think the CQC should be bigger or smaller or have a change in its focus? What level of change do you think is likely?

**Peter Wyman:** I may regret what I am about to say—at some future hearing I may be eating my words—but I would think over time it would be smaller, if we really use technology properly, and also there is a massive amount of information that we already have. If the world was not changing, I still think it would be smaller because you would not need to be doing these massive great inspections. But the world is changing, and if we use technology properly we should be able to be smaller still. We may need more higher-skilled people, so you may see a slightly disproportionate reduction in the pay bill from the number of people you are employing. I do not know. Again, until you are inside an organisation you cannot be exactly certain. Overall, it should be operating on a smaller budget, releasing at least some money back into the front line and have a smaller number of people.

**Q45 Helen Whately:** Given the difficulty sometimes of assessing and comparing outcomes between organisations, particularly in some, apart from acute trusts, but mental health and community services—the broader perspective—what is your thought on the feasibility and challenges of this ambition to focus more on outcomes?

**Peter Wyman:** I am sure it is feasible. There is some risk associated with it. If one of your outcomes is that you want people to be able to live independently in the community rather than in some secure institution, from time to time that will go wrong and everybody will be blaming everybody else for how it did not work for that one particular person, whereas it is much safer, from an inspector's point of view, to be able to tick lots of boxes and be able to say, "They have followed all the right procedures." It is riskier to be looking at outcomes, but I am absolutely convinced it is the right thing to be doing. A lot of the outcomes, whether infection, mortality or a reduction in hospital admissions, are important things, partly because it is much better for the patient, and that is ultimately what we are all here for, but, frankly, it is the only way we can ever afford to make the system work.

I am very clear in my mind what type of care and health service we should have and what the public should expect, but it has to be at a price that the public purse can afford. That means quite dramatic changes in certain respects with the way things are organised. The CQC needs to be up with that, and from time to time I suspect it will be criticised because something will go wrong somewhere, but it would have gone wrong anyway. It is not because the CQC was not inspecting it the right way, but you have less defence when you look at outcomes than if you just look at the inputs and you sit there and tick all the boxes and say, "Everything was done as it should have been and the fact that the patient died," or whatever, "was just bad luck. We did all the things we were supposed to do." Outcomes is more difficult, but I am convinced it is the right approach.

**Helen Whately:** Thank you.

**Q46 Maggie Throup:** I want to explore how you anticipate your relationship developing with different bodies. You have answered quite a lot about NHS Improvement, so I am not going to go further down that avenue; we have covered that quite nicely. I want to focus on Healthwatch England. In the light of the fact that the CQC holds the budget for Healthwatch England, but obviously it is specifically for Healthwatch England to spend, how do you anticipate your relationship with the chair of Healthwatch England developing and how do you think your responsibilities should be in relation to Healthwatch England?



**Peter Wyman:** Healthwatch England is very important. Getting that patient voice coming in through Healthwatch is important. The fact that it sits within the CQC potentially causes a problem, but that is how it is and we will have to manage that problem. There will, I suspect, be some debates on budgets. If money is going to be tighter than it has been right across the piece, then we will have to look at whether any part of that pain, if I can put it like that, should be borne by Healthwatch. I do not know. Again, I am not inside the organisation, but I hope that the chair of Healthwatch England and I would have a suitable relationship, and indeed the whole board. I know I keep coming back to this, but, ultimately, everything that happens within the CQC comes from the board. If you have a really effective board, then these issues will be dealt with in a sensible and grown-up way. There may be some tensions—there will be tensions in any organisation—but, fundamentally, we will manage those through an effective board. I will just go back and say that certainly I—but, as far as I know the whole of the CQC—recognise the importance of capturing that patient experience and patient voice through Healthwatch.

**Q47 Maggie Throup:** But if the budget for Healthwatch England has been allocated to be a set amount and it has been safeguarded for their use, do you think that relationship with the chair of Healthwatch England will be a good one if they fear they are going to pinch bits from it?

**Peter Wyman:** Their budget is their budget and it is not pinching bits from it, but if the Government say, “CQC, you have a 25% reduction in your budget and we are not going to ring-fence elements of that,” then there has to be a discussion across the whole piece as to where the most effective use of the resource is that the CQC is allocated by the Government. I would expect the chair of Healthwatch England to engage in that debate with the rest of the board in a mature way.

**Q48 Maggie Throup:** But that budget is meant to be safeguarded by the CQC.

**Peter Wyman:** So long as that is the order of things then it is safeguarded, but I am saying that if at some future date—we are living in a different world and we are living in a world where there is going to be a lot less money available to bodies like the CQC—the Government are prepared to say, “Right, that amount of money goes to Healthwatch England and that is safeguarded, and your reduction comes out of the rest of your budget,” that is fine, but if it is a 25% reduction, it is 25% of the budget that is not ring-fenced, if you like, rather than 25% of the whole. If the Government say, “25% reduction. You, CQC, need to decide among yourselves where the remaining budget is most effectively used,” that is the discussion with Healthwatch England. I am absolutely not saying that I will come in and try and undermine Healthwatch England, cut its budget or do anything like that. I am trying to say that, if in the real world those discussions are needed, they will happen in a mature way. That is what boards are there to do.

**Q49 Maggie Throup:** Is safeguard the right word? Is that going to protect that budget?

**Peter Wyman:** I am not exactly sure what the existing commitment is. It is something I would need to find out. I do not know whether it is a ring-fenced amount and there is no discussion about it, and that is what the Government have decided, or whether that is a matter for the CQC board. I really do not know—I am sorry; but if it is clear that that is

the amount of money that the Government have allocated to Healthwatch England, then that is the money that goes to Healthwatch England. If the Government say, “This is the money for the CQC. You guys decide how it gets allocated,” then that is a board or a CQC discussion. Which it is I am afraid I just do not know; I am sorry.

**Chair:** Thank you. For the final group of questions, we move to Helen.

**Q50 Helen Whately:** One of the things I have found in contact with trusts that have had a bad CQC report is that, although it has been very helpful in flushing out the problems, there is a feeling that in the blanket judgment they get from it—that this trust has essentially failed an inspection and needs to go into special measures—the positives get lost with the consequence that the morale of all staff is knocked. Do you have a view on what could be done about that?

**Peter Wyman:** Yes. I hear exactly what you have said and I can absolutely understand that. As I said earlier, people are very proud of the service that they provide, and if their bit of the organisation is providing a good service, the fact that, overall, for some reason, it is getting a really bad rating is going to cause a lot of upset. It is about communication first off. We are not good at getting across the message that different services, different wards, or different whatever are rated differently. If you look at the grid that the CQC publishes in its report, I could be in a part of the hospital where everything is green and I would be proud of that; overall, the hospital is deemed to require improvement, so I am not very happy about that, but my bit is looking pretty good. I think it is that, somehow, that message does not come out.

More fundamentally, and in anything other than the short term, it is about going back and giving the trust the opportunity to improve, and having different parts of the system hopefully working with the management of the trust so that it does improve, and then being able to go back quite quickly and say, “We inspected the bits that we were unhappy with. They are now excellent,” or better, or whatever, and so they are moving the ratings up. As I said earlier, success to me would be a situation where everything is rated good or better and we need to try and work towards that end, absolutely not by lowering the bar but by seeing standards improve.

**Q51 Helen Whately:** I take your point about re-inspection, albeit that it might take quite a long time to improve some of the things. From trusts in trouble that I am familiar with, it takes quite a long time to resolve whatever it is that gave them their bad CQC rating. There still could be a case for looking more specifically.

**Peter Wyman:** I think both of those, but I also think there is a risk of trust leadership using the CQC as an excuse for its own failings. I see it is as the responsibility of the leadership of my trust to make sure that our staff are well motivated, well informed and understand what is going on. That is my responsibility. If we had—and I sincerely hope this is not the case—a really bad CQC report, I would be in overdrive about making sure that those parts that had come out well of the CQC inspection understood and felt good about what they were doing, while, obviously, equally being in overdrive about trying to improve the bits that had not. It is a management issue. Most things that do not work come back to poor leadership and poor management. A lot of the onus on the trust falls with their own leadership.

**Q52 Helen Whately:** Thank you. Earlier, you were quite clear that you understand the burden of a CQC visit and the cost of regulation on acute trusts. Do you have a perspective on the burden on GPs, how to get the balance right between the need for transparency and the quality of GP services as against what we have heard from speaking to GPs, which is how difficult it is when a large team comes in and that they may have repeat inspections because they are training practices? So they have several different inspections. Do you have a view on that?

**Peter Wyman:** If I step back a little, I am concerned—this is nothing to do with CQC inspections—generally about the burden on the smaller GP practices. It is hugely difficult to have a really demanding clinical life and run your own small business—actually not that small, quite often. Even the smaller GP practices are not necessarily that small, so having an inspection hitting you at the same time as all these other things is very tough. Part of the answer, I think—and it is much wider than just the CQC—is about looking at how GP practices organise themselves to share that burden differently. As I say, that is not with a CQC hat on; that is just from what I observe we are trying to do in south Somerset in trying to support our primary care colleagues in different ways and join up what we are doing. They are silly things such as why does every part of the system have a separate payroll and separate this and that, and can we not take some of the burden off some of the small practices by economies of scale? It takes two to tango. They need to want us to do that, but this is about back office and administration and stuff. If you could do that, it would give them a bit more capacity to manage things like a CQC inspection. That is my starting point.

I am not close enough yet to know whether the CQC inspection process of general practice is overly burdensome at the moment. I have read probably much of what you have read as well and certainly that is one of the messages that comes back from primary care. Whether it is valid or not, I do not yet know. Going forward, I would hope that what I was saying about trying to reduce the burdens on the big hospital trusts in a different but similar way can apply to general practice. You will not need to inspect those that are doing really well in the same way as those that are failing, but if they are failing then we do have a duty to do something about it. It may be burdensome, but we cannot just walk away and say, “Bad luck. You are failing your patients, but we do not want to be a nuisance.” There has to be that balance.

**Q53 Helen Whately:** I am with you on that. The country is trying to move more care out of hospitals into community settings, primary care and people’s homes. Arguably, it is much easier to inspect acute trusts and make sure that they are doing what they should on quality. Do you have a view on the challenges there will be to regulate the quality across a more dispersed health system?

**Peter Wyman:** It comes back to what I was saying about needing to find ways to inspect pathways and local health systems. It is much more difficult, but again you look at outcomes: a good outcome is reducing hospital admissions and reducing the length of stay. Obviously, you need to look at all the other outcomes to make sure you do those things safely and in the patient’s interest, but, in principle, nobody should be in hospital other than for the period of an acute episode. Nobody wants to be in hospital longer than necessary. If they are able to get back into their own home or their normal place of residence, that is where they should be. Lots of different things are going on to try and

achieve that. The CQC is going to have to learn to inspect in a way that looks at the effectiveness both of that happening, because that is a good thing in itself, and to make sure that the medical outcomes, if you like, for those patients, are not being adversely affected. Hopefully it is quite the opposite—that they are being improved.

**Helen Whately:** That makes good sense. Shall I move on to the financial questions, Chair?

**Chair:** Yes. We should be getting on.

**Q54 Helen Whately:** What is your view of the financial position of the CQC? It would be helpful to have your view as an accountant on that question.

**Peter Wyman:** Where do we start? There is an interesting debate about how much of the costs should be borne by providers and whether that ensures the independence of the CQC. In another life, I frequently heard the arguments that, if the people being regulated were bearing the costs, it diminished the independence of the regulator. We saw that very much in some of the financial regulatory areas: if the banks were paying for the regulator, were the banks diminishing the independence of the regulator? There is an interesting set of discussions around who pays and, whatever the answer to that is, either way, absolutely, the answer to the earlier question is that you have to guarantee the independence of the CQC. There is an interesting discussion about what resource should go to the CQC. Again, I am sorry if I am repeating myself, but I think it is important that the CQC is effective and has the resources to be effective, but every pound that is spent either by the CQC or on servicing the CQC is a pound that is not being spent on the front line. So there is a whole series of discussions around that. I would expect the Department to be quite challenging on the amount of money the CQC has and to be able to demonstrate both to you and to the Department that it is using those resources effectively. It is the world we live in today and we all have an obligation to be as cost-effective as possible. That is both words: you have to be effective in what you are doing as well as doing it as cheaply as possible.

**Helen Whately:** Thank you.

**Q55 Chair:** Does anybody have any further questions? No. Thank you very much for coming today, Mr Wyman. Is there anything else you would like to say to us before we finish?

**Peter Wyman:** I should have thought that you might ask that and I did not. I would like to say thank you for today. If you do confirm the appointment, I will be absolutely delighted because this is a role that is very important and that I would very much like to do. Either way, thank you very much for your time today.

**Q56 Chair:** Thank you for your time and your patience with the interruption as well. We appreciate that.

**Peter Wyman:** Thank you very much indeed.