Transcript of Radio Ombudsman #18: Ian Trenholm, Chief Executive of the Care Quality Commission on integrity, curiosity and effective regulation

Ian Trenholm, Chief Executive of the Care Quality Commission and Rob Behrens discuss the big issues affecting health and social care. Ian explains why integrity and curiosity are vital for effective regulation, and tells us why the thinks the Complaint Standards Framework will make the NHS complaints process better for everyone.

Rob Behrens: Hello. This is Rob Behrens here, welcoming you to a great edition of 'Radio Ombudsman'. My guest today is Ian Trenholm. Thank you very much for coming, Ian.

Ian Trenholm: Hi Rob. It's good to be here.

Rob Behrens: We're very lucky to have Ian. He's a distinguished public servant, with a remarkable record of leading a number of important agencies. He's been Chief Executive of the Care Quality Commission since August 2018, and previously, he was Chief Executive of NHS Blood and Transplant. Before that, he had a range of jobs, including Chief Operating Officer at the Department of Environment, Food and Rural Affairs and roles in local government, I think the Royal Borough of Windsor and Maidenhead, and Strategic Director for Resources at Buckinghamshire County Council.

You've served in the Royal Hong Kong Police Service. I wonder whether it was as exciting then as it is now. But you then moved to the Surrey Police, before going into the commercial sector. So a formidable range of experience. You have a degree in geology from Goldsmiths College, London and an

MBA from Durham University, so that's very impressive and we'll ask you a bit more about it.

But could you start off, as we always do, by telling us a bit about where you were born, your background, and what values you were brought up with?

Ian Trenholm: Okay. Thanks, Rob, yes. I was born and brought up on the Wirral, in Merseyside. I think I was always brought up, I suppose, to see things in a very straightforward way. My parents were very good at instilling, in me and my three brothers and sisters, the values of honesty and fairness. As I progressed through school and onto university, I think those values were something that stood me in great stead.

I'd always been thinking about joining either the military or the police service, so when I left university, I went out to Hong Kong. Again, I think this was all about me playing into my core values of wanting to do something decent for the public. I felt I had a good upbringing. I had a really, really decent upbringing, and I felt I wanted to make a contribution to society, in the broader sense.

But obviously, at 21 years of age, you don't really know what that is, so I went off to Hong Kong to do something that I thought was exciting, and it was. Whether it was as exciting then as it is now is a whole other debate. But certainly, I saw the importance of that honesty and fairness thing, but I also saw that, as a police officer, you get the privilege of dipping into people's lives and seeing, often, the dark underbelly of what's going on. Quite often, you see things which are not always as they may first appear.

So again, I think it was a really useful experience, on my part, to be able to understand how people think, some of the challenges that people lead, and the really difficult lives that people lead. Certainly, in Surrey, in particular, what I saw was, as a police officer, you would turn up at someone's house at 2 o'clock in the morning and you'd see an event happening, but that event was driven by a series of other events, where the local council, perhaps, hadn't been able to help someone, where Social Services weren't where you wanted them to be, or even a long-term health condition, particularly a mental health condition, where the person was not being looked after.

So it gave me that sense of wanting to see public services in the broader sense. So that's really what set me off on the rest of my career, around trying to work out what contribution I could make to gluing together public services in a way that made sense for people's real lives.

Rob Behrens: Would you say your career, since the time you left the police, has been planned?

Ian Trenholm: Oh God, no. I don't think so. I think what I've tended to do is to say, "Well, what's important to me? What are the things where I can add value, versus what are the things I would never consider doing?" So there have been times when people have talked to me about jobs and I've just thought, "Yes, but I don't think that job would be consistent with my values and what I actually want to do," which is why I've been largely drawn back to the public sector type roles.

But I think my career has been quite opportunistic. There have been things that I've known that I've been interested in, and I've started to pursue them in every one of the jobs that I've done, and that set me up for the next step. So I think, to a large extent, it's been pretty opportunistic.

Rob Behrens: So you've held leadership roles in lots of different sorts of organisations. We've heard a bit about local government, central government and arm's-length bodies. You've now been at CQC for around a year-and-a-half or a bit more. How does this experience compare with your previous leadership roles?

Ian Trenholm: I think a lot is the same and a lot is different, as you would expect. I think CQC is a large corporate organisation. We employ nearly 3,500 people, and we have a complementary workforce of experts by experience and specialist advisors that number at least another 1,000 on top of that. So it's a large corporate organisations, and I've lead large corporate organisations before. So with that, comes all of the things that you would expect, and all of the challenges of leading a large corporate organisation.

But I think the big difference with CQC, being a regulator, is that, sometimes, people aren't pleased to see you, and they will…

Rob Behrens: I know the feeling.

Ian Trenholm: Exactly. You will know that feeling. I think, sometimes, you have to have those difficult conversations with other organisations, or with individual providers, in our case, and sometimes, with members of the public, where we have to tell them that we can't do what they really want us to do, either because we don't have the legal powers, or because we don't think it's the right thing to do. That can be quite difficult.

I think I often compare what we do, as the CQC, to going to eat in a restaurant. When you walk into a restaurant, you don't sit down and interview the chef; you just sit down and eat whatever comes out of the kitchen. You assume it's going to be safe and you're not going to get food poisoning. In health and social care, you pick a provider, and you assume that somebody, i.e. the CQC, has certified that it's going to be okay.

So the sense, for me, is that a lot of the positive work that we do that people passively consume isn't ever really seen. So I think that's quite an important difference. Whereas in most other organisations, when you're doing work, the positive side of things is more frequently seen, I think it's much more difficult to see when you're a regulator.

Rob Behrens: How important is it to have a public profile, as the CQC, as a regulator?

Ian Trenholm: I think it is important to have a public profile, because I think where people do see themselves as having a genuine choice- Most people will register with their local GP, and won't perceive themselves as having a choice around their doctor.

They probably have more of a choice than they realise. The same is true in hospitals. But certainly, in social care, in particular, I think if you've got a relative and you're looking to place them into social care, in some way, that's a really difficult, emotional experience. Certainly, we, as a family, have been through that a few years ago.

I think having an organisation whose viewpoint you trust is an important part of that, so at least you can feel that going through this really difficult decision, you're doing it with the best interests of your loved one at heart. I think the CQC having a public profile is an important part of that mix.

Rob Behrens: Trust is a key issue in public service, and it's at least about competence and about transparency and honesty, and all those feature in what you have to do, I imagine.

Ian Trenholm: Very much so. I think we talk to the providers that we regulate and we talk about them having a duty to be candid with the people that they serve, and sometimes, people can find that hard. But our view is that that candour and that transparency means that they, as an institution, can learn. But I think probably, more importantly, that that learning is shared across the different sectors. Because an important part of what we do, as CQC, is, we protect the public, in terms of safety and quality of care, but we also promote improvement.

It's something which people don't often talk very much about, but I think promoting that openness and transparency in providers helps promote improvement in a really powerful way.

Rob Behrens: The CQC regulates one of the most sensitive and challenging areas in British public life. What does that mean, in terms of challenges, for your organisation?

Ian Trenholm: I think we've got a number of challenges. I think one of them is to make sure that we can differentiate between the emotional side of the way health and social care is delivered and, if you like, the technical side. I think there's something about keeping those things in balance. But we sometimes find that if we are taking enforcement action against either a care home or a GP, or even a hospital, we'll actually have people complaining to us about us not knowing what we're doing, because they had great care when they went. Therefore, they can't understand why we would be seeking to close down a care home when they had great care.

So one of the challenges is to make sure that we can recognise that public viewpoint and balance it off against that, if you like, more technical viewpoint. So I think that's one of the challenges, but I think there is this sense that when you work in health and social care, you start working in that environment because you care. People's core values are pretty decent. Then someone like us comes along and says, "Well, actually, you're not doing a terribly good job," and that can be a really difficult message to get right.

So I think messaging that in a way that people take it in the spirit in which it's meant, and then they, themselves, can then say, "Right, okay, how do we learn? How do we improve?" That's particularly acute, I think, in social care, where we'll be talking to people who, perhaps, have spent the last 20 or 30 years building a business, and it might be

just a couple of partners who are pulling it together, and they maybe have one location. There comes a point when we arrive and say, "Actually, you're not good enough," and they find that very, very difficult, personally.

So trying to get people to move away from that personal side of things and look at it a more dispassionately is really tough. I think it's something which is just hard to do.

Rob Behrens: Is it important that the people who work for you have had experience in the area that they regulate?

Ian Trenholm: I think, generally, yes. I think what we tend to do is, we split our organisation into, broadly, three areas. One is around primary medical services, which includes dentistry. We have hospitals and we have adult social care. So generally speaking, the people that work in each of those areas have worked in those areas beforehand. Although increasingly, I think, the experience we're having with our methodology suggests that people can, with a bit of training, move between areas, and sometimes, we put together joint teams.

But I think we're increasingly seeing that one of the bigger challenges for the health and social care system, generally, is this notion of systems and how systems come together. We're finding that, when we talk to the public, they're often much less interested in talking about a single institution, and much more interested in talking about their ability to access care, and how they transit across the health and social care system.

So having inspectors that have got some experience of working in regulating GPs and some experience in hospitals

and some experience in adult social care is going to be increasingly important to us, I think. Because I think we're more and more interested in how individual providers are working and collaborating with each other than simply operating in a series of silos.

Rob Behrens: It's interesting that your mandate includes both health and adult social care, whereas my mandate doesn't include adult social care, which is a nonsense, because the two are so intimately connected. So we've got a lot to learn from your mandate.

Can we just talk a bit about Whorlton Hall?

Ian Trenholm: Hmm.

Rob Behrens: You recently published one of the reviews around CQC's actions related to this organisation, the learning disabilities facility in the Northeast. We know that a 'Panorama' investigation uncovered abuse of patients. This review has looked at how CQC handled an internal whistle-blower who complained that their concerns about the service were being ignored. This was obviously a very challenging issue for you. Can you tell us a bit about how you've responded to that scandal?

Ian Trenholm: I think the first thing to say is that I think we were all devastated and really disappointed with what happened at Whorlton Hall and how the fact that our regulation just didn't catch what was a terrible set of events. I think when we look

at the regulatory history – and we've actually got two reviews, one of which was published in January, and the other one will be published in the next few months – they do expose the real challenges of visit-based regulation. At its heart, our regulation involves us looking at intelligence around an individual institution, and then physically visiting and seeing what's put in front of us.

What we find, particularly in close locations around mental health, but also learning disability and autism, which is what Whorlton Hall was, is, it takes five or ten minutes to get through the door. As we walk through, we are clearly identified as CQC inspectors. It would be naïve to expect that people are being abused in front of us. So we then have to go through a series of conversations with members of staff and with patients.

I think it's particularly difficult in environments with learning disability and autism patients, because some of them are non-verbal. So getting to the bottom of what's gone on can be quite difficult. But I think we have learnt a number of lessons over the last year in particular, around making sure that our inspectors are really well briefed in terms of what they're looking for, and that all of the learning that we've got is distilled in a way that inspectors know what they're looking for. We're looking, also, at the intelligence that we gather, and looking at that, probably, in a bit more detail as well.

The challenge that I think we continue to have about a visit-based methodology means that it is quite difficult to get to the bottom of some of these things. When we reflect on what Panorama did, they had an undercover report in Whorlton Hall for a number of months. That reporter watched what was going on a number of times. Some people have said, "Well, why don't you put undercover inspectors in?" I think we

could, but I don't think it would've actually exposed Whorlton Hall. What it would've exposed was one individual.

Because as soon as one of our inspectors sees abuse taking place, they would have to step in and stop it. I certainly wouldn't want any of my team knowingly allowing abuse to take place. Whereas I think, with journalists, they're trying to make a programme. Their starting position is quite different.

But when we get right down to this, I think the thing that we've been saying for a number of years, and continue to say, is, these locations are just not fit for purpose for people with learning disabilities and autism. People are spending too long in these services, and the lack of community services is meaning that there isn't an alternative place for people to go. So what we've seen is patients in these services who, last week, were living at home. They go into crisis, and they go straight into a closed environment. That's a very difficult environment for us to regulate.

Really, what we'd like to see is a change in commissioning behaviour, so the patients, as they start to need more and more support, that's available, closer to home, for them.

Rob Behrens: I've just come back from a working visit to Canada, where some of the ombudsmen there have powers to go into organisations without notice, and even without permission. So if they're not welcome, they can still go in. Do you have that power?

Ian Trenholm: We do. I've got a warrant card in my wallet that enables me to enter any health and social care location and demand

records, in essence. That's the basis of entry for our inspections. An awful lot of our inspections are unannounced and will be based on intelligence. So if we get somebody who contacts us – perhaps a member of staff, or perhaps a carer or family member of somebody who is a patient – we will go in and look at what's going on. We did exactly that, actually, at Whorlton Hall.

So we have that power, but again, it's a question of where you've got occasional harm being committed, or you've got individuals who are actively seeking to thwart our regulation, that can be an incredibly difficult environment in which to try to regulate.

Rob Behrens: I think that was one of the most shocking things about the Panorama programme, that people were talking about how to avoid your regulation. That's not impressive, and it adds to the difficulty in which you have to operate.

Ian Trenholm: It does. I think, when you look at what we've done subsequently, we've done an inspection of the provider themselves and looked at their governance structures. Sometimes, we are criticised for being overly interested in governance and the way organisations are run, and overly interested in leadership. But the reality, I think, is that a really well-run organisation with clear, solid governance has fewer problems.

I think this whole issue of, "How important is leadership?" is something which we've always thought was important, but I think we're increasingly of the view that if leaders are setting the right tone of voice in the organisation, the chance of

recruiting and retaining individuals who are going to do bad things is much reduced. I think that feels, to me, like it's something we need to continue to do, and it's a really important part of what we do, even if it isn't necessarily always welcomed by providers.

Rob Behrens: I think one of the issues about this is that you're not on your own. It's not all your responsibility. There are more regulators in the Health Service than I've had hot dinners. We're not short of regulators. But in order for it to be effective, it all has to be joined up and organisations have to share intelligence. So it's no good just talking about one body. It's a whole machine that has to work together. I don't think we've been terribly good at that.

Ian Trenholm: Yes and no. I think there's definitely work to do on that, but I do think that the relationships that we've all built with each other over a period of years are, actually, relatively effective. There are still times and places when things don't work out. I think the issue, possibly, from a public point of view, is that if you're a member of the public and a thing happens to you, you're not terribly interested in whether this is the General Medical Council or the Nursing and Midwifery or CQC, or whatever.

I think we sometimes find that people will complain to us, and we'll say, "That's very interesting, but it isn't really us, it's someone else and someone else." I think that's when the public can get frustrated, and ultimately, I guess, Rob, end up with you, where we've not been able to help them, or we've not been able to help them on all of what's been said.

Because we don't do investigations of individual complaints, but people sometimes think that we should.

So I think there's something about the way the different regulators have been set up, which probably, sometimes, doesn't help us. But I think we have got relationships, now, so that if somebody complains to one of the other regulators and they think the issue is for us, they'll, in some cases, warm transfer that person. If they're on the phone, they'll actually just directly transfer into our contact centre, and we can pick it up and help them.

So I think we're getting better, but I'd agree. I think, as ever, are we delivering the absolutely slickest service for the public in the round, as a collective of regulators? Probably, not yet.

Rob Behrens: Could we just talk a little bit about our relationship as two different institutions? You're a regulator. I'm not a regulator; I'm an ombudsman. Do you think there's a tension in our relationship because we have to do two things? We have to hold you to account as a body and jurisdiction, but we also have to work together to drive improvements. I think it's possible to work that, but do you think that is the case?

Ian Trenholm: Yes, I think so. There have been times when we've not had the same point of view on a particular topic, but equally, I think we've got a professional relationship. I think we can't look each other in the eye and demand high standards of integrity if we're going to let personal disputes get in the way. So if I look at, if you like, the nett position, I think we've done a lot more together than we've disagreed on.

Certainly, within my organisation, if we do start to get into a conversation around something where we might disagree, then we will look internally and say, "Well, okay, what's the PHSO's perspective on this?" to try to see that other perspective.

And I think this probably also applies to some of the other regulators. GMC and NMC are another group that we work closely with, and of course, they're going to have a particular perspective on individuals, whereas we tend to deal with providers. So I think it is possible to work in a professional way, because I think we do all share a set of values. That value of integrity that runs, like a stick of rock, through all of us, I think, is what makes regulation in this country work.

I think when you talk to people overseas, you often find that they're pretty jealous of that collective regulation that we're able to deliver.

Rob Behrens: We have to demonstrate that integrity through transparency. But my view would be that if there wasn't tension, then people would accuse us of having a cosy relationship, in which there wasn't that proper accountability. So I don't see tension being a problem. You publish, each year, a State of Care report that highlights the strengths and challenges of the quality of health and social care. Where are we at the moment? You've published a big report.

Ian Trenholm: Yes, we publish our State of Care report, normally, about October time. I think when you look at the performance of individual providers, what we see is, this year, the number of outstanding goods, requires improvement and inadequate

providers in each sector is broadly the same as it was last year. So at a provider level, one would say that's quite a good story. And that's quite a good story from the point of view of what we know is significantly increased demand in a number of sectors.

However, I think the big issues is this issue of access. This issue that people are saying they can't necessarily get access to the type of care that they need when they need it. That's about whether they can access primary medical services when they need it. That's not just about getting a GP's appointment; that's about things like, if you've got a young child and you need CAMHS – adolescent mental health services – and you can't get an appointment for a number of months. Then months and months and months go by, and then, suddenly, you find yourself in A&E with your son or daughter trying to take their own life.

That's a story which gets repeated again and again. We talk a lot about the pressures on emergency departments at the moment, and they are well talked about and well documented. But I think when you go and stand in an emergency department, it becomes very clear, very quickly, that a number of things are going on: that the relationship with local primary care is not as good as it could be, and that people are not flowing through the hospital fast enough, because there are people who are stranded in hospital because of a lack of social care, locally.

So that issue of how people move through a system of health and social care is a really important issue, so we talked about that a lot in State of Care this year. The other, I think, linked point we particularly focused in on was mental health, learning disabilities and autism, where, again, that lack of services in that community space meant that people who are

living at home, perhaps, often with families that are really struggling just to keep things together, are finding that the services they previously relied on – things like respite care, for example – are being cut back.

The consequence of that is that the person then goes from living at home to being in some kind of closed environment. Then they become stranded there and they can't get out, and they actually deteriorate, rather than improve. So these environments are described as hospitals. The expectation is that they're therapeutic, and people are just not getting the benefit of that.

When you then unpack that, what you see is issues around staffing and issues around training. Because if you can't recruit staff, you tend to recruit staff and then not invest enough time in training them, which means people are in these quite difficult environments, and not able to perform at the levels that we would expect.

So I think that combination of, "Let's look at the system. Are there issues in the system? Why are there issues in the system?" It's largely about staffing, and a linked point is training. The final point, I think, is just this long-term sustainable funding solution for social care. I think we've been round and round this topic a number of times. For the last couple of years, we've been really very pointed about that, because it is clear to us that the amount of money in social care, in particular, is having a really detrimental effect on the sector's ability to perform.

That, in turn, means that people are being stuck in primary medical services and in hospitals. Unless there is more money going into social care, then the extra money that's going into

the NHS at the moment is going to be, if you like, wasted on looking after people who shouldn't really be there.

Rob Behrens: We're just about to produce a report on people who receive mental health care. One of the difficulties about that is that the very people who have the need are the most reluctant or unable to complain. My counterparts in other countries have the right of own initiative, to be able to go and look at those issues. So in Ireland, in Finland, and so on, abuses have been spotted about people who haven't been able to complain themselves. I don't have that power, so I can't assist your organisation in identifying things like that, which I think is a strategic weakness.

But just finishing this off, feedback and listening is obviously critical. How do you, as a leader, encourage your organisation to make that a high priority?

Ian Trenholm: I think in a number of ways. If you look at the way that we are structured, we have a pretty big intelligence team, and we create data packs, which support our individual inspectors as they go out on inspections. So we'll start off by saying, "What's the shape and size of this organisation? What are the issues? Just looking at the data alone, what do we think some of the issues are?"

We also have a large contact centre in Newcastle, so people can telephone us and talk to us about their experience of care, whether that's a member of staff, or whether that's a patient or a carer. What we do is bring all of that together, so when inspectors walk through the door of a provider, they are starting to know where to look.

When we go on site, what we do is, we make ourselves visible. A lot of the things that, often, people talk to us about, who are members of staff or patients or relatives, who just come and talk to us about what they've seen. I was talking to one of our inspectors the other day. She was on site, and one of the sisters in A&E just came to her and just started crying, and just said, "Look, I'm completely overwhelmed by this. I'm so glad you're here. I don't know what to do."

So sometimes, people see CQC as an escape valve, almost, to say, "Well, look, these are what we think the problems are." We can then take that and present them to management and leadership teams in a constructive way.

So there's all of that. We've just launched our give feedback on care service as well. It's an online service. You've always been able to let us know, using an online form, as to what you think about care, but it was never particularly well used. But we spent some time with our experts by experience and with members of the public, doing a lot of really in-depth analysis of how people would use the internet to raise complaints and concerns, and we've created a new service.

One would argue, at its simplest, it's an online form and you fill it in. But actually, it's been designed in a particular way, to make it as easy as possible to fill in and take people through a series of steps, to give them some reassurance, as they go, that we'll take the information they're giving us and treat it with respect. If they want to stay anonymous, they can. If they want us to call them back and talk in a bit more detail about what they're telling us, we can.

The impact that has had has been phenomenal in terms of the number of extra people who have completed the

transaction and come through. Plus, we're looking to introduce some chat functionality as well, so that particularly younger people or people who don't necessarily feel particularly confident speaking to somebody may use chat functionality, or whatever.

So I think what we're trying to do is create a number of channels into our organisation, and then overlay that with the relationships we have with other regulators, and of course, with you, to say, "Well, actually, are we the best person to take this complaint in the round and do something with it?" Sometimes, these things are not necessarily complaints in the orthodox sense. They might just be bits of feedback. Then, when we start to unpick a little bit and we add it to three or four other things that we know, that might give us a sense of something really important going on.

Rob Behrens: We're coming towards the end. I'd like to keep you here much longer, but you're a busy man. One of the things we're working on together is the Complaint Standards Framework, which your organisation has been very constructive in helping to push along, so that, for the NHS, we get one basic standard of excellence in complaints handling. Do you agree this is an important initiative?

Ian Trenholm: Very much so. I think what we want to do with the Framework is try to give people a mechanism that has a series of logical steps to it. Because if I reflect on speaking to my own parents, if they don't have a good experience, I say to my mum, "Well, why don't you complain?" "Oh no, we couldn't possibly complain. That would be very bad." I know, from my own experience of having given feedback to

providers, that the providers really value this, but their complaint process may appear to be a bit clunky and a bit confrontational.

I think what we're trying to do, together, with the Complaint Standards, is to try to get almost a sense of logical escalation, so that people can give sensible feedback. That sensible feedback can lead to something changing and some learning and some improvement going on, and the public feeling that that's a logical and sensible thing to do, rather than this sense of, "Oh no, I couldn't possibly complain."

Yet, you know very well that if you're in a supermarket and you've got something that wasn't entirely right, you would go and talk to the person on the desk, in a sensible, adult way, and something would be done about it. Whereas people don't feel they can do that in health and social care, and I'd really like them to be able to do that.

Rob Behrens: Well, we're currently seeking public feedback on the Complaint Standard Framework. Listeners can visit www.ombudsman.org.uk/csf to have their say in the way you've just described, and that will push us along. So that's good to hear.

Last question, Ian: we both work in the oversight realm. We both have lots of good people as colleagues, many recent graduates. What would be your advice, as an experienced regulator, to people coming into either the regulatory or the ombuds profession?

Ian Trenholm: That's an interesting one. I think one of them is probably advice in most jobs, which is, "Be curious." I think one of the

things that we are certainly very interested in at the moment is how one regulates innovation, because things are happening. There's an aggregation of providers. There are systems. There are digital services. There are all sorts of stuff. I think if you don't get into the habit of being curious really early on in your career, then you find your career can stall.

So I think it's advice for everybody, really, which is, "The more curious you are, the more interested in what's going on, the better," and I think, therefore, the more effective we can be as a regulator. Because I think we've got to be able to regulate in this new digital, fast-paced, joined-up sort of way, and curiosity is really the only way we can be effective at that.

Rob Behrens: So you heard it here first from Ian Trenholm: be curious, so that we can aggregate innovation. That's great. It's been an absolutely pleasure. Thank you very much indeed, Ian.

Ian Trenholm: I appreciate it. Thanks, Rob. Cheers.

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