**Transcript of Radio Ombudsman #7: Driving improvements in mental health care**

Rob Behrens: Okay. Well, good morning and welcome to Radio Ombudsman. My guest today is Claire Murdoch. I'm very pleased to have you here, Claire. Claire is Chief Executive of the Central and North West London NHS Foundation Trust, and National Director for Mental Health in NHS England.

Claire was involved in the development of a rating system for the Clinical Commissioning Group's performance in mental health during 2016, and she has particularly supported moves to ensure mentally ill people, especially children and adolescents, are treated nearer their homes, a key issue.

We're lucky to have her. She's rated by the Health Service Journal as one of the most influential people in the National Health Service. So, thank you very much for joining us.

Claire, we like to start each episode of Radio Ombudsman by hearing a bit about the background of our guests. So, could you tell us where you were born and brought up?

Claire Murdoch: Yes, yes, and good morning. I was born in Faversham in Kent in 1960, the fifth of six children. I suppose had an incredibly happy childhood, and one of, I think, immense privilege, in that we had great love, and parents with huge values around how we all behave as citizens as we got older. So, lots of love, but also lots of guidance.

Certainly, I was from a very poor household though. My parents and my family were a bit like a sketch from Monty Python actually. Our house was condemned as unfit for human habitation when I was 15. There was only myself and my brother still living at home, and I came home from school one

day to find my mum crying and my dad pacing, because we didn't know where we would go from this rented house. A tiny rented house.

There used to be four in a bed. There was one cold tap in the kitchen. The toilet was in a shed in the garden. There was no electricity upstairs. When the Environmental Health Officer came and declared as unfit, four little houses in a terrace, it caused huge alarm in the family, where would we live?

We were then offered a really, really posh council house that had electricity throughout, a toilet indoors, central heating, and so on, but what those early days taught me really was the huge dignity in work actually.

So, my dad would have three jobs to feed his six children and keep us all independent, and that would be a milkman in the morning, leaving the home at about four o'clock. He'd come home, have his breakfast, then he'd do a window cleaning round, and then have his tea, and then he'd go out and pack fruit lorries until about 10 o'clock in the evening, and he'd do that six days a week.

Mum brought the family up, and when she could work, she did various cleaning jobs. Then when I was, oh, probably 15 or so, probably about the time that our house was being declared unfit for human habitation, Mum got a job she thought was a really good job, cleaning the public loos in the central car park in the centre of town.

It was a council job, and she would be paid sick pay for the first time in her life, or some holiday pay, not that she ever, or my dad, went sick from work really. I remember begging my mum not to do this job because it would be humiliating as a 15-year-old, for your mum to be the cleaner in the public loos, and now I feel very ashamed. In fact, I feel very proud of both

of my parents for what they did to look after themselves, look after their family, for the lessons they taught me about the merit in working hard.

I guess the final thing I would say is, that upbringing gave me a belief that I was as good as anyone, and better than no-one. I think that strongly came from the, sort of, love and confidence that my parents instilled in us all, but also a great sense of self-worth, but also duty to others.

Rob Behrens: Yes. Thank you for that. So, there's a mixture of things there. There's a strong family bonding, the commitment to the work ethic, but also, presumably, a strong belief in the benefit of public service, even at that early stage. Would that be fair?

Claire Murdoch: Hugely so. I mean, I grew up in a household where both parents were huge supporters of, for example, the NHS. They really thought the NHS was an incredible institution.

I don't think they ever thought that necessarily any of us would end up working for the NHS. I just grew up with a political background, I suppose. At home you look after your most vulnerable as a society, and that it's a great thing to live in a country that has organisations, institutions and systems in place that can do that. Equally, they taught me that people who can look after themselves should. You know, that you should work hard.

Certainly, when I became a nurse – I went into student nurse training when I was 23 – it took me a while to settle to something I actually wanted to seriously do when I was younger. Telling my mum and dad that I'd decided to train as a mental health nurse, well, you would've thought I was the only

person in the entire country to go into nursing when I qualified, they were just immensely proud that I was working for the NHS.

Rob Behrens: So, is there any connection between what you've just described, and the fact that you undertook training to be a mental health nurse?

Claire Murdoch: I don't think so. I was a university dropout at the age of 18. I did a term and absolutely loathed it. So, not an auspicious start to adult life really, and I then spent the next five years doing a whole range of jobs supporting myself, travelling. Also, I was very interested in the performing arts at that time in my life. I did lots of semi-professional acting and dancing, and had a great time actually.

I think I just had a growing sense as 23 approached really, of I didn't know what I wanted to do, but I knew I wanted it to make a contribution to wider society. I felt I wanted to do something with the underdog. I suppose there's a bit of a campaigner in me, and I didn't even know mental health nursing existed.

I remember just looking at a woman's magazine one day, and there was an advert, and I remember it still to this day, of four people, and the question was, "Which one of these people has mental illness?" and then a bit of explanation, and then, "Could you be a mental health nurse?" I thought, "Crikey, is this it? Have I found, after five years of having a great time, but probably not being a hugely productive member of society..." I remember, really, going for the nurse interview in a big Victorian asylum in the School of Nursing at Friern Barnet Hospital up in North London that has subsequently closed down and been turned into flats. I remember at the interview, I

really wanted this. I remember my interviewer looking at all my drama and dancing and saying, “mental health nursing is not a glamorous job, you know,” and I remember being quite insulted at that point, thinking, “I know that. I’m ready to do something serious”.

Of course, I’ve never looked back since those days. I fell in love immediately with the work, with the issues, with the people that I was privileged enough to care for and work with, and 35 years later, here I am.

Rob Behrens: Just before we look at where you are now, let me just ask you a bit about the acting and the drama part of it. Is there any part of that which you put into your current role, or which you took from it?

Claire Murdoch: That’s a really interesting question. I think you learn early on as a nurse that you must develop a professional persona. You must understand the role that you’re stepping into, one of service, of professionalism, of high standards. I think, in a way, maybe the acting, where you have to get into role and really think about the character that you’re portraying, could have helped.

I’ve never really thought of it that way before, but certainly, back in the days when I trained, you were instilled with the fact that you were stepping into a role in public office, where people would rely upon you. Where you needed to understand your duties and obligations, where you needed to understand even that your behaviour off-duty could have an impact on how you perform at work, or how you’re seen as a professional. Maybe the acting did. I never thought of that.

I think as well, where there is a link, is that huge interest in people and the different characters that we are. I'm definitely still one of those people that's quite an avid people watcher. I like trying to see what I can tell about someone from how they're being, or, you know, "Have that couple just had a big tiff? Is she more into him than he is to her? Is this person down on their luck and looking very sad?" So, I think that interest in people, motivations, what makes them tick, but also stepping into a role, maybe there was a link there somewhere.

Rob Behrens: Okay. So, you're now a critical leader in mental health provisions. Tell us a bit about your journey, from qualifying as a nurse to these big leadership roles, because that's unusual and heartening.

Claire Murdoch: Well, thank you. I think the first thing to say is, when I was a student nurse, I remember vividly having a session on the different career pathways that nursing could take you into. Whether that was, well, obviously frontline care and clinical specialism, or academia, teaching, clinical practice tutors, and one of the routes was into management. We were asked, you know, "Which of you would be interested in management?" and I remember being truly appalled at that stage, and I firmly crossed my arms and said never would I go into management.

Of course, what the career quickly taught you was that, from whether you're a student nurse able to manage other more junior student nurses, or a staff nurse with trainees and healthcare assistants working with you, or a ward sister managing a budget and a team of 25 people, management is an intrinsic part of how you deliver patient care actually. If you're not managing how you're organised, your

communication systems, reviewing properly, thinking about how you deploy resource, thinking about how you motivate yourself and others.

So, I suppose, though I said I'd never go into management, I then quickly found myself a ward sister back at Friern Barnet. I'd left and went to the Royal Free to be a staff nurse there, and then got invited back to take on a ward in the institution in the hospital, and part of the closure programme as well.

I think that taught me hugely to fight for what I think is right, and one of the biggest fights I had at that stage, as a ward sister, with the wider hospital, and it sounds ridiculous now, but it was terribly important at the time, was my ward was called Oak Ward. It was in a little modern part of the hospital grounds. I and the team loved Oak Ward. We were trying to do things differently, pay greater attention to people's preferences, really be a more egalitarian and warm mental health service. My colleagues at that time were great.

We got moved into the main hospital, as part of the hospital closure. We were decanting into a smaller and smaller part of the hospital, as services were moved into the community, and when we were moved into the main hospital, we were told our name would have to change to Ward 6, which is a Chekhov play as well about a psychiatric asylum. We wanted to keep our name because we thought that patients would often be… had relapsing conditions, and would feel reassured, if we kept the identity of the name should they need to come back, but also, I suppose we wanted to be different.

That was a huge battle. We would phone up reception and say, "Oak Ward here," and they'd put the phone down, and they'd say, "No ward of that name in this hospital." We would put posters up every day outside the ward door, saying 'Ward

6', and literally, the hospital administrators would come and rip them up and throw them into the ward.

In the end, we reached a compromise, which was we were allowed to call ourselves Ward 6 Oaks. It sounds silly, but it was really a fight against, "This is nonsense. Let us have a name."

So, I was a bit of a trouble-maker, but not too much of a trouble-maker, and quickly became a matron covering the Royal Free and Friern Hospital, as part of the closure programme, and overseeing the smooth transition of the area that I was responsible for, which was Camden patients. Then I was a matron, a senior nurse and a service manager for many years at Camden and Islington Trust, and the Royal Free.

So, a, sort of, dual role, and really, I was in those roles working in mental health services, as a manager and a professional nurse leader for many years. Until nearly 20 years ago, I applied for my first executive director role, to the then Brent, Kensington and Chelsea and Westminster NHS Trust. It was a little newly-formed mental health Trust. I was the Executive Director of nursing and operations there for eight years or so, and have been Chief Executive at Central and North West London NHS Trust (CNWL) for 12 years.

I should add, when I was a ward sister, I decided I ought to go back to university. So, did a degree four years part-time, in social policy and got a first-class honours degree. That, I think, was also an important part of my journey because, strangely, being older, I really appreciated what I was studying, some of the social policy, the philosophy, some of the law making. I think I was old enough at that point, and experienced enough at that point, to truly appreciate studying for a degree.

Rob Behrens: In the 1960s, that wasn't available, nursing degrees, in the way that it later became. So, you did well to wait.

Claire Murdoch: No. Well, exactly, and I think it did help me see health in a much broader and more political context as well, and certainly, to understand issues of inequality, and how any social policy, unless it's implemented well, can be the best policy in the world.

I was Chief Executive then, or I still am. I had been Chief Executive for CNWL for about ten years, when I broke another promise to myself, which is I never wanted to do a national job, and never would, thought I.

The visible commitment that I saw and felt from actually Simon Stevens at NHS England, and others, to mental health and the Five-Year Forward View for Mental Health, and the movement across the country, or movements across the country, demanding better, made me feel that now was a time to possibly step forward. Use some of my skills and experience, to help implement, not only the Five-Year Forward View for Mental Health, which has been a really key focus, but all of the associated awareness raising. The challenging of stigma, the mobilisation of the energy and interest that's definitely there across the country, whether that's people with lived experience or professionals.

Here I am, two and a half years, into that national role.

Rob Behrens: Do you see any conflict between your national role and your Chief Executive role?

Claire Murdoch: Well, a few things. One, the only reason that I can undertake both roles is that there are terrific teams in both organisations. So, any job is doable, I think, if your structures and your teams and the people you're working with are the right ones.

I was very fortunate in my Trust in that my team, my executive colleagues, are incredibly longstanding CNWL executives. We're a sort of trust where people very often come and stay forever, as I have done. I've been there 20 years. Even though we've never stood still, trebled in size, taken on community services.

So, I have a great executive team, and, similarly I think the mental health team at NHS England, and with other partners at NHSI and across the arm's length bodies, we've potentially got the best mental health team we've ever had. What that means is that I can do the job with the support and leadership of these two great teams.

One has to be alert to conflicts of interest. So, for example, when the transformation monies nationally are out for bidding. So, whether that's new money for psychiatric liaison services, new money for perinatal services, new money for eating disorder services, you know, all big improvements that we're currently making, I have to be nearly out of the country when those bids are happening. I go nowhere near them. I always look forward to seeing which areas have been selected.

So, I think many jobs, particularly at senior level, will have areas of potential conflict, and it's not necessarily about not having conflict. It's about recognising them and managing them, and mandating the people you work with to manage them, help you manage them as well.

Rob Behrens: It's about transparency as well, isn't it?

Claire Murdoch: You have to be transparent. You have to be transparent, and you have to have those conversations with colleagues that say, “If there’s something that you need me not to see or know about, because it wouldn’t be fair to other chief execs, then don’t tell me. I’m fine with that.”

These two roles can complement each other as well. So, I think the reason that Simon Stevens was so keen to appoint, a serving chief executive, to the national role, is he’s hugely committed, as is the NHSE Board, and NHSI. So, if you like, “concertinaring” all of the multiple layers that can exist between good policy and transformation policy, and what it lands like really on the ground.

So, in many ways, I think that the benefits of having to sit, still a registered nurse, still a trust chief executive, with all of the challenges in my Trust, that any trust across the country will have, and yet improve patient care, expand services, increase access, I think that the two roles are hugely complementary. I feel that it’s an uncomfortable place to sit sometimes for me, particularly if my own Trust… you know, I love it when we do something fantastic and leading.

It hurts when we let people down still, and although it’s an uncomfortable place, I think it’s a right place to be, holding the implementation of great policy and holding myself to account, and my colleagues, for, “Is it real? Is it doable? Is our next bright idea going to create untold burdens of bureaucracy? Are we creating a counsel of perfection, which, again, becomes a burden? It also paralyses services. Is what we’re asking reasonable? Are we being ambitious enough? How will it affect patients?”

So, I think the two roles make me, with my colleagues, think about, “Is what we’re doing the right balance between ambition and raising standards, and deliverable in a real world?” as it were, and I think that’s the line we have to make sure we walk always.

Rob Behrens: Thank you. Now I want to ask you about a couple of our insight reports dealing with mental health issues, which you will have seen. But, before I do that, it’s clear from what you’ve told us that you’ve really lived through a revolution in service provision in mental health. Would you describe it as that?

Claire Murdoch: I think it has been a revolution. When I look back these last 35 years, the mental health sector, and how we treat people, and the range of services on offer, the fact that we closed 70% of our beds – 70% – which does very much indicate a much more community-facing model of care, I think the sector is almost unrecognisable.

Certainly in the early days of my training, it felt like two worlds colliding. One of the first things I was told as a student nurse at Friern, by a very eminent consultant psychiatrist, was that I would hear a lot of stuff and nonsense about the hospital closing, and I wasn’t to believe it, because it never would.

A few years later, as a ward sister, I was very privileged to be asked to speak at the closing ceremony of Friern Barnet Hospital, and it did feel like we were standing on the brink of a new era, an end of the Victorian era of healthcare, and the beginnings of community care.

I remember things like patients being offered cups of tea at teatime every day, from a huge metal pot where the milk and

sugar had all been added, and where doors were seemingly needlessly locked, where there were some institutionalised rules that made no sense for people.

I think, because the two worlds of the new and the old were colliding, we were a pretty militant bunch as student nurses. I think we really felt we were batting for a different future. Of course, there were groups like Mind and other groups external to the organisation, also campaigning for something different.

I think we were the campaigners from within, so we would start to do things like refuse to put the milk and sugar in the teapot. Although this might sound silly now, that caused huge resistance to whether it was the ward domestic or the ward charge nurse, who would think, “Who are you to come along and change something that’s worked perfectly well for years?”

There were more serious things about changing frail elderly patients behind a screen in the sitting room, as opposed to taking them to a bedroom to change them, and all manner of things like that – silly rules which we wanted to throw away the big iron keys that you had, huge metal keys. We wanted to stop wearing uniform in those days.

Actually, I’ve become a fan of bringing uniform back increasingly in recent years, but then it was part of saying, “No, we must change this heavily institutionalised, heavily medicalised model,” where I think, although there was great kindness – we mustn’t think that it was all unkind – but it was highly paternalistic. People were offered very few choices, particularly the ones that had been in hospital for years.

I remember weeping one day as the hospital was closing. Patients who’d been in hospital 20 or 30 years, they’d been admitted a long time previously, with a diagnosis of moral

deficiency because they got pregnant at 15, unmarried, or they'd stolen sheet music.

I remember working with cohorts of those patients as the hospital closed, and they were moving into supported housing, and literally going out shopping with them as a staff nurse, for things like duvets. They were able to choose their duvet covers, and feeling really – and I still do to this day – feel emotional thinking about… these were some of the first times that certainly people who'd been very institutionalised were making simple choices about their lives.

I think now, fast forwarding it, we've seen various iterations of community services. I think inevitably we learned a lot about what went well in that first decade post major closure programmes, and what didn't.

Certainly the care programme approach was introduced in the early '90s, from memory, which was a recognition that, in particular, if people are living more independently in the community, with particularly complex or enduring problems, you need to make sure that their care is well coordinated, that the multidisciplinary team supporting them are sharing information, are properly thinking about how to prevent relapse and promote choice.

So, I've seen that move. I think we've gone from an era where we did things predominantly for patients, to increasingly an era where now we do much more with patients and their families. It feels a much more equal relationship than it did, and quite soon we'll enter the era of patients leading the delivery of many services. That's begun now.

Rob Behrens: You've eloquently catalogued the transition and the revolution that's taken place, but we shouldn't underestimate the real

challenges that are still there. While paying tribute to those who give their public service to working in mental health, we know that there is structural underfunding of mental health in comparison to other health provision.

As a relatively new ombudsman, I have been hugely impressed in the visits that I've made to mental health provision.

Two of our insight reports were fairly critical of current provision, while appreciating the public service that goes into it.

The 2017 report we did into anorexia provision demonstrated a lack of willingness to learn from mistakes that are made in the provision, particularly to young people, the lack of training that is given, and the weaknesses in some of the curricula that are provided to those dealing with anorexia. NHS England has agreed to look at this and set up a taskforce. Is there anything you can tell us about how that's going?

Claire Murdoch: Yes. Look, first of all, I do just want to say that we've come a long way in 35 years. I say to anyone and everyone who will listen to me, and every staff induction at the Trust I make the same point: "We've got at least as far again to go but we haven't got the luxury of 35 years." We need now to move much faster to make the sorts of improvements that your insight reports have rightly pointed to.

I think the first thing to say is that, particularly with the anorexia report that you're talking about here, I've been impressed with a) the report. I thought it was fair. It's painful reading. These are the sorts of things that I, and probably other professionals who care passionately, feel hurt by – but not hurt in a wounded way, hurt because we probably recognise it as a really searing,

independent insight to things we must fix, things we must address, things we must do better.

I've also been impressed because the NHS England board, I know, scrutinised that report really carefully, required of myself and my colleagues a very clear action plan about what we would do – not only NHS England but with NHSI. You mentioned training and education: HEE, Health Education England; NICE, the National Institute for Clinical Excellence, and also the Department of Health.

I've seen the mobilisation of your report and your findings of those bodies, those arms-length bodies, all of whom have a role to play in making the improvements you rightly pointed to.

We asked Professor Tim Kendall, our Clinical Advisor, to chair that working group. We've been busily working this last year or so with that working group, who also have people with lived experience on it. So, I think it's really important that the family and patient or service-user voice that you bring to life so eloquently in your reports, and so vividly, also informs our taskforce. The sorts of work-

The sorts of work that we've been doing have been, firstly, we've been rolling out, as you may know, as part of the 'Five Year Forward View', 72 new community-facing eating disorder services for children and young people. The last 18 months has seen very significant investment in community-facing eating disorder services.

They're achieving two things at the moment. One is access and treatment of youngsters with an eating disorder. We've seen some of the first ever access and waiting-time standards for eating disorders, or mental health as a whole, so one-week referral to treatment for urgent referrals, and four-week for routine referrals.

Our goal is to, by 2021, have 95% of all referrals meeting those two standards. At the moment, our routine referrals, 81% of them are being seen within four weeks within those new services, and something like 72% are being seen within a week. So I would say we're well on track to hit those rather exacting but important standards by 2021. These new teams really are seeing more people differently and intervening earlier.

I spoke to two families not long ago at the launch of one of these new community services. One of the families had a daughter who had, if you like, missed: had become an adult and had missed the existence of such services. They described her care and treatment, and it had so many echoes of what your report found.

I then spoke to a current father and his daughter, talking about their current experience with the new service. What they pointed to, actually, was a school who'd become concerned about this young woman – child – a family that hadn't realised that their daughter had eating disorder issues. They went to the GP together because school contacted family. The GP said, "There's this team. I'm referring you." They were seen within a week.

That team have worked with school, the family, the acute hospital, because BMI was lower than anyone had realised. Really, what the father talked about was how rapid the intervention and intense it was, and how his daughter was back at school. The first family, the daughter missed years of schooling, was in and out of hospital. I don't say yet that we're there everywhere, but by 2021 we'll have made those improvements.

The second role of those specialist teams is to do some more of the work that you've pointed to in your report. So it's to work

with the wider system on training and education, on early identification, on going into the GP practice or the acute hospital and giving talks and lectures, disseminating information, being available to help the wider system.

Other things we've done, in addition to setting up those services, is we've commissioned a piece of work which has been ongoing over these last several months with the NHS Benchmarking Club. We've asked them to look at adult services for eating disorder, the activity, the funding, and the outcomes, and to report on the state of play currently.

We've also had, through this taskforce, input from people with lived experience and others, really helping us understand the scale and extent of existing problems. We hope to take the findings from that work, which was ongoing from about April until July of this year, into our long-term plan. Obviously, yesterday the Chancellor made a big announcement about mental health funding, but we will be using that to inform our proposals around what next.

In a way, I make no apology, in a world of finite funds, for commencing with child and adolescent eating disorders, because we can change, we hope, the trajectory for those youngsters and their families for good. But it really is high time now that we take the learning from the last year and your report, and take it into our long-term plan. We're hoping, of course, to make some further announcements about the long-term plan and which services we're developing next, within the next four to six weeks.

Also, the only other thing I'd add is that NICE have, in September, so the National Institute for Clinical Excellence, as part of the work over the last year, were asked to look at your report and your recommendations, look at best evidence base,

and reissue the eating disorder guidelines to the system, which they did in September.

Rob Behrens: Yes, good.

Claire Murdoch: So, quite a lot of work has been mobilised by your report.

Rob Behrens: Okay. The second report was about general provision of mental health, and it highlighted the absence of human rights for citizens using mental health services, in some fairly horrific instances. That is on the record, and I don't think anyone said, "This doesn't happen."

We know that there's been a reduction in the number of nurses dealing with mental health. We know they have vacancies, particularly in London. We know that they have sickness and long-term absences because of the stresses around mental health provision. How can you chart a way through that, given the financial constraints that you're operating under?

Claire Murdoch: Yes. I think, undeniably, mental health services have not received the level of funding that they ought, until the last three years, where what we've seen is a sea change, led very much by NHS England and government. We've heard the Prime Minister talk about burning injustices. The public are demanding better and more.

NHS England, over the last three years, have set a really clear financial standard called the 'Mental Health Investment Standard', which basically sets out that all CCGs must invest a

higher percentage than their overall allocation in mental health each year.

We're in year three now of this financial standard, really stipulating what we expect. In year one, 85% of CCGs achieved that. Here we are in year three and we've stipulated that all, without exception, must, even if they're in deficit. What that's led to is a year-on-year increase in funding for mental health services, and at a higher rate than the increase in funding for the NHS as a whole.

That's a first step. It has to be the first step of many, so I think we're on… Colleagues, as well, at NHSE and I, and across health leadership, think that we're on a journey of a decade to really balance and rebalance investment in mental health.

I'm cautiously optimistic about what the long-term plan will say in light of yesterday's Treasury announcement, which said two things: that funding for mental health will increase by at least £2bn over the next five years, and that the overall share of health funding for mental health will increase as a proportion of all health spend. So, I think that we're on the money case.

On the workforce case, there is this relationship about, if you have the money but you haven't got the staff, in a sense there's no benefit at all. You have to grow your workforce, as well.

I've been, as have many colleagues, very concerned about ensuring that we grow the workforce – and not just grow the workforce but retain the workforce that we have, and that we tackle issues such as burnout, support to staff, and so on and so forth.

NHS Improvement have been running, over the last year now, about 12 months, a bespoke retention programme that all mental health trusts are part of. That's involved quite intensive

deep dives, looking at the culture of each trust, the practices of each trust around staff support, welfare, flexible working, routes to promotion, Continued Professional Development (CPD), and so forth. So, we have to look at retaining the workforce.

We did publish a plan in 2017, so last year, that set out an ambition for approximately 20,000 more staff to come into mental health as the money and the service developments hit the ground. That's not easy. I think if you asked me, "What's my biggest concern about the programme?" you'd think it would be money. It's workforce, so we have to retain the staff we've got. We have to bring more nurses, doctors and others into the profession.

I do commend to people the Royal College of Psychiatrists' 'Choose Psychiatry' campaign, because they are already pointing out what a wonderful profession it is, by using real case studies, real people. They're already seeing an increase in doctors-in-training choosing psychiatry. We have to redouble our efforts.

I also hope, and it does talk to some of your points about human rights, that by stabilising the workforce that we will build the relationships, and continuity, and knowledge that most families and service users say they crave in understanding their wishes and the nature of their illness or mental health struggles.

Stability is important, but I'm hoping to bring into the workforce many, many more people with lived experience as peer support workers, on 'Agenda for Change' pay scales, proper routes to promotion, and with a clear mandate to bring, if you like, patient rights, patient experience, and patient choice, right into the A&E departments, the acute wards, the community teams.

Rob Behrens: Okay, thank you for that. We're coming to the end. Can we have some quick-fire questions? Do you think that many people say that healthcare is over-regulated? That's one of its problems. Would you agree with that?

Claire Murdoch: I think that's a tricky question because I think you do need regulation, and you do need others to hold a mirror up to you and hold you to account. It's vitally important. When you're working in an industry like health, you really, really are often working under pressure. You're moving fast to make developments.

You're definitely doing your best, in nearly every instance, to deliver high standards of care, but you have to acknowledge that others need to hold that mirror up to you, that you have to look across the country – and it's one of the big parts of our programme – and look at taking out unwarranted variation.

You can do some of that through clinical practice networks, training and education, choosing the right staff. That can help; listening to what patients say, having a good complaints system, having users at the heart of how you provide care. You can do some of that, driving out the unwarranted variation, which is often linked to lapses in standards, but actually I think you do need regulators to do that with you, as well.

Sometimes I think all the regulators are not as aligned and as coordinated as they could be, which does mean that you do things two or three times. I would like to see a culture of any bureaucratic burden that doesn't genuinely add to patient care, or that duplicates, I'd like to live in a world where that's seen as a cardinal sin. This plays out in my national role, and that's

where it's so helpful seeing how policy lands on the ground with regulation.

I really think that we need to work hard across the regulators to make sure that we're aligned. I really welcome the fact, for example, that NHS England and NHS Improvement have declared they're going to work much more closely together to take away some of that duplication, but I'm a fan of regulators, in the main.

Rob Behrens: Okay. Are you a fan of ombudsmen? Ombudsmen are not regulators, but they're part of the regulatory framework. Do you think there needs to be, as I think, a constructive dialogue between ombudsmen and regulators through learning from complaints?

Claire Murdoch: A hundred per cent. I absolutely think that. I've grown up, I suppose, with an expectation that the ombudsman will be taken seriously, probably from my very early days in health, where the ombudsman was taking an interest in an aspect of care, or care failing. I've certainly grown up in a culture where that's a serious thing. I think that now in my role – certainly in my Trust – it's hugely serious when complaints escalate to the ombudsman.

I think it's a shame when the ombudsman finds that my Trust and trusts like mine have not done all they could have or should have to resolve complaints or issues, but I think it's absolutely right that's called out. It's a great opportunity then for boards to understand why their processes didn't discover what the ombudsman discovered, but I've also seen that now played out since I've been at NHS England. For example, the two reports you talked about earlier, the board of NHS England

– the executives, my team – were all over those reports, taking them seriously.

I think, so long as the ombudsman is… It must be a tough job to walk the line between hearing some of the heart-breaking stories you hear, and seeing the failures that you see, and then being able to step back and make, if you like, requirements and demands of us, through your recommendations, that can have national relevance. Generally, I think – almost exclusively – that's done really, really well.

Rob Behrens: A couple of quick questions from Twitter. Thank you to followers on Twitter for their interest in this. How will you ensure that mental health professionals start to act within the law by recognising they cannot take best-interest decisions for adults with capacity?

Claire Murdoch: Yes. I think that acting within the law is clearly a prerequisite. What we've seen in recent years is the best interest, the capacity, DoLS (Deprivation of Liberty Safeguards), now 'Mental Health Act', and now a new 'Mental Health Act'. I think that the CQC work very closely with us, as well, on inspection and how we make sure that trusts and providers are a) doing enough training and awareness raising, b) giving enough support to their staff to understand the different requirements of this quite complex interface between DoLS, 'Mental Capacity Act', and the 'Mental Health Act', but b) call out and correct very quickly where this is not working well.

I know, and I don't want to steal his thunder, but I've been meeting recently with Sir Simon Wessely, who's leading a review of the 'Mental Health Act' currently. He's determined,

having listened to people from across the country – and it was your point of earlier about a more rights-based system – and he's really determined to look at the interface between 'Mental Capacity Act', best interest, and the 'Mental Health Act', and to further raise awareness of where we're getting this wrong currently and what we need to do to improve.

I think we can probably expect to see a new code of practice. I think from that we will expect to see evidence of really good training, both pre- and post-registration, really good audit, and clear routes for stronger patient feedback or person feedback if they feel that anyone has acted illegally or outside of the law in relation to how decisions are made.

Rob Behrens: Okay. You've talked a lot about the need to take service users with you as leaders and co-producers of services. Another follower on Twitter says that the National Patient Surveys don't show much sign that this is happening. What do you expect from the next surveys that we get?

Claire Murdoch: I think the patient surveys are interesting because they're one way that we try and understand what people are saying about the quality of the care they receive. Sadly, the response rates are still pretty low. They're between 20% and 30% each year. That's probably not bad for a survey. Certainly we haven't seen much change in patient survey results over 10 years, and we have to try and move the dial on that.

Whether it's friends and family tests, which generally show much better results than the patient survey, and other avenues into understanding what patients are saying, I'm not sure we've still got a good and fair picture.

I don't think a lot will change in the next patient survey. I don't say that lightly, because everything we're doing, whether it's making more services more readily available, more of the time, whether it's trying to recruit more staff of the right calibre, including peer support workers, whether it's having bespoke teams in A&E, mental health teams – we funded 72 new A&E liaison services over the last two years – there are a whole range of developments, some of which I mentioned earlier, where we're trying to make sure that a) we've got the right staff working with the right values, but b) we've got the right services, in the right place, that can give people better treatment, perhaps kinder, more compassionate care.

I come back to my journey of a decade, really. I think we have to attack the quality and the patient satisfaction in services, through a whole range of measures. This national survey is but one indicator around how we're doing, but we definitely have to do better, and we're determined to.

Rob Behrens: Thank you. Last question: what advice would you give to young professionals joining the health service today or the ombudsman service today as clinicians, managers, or regulators?

Claire Murdoch: That's a tough one. I've forgotten what it's like to be young, although I have got two sons, a 21-year-old and a 23-year-old, and the advice I give them generally is, "work hard". My dad always used to say, "If you take the King's shilling, you do the King's work." So, work hard. I think it is hard work. Have a job that you believe in, so come and work in the NHS. Come and work for the Ombudsman.

I've considered it the biggest privilege ever to have had 35 years of working in the NHS. No two days are the same – undeniably some tough points, of course. You've got to build resilience. You've got to look after yourself. You've got to have the mentoring, and the supervision, and the friends to let off steam with. You need to build resilience, but my strong advice would be, "Do it. Come and work in the NHS."

We've got more careers than ever before. We were advertising just this week, for example, for graduates and others to come and work in our new schools-based counselling services, so, if there are graduates out there who want to get a job working as a counsellor in schools, supervised by the NHS, there are hundreds – soon to be thousands – of those jobs coming on stream. We'll train you. You'll do something that's worthwhile.

Rob Behrens: Okay. Claire Murdoch, you've been eloquent and frank, and we're very grateful to you. My next guest is Dr Henrietta Hughes, the National Guardian. This is Rob Behrens signing off from Radio Ombudsman.