Listening, learning, responding to concerns

A review to identify improvements in how we learn from, respond to and act on concerns

Foreword

In my role as Director of this review, maintaining a sense of openness and impartiality has remained my priority. An undertaking of this scale and focus is significant and has benefitted from the skill and knowledge of colleagues with a long history of working at CQC. It has also been vital to take on board the contemporary perspectives of the independent review board members and external experts who have helped me to get to the heart of the key issues raised. My position sits between these two groups. I had only been working at CQC for a fortnight when I was asked to undertake this report. I made a conscious effort to maintain a level of distance from the organisation during the writing process to strengthen its objectivity.

CQC's role is to make sure health and social care services provide safe, effective, compassionate, high-quality care and it also encourages care services to improve. Intelligence from all parts of the health and care system is critical to help deliver on this mandate. Intelligence-led health and care inspection relies heavily on an inclusive and trusted culture where concerns can be raised with confidence and acted on promptly. Those who speak up must feel safe to engage with CQC positively and honestly, working together to achieve its core purpose.

Last year, several cases demonstrated occasions where CQC fell short of its obligation to support people who were speaking up. This risks damaging people's confidence in the process of speaking up and can lead to harm if issues go unidentified or cannot be addressed in a timely way. Ultimately, this impacts CQC's ability to regulate effectively and without gaps or failure.

Reviewing the case of Mr Shyam Kumar, a consultant orthopaedic surgeon, has highlighted the impact of CQC's actions on Mr Kumar as an individual, his family, his clinical standing and the wider population. CQC has also needed to consider the impact of the case on people's confidence in the organisation and to ensure that it remains a regulator and employer that listens inclusively, is supportive, acts appropriately and learns.

The best-led organisations are ones that recognise their success, quickly identify and acknowledge their failings, and respond humanely and openly. These organisations are accountable for and, importantly, lead in addressing their own problems. This review looks at CQC's culture, practice and values. Rather than focusing on a particular moment in time, most of the areas reviewed explore what CQC does daily to keep people safe and how engrained processes can be improved. This includes CQC's Speak Up policy and how it responds to concerns and the experiences of those who raise concerns.

Part of the review looks at how CQC dealt with an instance of organisational change, which coincided with Mr Kumar's tribunal case. This section examines CQC's decision-making process and the impact on culture, and may have limited relevance with external readers, but it was important to include all the issues of decision making and underpinning culture.

The approach that CQC took in commissioning this review and committing to full public candour should be recognised for leading in a way that looks for truth, not blame, and looking to improve and learn. Ultimately, this is about CQC understanding the impact of its actions, how it can be better, and crucially, how it can cement that learning to deliver improvement that yields tangible results.

In line with current reforms of the UK health and care system, it is important to acknowledge that structural and procedural changes must be accompanied by changes in culture, if improvements in performance and quality of care, inspection, regulation and practice are to be achieved. CQC therefore recognised the need for a better understanding of the nature of organisational culture and how it can be improved.

This review looks at a number of areas relating to CQC's handling of cases, processes and culture, and the impact of its actions on numerous stakeholders. These include whistleblowing and its response to people raising concerns and speaking up. I have used these terms throughout the review and have defined them in the terminology section.

At the outset of this review, there was a clear need for a deep exploration of both CQC's intentions and the impact of its actions. This was done with full recognition that the absence of intent does not negate the impact.

Working with external experts has been integral to maintain the independence and integrity of this review. It has also helped to ensure transparency and build confidence. Special acknowledgment must go to Mr Shyam Kumar, who has engaged with the review in a way that has demonstrated his commitment to patient safety and care. Mr Kumar has always shown his compassion and desire for improvements that make a difference to patients.

As this review also examined impact on CQC's workforce, I would like to thank all trade union representatives, internally and nationally, who have supported the review and created a co-designed, positive working relationship now with CQC, that I hope may continue in developing the response to this review.

I would also like to thank all CQC staff equality networks for their openness, honesty and passion in helping to inform this review and supporting CQC to deliver on the recommendations.

Finally, I would like to thank all people who courageously speak up. I hope to work towards a future where everyone in the health and care system feels empowered to raise concerns, and speaking up is seen by all as a positive act to keep patients safe, is part of professional practice, and is an important indicator of the health and care culture and standards that support CQC to keep people safe and free from harm.

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