Introduction

The Care Quality Commission's Listening, learning, responding to concerns review has a strong independent voice to identify improvements to how the organisation learns from, responds to, and acts on concerns that are shared with it.

CQC's purpose, values and history

Care Quality Commission's (CQC) purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

CQC was established in April 2009 as the independent regulator of health and adult social care in England, replacing 3 former regulatory bodies.

The organisation's values are:

- Excellence – being a high-performing organisation
- Caring – treating everyone with dignity and respect
- Integrity – doing the right thing
- Teamwork – learning from each other to be the best it can.

CQC's operating environment and significant learning events

CQC has played a pivotal role to help keep people safe in health and care, through its regulatory functions, interventions and subsequent improvements across health and care. On occasion, however, there have been notable failures, in practice, policy and action resulting in unacceptable human impact. This includes failures to listen to workers' concerns. Some of these incidents are mentioned below, and briefly describe how CQC is learning from them, and how they have helped shape CQC.

Winterbourne View

Winterbourne View was an independent hospital for the assessment and treatment of people with learning disabilities and other complex needs.

In 2011, CQC carried out an internal management review in response to the serious issues raised about Winterbourne View.

The hospital closed in June 2011 following a BBC Panorama investigation that exposed the systemic abuse of patients at the hospital. The investigation also raised concerns about the failure of the health and social care system to protect some of the most vulnerable individuals in its care.

The management review, which considered the regulation of the hospital from its registration to its closure, showed failings in the way that CQC involved staff who speak up, and how CQC processed the information it was given.

Following this review, CQC adopted 13 recommendations for improvements to systems and working practices. It also carried out 150 unannounced inspections of services for people with learning disabilities, which showed some serious concerns, but no evidence of abuse on the scale uncovered at Winterbourne View.

Mid Staffordshire

In 2013, the report of Sir Robert Francis KC's inquiry into the failings at Mid Staffordshire NHS Foundation Trust was published, which described that "conditions of appalling care were able to flourish" between 2005 and 2008 in Stafford Hospital, which was run by the Trust. The report made wide-ranging recommendations for the NHS and the wider health system, including CQC.

CQC's response was to bring forward changes to the way it works, including the appointment of a chief inspector of hospitals. It also committed to changing its approach to inspections to focus on the key areas that are most important to people: safety, caring, effectiveness, responsiveness and how well services are led.

It introduced expert inspection teams that included specialist inspectors, clinical and other experts, and people with experience of care.

CQC also committed to using data, intelligence, and evidence in a more sophisticated way to identify, predict and respond to varying standards of care more quickly.

Hillgreen Care Ltd

Hillgreen Care Ltd operated a care home for younger adults with learning disabilities. In 2017, CQC commissioned an independent investigation into the regulation of this care home.

The resulting investigation report found that there was no evidence that CQC covered up an allegation of a serious offence at the home in 2015. However, the review made 14 recommendations to improve CQC's consistency, policies, processes and training, which were fully accepted by the CQC Board.

Whorlton Hall

Whorlton Hall was a specialist hospital in County Durham. In May 2019, the BBC broadcast evidence of abusive treatment of people with a learning disability and autistic people there.

In 2020, CQC published independent reviews of the regulation of Whorlton Hall between 2015 and 2019. The review looked at whether the abuse at this independent hospital could have been recognised earlier by CQC's regulation.

The first report in March 2020 concluded that, although CQC followed its procedures, a number of improvements, described in 6 recommendations, were needed to strengthen its inspection and regulatory approach.

The second report in December 2020 outlined the progress that CQC had made to implement the recommendations. The second report also made a further 5 recommendations relating to our ratings, and the trialling of tools and the development of guidelines to better identify closed cultures and improve outcomes for people using services.

About this review

In designing and delivering this review it has been important to start with connecting the aims of the review to the core purpose of the organisation and the values which it holds. There has been a clear focus on examining the impact and, wherever possible, the experience of CQC colleagues, NHS and care workers and the wider public in line with the aims of this review.

All providers are required by law to meet standards of quality and safety. CQC is responsible for regulating against these standards and taking appropriate action when they are not met. This could include using enforcement powers.

In 2021/22 CQC received 17,937 enquiries categorised as whistleblowing. This was a 13% increase from 2020/21. Using and acting on this information is a critical part of how CQC delivers its role as a regulator.

Incidents which reduce the likelihood of people raising concerns risk damaging the ability of the organisation and the staff who come to work to make a difference in delivering the core purpose of the organisation.

In the summer of 2022, a number of high profile issues were raised. These issues are now understood to have had a material impact on people in a way that is not compatible with CQC's values. These issues were highlighted by:

- the Employment Tribunal findings of Mr S Kumar -v- CQC in Sept 2022
- the Letter from the CQC trade union representative bodies to the then Secretary of State on 13 September 2022 relating to a major organisational change programme and how staff involved were feeling from the experience
- during 2022, internal concerns regarding the application and availability of reasonable adjustments for staff had become more frequent and being heard by CQC's executive.

In September 2022, the Executive decided an independent review made up of 2 phases was necessary. Phase 1 was the independent review which Zoë Leventhal KC was appointed to lead into the handling of protected disclosures shared by Mr Shyam Kumar, alongside a sample of other information of concern shared with CQC by health and care staff. Phase 2 was made up of 5 workstreams that addressed areas that were deemed critical by the CQC Board to address.

Mr Kumar is a consultant orthopaedic surgeon who worked part-time for CQC as a Specialist Professional Advisor. Specialist Professional Advisors are health and social care professionals who offer particular knowledge and expertise to CQC inspections when this is needed. Mr Kumar worked on hospital inspections between 2014 and 2019 and during this time, he raised concerns to CQC, including about patient safety. In 2019, Mr Kumar was disengaged by CQC from his role as Specialist Professional Advisor. He took this decision to an employment tribunal, which found that:

- the emails and concerns raised by Mr Kumar in the form of protected disclosures between 2015 and 2018 had an influence on the decision to disengage him
- the decision to disengage Mr Kumar had a serious impact on his reputation.

The outcome of the employment tribunal judgment was a concern to CQC internally and was fully accepted. The findings generated considerable negative media coverage and social media comment. It also led to expressions of a lack of confidence in CQC by professional bodies as well as by individual professionals. This erosion of trust clearly had the potential to impact on the confidence of people who use and work in health and care services to raise concerns with CQC.

CQC accepted all of the findings of the tribunal and recognised that the process of disengaging Mr Kumar was not in line with the CQC values. CQC apologised to Mr Kumar in writing in a letter, and subsequently in public; it is recognised that this second, but public apology, may not have articulated an understanding of the impact of the case, as well as Mr Kumar's experience adequately, unlike the letter. CQC also thanked him for the concerns he raised, which were used in our ongoing regulation of the University Hospitals of Morecambe Bay NHS Foundation Trust.

Phases of this review

Zoë Leventhal's report forms phase 1 of this review can be found here.

At the same time, CQC committed to carry out a wider review (phase 2) to explore whether, in relation to the issues raised above, there are areas of culture or process within CQC that need to be improved. CQC recognises the importance of ensuring that it is able to effectively listen and to act on what it hears when information of concern is shared with it. It also committed to looking at whether race or any other protected characteristic has any impact on how it treats information of concern, reflecting on findings from Mr Kumar's employment tribunal.

Running throughout the review will be a focus on detriment in treatment or experience of disparity across the protected characteristics. This includes understanding whether race or any other protected characteristic has had any impact on how CQC treats information of concern or impacts on organisational culture and its ability to fulfil the obligations placed upon it pursuant to the Equality Act 2010.

The review's phase 1 was fully independent. Phase 2 was overseen by a review board with 3 independent members to support the governance and assurance of the review as well as build confidence and credibility with stakeholders.

What are the aims of the review?

The concerns that health and care workers and the public share with CQC about health and care services are critical to its work. It is also vital that CQC listens to its own staff.

It is clear from the events listed last year that CQC needs to make improvements to ensure that it has a culture that values speaking up. The recommendations listed in this report seek to make those improvements. These recommendations will be tracked to understand the degree to which CQC has taken the action expected of it to adequately respond to the review.

The evaluation will then seek to understand the impact of CQC's response to the review. It will do this by investigating whether the following aims of the review have been met:

1. The public, workers of services registered with CQC, and other stakeholders trust CQC to listen to and act on their feedback and concerns in an inclusive manner.
2. CQC has a culture, supported by effective policies, processes and practices, to listen to, act on, or respond to concerns raised by colleagues, including advisory and complementary staff, about CQC. This means staff feel safe to speak up and that speaking up is invited, welcomed, celebrated, listened to, and responded to well.
3. CQC has a culture in place, supported by effective policies, processes and practices, to listen to, act on, or respond to information of concerns about care from workers of services and others. It does this in a way that is free from institutional or interpersonal discrimination.
4. CQC works well with partners and providers when concerns about care are raised.

5. CQC's culture, processes including governance, decision-making and outcomes comply with, and look to lead best practice regarding, the Equalities Act 2010, ensuring:
   - there is a clear understanding of best practice where discrimination is identified, addressed and, wherever possible, prevented using anticipatory measures
   - the handling of concerns about CQC raised by colleagues, including advisory and complementary staff, are free from institutional or interpersonal discrimination
   - CQC makes reasonable adjustments for CQC colleagues and CQC applicants in a timely manner and in line with best practice.
6. Relevant CQC colleagues feel confident, skilled, empowered and supported to handle whistleblowing and information of concerns about care.
7. Relevant CQC colleagues feel confident, skilled, empowered and supported to respond to concerns raised by other staff, including advisory and complementary staff, about CQC.
8. CQC has a culture, underpinned by best practice policy, processes and practices, where staff, including advisory and complementary staff, feel empowered to make a meaningful and timely contribution during change to support improvement and transformation. This should include ensuring there is learning from, and an adequate response to, feedback from formal consultation and informal engagement.
9. CQC's appointment, contracting, engagement, deployment and disengagement processes relating to advisory and complementary staff are non-discriminatory, consistent with the values of CQC and ensure employment rights are maintained.
10. Relevant CQC colleagues feel confident, skilled and empowered to deal with employment litigation, including working with internal and external lawyers.

How this review was carried out

CQC's wider review to explore whether there are issues of culture and process that need to be improved were designed across 5 workstreams. While workstreams 1, 2, and 5 were led by CQC staff with expertise in each area, it was ensured that these individuals had no conflicts of interest. As this was not possible for workstreams 3 and 4, a decision was made to employ an independent barrister and an external expert. The review was then overseen by an independent review board.

The review approach for each workstream is summarised below.

1. Reviewing how well CQC listens to whistleblowing concerns

This workstream reviewed how well CQC listens when workers raise concerns. This workstream built on previous work carried out in this area that included improvements to processes and staff training. The workstream:

- carried out an analysis of data
- undertook checks of CQC's response to speaking up which had been triaged as high risk
- contacted workers who have raised concerns with CQC
- reviewed complaints from workers who were dissatisfied with how CQC had handled their concerns
- engaged with various CQC teams through focus groups
- spoke to external advisors and a representative of a whistleblowing charity.

2. Reviewing how CQC supports people at CQC to speak up

This workstream reviewed the current arrangements to support people to speak up at CQC. It looked at how well CQC's Speak Up policy and practice reflected the latest national guidance.

It considered the national policy and accompanying guidance published by NHS England. Working with and through the National Guardian's Office it reviewed exemplar policies in the NHS and other arm's length bodies. It also aimed to ensure that the role of the National Guardian is clear to support people speaking up at CQC.

Discussions were held with a number of stakeholders, including the National Guardian for Freedom to Speak Up, CQC's Guardian and Guardian team at NHS England.

Recognising that there is often confusion, cross-over and interdependency between speaking up and whistleblowing, the review ensured that the policies align and complement each other, avoiding duplication and ensuring there are no gaps.

The review has led to a new draft policy being developed and shared within CQC (including following the usual consultation process with Trade Unions and Staff Networks) and externally with the National Guardian's office and NHS England.

3. Learning from the tribunal case raised by Mr Shyam Kumar

This workstream reviewed our internal case handling processes, as well as how CQC instructs and communicates with the Government Legal Department and Counsel and its internal processes.

To complete this workstream, CQC commissioned a review by a specialist employment barrister to identify areas of improvement.

4. Reviewing how CQC listens to its staff

This workstream reviewed how CQC listens and responds to feedback from its staff.

It was led by an HR expert with substantial experience working in the health and social care sector, overseen and supported by a senior independent Chief People Officer. The workstream looked at 3 main areas, which were refined through engagement with CQC's staff equality networks and trade union representatives. These areas were:

- how CQC makes reasonable adjustments for applicants and CQC staff at recruitment and employment stages
- CQC's 2021/22 Operational Directorate change process
- CQC's appointment, contracting, deployment and disengagement processes relating to advisory and complementary staff.

These areas were reviewed through:

- analysis of CQC's staff survey
- focus groups and 1-to-1 interviews with staff
- review of relevant communications reports and policies.

5. Reviewing the expectations and experiences of people who raise concerns about care with us

In order to understand the expectations of people who raise concerns with us, this workstream:

- reviewed existing insight CQC holds on sentiment and expectations from people who use and people who work in care services in relation to raising concerns about care direct with CQC
- gathered additional insight through a survey on its online platform
- used an external organisation to carry out additional research with samples of people who use and work in care services who have a range of demographic and protected characteristics.

In order to understand the experiences of people who raise concerns with us, this workstream:

- analysed CQC's own performance data to identify any gaps in our data which inhibit this understanding

- carried out semi-structured interviews with people who have shared concerns with us to find out about their experiences of doing this.