1: Reviewing how well we listen to whistleblowing concerns

Key findings and recommendations

As a result of this review, we have developed aims to improve how we listen and respond to workers raising concerns, which will lead to improvements in the safety and quality of care for people using regulated services. They will also support how we evaluate the delivery of the improvements to help build confidence that they can be achieved.

Aim 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.

Findings:

Our review found that:

- The way 'whistleblowing' is defined (see appendix A) and understood within CQC has become overly complex and there is not a common and shared understanding across our staff. **In this report we will use the term 'speaking up' to describe concerns raised by workers, with 'whistleblowing' referring to when workers have shared information that meets the definition of a 'qualifying disclosure'.**
- Most information is currently received and handled by the National Customer Service Centre (NCSC). Our process if information is received by another route is to send it to NCSC to be processed. If information is not handled in this way, there is an increased risk of poor record keeping and insufficient evidence of the action we took.
- We are not collecting data about workers' protected characteristics and whether we knew the identity of the worker.
- Our initial action in response to concerns currently categorised as whistleblowing is consistently taking place within 5 days. However, we do not have performance measures in place to provide assurance that the action has mitigated any presenting risk or to consider how well concerns were handled.
- Our closed cultures work programme has increased staff awareness and provided improved intelligence and tools for our staff, but this is not fully embedded in our work.
- Workers often tell us when they have experienced poor treatment or victimisation in response to their attempts to speak up to their employer. We do not always ask whether the worker has raised their concerns with the provider and, if so, what their experience has been.

We recommend that CQC should:

- Promote a common understanding of definitions of workers speaking up and when this means they are 'whistleblowing' through a revised policy, updated systems, and associated training and guidance.
- Gather equality demographics on workers speaking up and where possible on anonymous reporting to identify themes and trends; then take action to address them to improve how we support and protect workers.
- Measure both the timeliness of how workers' concerns are responded to, and whether the action has mitigated the presenting risk; and implement an effective quality assurance governance system.
- Develop systems so staff have contextual information and information from our closed cultures dashboard available in one place when they are handling information of concern.
- Capture information and flag cases where workers have said they experienced victimisation. This should be made visible for inspectors to inform regulatory decision-making including follow up on inspection.

Aim 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.

Our review found that:

- Our reporting of whistleblowing concerns, which is a requirement of our role as a prescribed body, has been limited, which means workers who speak up in services and the public have not had enough information about how we have been handling concerns raised with us by workers.

- We do not gather information to understand enough about the barriers workers experience in raising concerns with us, or their confidence in us to respond well to their concerns.
- Only a small number of workers who raised concerns with us made a complaint about CQC's response. The outcome of most complaints found that CQC acted appropriately. A common theme was a difference in understanding between the worker and CQC about how concerns should be handled, and that we have not contacted them to let them know what was happening with the information they had shared.
- CQC staff reported that information reported anonymously often contained limited detail. This makes it more difficult to follow up those concerns effectively.

We recommend that CQC should:

- Publish a standalone Annual Prescribed Persons Report from 2023/24 to clarify and raise confidence in CQC's response to whistleblowers and all workers who speak up to us.
- Develop a system to gain feedback from workers when they have contacted us to raise concerns with an initial focus on recognising and overcoming the barriers experienced by ethnic minority workers.
- Commission research and engage with external organisations with expertise in speaking up to understand workers' confidence in CQC to handle their concerns. Specific attention should be given to workers from ethnic minority groups; other marginalised groups; and the role held by the worker within the service. This must lead to action to address the findings.
- Commission research to explore the implications of an increased level of workers speaking up from deprived areas.

- Review guidance on our website, and web forms for workers speaking up to ensure they clearly communicate how CQC will handle and act on their information, including for anonymous reporting.

Aim 6: Relevant CQC colleagues feel confident, skilled and empowered to handle whistleblowing and information of concerns about care.

Our review found:

- An unacceptable level of variation in our practice and some concerns had been handled poorly.
- Evidence of positive intention from CQC staff, and examples of good practice.
- Staff did not always feel they were able to act on the concerns raised by workers in the way they wanted to. For example, not carrying out an inspection in response to a concern because this was not in line with organisational priorities at the time; or because there are capacity issues in an area where there are higher risks.

We recommend that CQC should:

- Revise guidance and training for staff to provide clear principles of how to:
    - handle concerns raised by workers
    - keep in touch effectively with those speaking up
    - define what good practice looks like
    - raise awareness of the issues faced by the ethnic minority workforce and other marginalised groups and understand why and how we need to modify our approaches.

- Ensure high-risk cases are regularly discussed and recorded during inspectors' supervision with their manager through to closure.
- Review available staff resources to make sure these are sufficient to enable both effective monitoring of services and responsive on-site inspections when there are early indications of deterioration in quality or of the emergence of a closed culture (shared recommendation with section 5).

Aim 4: CQC works well with partners and providers when concerns about care are raised

Our review found that:

- Effective partnership working with local authorities is important when responding to workers' concerns. We found we were not consistently following the progress of safeguarding investigations.

We recommend that CQC should:

- Routinely follow up referrals proceeding to a safeguarding investigation, and the outcomes of any investigation undertaken.

Why we looked at this area of our work

The purpose of this part of the review was to consider how well we listen and respond to the workers of providers registered with CQC.

The information we receive from workers of providers registered with CQC can shine a powerful light on the culture and practice within an organisation. It can also help us to identify when the quality and safety of care provided by a service has started to deteriorate. The importance of us listening well when workers raise concerns must not be underestimated. The impact of us failing to do this effectively and inclusively can lead to missed opportunities to protect people who use health and care services, and to us letting down the workers who have spoken up to us.

The links between workers' ability to raise concerns within an organisation and its culture are clear. An organisation with a learning culture recognises speaking up as a gift and engages with that worker openly to drive change. An organisation with a poor or closed culture will seek to silence voices of dissent and to retaliate and victimise.

As highlighted in the introduction to this report, it would be hard to find a major health or social care report covering failings that did not reference workers' concerns. For example, in the Ockenden report into failings of maternity services staff told the reviewers about being fearful of speaking up, and reviewers found repeated concerns raised about safe staffing levels.

Our failure to respond well to the concerns raised by a whistleblower at Winterbourne View, an independent hospital for people with a learning disability, in 2010 played a key part in the delay to identifying the abuse taking place. Following this, extensive work was undertaken to improve our organisational response to speaking up information.

More recently, the experiences of Mr Kumar highlighted wider questions about our own organisational culture and behaviours in both handling speaking up concerns about services we regulate, and in our own processes for staff to raise concerns about CQC.

It is critical that when people working in services registered with CQC are concerned about things they have seen or experienced, they have confidence to contact us. They need to be able to trust that their concerns will be handled sensitively, that we will be clear about how we will use the information, and that we will take the right action.

Speaking up can be a difficult and distressing process, often involving real or perceived personal risk to the individual raising the concerns. We recognise that we need to better understand the barriers to workers raising concerns, and to proactively work to build trust that concerns will be acted upon.

Through this work, we need to strive to be aware of our current practice, understand how we engage with workers who raise concerns with us, and to continuously seek to improve. Our staff within CQC tell us they want to get this right and are committed to working towards best practice. We need to ensure staff have the right resources, guidance, training and systems to enable them to be confident in their approach.

During the review process, we experienced challenges with our methodology which meant that our efforts to speak directly to health and care staff about their experiences of raising concerns were unsuccessful (see section on listening to the experiences of workers who raise concerns).

What we looked at

In forming this section of the report and our findings, we used the following sources of evidence:

- Information available on our website – for the public, providers and employees of services registered with CQC about how we handle information from workers speaking up.
- Internal guidance – for our staff about workers speaking up and safeguarding.
- Data analysis – of 8,126 speaking up records (1 April 2022 to 30 September 2022).
- Records check – of a sample of 65 'high risk' whistleblowing cases taken from the 8,126 records, where the person involved had indicated we could contact them when they had raised their concerns.

- Internal staff focus groups – 3 focus groups involving 36 members of staff from across CQC who routinely manage information of concern, including those raised by workers speaking up.
- Annual provider survey – review of themes and trends relating to what providers had told us about whether CQC managed concerns from health and social care professionals in an inclusive manner.
- Complaints – from April to September 2022, from workers about how CQC handled their concerns.
- Interview process – we wanted to speak with workers who had raised concerns with us, to understand how well we had listened when they raised their concerns. To do this, we contacted 41 people by telephone to ask them if they would be willing to speak with us. Of these people, most did not answer the phone. We spoke with 6 people, of which 5 declined to speak with us as part of this review, and 1 person didn't respond to an email follow up.
- Stakeholder engagement – we engaged with a range of internal staff, external advisors, the Parliamentary and Health Service Ombudsman and the whistleblowing charity, Protect.

What we found from our internal review of how we handle concerns raised by workers

Contextual information from data analysis

Between 1 April 2022 and 30 September 2022, we received 8,126 contacts that were categorised as whistleblowing across 4,757 services. Of the 8,126 records:

- most related to adult social care services
- proportionately more enquires were received about services rated as requires improvement
- services in the most deprived areas were twice as likely to have whistleblowing concerns raised as those in the least deprived areas of the country.

Findings and recommendations for aim 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.

Receiving information and triage

All information that comes into CQC through our National Customer Service Centre (NCSC) is triaged. NCSC triage all incoming concerns into priority levels. This is based on the level of risk present within the information shared. Priority 1 information is the highest risk level through to priority 4, which is a low risk level. Priority 1 and 2 information contain safeguarding information. Priority 3 (medium risk) information indicates a concern that could include a breach of fundamental standards, or a significant concern.

The analysis of the data indicates that the level of risk within the 8,126 records varies (see figure 1).

Figure 1: Concerns categorised as whistleblowing received by sector by priority assigned 1 April 22 to 30 September 2022

Sector priority	ASC no.	ASC %	Hosp no.	Hosp %	PMS no.	PMS %	Unsp no.	Unsp %	**Total**	**%**
1-ASAP	157	2%	9	1%		0%		0%	**166**	**2%**
2-High	3187	48%	328	26%	49	19%	2	40%	**3566**	**44%**
3-Med	3220	49%	930	73%	208	80%	3	60%	**4361**	**54%**
4-Low	19	0%	10	1%	4	2%		0%	**33**	**0%**
Total	**6583**	**100%**	**1277**	**100%**	**261**	**100%**	**5**	**100%**	**8126**	**100%**

ASC: Adult social care
Hosp: Hospitals
PMS: Primary medical services
Unsp: Unspecified

As a prescribed body, we have a responsibility to decide whether we accept protected disclosures only or also accept wider information. We accept all information of concern from workers and use it to inform our regulation of health and social care services. We found our staff had differing views about the definition of a 'qualified disclosure'.

Across the staff focus groups there was a consensus that a common understanding, language and terminology was needed. This has previously been identified and clarified within the production of the internal policy 'Handling concerns raised by workers registered with CQC', which was agreed by the Executive Team. The policy will be reviewed against the findings from this review for any required changed prior to implementation. A new IT system is under development; as part of this, the way information from workers speaking up is triaged and recorded is being streamlined. This includes ensuring we have a consistent approach to identifying and acting on 'qualified disclosures'.

Recommendation: CQC should promote a common understanding of definitions of workers speaking up including 'whistleblowing' through a revised policy, updated systems, and associated training and guidance.

Most information of concern raised by workers of providers registered with CQC (99.1%) was received and logged onto the system by NCSC. This process is outlined in CQC's current internal guidance for handling information of concern. In the case of Mr Kumar we found his disclosures were not consistently logged through the usual route through NCSC. We have concluded that if information is not logged correctly, there is an increased risk of poor record keeping and insufficient evidence of the action we took. We have responded to this by issuing a communication to all staff, highlighting this part of the guidance and the expectation for all information to be logged on to the system. This will be monitored following the implementation of quality assurance (see section on performance and quality assurance).

Data collection

CQC does not collect any demographic information about the workers who contact us, such as people's protected characteristics or role within the service. This means we have been unable to provide an analysis of the demography of the workers who contact us.

We have been carrying out a project since early 2022 to address the absence of this demographics data. This is being developed using Office for National Statistics demographics definitions.

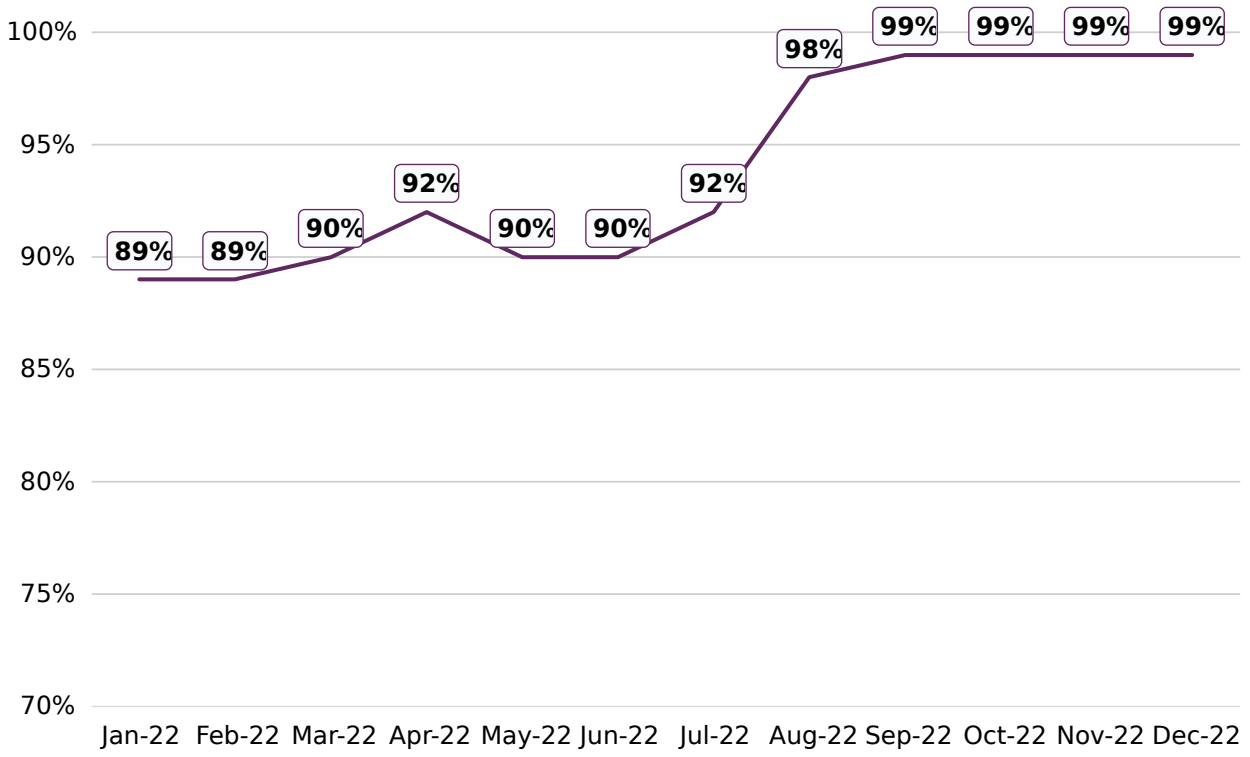
Many workers who contact CQC do not disclose their identity to us. Of those that do, some directly tell us they don't want their identity sharing with the provider or other organisations such as the local authority. We do not collect this information in a format where it can be reported on; this means we do not know the proportion of 'qualified whistleblowing' where the worker has shared their identity with us.

Recommendation: CQC should gather equality demographics on workers speaking up and where possible on anonymous reporting to identify themes and trends; then take action to address them.

Responding to concerns: performance and quality assurance

We monitor all records that are currently categorised as whistleblowing for timeliness of action taken as a corporate key performance indicator. The initial action taken to mitigate risk to people within the service must be recorded by the inspector within 5 working days of receipt of the information. When the information is received, we may take a variety of actions, for example, contacting the provider or local authority, triggering a regulatory response such an inspection or direct monitoring activity or liaising with other external stakeholders such as infection control teams or district nurses. The percentage of cases being actioned within 5 working days has improved throughout 2022 (see figure 2).

Figure 2: Percentage of whistleblowing actioned within 5 working days 1 January to 31 December 2022



The 5-day measure is important as this demonstrates concerns are reviewed and action taken in a timely manner. There is no measure in place to monitor what takes place after the initial action is taken. It is important that we can confirm the action we took did mitigate the presenting risk. For example, if the action taken was to contact the provider and to ask for information, then the response needs to be received, reviewed and a decision taken and recorded as to whether the risk has been managed. If the risk has not been managed, then further follow-up action should be evident. The introduction of a measure would provide oversight and assurance and allow the tracking of the time taken to gain this assurance.

Quality monitoring to review how concerns from workers are being handled is not embedded into routine practice. Putting this in place is of key importance, as our review of records continue to show variation in practice, which requires improvement (see section on reviewing the quality of how CQC staff handle concerns raised by workers). A Quality Management Framework is currently under development within CQC; this is intended to establish and measure how concerns from workers are being handled, with quality principles and standards that define the cultural approach and definition of 'good'.

Recommendation: CQC should measure both the timeliness of how workers' concerns are responded to, and whether the action has mitigated the presenting risk; and implement an effective quality assurance governance system.

Responding to concerns: Using information to identify early warning signs of closed cultures or a deterioration of quality in a service

The voice of workers is of immense value in understanding the culture and quality of care within a service, and this was consistently recognised by staff in our focus groups.

Our closed culture work has promoted awareness among staff of what features can place a service at higher risk of a poor culture developing. There is also a closed culture dashboard that staff can use to look at the intelligence held about a service for signs of a closed culture. However, this is held separately to the main system used to handle incoming enquiries, which means it requires additional steps to access this information. One staff member said:

"I think the work that has been done in terms of the closed culture approaches and the sort of tools we have there now, I don't know whether or not that could be more closely linked into the whistleblowing guidance."

In the case study below, more focus should have been given to the contextual information. This service is inherently higher risk for developing a closed culture, and there are early warning signs of a potential deterioration in quality, or of a closed culture developing when the whole picture is considered. In cases like these, where we haven't recently entered the service, inspection must be prioritised to gain assurance.

Case study – Residential service

In 2022, CQC received information of concern from a worker about the care provided to people at this service. There was no call back made to the worker who had raised concerns. This information was shared with the local authority safeguarding team. Contact was made with the provider for assurance, and their response was accepted by the inspector, who noted the information would be used for monitoring purposes.

At the time the concerns were received, the service was rated as good overall with the last inspection taking place in 2017. An off-site desktop review had been carried out shortly before the concerns were received with no further regulatory action indicated. As part of this review, when we looked at wider information held about the service, we identified there had been other concerns raised by workers at the service over time, and the local authority had shared that there had been organisational safeguarding concerns. The intelligence held overall showed warning signs of a potential closed culture that should have prompted an inspection taking place. We raised this with the inspection team. On inspection, we found that the quality of care fell below what people had a right to expect. The evidence is under review to consider our regulatory response to make sure improvements are made.

Recommendation: CQC should develop systems so staff have contextual information and information from our closed cultures dashboard available in one place when they are handling information of concern.

Victimisation of workers raising concerns in the workplace

The Employment Rights Act 1996 as amended by the Public Interest Disclosure Act (PIDA) 1998 provides protection in employment law; however only 4% of cases brought to tribunal are successful. This does not however provide immediate protection to workers against any retaliation from their employer. In addition, only the Employment Tribunal can determine if the worker is a 'whistleblower'. Victimisation in response to raising concerns can make it difficult for workers to carry out their role. We recognise that across health and social care, when staff contact us, they may have had poor experiences and be fearful of their employer's actions.

Services with a positive learning culture in place would encourage and support their staff to raise concerns. Those with a poor culture can seek to supress or dismiss concerns being raised. Therefore, when a worker has experienced poor treatment or victimisation this highlights potential concerns about the culture within a service and how well-led the service is.

It is important that our staff can easily identify victimisation when workers are reporting it. Currently, while these questions are often asked, they are not recorded and flagged in a way that makes this easily visible to inform regulatory decision making or for external reporting. We also found it was difficult to track how any concerns of victimisation were being taken through to, and examined, on inspection.

Out of the 65 records we looked at, we found 7 cases where the worker had said they had raised concerns, but their employer has ignored them or taken no action. In 2 cases, workers said their employer had implied they would suffer detriment if they continued to raise concerns. An example of our response can be seen in case study 2.

Case study: Nursing home

CQC received information of concern from an ex-employee of the service. This included neglect of named individuals, poor moving and handling, lack of personal care and weight loss. They also said if anybody 'spoke up' the managers made it difficult for employees.

This information was shared with the local authority safeguarding team by the inspector. Contact was made with the provider as the manager had been implicated in the concerns.

At the time the concerns were received, an inspection had been carried out a few weeks earlier and the home had been rated as inadequate. The inspection report referred to the service showing signs of a 'closed culture' and highlighted safeguarding concerns that had been raised. It also highlighted the failure of the provider to address issues raised. This service has since been inspected again and progress has been seen.

In our focus groups, there were a couple of comments made about being particularly aware of the risk of indirectly identifying a person if they had already been victimised. For example, one staff member said:

"I think in my experience, if somebody says they've already been victimised, or they're worried about what they've said because they feel like they would be victimised in the future over it, you are very, very much more cautious about how you might process that information or go back to the provider about certain things."

Currently, workers' 'freedom to speak up' is considered as a part of 'well-led' inspections in NHS trusts. We are developing a Single Assessment Framework as part of our new approach to regulation. This will apply to providers, local authorities and integrated care systems. Within this framework, 'freedom to speak up' is a quality statement within the well-led key question. In addition, this approach involves making judgments about the quality of a service more regularly. This includes acting responsively when we receive information that indicates an immediate risk, concern or change in quality, such as concerns raised by workers including whistleblowing disclosures.

Recommendation: CQC should capture information, and flag cases where workers have said they experienced victimisation. This should be made visible for inspectors to inform regulatory decision-making including follow up on inspection.

Findings and recommendations for aim 1: The public, workers of services registered with CQC, and other stakeholders trust CQC to listen and act on their feedback and concerns in an inclusive manner.

Reporting on concerns raised by workers including whistleblowing

CQC is a prescribed body. This means we can be contacted by workers outside of their workplace to report suspected or known wrongdoing. This can be if the worker doesn't feel able to report directly to their employer, or as a route to escalate if their employer has ignored their concerns or not acted on them. This information is of high value to us as a regulator as it provides an insight into regulated health and social care services.

As a prescribed body we are required to publish information externally each year on the number of qualified disclosures received. Of these, we should also report on the action we have taken and provide a summary of actions taken. This is currently included within our Annual Report and Accounts. The All Party Parliamentary Group (APPG) for Whistleblowing has raised concerns about the wider quality of Prescribed Persons Reports across all prescribed bodies, and states, "examination of these reports exposes failures to adhere to required standards."

Our last 2 published annual reports show the number of 'qualified disclosures' alongside data taken from the key performance indicators. This high-level performance information is also routinely shared with CQC's Board. The information shared is limited. During the Covid-19 pandemic the recommendations for performance analysis were reduced, which also had an impact on the amount of information shared about whistleblowing. There is now an opportunity to increase transparency to workers of providers registered with CQC and the public by more comprehensive reporting and analysis.

We have a responsibility to decide whether we accept protected disclosures only or accept wider disclosures, and to clearly communicate this. As a prescribed body, we do not hold responsibility for determining whether any workers' disclosure would qualify for protection under PIDA. This falls under the role of an Employment Tribunal if a worker was to bring a claim under PIDA. However, it is important for us set out publicly how we categorise concerns and subsequently act on them.

Recommendation: CQC should publish a standalone Annual Prescribed Persons Report from 2023/24 to clarify and raise confidence in CQC's response to whistleblowers and all workers who speak up to us.

Listening to the experiences of workers who raise concerns

This part of the review has been limited by the lack of information we gather about the demographics of the workers who contact us. This has also meant the data analysis and records review we carried out could not be used to consider if our staff handle concerns from people with protected characteristics differently.

Our intention was to speak with workers who had raised their concerns and, as part of this conversation, to ask whether any of their concerns had related to discrimination or poor experience due to any protected characteristics. We attempted to contact 41 people. Most people did not answer the phone, and voicemails were left. We had an initial conversation with 6 people to outline the request; of these, 4 declined on the call. Two people received further information by email; of these, 1 then declined to take part and the other did not come back to us. This highlights gaps in our understanding of how to engage with workers about their experiences of raising concerns with CQC.

The results from the latest NHS Staff Survey indicate falling confidence amongst workers to speak up within their organisations. This highlights the importance of us proactively building confidence and trust within the workforce, by listening well and handling and acting on workers concerns effectively.

Findings from published reports particularly highlight the barriers workers from ethnic minority groups can face when considering raising their concerns. It is important that we proactively build a receptive culture to hearing workers concerns well, to build confidence for workers from these groups to speak up to us. Sir Robert Francis KC in the Freedom to Speak Up Report found there can be a reluctance to speak up due to fear of factors such as being blamed, bullied or afraid of wider consequences for their career. Section 3.3 of the report sets out a survey of workers from a Black and minority ethnic background conducted for the Francis Report and includes the following conclusions:

- A higher proportion of Black and minority ethnic staff reported fear of being victimised as a result of raising a concern.
- Black and minority ethnic staff were more likely to have reported concerns about harassment and bullying than white staff.
- After raising a concern Black and minority ethnic staff were more likely to report being victimised or ignored by management than workers from a white background.

Despite this evidence of differential experience, we have not recognised that discrimination can be an issue to speaking up within the health and social care sector; and / or of contacting us as the regulator. We do not adequately understand the barriers experienced by the ethnic minority workforce or other marginalised groups. This needs to be addressed and there is an important opportunity for us as an organisation to be aware of and work to remove these barriers throughout all the changes we make.

Recommendation: CQC should develop a system to gain feedback from workers when they have contacted us to raise concerns with an initial focus on recognising and overcoming the barriers experienced by ethnic minority workers.

Recommendation: CQC should commission research and engage with external organisations with expertise in speaking up to understand workers' confidence in CQC to handle their concerns. Specific attention should be given to workers from ethnic minority groups; other marginalised groups; and the role held by the worker within the service.

Recommendation: CQC should commission research to explore the implications of an increased level of workers raising concerns from deprived areas.

Understanding expectations from workers about how CQC handled their concerns

We looked at information about complaints we received to help us understand workers' experiences. In the 6 months from 1 April to 30 September 2022, we received 172 complaints about CQC; of these, 7 (6%) were from workers who were dissatisfied with how we handled their concerns. Of these, 6 were not upheld (CQC was found to have acted appropriately) and 1 was partially upheld. While the number of complaints was low, these do highlight important areas for consideration.

For the complaint that was partially upheld, the worker told us the inspector had taken their email to CQC and shared it almost 'word for word' with the manager of the service where they worked. They felt the manager suspected they had shared the concerns, and this was having an impact on them at work. The review of the complaint found that the information had been shared anonymously with CQC, but not enough care had been taken to summarise the information to reduce the likelihood of the service indirectly identifying the worker.

The main theme from the complaints that were not upheld was that CQC was not 'investigating' concerns or not making contact to explain our actions. These cases were not upheld because CQC does not investigate individual concerns. All cases had information about how the concerns had been acted upon, so we need to do more work to improve how we communicate these actions to the person making the complaint.

These cases highlight the difference in expectation between what workers expect CQC to do with the concerns they have raised, and how the information is used in practice. This was also mentioned by inspectors in the focus groups held for this review. One staff member said:

"I think sometimes you're stuck in a difficult dilemma; you know they want us to go and inspect the following day sometimes. It's managing that expectation if we feel that the risk level or other information we have doesn't merit that."

CQC staff perspectives on handling concerns raised by workers

We accept anonymous reporting from workers as a valuable source of intelligence into the quality and culture of services. Staff in our focus groups had mixed views about the credibility of information that is received when the worker does not share their identity. For example, one staff member said:

"I've seen this over the years that inspectors may treat an anonymous whistle-blower differently to named ones. I don't know how you solve that problem, but it's almost like someone's been mischievous if they don't give their name and I think that's probably down to our culture and training."

However, others did not agree with this and said they treat anonymous information with the same credibility:

"I wouldn't treat an anonymous whistleblower any different, other than to think to myself, actually they are probably more scared than someone saying their name."

There was consensus that anonymous information could often be more difficult to handle, as it was not possible to have further contact for clarification or to ask for more details. Sometimes the information contained allegations of abuse but without any specific details about when this occurred or who was harmed. This meant the local safeguarding team would be unable to investigate this.

All staff were aware of the importance of, wherever possible, protecting the identity of the person making the disclosure from the provider, but we heard this can be difficult with anonymous feedback. For example, we often summarise the information to ask the provider for assurance. Inspectors told us they felt more concerned about the risk of indirectly identifying the worker when they didn't know who they were. Staff working within NCSC said they were trained when taking phone calls to support workers to share information in a way that minimised the potential for indirect identification.

Staff suggested we could improve how we engage with workers, for example by providing more information to explain the limitations of reporting anonymously and a process that allows anonymous reporting but does not encourage it.

Recommendation: CQC should review guidance on our website, and web forms for workers raising concerns to ensure they clearly communicate how CQC will handle and act on their information, including for anonymous reporting.

Findings and recommendations for aim 6: Relevant CQC colleagues feel confident, skilled, empowered and supported to handle whistleblowing and information of concerns about care.

Reviewing the quality of how CQC staff handle concerns raised by workers

Within our focus groups, staff told us they needed more support and training in how to handle information of concern from workers. One staff member said:

"CQC should be really clear about what we're supposed to do and how we're supposed to react to certain types of information; because it's kind of left up to our judgement at the moment, and obviously not all of us have the same level of experience."

During our review of whistleblowing records, we found all had initial action taken. However, we identified issues with how concerns were handled, including the following themes:

- Sharing information with the provider about a worker's concerns in a way that could 'indirectly' identify the worker –
  Inspectors regularly ask providers for assurance about issues that have been raised. This needs to be done carefully to minimise the chance of the worker being indirectly identified. We found cases where this didn't happen. In 1 case, the call log taken by the contact centre team had been shared almost 'word for word' with the provider.

- Asking a provider or registered manager to investigate concerns about themselves –
  When concerns are raised about a registered manager or provider, it is not appropriate to seek assurances from the person the concerns are about. We identified 2 cases where this had taken place. Instead, different approaches should be considered, such as contacting the nominated individual in a larger provider, liaising with the local authority or by carrying out an on-site inspection.

- Lack of further contact with the worker raising concerns –
  CQC's internal guidance states: "We assess, prioritise and act appropriately on all information we receive when people speak up. This always involves thanking the person who tells us about their concern, ensuring they receive feedback on the actions taken where this is possible, and asking for feedback from them about how the matter was handled."

  Having ongoing contact with workers is often positive when they have told us they are willing to be contacted by the inspector, as it means we can tell them what we are doing with the information, as far as is possible.

  In our focus groups, staff told us they used their judgment on whether to call the worker back about their concerns. This was often linked to whether they thought they had enough information to respond to the concerns. This was reflected in the records, with approximately half being contacted, or contact attempted and half with no contact made.

- Not identifying and following up on all the concerns raised –
  The information within workers' concerns can be wide-ranging. It is important that we seek assurance and follow up on all issues raised. We found cases where it was unclear whether all the concerns had been considered and assurance received.

- Lack of scrutiny of, or no evidence recorded of follow up of the provider response –
  When we request assurance from the provider, we need to follow this up and review it to ensure any risk to people has been appropriately managed. There were cases where responses had not come back promptly, or assurance had been accepted without sufficient scrutiny as to whether the provider had looked at the issues thoroughly.
- Poor recording –
  We expect our staff to record all action taken in response to concerns raised. Where we followed up cases for this review, we found examples of more follow up or actions taken than had been recorded on the system. This was sometimes linked to workload pressures.

In addition to these themes, we found examples where we could have given more consideration to responding by carrying out an on-site inspection as opposed to asking the provider for assurance (see previous section on Using information to identify early warning signs of closed cultures are deterioration of quality in a service).

Recommendation: CQC should revise guidance and training for staff to provide clear principles of how to:

- handle concerns raised by workers
- keep in touch effectively with those speaking up
- define what good practice looks like
- raise awareness of the issues faced by the ethnic minority workforce and other marginalised groups and understand why and how we need to modify our approaches.

Recommendation: CQC should ensure high risk cases are regularly discussed during inspector's supervision with their manager through to closure.

Barriers to responding to concerns from workers experienced by CQC staff

Participants in our staff focus groups discussed the pressure of resources and time, with many feeling that they did not have the ability to respond to risk in the way they would like to.

We have set our priorities centrally and, over the course of the pandemic, this has led to a predominately risk-based approach – both of known risks and to respond to serious emerging risks. There have also been periods where we have focused on infection prevention control inspections and inspecting for improvement within adult social care to support capacity in the system. Staff told us that work was also often led by known risks. For example, services that were inadequate and that required a follow up inspection; or where monitoring activity indicated an inspection was required. This meant they didn't have flexibility to use their judgement to carry out an on-site inspection unless there was clear evidence of risk.

Our staff also said that thresholds for action, such as inspection, were not clear, resulting in variation, and that this was also influenced by resources and capacity.

"But again, with the priorities, it does limit you. You want to get in before people are at serious risk. It would make more sense to us to do that."

"It's no surprise for anyone to hear that we can't get out and inspect all the services where there are bubbling risks happening. We just don't have the resources."

Some staff highlighted having limited options if the threshold to inspect isn't met. Therefore, having contact with the provider is important, as we need to take action to gain assurance the concerns are being responded to.

Inspection staff also talked about their portfolios (the services they are responsible for having oversight of). They highlighted that having a consistent portfolio of services made it easier to identify signs of deterioration in the quality of care. There were also comments made about the impact of the size of portfolio. One said:

"The size of the portfolio is too big to have that type of oversight or relationship building where you can pick up the subtle differences or when a dynamic has changed. When you have a smaller portfolio, you get to know those relationships. Those little warning signs become quite obvious quite early on."

Some inspectors felt there was a benefit to not knowing services as well, as that made them look at the issues more carefully. One inspector said:

"If I don't know the service, I am more attentive to anything that's raised. The fear of missing something and not knowing the service actually makes me think a little bit more and think, 'is there something I need to do straight away about this? Who do I need to speak to?'"

Recommendation: CQC should review available staff resources to make sure these are sufficient to enable both effective monitoring of services and responsive on-site inspections when there are early indications of deterioration in quality or of the emergence of a closed culture.

Findings and recommendations for aim 4: CQC works well with partners and providers when concerns are raised

Engaging with providers when concerns are raised

Our Annual Provider Survey indicated that providers were concerned that we are overly focused on negative feedback and do not consider positive practice enough. When responding to concerns, providers also felt we are quick to accept the feedback as fact. For example, a few providers shared experiences when ex-employees had made 'vindictive' comments in response to losing their position. Other providers were not confident that we always act on complaints, whistleblowing and concerns, which some feel is resulting in a risk of harm to people who use services.

A small number of providers also felt that inspection staff were overly critical and had a 'pre-determined' view of their service.

Our staff in the focus groups had a range of opinions on engagement with providers when concerns are raised by workers. One staff member said:

"I share these concerns with [providers], because we need to make providers aware if we are receiving concerns, because they've got legal accountability for people's health and safety in their service. If we're not informing them of the concerns that we've received, whether they're from whistleblowers or not, how are they assuring themselves that they're listening and taking action?"

Another staff member shared,

"I have always been concerned about how much assurance we take from the provider when we become aware of concerns. It has always been difficult for us to explore the issues any other way and arranging inspections has got harder than when I first started. From a whistleblower, service user or family's perspective we can appear to take too much adherence from the views of the provider or registered manager, which can make us appear to be on their 'side' so to speak. I have definitely found this when speaking to families and staff after specific incidents."

This highlights the range of perspectives when concerns are raised.

Working in partnership with the local authority

Our staff focus groups discussed the ways we can work together with local authorities to get the best result for people receiving care. One inspector highlighted worries about receiving information of concern about people who are placed out of area, as the local contract teams do not monitor these people and the placing authority rarely do compliance visits. This means the burden of protection rests with CQC.

A common issue identified in the review of the 65 whistleblowing records was that outcomes from safeguarding referrals were either not received or were not visible within the original record. This would include whether the local authority progressed this to a safeguarding investigation and, if they did, whether it was substantiated. During our review of records, it was often difficult to find safeguarding outcomes on the system; these often came in some time after the initial referral was made and were not consistently linked back to the originating matter.

Inspectors recognised this as a problem and highlighted the difficulty they can experience both in trying to find out outcomes from safeguarding referrals, and from barriers in CQC's system that make matching up and tracking cases complicated. This is also linked to the need for inspectors to routinely seek assurance from the provider in parallel to sharing with the local authority. One inspector told us:

"We have totally limited options really. So, say the whistleblower comes through and raises some significant concerns. We can obviously raise a safeguarding [referral] about that. So, we will do that but the question I always ask is – well what have we done?"

Without following through referrals to outcomes, whether that be through provider or local authority investigation, we cannot be assured that people have been protected. In addition, the quality of provider investigations should also be used to inform our regulatory response.

There must be better communication between CQC and local authorities to enable a shared view of quality about services. Otherwise there is the risk of delays to acting on concerns. For example, the Whorlton Hall Safeguarding Adults Review recommended that there needs to be closer working between CQC and local authorities to improve outcomes from organisational safeguarding in specialist hospitals. The report said that without such collaboration there can be "repetitive cycles of organisational safeguarding enquiries, which result in them telling providers to do what they should already be doing, and which have little sustained effect on improving the experiences of patients".

Recommendation: CQC should routinely follow up referrals proceeding to a safeguarding investigation, and the outcomes of any investigation undertaken.

Evaluation

CQC should undertake a thorough evaluation of how well it listens to concerns from workers of providers registered with CQC including whistleblowing following the implementation of recommendations from this review. This should seek to understand whether CQC has improved its practices against the following aims in this review:

- 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. [Aim 1]
- 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. [Aim 3]
- CQC works well with partners and providers when concerns about care are raised. [Aim 4]
- Relevant CQC colleagues feel confident, skilled and empowered and supported to handle whistleblowing and information of concerns about care. [Aim 6]

Six months after this review is published, CQC should look at progress against the implementation of the recommendations. After 12 months there should be an evaluation report on the outcomes of CQC's response and this should mark the formal close of the review. The evaluation should then continue to understand the full impact of the recommendations in achieving the aims set out.

To evaluate how this review has impacted CQC's ability to listen to whistleblowing concerns, possible methods include:

- recommendation tracking
- a survey of people who have provided feedback or raised a concern about care
- focus groups with those responsible for handling whistleblowing and information of concern about care
- interviews with partners and providers about how well we have worked with them when concerns about care are raised
- analysis of whether CQC has acted on information of concern about care, and how this varies by protected characteristics.