INDEPENDENT REVIEW INTO CQC'S RESPONSE TO PROTECTED DISCLOSURES MADE BY MR SHYAM KUMAR AND A SAMPLE OF OTHER CASES

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Section 1: Introduction

1. On 24 August 2022, the Employment Tribunal found that Mr Shyam Kumar, a consultant orthopaedic surgeon employed at University Hospitals of Morecambe Bay NHS Foundation Trust (**UHMB**), had been disengaged from his role as a Specialist Advisor within the Care Quality Commission (**CQC**) on account of having made "protected disclosures" to the CQC. This means he had raised concerns with CQC about the health of patients and other important issues and had done so in the public interest[1]. The Employment Tribunal found that the fact that he had raised these various concerns with CQC had materially influenced its decision to disengage him. It awarded him £23,000 in damages for injury to feelings, on account of what it described as "the inevitable impact" of CQC's actions upon Mr Kumar's reputation among his peers and the shock, confusion and concern it caused to him.

2. The CQC has accepted these findings and apologised to Mr Kumar. CQC's Chief Executive, Ian Trenholm, issued a public statement on 6 September 2022 about what occurred, including a recognition of the importance of the concerns Mr Kumar raised, the importance of the information raised by staff and the public generally, and the "vital role" played by Specialist Advisors in CQC's inspections.[2]

3. Following this, I was appointed by CQC's Executive Board to carry out an independent review into whether CQC took appropriate action as a regulator in response to the protected disclosures that Mr Kumar made, and whether it dealt appropriately with a sample of other instances where concerns have been raised with CQC.

4. My Terms of Reference[3] are as follows:

[1] The concept of a "protected disclosure" is explained in detail in section 4 below.
[2] www.cqc.org.uk./about-us/2022-09/statement.
[3] Reproduced in full in Annex I.

In relation to

(1) the protected disclosures made to the CQC by Mr Kumar; and

(2) a sample of whistleblowing concerns received by the CQC related to NHS Trusts, the size and date range of which is to be agreed:

The Review will:

(3) consider how CQC used these disclosures in its regulation of the relevant NHS Trusts and whether appropriate action was taken, taking account of all relevant factors including whether ethnicity played any part in the management of those disclosures; and

(4) make recommendations for improvement.

5. My review is therefore concerned with a) what CQC did with the information it received from Mr Kumar, b) how, if at all, it used this information in its role as the independent regulator of healthcare in order to establish whether the relevant providers (here various NHS Trusts) were meeting the standards in the relevant regulations, and c) whether that action was appropriate, bearing in mind all relevant factors. I have done the same exercise, in a more summary form, with a sample of 18 other instances of protected disclosures made to CQC.

6. I have also been asked to ensure that I include specific consideration of whether Mr Kumar's ethnicity played any part in the way that information was treated. Mr Kumar is of Indian ethnic origin. A person's ethnic or national origin is part of the protected characteristic of race under the Equality Act 2010 (**the EA 2010**). This is also an issue I have considered in relation to the sample cases.

7. In line with my Terms of Reference, I am making recommendations for improvement (see Section 9 below). My review is intended to enable CQC to learn lessons from what occurred in Mr Kumar's case, and to implement any appropriate improvements to various parts of its processes so that it can ensure it is fulfilling its regulatory functions effectively. The intention of this review is not to apportion blame to individuals for what went wrong; however, learning lessons does involve identifying in some detail where the errors occurred and/or if the problems arose from CQC processes.

8. Mr Kumar's protected disclosures concerned NHS acute hospitals i.e. hospitals which provide urgent or short-term care, generally including accident and emergency (A&E) departments, inpatient and outpatient medicine and surgery. The sample also concerns NHS acute hospitals.

9. It is important to be clear about what this review is not doing. I am not intending to examine again the reasons why Mr Kumar was disengaged and the process by which that occurred. This has been covered in detail by the Employment Tribunal. It is not part of my Terms of Reference. I do make reference to this where it is relevant to the focus of my review and where it overlaps, and some of my recommendations flow from that.

10. It is also important to be clear that many of these issues arose some years ago (mainly in 2018 and 2019, and one in 2015). There have been many changes and developments at CQC since then, and further change planned (in CQC's ongoing 'Transformation' programme, and proposed changes to its assessment and inspection framework). However, many of the issues are still relevant now.

11. It is also not part of my role to seek to pass judgment or criticise the Trusts involved, for whom circumstances have also moved on significantly over time.

12. Finally, separately, the CQC is also undertaking a review entitled "Listening, Learning, Responding to concerns" to identify improvements into how CQC learns from, responds to, and acts on concerns, with five different workstreams looking at different aspects. Because my review has been progressing alongside, I provided CQC with an interim update on the emerging themes which may be relevant to the five workstreams so that those could be captured where possible.

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13. This report is structured as follows:

Section 2: Methodology

14. My review has involved i) a detailed examination of various types of documentary evidence, and ii) a series of interviews with CQC staff and other individuals.

15. I have reviewed:
    - The full file of documents that formed the Employment Tribunal bundle (and supplementary bundle) in Mr Kumar's case (running to over 1200 pages).
    - All documents underlying each of the protected disclosures, where available. I called for documents on each inspection, the planning for the inspections and relevant follow up material, including correspondence and meeting notes, individual 'enquiry' records on CQC's Customer Relationship Management (**CRM**) system, and complaints / human resources records.
    - Relevant policies and training on dealing with and processing information raised by whistleblowers, and on a range of other issues.

16. I interviewed 35 key individuals. Of those, 13 were involved with Mr Kumar, 13 were involved in the sample cases (which I explain below) and 9 were interviewed for context and background, including senior leaders in the organisation. I found this to be an invaluable way to understand the documentary evidence and to build a picture of what occurred, as well as to gain an insight into people's perspectives of how the relevant processes work (or do not work), and as to the culture within CQC.

17. As to the sample of other protected disclosures, this was a complex exercise. The intention was to find a cross-section of significant whistleblowing information about acute hospital trusts coming into CQC at around the same time as Mr Kumar's did. This started by capturing a random selection of cases logged on the CRM system for the period 2017 to 2020; within this, I asked that approximately ¼ of these included allegations concerning race. Because it became clear that some of Mr Kumar's protected disclosures were not recorded on CRM, I asked that another random sample of cases (from 2017 to 2020) be captured via an alternative method. This involved looking at inspections that had been triggered by whistleblowing information for the same period. A total sample of 18 cases was selected including 13 CRM case and 5 inspections (resulting in overlap between the two lists). This provided a good range of examples to review. A full explanation of the methodology is at Annex IV.

18. The sample review was initially intended to be a desk-based exercise i.e. documents only. However, the documentary records available in many of the 13 CRM cases were very limited. It was very difficult to get an accurate picture from the records alone. I therefore sought to interview as many of the inspectors (or managers) who received the whistleblowing information or who were involved in the inspection as possible, where they were still working at CQC. Where this was not possible, I worked through the available records on CRM with the assistance of the Head of Performance.

Section 3: Detailed background to Mr Kumar's case

Mr Kumar and his background

19. Mr Shyam Kumar is a consultant orthopaedic surgeon. He specialises in upper limb surgery. He has been employed by the University Hospitals of Morecambe Bay NHS Foundation Trust as a consultant in the Trauma & Orthopaedics department since August 2011. He has been a consultant for c.12 years.

20. He is a Fellow of the Royal College of Surgeons and of the European Board of Orthopaedics and Trauma. He also has a LLM in Medical Law & Ethics. Since 2016, he has been an assessor for Practitioner Performance Advice to investigate doctors with performance concerns. Most recently, he was selected as a Regional Specialty Professional Advisor for Trauma & Orthopaedics for the Royal College of Surgeons (in 2022), as a medical assessor for the General Medical Council for fitness to practice assessments (2023), and as a member of the Medico-Legal Committee for the British Orthopaedic Association.

21. As the Employment Tribunal recorded (§29), he had never been subject to any disciplinary action nor any negative performance reports during his employment at UHMB.

22. In 2014, he applied via an open competition to become a Specialist Advisor with the CQC; this role is explained further below. His contract which commenced on 11 July 2014 was as a secondee for an undefined period.

23. As such, he would be invited to attend hospital inspections along with the CQC inspection team to provide specialist clinical input. He was also asked on occasion to provide one-off pieces of advice on orthopaedic surgical issues which came in to CQC's National Professional Advisor for Surgery.

National Professional Advisors or NPAs and Specialist Advisors or SpAs

24. Within CQC, there are NPAs and also SpAs.

25. The NPAs are practicing clinicians who are engaged by CQC to provide expert clinical input, advice and leadership for CQC, alongside their ongoing clinical commitments.

The NPA role is an ongoing and regular one within CQC (e.g. on a 2 day per week basis, which may be spread across more than 2 days). Initially, when CQC was established, I was told that there were only a few NPAs (e.g. for surgery, medicine and Accident & Emergency), and since then a number of other NPAs have been appointed in other sub-specialties (covering primary care, community services and hospitals): there are now approximately 20-25 NPAs within CQC, all of whom are practicing clinicians. Generally, NPAs are not employed by CQC but are on secondment from their clinical roles for this part-time commitment (sometimes on a long-term basis). CQC calls on the advice of an NPA on a particular issue which arises (whether with a particular hospital, for example, or with a strategic issue). In turn, if the issue the NPA is asked to look at is itself a specialist issue which is outside of their particular expertise, they may call on the expertise of a SpA.

26. SpAs are also not employed by the CQC but engaged on a contractual basis (whether under secondment or otherwise) to undertake particular pieces of work as they arise – whether this be inspections or specialist one-off pieces of advice.

27. There are various types of SpA, from consultant surgeons like Mr Kumar, to theatre nurses, to mental health specialists, across all types of clinical specialty. They are part of what CQC calls the Flexible Workforce, which also includes a bank of inspectors who can be called on when supplementary inspectors are required to support full-time inspectors.

28. In the Hospitals Directorate at CQC, the role of a SpA is usually to supplement an inspection team inspecting a particular type of core service (e.g. maternity, surgery, A&E[4]) by providing their specialist expertise and/or clinical input. So, for example, when an inspection team is inspecting the maternity service of a hospital trust, they will ask for a SpA or team of SpAs with maternity expertise to support that inspection. The same is true when an inspection team is going into inspect the surgical function of a hospital, although surgery often covers a variety of different surgical sub-specialties. I have set out a summary of CQC's inspection process in Section 4 below.

[4] There are eight acute hospital core services: 1) Urgent & emergency services; 2) Medical care (including older people's care); 3) Surgery; 4) Critical care; 5) Maternity; 6) Services for children and young people; 7) End of life care; and 8) Outpatients.

29. The CQC's current induction handbook for SPAs[5] says:

"Your role as a SpA while on inspection is vital. You are there to:

- *Support the inspection team*
- *Provide specialist advice*
- *Ensure that CQC's judgements are informed by up-to-date and credible clinical and professional knowledge and experience."*

30. In terms of how SpAs sit within CQC as an organisation, this can be described as follows:

a) The Flexible Workforce team is an administrative team which liaises with SpAs (and other members of the flexible workforce) and allocates them to inspections, based on a schedule of requests for SpA support from inspection teams. It is (or at least was at the time of Mr Kumar's tenure) a separate team from CQC's Human Resources (**HR**) team (known in CQC as the People Directorate).

b) SpAs work with a team of inspectors at inspections, led by an inspection manager (or other senior manager within CQC) who will lead and direct the team over the course of the inspection.

c) The current process (which has developed since Mr Kumar's period) is that there is a feedback form which can be completed by an inspector about the SpA's performance. I heard concerns in interviews about this process or an earlier similar process being unsatisfactory and not often used because the feedback from the inspector or inspection lead is given openly to the SpA (either directly or via the Flexible Workforce team) i.e. they see the form. (It does not appear to have been utilised in Mr Kumar's case at all, see Section 6 below). There is a reference in the current SpA induction document to SpAs being able to give feedback on inspections (via the same form) or to a dedicated feedback email – again this does not seem to be well-utilised.

31. As to the management of SpAs, this is currently unclear; or rather it is clear in my view that there is no such functioning management structure within CQC.[6] NPAs may contact and call upon the advice of SpAs where needed for a particular subspecialty issue as noted above, and they may therefore be known to, and the main point of

[5] Current version is in interim version 2022: https://www.cqc.org.uk/sites/default/files/2022-11/20221108_SPA_Induction_Handbook_hospitals_interim_v1.01_0.odt .

[6] I understand that this is an issue being looked at by various parts of the CQC including as part of the CQC's ongoing transformation programme.

contact for, the SpA in question within CQC (as occurred in Mr Kumar's case). However, the NPAs do not manage SpAs and do not consider themselves to be responsible for the SpAs (of whom there are a very large number within CQC), in terms of any line management function. The position as it was described to me was that NPAs and SpAs are all a group of clinical professionals, and there is no management structure in place between them.

32. There is no formal appraisal process for SpAs in terms of their role within CQC, nor any proper feedback process as above. Moreover, there is (or was) no formal process for their disengagement nor any clear pathway as to who is responsible for any such decision (as was evident in Mr Kumar's case). There has already been work undertaken to resolve these issues, pending the outcome of this review.[7]

33. The situation is obviously unsatisfactory. In Mr Kumar's case, it was one of the surgical NPAs at the time who started the process with HR for the disengagement of Mr Kumar (see further below). The Employment Tribunal concluded that it was the NPA's decision to take this step (after receiving concerns from the CQC inspector who was the 'Relationship Owner' (**RO**) for UHMB).[8] This lack of management function and process was a factor in how issues developed in Mr Kumar's case.

34. Finally, it is important to note a key concern about the way that CQC exercises its functions in terms of inspections, and one that was shared by both by Mr Kumar and by the surgical NPA involved in his case, and which I heard echoed or at least acknowledged by others within CQC. It is difficult for a specialist clinician (like an orthopaedic surgeon) to give proper expert input at an inspection on an area outside of their subspecialty. Surgery, as with other branches of medicine, covers a variety of subspecialties e.g. urology, orthopaedic, paediatric, vascular surgery. Because CQC usually inspects a hospital's surgery service (i.e. one of the core services[9]) with one inspection team within a hospital trust, this can create difficulties for the professional involved (who cannot comment on another subspecialty other than at a very high level of generality). In turn, this can also mean that CQC does not have access to the appropriate clinical expertise at an inspection if it involves a specialist area outside of

[7] I was told that significant work has already been carried out on the disengagement process (which is now available, including structured meetings and a right of appeal for any disengagement).
[8] The Employment Tribunal found at §104 that the NPA was the individual with the authority to terminate SPA contracts and as at this date he was instructing that [Mr Kumar] was removed from the SpA list and disengaged. This appears to me to be correct in the sense that the email to HR requesting that Mr Kumar be removed from the SpA list came from the NPA. I address this in detail later in this section.
[9] See footnote 4 above.

the expertise of the SpA on site. Again, this is an issue which has come to the fore through Mr Kumar's case.

35. In this regard, I was told about an ongoing piece of work within CQC, led by one of the NPAs and ongoing for several years, which seeks to address this issue by using intelligence-led monitoring to seek to anticipate the issues which will come up at an inspection and ensure that the appropriate SpA is matched to the right inspection in advance, so that CQC has the correct clinical expertise on the day or days. This uses the available data about a service to enable planning in advance about the likely areas of concern. I was told that its particular importance has been highlighted and given new impetus already by Mr Kumar's case. This is obviously an important piece of work and in my view should be prioritised and developed further, particularly in light of my findings below (and I return to this in my Recommendations at Section 9 below).

36. This last point is linked to a concern about adequate resourcing which also flowed through the interviews I undertook as part of my review. I heard concerns from a variety of sources that resourcing for inspections was under such pressure (at least at the time of Mr Kumar's experiences in 2018 and 2019) that there were often felt to be neither enough inspectors nor enough SpAs to cover large hospital trusts over different sites, over only a few days. I heard accounts of the level of pressure (professional and personal) this placed on inspection teams, and the consequential turnover of staff. One of Mr Kumar's concerns related precisely to this point.

A summary of what occurred in Mr Kumar's case

37. What occurred in Mr Kumar's case is complex and multi-faceted. It raises a number of thematic issues which are relevant to the proper exercise of CQC's regulatory functions:

- Firstly, it raises issues as to how CQC looks at, records and uses whistleblowing information coming from *outside* CQC from employees of Trusts (whether or not they are also SpAs).

- Secondly, it raises issues about how CQC deals with internal concerns raised (in particular) by SpAs following inspections, where there are concerns as to how the inspection functioned and/or whether their clinical input or clinical issues raised at inspections were taken on board or

reflected in the ultimate inspection report (which in turn is closely linked to management of, and appropriate resourcing for SpAs).

- Thirdly, a particular issue raised by Mr Kumar's case is the extent to which CQC can and does engage with clinical concerns as part of its regulatory role, and how it goes about doing this appropriately (which overlaps with the point about SpAs at §34 above).

38. In terms of the specific factual issues, the Employment Tribunal (**ET**) looked at eleven protected disclosures which Mr Kumar made over time. These can be divided into three main sets of concerns raised which are the subject of this Review.

- 1) South Tyneside, May 2015: this was a written complaint Mr Kumar made to CQC's Chief Inspector of Hospitals following an inspection in which he participated as a SpA at South Tyneside hospital, raising clinical concerns identified by whistleblowers at the inspection (amongst other things) which he said were not being properly addressed, to the detriment of patient safety (Disclosure 1 in the ET); (see Section 6(1) below).
- 2) UHMB, June to Oct 2018: the second set of issues relates to concerns Mr Kumar raised with CQC in his capacity as an employee of UHMB, as an orthopaedic surgeon. Mr Kumar had serious concerns about patient safety and governance as a result of a) the practice of one particular orthopaedic doctor (Dr X) who had been operating unsupervised, which was said to have given rise to a series of serious clinical incidents, and b) in terms of the way the Trust was responding to investigate this and mitigate the ongoing risk (Disclosures 2-5, 9-11 in the ET). Dr X's practice was eventually restricted in August 2018 (as requiring consultant supervision), after Mr Kumar reported them to the GMC. These concerns were raised initially with the NPA in CQC and then with the inspector who was the Relationship Owner for UHMB. (See Section 6(2) below and the UHMB Chronology at Annex II).
- 3) East Lancashire, Sept 2018: the third set of issues relates to concerns Mr Kumar raised following an inspection in which he participated as a SpA at this NHS Trust: he was concerned again about patient safety (e.g. rates of return to theatre), resourcing issues for the inspection, and bullying and harassment of doctors in surgery (Disclosures 7 and 8 in the ET). These

were raised with the inspection team directly and then with the NPA thereafter. (See Section 6(3) below and East Lancashire Chronology at Annex III).

39. Before turning to the detail, it is important to note two things.

40. Firstly, Mr Kumar had also raised other concerns with CQC previously which were properly and promptly addressed, and it is important to recognise this. In October 2016, Mr Kumar was involved supporting a different group of staff from within UHMB with a concern about a different unit. This prompted CQC to meet those raising concerns at a local venue outside the hospital so that their concerns could be listened to and addressed (this was described by Mr Kumar as the "gold standard" service which he appreciated).

41. In addition, he also wrote a letter on 16 February 2018 to CQC raising an issue about a letter sent to the patient's association detailing the autonomous working of Specialty and Associate Specialist (**SAS**)[10] doctors, and his concerns about that practice within trusts. He received a response to this from the Chief Inspector dated 17 April 2018.

42. Secondly, for a CQC inspector or manager, it can be challenging and resource intensive to deal with a concern being raised by a staff member at a trust, particularly alongside all the other live issues facing a busy large acute NHS hospital trust. From what I have seen, inspectors and the management team at CQC have a vast array of issues to deal with across different specialist areas, and may be receiving numerous pieces of information of concern each week which need consideration. This is a difficult, but important, job, and I do not underestimate that. The resourcing issue already identified at §36 above makes this even more difficult.

Mr Kumar's disengagement and the ET proceedings

43. It was in the course of events within UHMB (i.e. the second set of concerns, §38(2) above), which overlapped in time with the third §38(3)), that Mr Kumar was disengaged from his role with CQC. The ET made detailed factual findings about what occurred here, based on the documentary record and a hearing taking 13 days including cross

[10] SAS stands for Specialty and Associate Specialist doctors and refers to specialist doctors with at least 4 years post graduate training two of which are in a relevant specialty. They may be very experienced doctors but are not consultant grade.

examination of all witnesses by counsel on both sides: see ET §79-99, and ET §100-124 (Annex VI). I take these as established facts for the purposes of my Review.

44. By way of brief summary, Mr Kumar had been raising his concerns about Dr X within UHMB from March 2018 onwards and was not satisfied with how they were being addressed by UHMB's management (hence he raised them with CQC from June 2018 onwards).

45. In that context, an issue arose between, on the one hand, Mr Kumar and another orthopaedic consultant, being the two consultants who had gone on record with their concerns (initially supported by a wider group of consultants), and a SAS doctor (i.e. an experienced specialist orthopaedic doctor but not a consultant) (Dr Y) on the other hand. Dr Y perceived the actions by Mr Kumar and his colleague as targeting SAS doctors generally, whereas Mr Kumar's position was he was motivated solely about the patient safety issues at stake. The issue was complicated, because the SAS doctors were predominantly of Indian ethnic origin, and Dr Y went onto describe Mr Kumar's actions in raising concerns about Dr X as being a "traitor to his community" (as someone also of Indian origin; this was in an email on 30 October 2018 to a broad recipient list, see ET §80).

46. This was the backdrop to the focus group that took place on 31 October 2018: it was a CQC focus group with BME doctors, unrelated to these issues. Mr Kumar wrote to the Relationship Owner (**RO**) for UHMB on 30 October 2018 (the day before the focus group) setting out the background to the issues with Dr X (which had already been raised several times with CQC via the NPA and passed on to the Relationship Owner: see UHMB Chronology[11]). He stated that he was being intimidated by friends of Dr X who were *"trying to turn it into a BME issue / SAS doctor issue."* He indicated that he and others would not be attending the focus group because of these issues which meant that *"people with an agenda might deliberately make the atmosphere unpleasant."* The ET found that the RO did not read the email in advance of the focus group, and when they did read it and reply, they either did not read the email in full or did not process the information contained within it: ET §84.

47. It was in the above context that the CQC became involved in the dispute between the doctors directly, whilst attending the focus group. This course of events ultimately led

[11] Annex II.

to Mr Kumar being disengaged from his role within CQC (the subject of the ET proceedings).

48. There was a dispute arising from what was said at the focus group about Mr Kumar (who was not present) by Dr Y, which was subsequently reported to Mr Kumar by two colleagues who were present. The ET found that Dr Y made comments about the claimant at the focus group (including *"concerns of bias discussing personal grievances, allegations of patients going private to benefit a group of surgeons that are not BME, that there was some motive to report clinical incidents and linked matters to his ethnicity."* (ET §85)).

49. In the circumstances, the ET found that Mr Kumar had a right to feel upset, in particular as to matters of probity or race; all such matters were serious and could have impacted on Mr Kumar's fitness to practice if correct (ET §90). A letter was written by Mr Kumar to Dr Y in response, which the ET saw and found was *"an attempt to resolve matters informally."* It is summarised at ET §88 as follows:

> *88. On 12 November 2018, the claimant raised issue with [Dr Y] for having named him in the Focus Group alongside various allegations. … This letter includes the following:*
>
> *a. It informs [Dr Y] that the letter is not a formal complaint*
> *b. That the letter is giving [Dr Y] the opportunity to rectify any misunderstandings and rectify any errors he may have made.*
> *c. That further action would only have to be taken, depending on the outcome from this exchange*
> *d. The claimant, along with other colleagues, had raised performance issues in relation to a doctor. He had no concerns about any other SAS doctors.*
> *e. That the claimant always valued the clinical work of [Dr Y], and that he has never expressed any concerns about his clinical ability.*
> *f. That the claimant became aware of emails written by [Dr Y] (the emails referred to above), in which there are allegations that have been 'extremely' hurtful and has damaged his reputation and professional standing among his peers.*
> *g. That he recognises that [Dr Y's] change in attitude toward him coincided with him having escalated concerns about a colleague, that being Dr X.*

h. The claimant understood that [Dr Y] had named the claimant at the Focus Group meeting and that he has raised an allegation that the claimant had stopped another colleague from operating in order to take cases privately.

i. That such an [sic] *could only be to mislead the CQC as there was no truth to it based on the data.*

j. That such an allegation is very serious.

k. That [Dr Y] has breached the claimant's confidentiality by naming him directly in front of others at the meeting, which was not a Trust meeting but a CQC Focus Group meeting.

l. Lists what he considers [Dr Y]'s actions could amount to.

m. Suggests actions that [Dr Y] could take to fix the situation. This included an apology and an email to the groups previously emailed to the effect that what he had said was false and defamatory.

n. The claimant required a response to this letter within 5 working days, after which he would be considering whether he was going to take formal action in relation to the matter.

50. As a result of this letter, Dr Y contacted CQC and this was passed onto the UHMB Relationship Owner who went to the Trust to interview Dr Y. The Relationship Owner did not speak to Mr Kumar or meet him. The RO then raised the matter with the NPA by telephone (see ET §100), contending that there was a concern that Mr Kumar was bullying and intimidating his colleagues, and using his position with CQC to do so. As above, the ET found that they had not processed the information Mr Kumar had given them about the 'other side of this story', nor did they appear to see how this fitted in with his previous protected disclosures about the ongoing issues with Dr X.

51. Shortly afterwards, the NPA sent an email to CQC's HR team asking that Mr Kumar be taken off the SpA list. The ET found that in taking that step the NPA on behalf of the CQC was materially influenced by the series of protected disclosures Mr Kumar had already made (see ET §124), which included those concerning UHMB and East Lancashire.

52. The internal email which is reproduced in the ET judgment at §122 from the NPA at a later date summarising the basis for the disengagement states:

"Essentially Mr Kumar sent me a number of emails expressing concerns that his own organisation were allowing an Associate Specialist [i.e. SAS doctor] *to operate independently and that this was leading to poor patient outcomes.*

In his letter he stated that he was representing 'concerned colleagues'….
I brought these concerns to the local team who told me the Trust were aware of the concerns, had investigated them and had not found them to be valid.

In addition, much of the problem appeared to be related to Mr Kumar, who was unhappy with the arrangement and wanted it stopped. It was also brought to my attention that Mr Kumar had been using his position within CQC to intimidate his colleagues.

Following a discussion between [the RO] and myself it was decided that he should no longer be used as an SPA and I informed the FWO accordingly."

53. The ET found that Disclosures 2-10 had had a material influence on the decision to disengage him: ET §145-146. It found a causal link between the detriment (his disengagement) and these protected disclosures. It went onto accept Mr Kumar's evidence as to the serious impact of this on him, in terms of the damage to his previously "untarnished reputation" with both the Trust and the CQC at the time the decision to disengage him was taken: see 153-159. Accordingly, it awarded him £23,000.

54. For completeness, insofar as there might remain any suggestion that Mr Kumar's actions in writing the letter to Dr Y were bullying, I do not consider that this can now be maintained. The ET (ET §88, see §49 above) did not consider it to be a bullying letter. Having interviewed the CQC staff involved and Mr Kumar, I cannot see any proper basis on which CQC could reasonably have concluded, on the basis of the information it had (and in the absence of having met or spoken to Mr Kumar about it), that Mr Kumar's actions constituted intimidation or bullying (nor that Mr Kumar was somehow misusing his CQC position). Moreover, had CQC properly understood the position and Mr Kumar's role as a whistleblower raising concerns (both with CQC; and with the Trust, which resulted in the dispute with Dr Y), CQC would have seen that there was an obvious context within which these issues were arising. This appears to have been overlooked or misunderstood – this should not have occurred.

55. Moreover, as the Chronology shows (see Annex II), this has now been overtaken by the events which followed; UHMB has recognised following an investigation in June 2022 that Mr Kumar was not properly treated as a whistleblower and suffered detriment as a result of the concerns he raised with them.

Context for this Review

56. It is impossible to disentangle entirely the above events from the content of what Mr Kumar was raising. It is also clear from the findings of the Employment Tribunal that Mr Kumar was subjected to the detriment of being disengaged from the CQC in material part on account of his taking action to raise concerns. That is a very serious matter for CQC, as it has already recognised.

57. However, as above, my focus is primarily on the specific points Mr Kumar was raising as a matter of substance, and whether CQC discharged its regulatory obligations in terms of appropriate action in response to that. I turn to the three sets of issues in turn below, in Section 6.

Section 4: Summary of Legal Framework & CQC's processes

CQC functions and objectives

58. The CQC is the independent regulator of healthcare, adult social care and primary care services in England, established by the Health and Social Care Act 2008 (**the 2008 Act**). Its main functions are set out in that Act (s.2). The CQC's main objective is to "*protect and promote the health, safety and welfare of people who use health and social care services*" (s.3(1)). Section 3(2) requires it to perform its functions for the purpose of:

    a) The improvement of health and care services;
    b) The provision of health and social care services to meet needs and experiences of service users;
    c) The efficient and effective use of resources in the provision of health and care services.

59. Section 4 of the 2008 Act provides that, in performing its functions, the CQC must have regard to, among other matters:

    a) the views expressed by or on behalf of members of the public about health and social care services,
    b) the experiences of service users,
    c) the need to protect and promote the rights of service users, and
    d) the need to ensure that any action taken by the CQC is proportionate to the risks against which it would afford safeguards.

60. The views of the public and of service users, in order to protect service users' rights, are central considerations.

The Fundamental Standards

61. The CQC regulates healthcare providers according to the requirements set out in regulations made by the Secretary of State under section 20 of the 2008 Act.[12] These are the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/2936 (**the 2014 Regulations**), which set out the activities which the CQC regulates, known

[12] Section 20 provides that the Secretary of State must by regulations impose requirements that he considers necessary to secure that the services provided cause no avoidable harm to service users. Those regulations may impose any other requirements that the Secretary of State thinks fit, including those that will ensure that the services provided are of an appropriate quality.

as the “Fundamental Standards” (which are the standards of safety and quality below which care and treatment should never fall). In summary:

a) Regulation 9 requires the care and treatment of service users to be appropriate, meet their needs and also reflect their preferences.
b) Service uses must be treated with dignity and respect (Regulation 10).
c) Care and treatment of service users must be provided only with their consent (Regulation 11).
d) Regulation 12 provides that care and treatment must be provided in a safe way for service users. This includes (a) assessing risks to health and safety of service users receiving care or treatment; (b) doing all that is reasonably practicable to mitigate such risk; and (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely (Regulation 12(2)).
e) Service users must be protected from abuse and improper treatment (Regulation 13) and care or treatment must not be provided in a way which includes discrimination on the grounds of any protected characteristic, as defined in section 4 of the Equality Act 2010 (Regulation 13(4)(a)).
f) Service users’ nutritional and hydration needs must be met (Regulation 14).
g) Regulation 15 relates to suitable and safe premises and equipment.
h) Service providers must investigate and act on complaints and have in place accessible systems for managing complaints (Regulation 16).

62. Regulation 17 provides that systems and processes must be established and operating effectively so as to ensure good governance in the provision of regulated services. Such systems or processes must enable the provider to:

a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;
c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

d) maintain securely such other records as are necessary to be kept in relation to—
   (i) persons employed in the carrying on of the regulated activity,
   (ii) the management of the regulated activity;
e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;
f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

63. Regulation 18(1) provides that sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed to provide a regulated service. Regulation 18(2)(a) provides that employees of registered providers must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

64. Employees of registered providers must be fit and proper persons who are appropriately qualified to carry out their work (Regulation 19).[13]

65. Regulation 20 provides that registered providers must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users: i.e. the "duty of candour". This requires NHS bodies to be open and honest with people. It applies to registered providers, not individuals. Where, in the view of a healthcare professional, an unintended or unexpected incident has resulted in, or could still result in, death, severe or moderate harm, or prolonged psychological harm to a patient, the regulations prescribe a formal set of notification procedures that the provider must follow when informing the patient, or their representative, of that harm (Regulation 20(2)-(4)). Providers must notify the patient, give an apology and follow up the incident in writing (Regulation 20(3)).

[13] Schedule 3 of the 2014 Regulations requires providers to provide CQC with evidence to assess whether the Fit and Proper Person test has been properly applied. The criteria for eligibility as a director includes a requirement that the individual must not have been responsible for, or have permitted or colluded in, any serious misconduct or mismanagement, in the course of carrying out an activity regulated by CQC (Regulation 5). The CQC has specific Fit and Proper Person Guidance and guidance on directors.

66. The CQC Guidance on Duty of Candour, updated on 30 June 2022, emphasises that providers should be "*creating an environment that encourages candour, openness and transparency at all levels*", including by having "*training, policies and systems in place*". The Guidance says that there are a range of ways to assess compliance with the Regulation 20 duty, including:

    a) question frontline staff about their understanding of the duty of candour and notifiable safety incidents;
    b) question the registered person about their policies and processes for recording and carrying out the duty, and for training staff;
    c) investigate senior staff and board members' level of understanding of the duty and how they ensure staff feel supported to speal up and be open and honest about incidents.

Enforcement

67. The CQC has various enforcement powers. The CQC can suspend or cancel registration if the provider fails to comply with relevant requirements or if the registered manager has a conviction or there is no registered manager (ss.17 and 18). It may issue a requirement notice (requiring a report from a provider as to how they will comply with their obligations and actions they will take), or a warning notice to notify a provider that they are not meeting a condition of their registration (see s.29). CQC may make changes to a care provider's registration to limit what they may do, for example by imposing conditions for a given time. CQC's website explains that it can also place a provider in special measures, "*where we closely supervise the quality of care while working with other organisations to help them improve within set timescales*."

68. The 2008 Act also provides for emergency civil enforcement procedures for suspension, variation (s.31) or cancellation (s.30) of a registration. It also has criminal powers to issue cautions, fines or to prosecute cases where people are harmed or placed in danger of harm.

69. The CQC Enforcement Policy[14] sets out its approach to taking action when it identifies poor care, or where providers fail to meet the required standards. There are two primary purposes:

[14] https://www.cqc.org.uk/sites/default/files/20150209_enforcement_policy_V1-1.pdf

a) First, to protect people who use regulated services from harm and the risk of harm, and to ensure they receive health and social care services of an appropriate standard; and
b) Second, to hold registered persons to account for failures.

Performance Assessment

70. CQC carries out regular "*comprehensive inspections*" and "*focused inspections*", which are smaller in scale than comprehensive inspections, but follow a similar process[15]. This is how it discharges its statutory duty to periodically review and assess the performance of registered providers (s.46).[16]

71. CQC cites two reasons for carrying out focused inspections: (i) "*To look at something we're concerned about, which might have been raised during a comprehensive inspection or through our monitoring work*"; or (ii) "*If there is a change in a care provider's circumstances*".

72. Section 64 empowers the CQC to require providers to provide it "*with any information, documents, records (including personal and medical records) or other items which the Commission considers it necessary or expedient to have for the purposes of any of its regulatory functions*".

73. CQC also has the power to conduct special reviews or investigations into the provision of NHS care (s.48),[17] which are distinct from inspections. CQC terms these "thematic reviews."[18]

74. The CQC publishes a Provider Handbook which describes its approach to regulating, inspecting and rating service providers.[19] It explains that CQC awards ratings on a four-point scale: Outstanding, Good, Requires Improvement, or Inadequate.

[15] See CQC website, Types of Inspection.
[16] Section 60 empowers the CQC to carry out inspections of the manner in which service providers carry out their functions. The CQC is obliged to publish its report from any such inspection (s. 61). In order to carry out such inspections, the CQC has powers to enter and inspect any regulated premises (ss.62-63).
[17] And adult social services, the functions of NHS Boards, English local authorities (in arranging the provision of adult social care services) and English Health Authorities. CQC has a duty to conduct these if requested by the Secretary of State and the Secretary of State's consent is required for CQC reviews on commissioning.
[18] see https://www.cqc.org.uk/publications/themes-care/themes-health-social-care.
[19] Pursuant to s.46.

75. It explains that the CQC inspectors will use their professional judgment, supported by objective measures of evidence, to assess services against 5 key questions (relating to 5 aspects or "domains"): are services (i) safe, (ii) effective, (iii) caring, (iv) responsive to people's needs and (v) well led? It also explains that the inspectors will examine how services are provided to 6 specified population groups, including older people and people with long-term conditions. Judgments and ratings are made for each population group and every key question. Ratings are then aggregated for every key question and population group, to provide an overall aggregated rating for the practice.

76. There is no statutory right of appeal against an assessment of rating. However, Chapter 11 of the handbook sets out procedures to be followed before and after publication. This is a two-stage process (i) prior to publication, a factual accuracy check and challenge to the proposed rating, and (ii) post-publication, a rating review if the CQC did not follow the correct process of making ratings decisions and aggregating them.

Equalities Duties

CQC's obligations

77. The CQC's services and functions fall under Part 3 of the EA 2010. Section 29(2) in this Part prohibits discrimination by a service provider and s.29(6) prohibits discrimination in the exercise of a public function.

78. The relevant protected characteristics under Part 3 are: age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Section 9 defines race as including (a) colour, (b) nationality and (c) ethnic or national origins.

79. The EA 2010 protects against direct discrimination (s.13), indirect discrimination (s.19), harassment (s.26) and victimisation (s.27).

Public Sector Equality Duty

80. Section 150 EA 2010 defines a public authority as a person who is specified in Schedule 19. CQC is so specified and is therefore subject to the Public Sector Equality Duty under s.149 (**PSED**).

81. In the exercise of its public functions, the PSED requires CQC to have due regard to:

    i. The need to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the EA 2010;
    ii. Advance equality of opportunity between people who share a protected characteristic and those who do not; and
    iii. Foster good relations between people who share a protected characteristic and those who do not.

82. Advancing equality of opportunity means having due regard, in particular, to the need to:
    i. Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic (s.149(3)(a));
    ii. Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it (s.149(3)(b);
    iii. Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low (s.149(3)(c)).

EHRC Memorandum of Understanding

83. The Memorandum of Understanding (**MoU**) between CQC and the Equality and Human Rights Commission (**EHRC**), dated 9 March 2021[20], sets out the framework that supports the work of both organisations, with a view to safeguarding the wellbeing

[20] It is understood that this is a longstanding agreement, which was most recently updated in April 2022.

and rights of the public receiving health and social care in England. It details general principles of cooperative working (§6) and key areas of cooperation (§7).

84. The MoU says that CQC must also have due regard to the PSED where it relates to the CQC's regulation of health and social care providers in England and extends to providers where they are exercising public functions (§13). It acknowledges that the 2014 Regulations are closely aligned with the EA 2010 and it says that leadership on equality is "*included in how CQC assesses compliance with fundamental standards of quality and safety and whether services are well-led*" (§14).

85. The MoU provides routes for each organisation to share with the other information which may be of interest. If the MoU lead at CQC receives information from the EHRC it will be passed to the relevant inspector or policy team (§18(a)). Both organisations "*will ensure timely and focussed exchange of relevant information that enables effective coordination and cooperation*" (§21).

CQC Guidance

86. CQC's Guidance for Providers (March 2015) on Regulation 13 says:

    a) Staff must understand their individual responsibilities in preventing discrimination;
    b) Providers should have systems for dealing with allegations and acts of discrimination regardless of who raises the concern or who the allegation is against;
    c) Providers must support people who use services when they make allegations of discrimination or actually experience discrimination.
    d) When allegations of discrimination are substantiated, providers must take corrective action and make changes to prevent it happening again (p480).

87. CQC's Guidance on "*Handling concerns raised by workers of providers registered with CQC*"[21], in the section on whistleblowing says "*Workers are protected in this way for the public interest, to encourage people to speak out if they find wrongdoing in their place of work, without fear of victimisation, discrimination or losing their job*" (p3).

[21] Addressed in further detail below under CQC's processes.

Protected disclosures

88. The Public Interest Disclosure Act 1998 (**PIDA**) inserted whistleblowing protection provisions into the Employment Rights Act 1996 (**ERA 1996**). Whether a whistle blower qualifies for protection depends on them satisfying two main tests: (i) whether they made a qualifying disclosure; and (ii) whether the qualifying disclosure was protected.

89. Section 43B of the ERA 1996 defines "*qualifying disclosures*" as any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show one or more of the following:

    a) that a criminal offence has been committed, is being committed or is likely to be committed;
    b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
    c) that a miscarriage of justice has occurred, is occurring or is likely to occur;
    d) that the health or safety of any individual has been, is being or is likely to be endangered;
    e) that the environment has been, is being or is likely to be damaged, or
    f) that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

90. A qualifying disclosure is made in accordance with s.43C if the worker makes the disclosure to:

    a) his employer; or
    b) where the worker reasonably believes that the relevant failure relates solely or mainly to –
        1. The conduct of a person other than his employer, or
        2. Any other matter for which a person other than his employer has legal responsibility, to that other person.

91. Protected disclosures can also be made to "prescribed persons". Section 43F (disclosure to prescribed person) provides that "*a qualifying disclosure is made in accordance with this section if the worker –*

a) *makes the disclosure to a person prescribed by an order made by the Secretary of State for the purposes of this section, and*

b) *reasonably believes –*

1. *That the relevant failure falls within any description of matters in respect of which that person is so prescribed, and*
2. *That the information disclosed, and any allegation contained in it, are substantially true*".

92. Workers have the right not to be subjected to any detriment on the ground that they have made a protected disclosure (s.47B(1) ERA 1996). The term "*detriment*" is not defined in the legislation but has been held by employment tribunals to mean that a worked as been disadvantaged in the circumstances in which they had to work. A worker (defined by s. 230(3) ERA 1996) therefore has the right to bring a claim against his or her employer if they are subject to a detriment. Available remedies include compensation and a declaration that they have been subject to an unlawful detriment.

93. CQC is identified as "*prescribed person*" for the purposes of s.43F, for "*matters relating to (a) the registration and provision of a regulated activity as defined in section 8 of the [2008 Act] and the carrying out of any reviews and investigations under Part 1 of that Act; or (b) any activities not covered by (a) in relation to which the [CQC] exercises its functions*". In other words, CQC receives protected disclosures in its capacity as the regulator as set out above.

Reporting on protected disclosures

94. As a prescribed person, the CQC is required by regulations[22] to report annually on the protected disclosures it receives. The report must be published on the CQC's website (or otherwise be made available to the public) within 6 months of the end of the reporting period which is 1 April each year. The report must contain:

a) The number of workers' disclosures received during the reporting period that the relevant prescribed person reasonably believes are—

1. qualifying disclosures within the meaning of section 43B of the Employment Rights Act 19961; and

[22] under the Prescribed Persons (Reports on Disclosures of Information) Regulations 2017/507 (**the Prescribed Persons Regulations**) made under section 43FA ERA 1996.

2. which fall within the matters in respect of which that person is so prescribed;

b) The number of those disclosures in relation to which the relevant prescribed person decided during the reporting period to take further action;

c) A summary of—

1. the action that the relevant prescribed person has taken during the reporting period in respect of the workers' disclosures; and
2. how workers' disclosures have impacted on the relevant prescribed person's ability to perform its functions and meet its objectives during the reporting period;

d) An explanation of the functions and objectives of the relevant prescribed person.[23]

Summary of CQC's processes

Overview of inspection / monitoring

95. The following is my understanding of the relevant processes, from the perspective of someone outside the organisation.

96. At the relevant time, CQC's hospitals directorate was divided into various regional teams across the country, led overall by the Chief Inspector of Hospitals. Each region was led by a Deputy Chief Inspector (**DCI**), and under them, within smaller regions, a Head of Hospitals Inspection (**HOI**), and then a series of inspection managers who managed in turn a team of inspectors.

97. An individual inspector would generally have responsibility for one NHS hospital trust, within a portfolio of other responsibilities (including for other private providers). This would be the trust's 'Relationship Owner' or **RO**; they would liaise with the trust, through regular engagement meetings and monitoring of the trust's data (with the help of CQC's analysts). They would also plan and co-ordinate, and often participate in, inspections for that trust.

[23] See regulations 3, 4 and 5 of the Prescribed Persons Regulations.

98. This means that the RO would be responsible for attending regular meetings on site with the trust, and receiving information of concern coming in from staff members, patients or members of the public, as part of the monitoring of intelligence about the Trust.

99. This structure has now changed under the CQC's Transformation programme, which is now structured into Operations and Regulatory Leadership, a detailed summary of which is outside of the scope of this review, and which is an ongoing process. For present purposes, the issues I am looking back at were under the old organisational structure so I will focus on summarizing that for the purposes of explaining my findings.

100. In terms of an inspection, whether comprehensive or focused, an overview of the process for this would be:

a) a Regulatory Planning Meeting (**RPM**), at which the RO would usually present the available intelligence and proposal for the areas to be inspected and/or any particular areas of concern; this was usually attended by the inspection manager, as well as the relevant HOI and often the DCI; this would enable a decision to be reached and approved by the managerial team about which core service areas would be looked at (if this was a focused inspection), for example; and
b) a briefing meeting involving a presentation from the RO in advance of the inspection, with the proposed inspection team (whether for 'core services' or 'well-led', which are usually held separately, the latter following after the former to allow information to be obtained and considered in the latter process);
c) the inspection itself, over a number of days and with a number of inspection teams looking at each core service, assisted by SpAs (as explained above, see Section 3, §24-28), incorporating corroboration between teams (though this seemed to differ in practice over time), and a feedback meeting at the end of the inspection with the teams / the manager, and then feedback given to the provider;
d) follow up meetings after the event (which involved a Management Review Meeting or **MRM**) to decide on outcomes, regulatory action, judgments about ratings, further feedback to the trust and so on;

e) finally, the factual accuracy and quality assurance process for the inspection report, and then publication of the report.

101. I have already summarised above the various requirements against which CQC inspects and its ratings process (See §61-76).

CQC Processes

102. CQC's process for people raising concerns about a service is as follows (and is set out in the internal and external guidance):

a) All concerns are to be directed via a national service centre, the National Customer Service Centre (**NCSC**) whether via email, via a form available of CQC's website (known as "Share your experience") or by phone call, or otherwise;

b) The NCSC then logs this on CQC's Customer Relationship Management (**CRM**) system, triages it according to its level of priority and the nature of the concern (i.e. whistleblowing information from a staff member, a safeguarding concern, and/or a concern raised by a patient or member of the public – which is termed a complaint rather than whistleblowing);

c) NCSC forwards this information on to the RO for the relevant Trust.

103. CQC's internal guidance entitled *"Handling concerns raised by workers of providers registered with CQC"*[24] provides as follows:

a) Information must be passed on swiftly, particularly where the concern is about poor quality or unsafe care, where people may be at risk of harm (p 2 Summary);

b) Defines a 'whistleblower' as a person employed by a provider or providing services for them, making a "protected disclosure" i.e. in line with the legal definition set out above in the ERA 1996 (pp 3-4);

c) Under section 5, "What we do with the information", it states that CQC will "[a]ssess prioritise and act appropriately on all information we receive" which includes thanking them, ensuring they receive feedback on the action taken where possible and asking for feedback from them about how it is handled;

[24] The current version is v2 dated 16 6 2019.

d) Further, the options given for what action may be taken are i) using the information to decide whether to urgently inspect or bring forward a planning inspection; ii) raising the issue directly with the provider (bearing in mind the need for confidentiality); iii) making a safeguarding alert to the local authority; iv) notifying another regulator or official body if appropriate for them to look at the information as opposed to or as well as CQC; v) notifying the police if necessary.

e) Under section 8, it explains (as above) that the team assesses categorises and prioritises disclosures, they enter onto CRM and then pass to the appropriate inspector within 24 hours. The inspector then reviews and decides what action to take and records on CRM. It states that CQC monitors the progress of action using the management information reporting tools and line manager discussions.

f) Under section 9, under "What to do if someone raises concern with you" it says that most people contact NCSC but if someone raises a concern e.g. at an inspection, you should note it down take a record and then pass on to NCSC.

g) Under section 12, under Monitoring, it states that CQC uses Management Information Reports for monitoring of this data. It also says that it is "important that inspectors record action they have taken in the Activity Plan of the enquiry and within the Safeguarding Record." This is important for CQC's requirement to report under PIDA (see above) every year.

104. As to the NCSC's triaging priority levels, these are as follows:

- Priority 1 – ASAP: Where an adult of child has experienced, or is at risk of abuse or neglect, CQC is the first agency, the individual concerned is identifiable and there remains a significant risk of the harm continuing.
- Priority 2 – High: An adult or child has experienced, or is at risk of, abuse or neglect and/or the police and/or local authority are aware of the incident, the individual concerned is not identifiable and/or there does not remain a significant risk of harm continuing.
- Priority 3 – Medium: Information may suggest a breach but the safety of people using the service is not affected.

- Priority 4 – Low: It may be of interest to the inspector but does not impact on the safety of people who use the service.

105. There are also a series of published documents on CQC's website which reflect the above information and are available for providers and staff members: all linked below.[25]

106. CQC has a Freedom to Speak Up policy (current version dated September 2018) for people who work for CQC, adapting from the standard policy developed after the Francis Speak Up review. CQC has a Freedom to Speak Up Guardian, and a series of Freedom to Speak Up ambassadors across CQC. Freedom to Speak Up is one of the workstreams in the CQC ongoing LLRC review.

107. The policy applies to anyone who works in CQC in any capacity including specialist advisors and other contractors or temporary workers. It advises raising a concern first with a manager informally or formally, and then with one of the Freedom to Speak Up Ambassadors. The purpose of the Guardian is to promote an open and transparent culture across the organization so that people can speak up with confidence.

CRM system

108. The CRM is CQC's information system for logging whistleblowing inquiries, and various other types of information across CQC (such as inspections). As with all IT systems, it often creates difficulties as well as solving them.

a) For whistleblowing information, they are logged as an Enquiry with a reference number, and then a series of drop down boxes and tabs including Activity Plans, Attachments, Assessments, Related Enquiries, Notes, Safeguarding and so on.

b) There are some free text boxes (Non Restricted Summary or Description), which tend to be used by inspectors to explain how they have responded to the information, but not always.

[25] Raising a concern with CQC: A quick guide for health and care staff about whistleblowing
Report a concern if you are a member of staff - Care Quality Commission (cqc.org.uk)
Guidance for providers – November 2013

c) The drop down boxes which are available for showing the Action taken do not always capture this appropriately and/or do not always tell the full picture (e.g. referred to another body).

d) Importantly, documents that relate to the Enquiry (such as meetings, email correspondence, background documents and particularly follow up inspections that occur) are not always attached, linked or clearly signposted. Those documents are saved elsewhere on the CQC's systems – sometimes elsewhere on CRM, or else on Sharepoint (and this used to be the y-drive).

109. This meant that in the sample exercise, I could not readily understand many of the whistleblowing sample cases by using CRM alone and accessing linked documents saved on that system. Unless I had spoken to the individuals concerned, I would have reached very different conclusions about the level of response provided to the whistleblowing information. I return to this below.

110. I was told about changes to this system over time, e.g. in April 2021, the action taken to mitigate the risk posed by the whistleblower is now something which should be noted on the entry, as opposed to just an action by reference to the drop down box. However, it is clear that there remain difficulties with it as a usable tool for any detailed understanding of how the whistleblowing information has been taken on board.

111. I understand that it is the process of being replaced by a system which is intended to create an information platform for all information across CQC; this is a general platform as opposed to one used for whistleblowing information only. This will be a welcome positive development.

Section 5: Other background – reports and previous reviews

112. My review is not the first to consider CQC's regulatory approach and in particular the importance of whistleblowing information, and the need for clinical expertise. I have reviewed a series of key previous reports which have informed my approach to this review – this summary cannot do them justice.

113. The first is the Public Inquiry into the Mid Staffordshire NHS Foundation Trust[26] dated February 2013, chaired by the then Robert Francis QC. This report was the background to various organisational changes in the CQC and new fundamental standards set out in the 2014 Regulations. Key conclusions relevant here are as follows:

a) It was important to have a single regulator to avoid regulatory gaps (recommendation 19) and to ensure that the CQC understood its responsibility for regulating safety of care for patients:

"*The combination of these "regulatory gaps", lack of effective communication and constant reorganisation led to a systemic culture where organisations took inappropriate comfort from assurances given either by the Trust itself or from action taken by other regulatory organisations. As a result, organisations often failed to carry out sufficient scrutiny of information, instead treating these assurances as fulfilling their own, independent obligations*…

The focus of the system resulted in a number of organisations failing to place quality of care and patients at the heart of their work. …."

b) It emphasised the importance of the duty of candour and ensuring that honest and accurate information was given.

c) The report focused on ensuring that information was gathered from individuals and patients rather than just by auditing. It also emphasised

[26] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

inspections and gathering information (Recommendations 26 and 27). As to Recommendation 27, this was:

"*27 The healthcare systems regulator should promote effective enforcement by: use of a low threshold of suspicion; no tolerance of non-compliance with fundamental standards; and allowing no place for favourable assumptions, unless there is evidence showing that suspicions are ill-founded or that deficiencies have been remedied. It requires a focus on identifying what is wrong, not on praising what is right*."

d) It recommended scrutinising that material and not allowing for favourable assumptions or self-reporting and assurance.

e) It highlighted the importance of specialist inspectors for NHS hospital care including clinicians being necessary because of particular concerns (see Recommendation 51).

f) Recommendation 54 emphasised the importance of ensuring that there was no inappropriate regulatory interference:

"*54 Where issues relating to regulatory action are discussed between the Care Quality Commission and other agencies, these should be properly recorded to avoid any suggestion of inappropriate interference in the Care Quality Commission's statutory role*."

114. The second key report is the Freedom to Speak Up review conducted by Sir Robert Francis[27] in February 2015. One of the most important conclusions was that feedback after raising a concern is vital for both individuals and other staff in organisations. This should include evidence of action being taken as a result of a concern or reasons if not. Without feedback staff are unlikely to see the point of raising concerns in the future, there may be suspicion about action or inaction, and there will be lost opportunities for wider learning.

115. The report recommended key principles that should be followed to bring about change. This included:

27 https://webarchive.nationalarchives.gov.uk/ukgwa/20150218151131mp_/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_Executive-summary.pdf

a) Principle 5 – Culture of valuing staff. Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.
b) Principle 8 – Investigations. When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
c) Principle 14 – Accountability. Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising, or receiving and handling concerns.

116. In relation to accountability the report recommended the following:

"There should be personal and organisational accountability for:
• poor practice in relation to encouraging the raising of concerns and responding to them
• the victimisation of workers for making public interest disclosures
• raising false concerns in bad faith or for personal benefit
• acting with disrespect or other unreasonable behaviour when raising or responding to concerns
• inappropriate use of confidentiality clauses.

70 Everyone should be held accountable for their behaviour and practice when raising, receiving and handling concerns. This applies to those raising concerns as well as to their leaders and managers. Absence of accountability puts people off speaking up, and can inhibit a person's ability to move on. Seeing a manager who has been responsible for bullying or victimisation move to a new post or even be promoted sends the wrong signal to staff and offends people's innate sense of fairness.

71 It is the responsibility of boards to ensure that there is no victimisation of or retaliation against whistleblowers, and they should be held to account for it. This will require them to maintain constant vigilance, and effective systems to enable them to keep track of what is happening within an organisation where so many people are under pressure to deliver a service. System regulators should look for evidence that this is being taken seriously. I was encouraged to hear optimism about the impact of the CQC's new inspection regime."

117. The report also identified various actions. This included:

a) Action 14.1: Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.

b) Action 14.2: Trust Boards, CQC, Monitor and the NHS TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.

c) Action 14.3: All organisations associated with the provision, oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.

118. In considering whether there should be an external review, the report observed that CQC would not ordinarily review the way in which whistleblowing investigations were carried out. In particular:

"The CQC can take account of how an organisation handles cases in its assessment of how well it is led. All the systems regulators who are prescribed persons can take action to investigate the issues raised in any protected disclosure made directly to them. But these would not normally include reviewing the way in which the organisation managed their investigation, nor the way in which the individual who raised the concern was subsequently treated. The only route available to an individual who feels he has been subject to detriment for making protected disclosure is to take a case to an Employment Tribunal. However, most do not want to take legal action: all they want is to be assured that patients are safe and to get on with their jobs."

119. It also identified measures necessary for protecting vulnerable groups. In particular, during the course of the review it became clear that there are some groups,

including non-permanent staff, who are particularly vulnerable when they raise concerns (§82-3). The review said that:

> "*83 Non-permanent staff are in a more vulnerable position not only because of the temporary nature of their roles, but also because they are not fully integrated members of a team, may miss out on induction explaining how concerns should be raised in this organisation, and lack support. Yet they may bring objectivity and good practice from other organisations which should be welcomed. They should have access to all the same support and procedures as permanent members of staff, and should be encouraged to share their insights".*

120. In response to the Freedom to Speak Up Review, the National Guardian's office[28] was established.

121. The third is David Noble QSO's report in January 2020[29]. This focused in particular on whistle-blowing concerns raised by Mr Stanley-Wilkinson about the Whorlton Hall inspection and the CQC's non-publication of the inspection report. The key recommendations were:

a) Recommendation 6: to write to Mr Stanley-Wilkinson and acknowledge the importance of what he had raised and apologise for not being fully involved in the complaint and outcome (Chapters 6 and 7.54.-7). CQC had investigated it well, but then management did not publish report at the time as recommended, and did not respond as recommended to what the investigator had concluded.
b) Recommendation 7: noting its updated Speak Up policy (2018), CQC *"should consider building more confidence in the process by ensuring wherever possibly that reports of the action planned or taken are part of the feedback to the complainant." "From the discussions …this lack of confidence in "actual change happening" following a complaint was referred to most frequently by individuals when asked why they had not pursued the*

[28] https://nationalguardian.org.uk/ The office leads, trains and supports a network of Freedom to Speak Up Guardians in England and conducts speaking up reviews to identify learning and support improvement of the speaking up culture of the healthcare sector.
[29] Report on how CQC dealt with concerns raised by Barry Stanley-Wilkinson in relation to the regulation of Whorlton Hall Hospital and to make recommendations https://www.cqc.org.uk/sites/default/files/Report_to_the_Board_of_the_CQC.pdf

"Speak Up" route." (§7.60). That contrasted with the Francis Speak Up report (at 7.56), which emphasised the importance after raising a concern both for individuals and other staff in organisations to see that action was being taken or reasons given if not.

122. It highlighted a huge amount of change and cultural problems and bullying within CQC at that time in 2015.

123. The fourth is Professor Glynis Murphy's independent review into Whorlton Hall[30] in March 2020. The review examined whether the abuse of patients at Whorlton Hall could have been recognised earlier by the regulatory process. Professor Murphy made a number of recommendations that were needed to strengthen CQC's inspection and regulatory approach.

124. In particular, Recommendation 3 was that CQC should take abuse allegations, safeguarding alerts and whistleblowing events extremely seriously and recognise that they are probably the tip of the iceberg. They should work closely with other agencies on these issues and should consider these data as a whole for services, and examine their trends over time (rather than just seeing them as a series of individual cases). The relationship owner should access the relevant data (see Recommendation 1) for a service on a regular basis, and work with the Local Authority to ensure there is a proper response to these. Repeated retracted allegations should be very carefully investigated.

[30] 20020218_glynis-murphy-review.pdf (cqc.org.uk)

Section 6: Mr Kumar's case

(1) South Tyneside inspection

Mr Kumar's complaint

125. Mr Kumar participated in an inspection at this hospital between 5 and 8 May 2015 in his capacity as a SpA for the CQC. This was a comprehensive inspection of the Trust, and Mr Kumar was part of the inspection for the surgery core service. This was (only) the second inspection he had been involved with; his first one had been in November 2014 and had progressed without incident (in fact Mr Kumar's evidence before the Employment Tribunal was that in his opinion that had been *"completed to a very high standard."*)

126. Shortly after the conclusion of the inspection, Mr Kumar wrote a letter to CQC's Chief Inspector of Hospitals, dated 10 May 2015 raising concerns about i) the conduct of the inspection and ii) the management of the inspection team. His concerns were summarised as:

> *"1. CQC's failure to act appropriately to address whistleblowers' concerns.*
>
> *2. Curtailing my professional independence and undermining or obstructing me from carrying out my duties in accordance with the GMC's guidance, Good Medical Practice.*
>
> *3. Bullying that I experienced at the hands of CQC officials."*

127. His primary concern was that *"patient safety is significantly compromised by the behaviour of some CQC staff."* In his view, this was because a group of whistleblowers, orthopaedic doctors (all SAS doctors i.e. experienced specialist doctors but not consultants) had presented themselves to the CQC inspection team at the hotel on the first day of the inspection and raised clinical concerns about the orthopaedic department at the hospital. They had also raised concerns about bullying and harassment within the hospital. Mr Kumar understood that these latter issues were being raised via the hospital's human resources (**HR**) department, which he understood to be appropriate. As to the clinical concerns, however, Mr Kumar's letter stated that the whistleblowers had been told that their concerns would be looked at as part of the inspection process.

128. Mr Kumar considered that he needed to meet with some of the other orthopaedic clinicians in the department and so he arranged meetings with the clinical lead in orthopaedics and two other orthopaedic surgeons. In advance of the meetings with the clinicians, he said he was instructed to cancel meetings which he had arranged (which he did *"with great embarrassment"*). He says that he was told by CQC management that these were HR issues and that Mr Kumar should not get involved with them.

129. Mr Kumar explained in the letter that his view was that these were clinical concerns which needed looking into; this gave rise to a difficult conversation with the management team within earshot of others.

130. After Mr Kumar had cancelled the relevant interviews, he reports being contacted by orthopaedic consultants wishing to speak to him, including the clinical lead in orthopaedics. He passed the requests onto the management team and pursued it with other members of the inspection team.

131. There were subsequent meetings with the inspection team and the whistleblowers, and also a consultants' focus group. The inspection team did therefore look at these issues and speak to the whistleblowers. However, Mr Kumar said that he felt he had to excuse himself from one of these meetings because he felt he did not have sufficient information to be properly informed (having been prevented from meeting the clinicians as planned).

132. Overall, he considered that the orthopaedic department was a *"major area of concern in the hospital. 100% of the SAS doctors (all BME) came to us with concerns and due to whatever reason they were not working in the department…. I saw no evidence that the clinical concerns were being looked into."* His view was that the CQC was turning its back on them and that this was inappropriate. His concern was that there *"appears to be a culture of not listening to whistleblowers or not wishing to take their concerns seriously."*

Inspection report

133. There were major issues at the Trust which were recognised in the inspection report. The Trust was subsequently rated "Requires Improvement" overall following the inspection. It was rated "Requires Improvement" under Safe, Effective, Responsive and Well-led. It was rated "Outstanding" under the Caring domain.

134. I could not see any specific orthopaedic clinical safety issues specifically referred to under the Safe domain for surgery. Under the "Well led" domain (pp 36-40), the report makes numerous references to staff having raised concerns about bullying and harassment. Under leadership, the report states that there were a number of areas of concern raised by staff including regarding orthopaedic surgery. Specifically it says *"we discussed….with the Medical Director that there had been an external review of clinical practices undertaken. The issues were predominantly human resource issues. At the time of the inspection the middle grade doctors were not at work…"* (Mr Kumar considered that the report was misleading on this aspect because the concerns raised by doctors were mainly clinical.)

135. In particular, the inspection report (see p 4) stated that the trust should i) review the continuing concerns raised by staff of bullying and harassment and difficult working environment within theatres; ii) review the concerns raised by medical staff from the trauma and orthopedic department about individual bullying and harassment leading to concerns about patient care. A number of requirement notices were also served.

Subsequent action by CQC

136. Mr Kumar never received a substantive response to this letter. The Chief Inspector of Hospitals acknowledged its receipt on 11 May 2015 and indicated that he would look into the matter as a matter of urgency. Some 4 months later on 17 August 2015, Mr Kumar followed up via email but again did not receive a reply. He also followed up by telephone some time later, when he heard that the Chief Inspector was retiring. He never received a response.

137. There is very little by way of audit trail as to what occurred on the CQC's side. The concern was not logged on the CRM system (as it would be if it had been treated as an external whistleblowing complaint). At this time there was no "Speak Up" policy in place within CQC (this was introduced in 2018).

138. The only documents available to me were those already provided in the ET bundle. These show as follows:

a) The Chief Inspector asked the Complaints team within CQC to advise on how Mr Kumar's concern should be treated (11 May 2015);

b) The Complaints team responded on 11 May 2015 to say that *"Technically as Dr Kumar is a SPA still working with us we would not be able to consider the issues raised under our corporate complaints procedures. The procedure is intended for providers and the public rather than handling staff complaints."*

c) Therefore, the decision taken was to undertake a "fact finding investigation" to determine next steps. The email trail states that it was passed onto the Deputy Chief Inspector (**DCI**) for the relevant region at the time who managed the relevant inspection team.

d) There is no further documentary trail available to show what, if anything, occurred after that, whether in terms of follow up on the clinical concerns raised, or the other aspect of the complaint.

139. During my interviews, a member of the relevant inspection team who inspected the surgery core service (alongside Mr Kumar) told me that they had been contacted by a manager within CQC subsequently to give their views on what had occurred. However, no copy of this witness statement has been retained, either by the individual in question nor on any of the HR files or any other complaints files. There is no record of this or anything else about Mr Kumar's concern on CQC's CRM system nor on its other computer systems (the y-drive or Sharepoint). I was told that when the IT systems were moved across, any remaining records were lost. It is surprising and worrying that no proper records were kept on this.

140. In terms of what occurred at the inspection itself, the recollection of the staff member in question was unsurprisingly hazy (c.8 years on). They did not recall the whistleblowing issue; they said that whistleblowing had not been a feature of the inspection as far as they were aware. This is itself could be a cause for concern, given the nature of the issues raised and that there appeared to be clinical concerns. However, it was a long time ago and it would be wrong to draw too much from the recollection of the inspector in any event.

141. I was able to speak to one of the management team involved, who has since left the organisation, and was speaking from memory. Their reflection was that the inspection had been a difficult one for all concerned, because there were a number of problems which had not been predicted in advance of the inspection and which became apparent across all areas of surgery on arrival. Their recollection was that numerous staff had concerns across a number of areas, not just orthopaedics. The

team were therefore trying to ensure focus on numerous areas, to ensure that the inspection objectives could be delivered, rather than becoming diverted onto just orthopaedics. Whilst they understood that Mr Kumar was understandably disappointed about having to cancel appointments, their recollection was that this was in order to ensure that a member of the inspection team could also be present at these meetings, as it was not appropriate for this to take place with just Mr Kumar. The meeting with the whistleblowers did ultimately occur, outside of the hospital, to ensure confidentiality, as they recalled. Their recollection was of a tension between the operational demands of the inspection, at which they had had to grapple with numerous issues, and Mr Kumar's focus on orthopaedics.

142. They too, like the inspector, recalled that there had been an initial investigation into the issues, and were surprised that no records would remain. They were disappointed that Mr Kumar had never received a response to the concerns he had raised.

143. The DCI to whom the issue was apparently referred was no longer working at CQC. When contacted to see whether they could assist, the former DCI was not able to recall anything about the incident or provide any other assistance. No one else within CQC was able to provide any further assistance to me about this.

144. There is no record of any further action being taken in response to the specific clinical concerns raised by Mr Kumar following the relevant inspection. The inspection report itself refers to the Medical Director having undertaken an external review of clinical practices; so this would seem to confirm that there were ongoing issues as Mr Kumar had said. As to why no follow up action was taken by CQC, there might be various explanations for this –the external review undertaken may have provided sufficient assurance that the clinical concerns were being addressed and/or had been resolved to CQC's satisfaction; it may be that the concerns were being explored further via data on patient outcomes and/or via engagement with the trust after the event. It may be that Mr Kumar's specific orthopaedic concerns needed to be seen in a wider context. It may be that in fact Mr Kumar was right and the clinical concerns were not properly looked at.

145. But the lack of any available audit trail as to the CQC's position means that this is unclear. Had the point been documented in response to Mr Kumar's complaint, there would be an explanation.

Findings

146. It is difficult to draw any firm conclusions about this incident bearing in mind how long ago it was, and the absence of documentary material. However, there are various points which are sufficiently clear:

a) No one ever spoke to Mr Kumar to get his point of view on what occurred after the inspection, either at the time or afterwards. No one ever responded to him at all.
b) He was raising what appeared to be important issues about the concerns raised by whistleblowers within the hospital and about the patient safety issues they raised, and whether they were being properly looked at, in his capacity as a SpA and based on his expertise as a consultant orthopaedic surgeon.
c) I cannot comment on whether those concerns were valid or not, and whether the clinical concerns were already being properly investigated. However, it is clear that CQC should have taken the time to look into and respond to those concerns because they were relevant to whether it had properly discharged its regulatory duties to protect patients at the hospital – both under regulation 12 (whether services are safe), regulation 17 (governance, including a related issue about whether the Trust's processes for, and treatment of, whistleblowers were adequate). This may have included a question arising from the fact that the group of whistleblowers were all BME doctors (as Mr Kumar identified).
d) Because of the lack of paper trail, it seems likely that these issues were not taken further. Instead, it appears that Mr Kumar's letter was treated solely as a complaint which ran into the sand. There is no proper explanation about this.

147. One point of context is that this occurred around the time of (or in the period after) the publication of Francis Speak Up report (see Section 5), and before the CQC had its own such process or policy in place. Things have moved on in terms of CQC's general understanding and policy for supporting people to speak up.

148. It seems likely that because of Mr Kumar's role as a SpA, his input 'fell between two stools,' or even three. He was treated neither as a CQC member of staff raising concerns internally, nor as a 'whistleblower' raised a concern from outside about a Trust, nor as a person raising a complaint about a CQC inspection. This seems to have muddied the waters in terms of understanding how to deal with his concerns.

149. The key point is that CQC did not respond to his concerns and cannot now show that it took them seriously or acted on them – whether valid or not. The communication with Mr Kumar was non-existent after he made his complaint, and the importance and value of his input was not recognised. It seems that there were some explanations for what occurred at the inspection (such as the reasons why meetings needed to be cancelled and/or as to the approach adopted). These points could have been pointed out to Mr Kumar in a constructive way, following his complaint, or (ideally) at a meeting with Mr Kumar and those within the inspection team, in order to resolve any misunderstanding or difficulty. It is also of concern that the fact-finding process (including a bullying allegation) was allowed to run into the sand with no follow up.

150. Finally, on the question of Mr Kumar's ethnicity, it has been very difficult to reach any conclusions about whether this played any part in the way he was responded to in 2015, or in the way CQC addressed (or did not address) the concerns he raised, bearing in mind the lack of information. Mr Kumar himself did not suggest that this factor was at play here (which of course does not mean that it was not). The difficulty is the lack of documentary material and the fact that many people had since left the organisation, and any recollections were hazy. I did not pick up any issues about ethnicity from any of the evidence or interviews I was able to undertake on this complaint, nor from any of the (limited) documentary material which exists. The basic response to Mr Kumar's complaint was silence. It is not appropriate for me to speculate on the interactions that occurred at the inspection itself. This underlines, however, the importance of properly engaging with complaints made at the time they are made.

(2) UHMB

151. I have summarised the background to this issue above (see Section 3, §37-55). The factual background here is detailed and occurred over a number of years. I have prepared a full Chronology (Annex II) detailing how and when Mr Kumar's concerns were received, and how they were considered and addressed at the point they came into CQC. This forms part of my factual findings and should be read in conjunction with this section.

152. The concerns that Mr Kumar was raising with CQC were primarily patient safety concerns arising from the clinical concerns he had about Dr X (which were ongoing at the time he first approached CQC about it in June 2018). His overall concern was that that unsupervised operations had taken place, that operations had occurred where they were not clinically indicated, that potentially serious errors had been made, and that patients had or would develop potentially serious complications as a result. His basic position was that all these cases should be looked into urgently to protect any future patients from similar harm, but also to ensure that the patients who had been subjected to any incorrect or unsupervised procedures could be informed of that, and any corrective action taken as soon as possible. His concern was also that the Trust was not properly undertaking the urgent review required to identify these issues, neither looking at the right scope of cases nor obtaining a proper external clinical review.

153. So, from a regulatory perspective, this raised potential issues to be looked at including under the following parts of the 2014 Regulations: a) regulation 12 (patient safety), b) regulation 17 (governance), and c) regulation 20 (duty of candour).

154. It is tempting to view this now with the benefit of hindsight. Dr X's practice was restricted as a result of the concerns raised in Aug 2018, after Mr Kumar had raised it with the GMC (albeit over 5 months after Mr Kumar's concerns were first raised with the Trust). The internal and external reviews undertaken by the Trust are now acknowledged not to have identified the clinical problems at stake.

155. When a Royal College of Surgeons' (**RCoS**) review was eventually carried out[31] (reporting in November 2021), 46 cases were looked at, of which concerns were

[31] Under what is known as the Invited Review Mechanism.

highlighted in relation to 26 of those cases. The gist of that report that was published as part of the Employment Tribunal proceedings (ET §77) stated:

a) Some surgeries undertaken by Dr X were not completed to an acceptable standard;
b) Some of the surgery and quality of care provided by Dr X was unacceptable;
c) Some clinical decision making to undertake surgery by Dr X was inappropriate;
d) In some cases there was either no or a lack of evidence of a "Duty of Candour".

156. The Trust has acknowledged that in raising his concerns about these cases Mr Kumar was "*correctly targeting improvements in patient safety*" (letter from the Associate Medical Director of UHMB in October 2021). This was the RCoS review that Mr Kumar had called for from the outset: he asked the Trust's Medical Director for this as early as 9 April 2018 and he raised this specifically with CQC for the first time on 16 August 2018 (and again specifically on 1 November 2018).[32] The Trust has also acknowledged that the external reviews it undertook beforehand *"may all have amounted to missed opportunities to address the areas of concern raised …in a timely and more thorough manner*"[33].

What did CQC do with the information Mr Kumar raised with them?

157. Despite the above, CQC's actions should not be judged simply with the benefit of this hindsight. It is necessary to look at the information that CQC had, including that provided by Mr Kumar, and evaluate the action that was taken (or not taken) by CQC as the regulator of the Trust over time. Was the CQC acting appropriately as a regulator in the action it took? Could or should it have done more to hold the Trust to account and/or otherwise to take regulatory action against the Trust? I look at this in stages and then overall. I bear in mind the key regulatory requirements at stake here, as above.

[32] Mr Kumar states that he raised this with his Clinical lead at UHMB and Divisional director, then the Medical Director and Deputy, CEO, UHMB Trust Governors, UHMB Trust Board chair, GMC and then NHS England, as well as with CQC.
[33] in the letter from UHMB's Chief Medical Officer dated 7 June 2022 summarising the results of the external investigation into the issues.

Concerns first raised: June & July 2018

158. Mr Kumar first raised his concerns with the surgical NPA, as this was the main point of contact Mr Kumar had within CQC in his role as a SpA. Strictly speaking, Mr Kumar should have raised his concerns via the NCSC[34] in line with CQC process (see Section 3, §102), but it does not appear that he was aware that this was the correct method of raising concerns about an external issue. He was not directed to so by the NPA either.

159. The NPA first received an email from Mr Kumar on this issue on 16 June 2018; he provided a chance for Mr Kumar to talk through his concerns on a phone call on 29 June 2018; and received a further email on 2 July 2018 in which Mr Kumar explained that the consultant group had reluctantly agreed to await the Trust's external review of 7 cases due in August. (See Chronology at Annex II).

160. It is unclear precisely when this information was passed on by the NPA to the Relationship Owner (**RO**) for UHMB.[35] CQC's process provides that all whistleblowing is to be forwarded to the NCSC so that they can triage it, log it on the CRM system and forward it onto the appropriate RO for the relevant trust (or service). This also enables a record to be kept and monitoring to be done (in line with CQC's legal duty to report on the protected disclosures it receives[36]). This did not occur. The NPA does not have access to CRM, and his general approach is to pass the information onto the local team.

161. On or around 2 July 2018, when Mr Kumar said he and his colleagues were planning to await the August review, the NPA stated by email that he would inform the local team (i.e. the RO) but would ask them not to act on it until further notice. Again, there is no email or other record to show that this was in fact passed on then, but the NPA recalled a telephone conversation with the RO around that time.[37]

[34] National Customer Service Centre, CQC's national contact centre.
[35] The ET found that it is likely that the RO was aware of it by 6 December 2018, as corresponds with the records I have seen (that these details were forwarded on or around 29 November 2018). It is not specifically clear whether and when this was passed on by telephone prior to that although this is what the NPA recalls.
[36] Section 4 above.
[37] The emails I have show that these messages were not specifically passed to the RO until 29 November 2018 at the time of Mr Kumar's disengagement as a SPA, when they were forwarded on and logged on to the CRM system at that stage only.

162. It is clear that the correct process was for the NPA to pass on all this contact to the RO as soon as it came in, so that it could be recorded on the system. Then the RO and their manager (and any senior leaders within CQC) could consider what (if any) action to take in response viz. the Trust, in the knowledge that there was now a challenge by Mr Kumar to the credibility of what the Trust was telling them about these issues. The NPA acknowledged this point in our interview.

163. This may have meant that the RO would have started a direct line of communication with Mr Kumar at an earlier stage. Again, this is a point of learning, bearing in mind the way things progressed.

16 August email

164. At this stage, Mr Kumar's 16 August 2018 email came in. In my view, the contents of that email should have been a red flag for CQC as the regulator both in patient safety terms for orthopaedic surgery, and in governance and candour terms:

a) Mr Kumar said that there was an ongoing risk to patient safety because Dr X was continuing to operate unsupervised, although Mr Kumar was also raising this with the GMC directly. He also said that there was a *"wider picture of faulty governance and a reluctance to act on concerns"*.

b) Mr Kumar gave a series of examples of problematic operations undertaken negligently by Dr X: 3 of these since March 2018 when his concerns had initially been raised, and two examples of patient deaths following complications which had occurred prior to March 2018. The letter was signed as being from a group of consultants wishing to remain anonymous.

165. This was important and valuable information involving potentially very serious risks to patient safety.

What happened next?

166. It is clear that CQC should have taken this information on board swiftly and used it to evaluate and/or assess any risks at the Trust, and a decision taken as to what action should be taken to ensure patient safety, and to understand whether the Trust was properly investigating the relevant incidents and/or taking appropriate mitigating action and/or complying with its duty of candour. Good practice would also

have been to make contact with the whistleblower to discuss and/or get further information if needed. I understand that the usual process, or at least good practice, would have been for the Relationship Owner and their manager to discuss and to hold a Management Review Meeting to undertake this decision-making process.

167. The NPA who received the email referred the matter onto the RO's manager 5 days later on 21 August 2018 (the delay may have been because it was a holiday period.) The RO followed procedure and immediately logged the issue into the CRM system and opened a whistleblowing inquiry (Priority 3 – Medium). The RO and their manager spoke by phone (there is no record of this conversation) and wrote an email response (dated 22 Aug 2018) to the NPA and the manager.

168. The overall response was that the RO was already aware of the issues based on ongoing engagement with the Trust – in particular details were given of July and August 2018 engagement meetings (see Chronology at Annex II); they were aware that an internal and external review were underway (although not yet complete or received).

169. The RO said they would take the following further actions i) to add surgery to the forthcoming unannounced (focused) inspection (being planned in September 2018 for November 2018, see further below) and ii) to follow up on the engagement with the Trust which was already ongoing.

170. There was no Management Review Meeting and it does not appear that any senior management were alerted to the issues at this stage, at least until the Regulatory Planning Meeting for the inspection (addressed further below). Mr Kumar was not contacted by the RO or any other managers for further information or for a meeting to explore his concerns in any more depth. The RO's view was that the NPA already had the relationship with Mr Kumar.

171. It is a simple fact in this case that no one from CQC ever met Mr Kumar to discuss his concerns at any point; the first time they met him was at the Employment Tribunal.

172. The NPA responded to him on 22 August to say that the RO was already aware of the issues and they were currently being addressed, based on the follow up proposed by the RO.

173. I take each of the follow up actions in turn.

Subsequent engagement

174. Although the CQC was aware of the general orthopaedic issue via ongoing engagement with the Trust, the local team had not previously been aware of Mr Kumar's specific concerns i.e. that the Trust were not properly investigating the relevant cases or taking appropriate action (including as to specific cases provided), nor was it yet clear whether Dr X was still operating unsupervised.

175. Therefore, CQC was presented with credible intelligence from a senior clinician (saying he was part of a group of wider clinicians), and he had been in touch to this effect in June and July 2018. Had they spoken to him at this stage or thereafter, the underlying credibility of his points could have been assessed. This would also have ensure that he realized that his input was valued and was being taken on board.

176. My view, based on my review of the documents and various interviews, was that urgent action should have been taken to follow up with the Trust at the very least to seek more information about what was going on, find out what (if any) mitigating actions were being taken, and to obtain copies of the reviews which were pending if available.

177. However, the follow up that occurred at this stage was very limited and does not appear to have probed the key issues. The sort of questions that one might have expected CQC to be asking at that stage were:

a) Was the doctor in question was still practicing independently? Had action been taken viz the GMC or by the Trust to mitigate any risk? In fact, Mr Kumar had written to the GMC on 18 August 2018 and following that the Trust took action to ensure that Dr X would be supervised (and they were moved to a different site within the Trust), but it does not appear that CQC were aware of this until 24 September 2018 when it was reported at the engagement meeting. That was potentially an urgent risk to patient safety.

b) Were the internal and external reviews available and could they be urgently provided, or when would they be available? Were the CQC assured that these reviews were fit for purpose, such as to satisfy regs 12, 17 and 20? Had they seen any underlying data about the cases? How was CQC assured that this was an appropriate 'look back' exercise to ensure that any

ongoing risk to previous patients was speedily addressed? Did the local team need to call on expertise from a NPA or SpA on the clinical side to get a view on this and the available data (called by a 'deep dive' by one senior CQC manager)?

c) What were the mitigating actions the Trust was taking in terms of governance? How was the Trust learning from the incidents or ensuring that they would not occur again?

178. It has been suggested that the immediate patient safety issue was a matter for the GMC alone and not for CQC. I do not agree. Individual fitness to practice is for GMC, but if a doctor who is or may be presenting a risk to patients is continuing to practice, it remains (in parallel) an issue for CQC under regulation 12 because services are at risk of not being safe and arguably the Trust are not taking appropriate measures to mitigate this.

179. There is no record of CQC chasing the Trust's internal ongoing review or the external review at that stage, nor can I see evidence that any of the above follow up questions were asked:

a) Instead, the whistleblowing CRM inquiry was closed. This was on the basis of NHSE's email chain which stated that NHSE had closed their concern in light of a brief email from UHMB's Director of Governance which in fact said that both the data review and the external review were ongoing (See UHMB Chronology).

b) Indeed, the record showing why the whistleblowing inquiry was closed is *"Trust have arranged for external review. Internal review showed no concerns. NHSE have closed their concern."* (emphasis added)

c) But there was no internal review at that stage, and so it incorrect to say that the internal review showed no concerns.

Inspection and planning

180. At the inspection planning meeting which followed, Mr Kumar's concern was identified and properly fed into that planning. At this stage the senior management of the local team were involved (the Head of Inspections and the Deputy Chief Inspector,

who attended the regulatory planning meeting). There was an unannounced inspection already planned for other core services, and surgery was added on to this, in part because of the information provided by Mr Kumar, which was accurately captured as follows:

A group of consultant orthopaedic surgeons working at the Royal Lancaster Infirmary raised serious concerns about one of the doctors working in their department. They have been concerns that trust management did not to take timely action, which has led to the harm of at least 3 further patients by way of faulty operations since March 2018. The GMC is being made aware of the individual failings but there is a larger picture of faulty governance and reluctance to act on concerns. One of the major concerns that remain is the subjecting of patients to operations where not indicated.

Allegations include:

- *Operation being undertaken that were not necessary*
- *Neglectful practice*
- *Trust not acting quickly to investigate*
- *Staff instructed not to access patient files to gather information as evidence.*
- *Various medical and non- medical staff came out with concerns to Orthopaedic consultants about the above doctor.*
- *We were told that 7 cases were sent for external review. Whistleblowers feel more need checked.*
- *Staff were told they cannot file any clinical incidents if they are more than 6 months old*
- *3 examples of negligent operations provided*
- *State doctor is operating without appropriate training or knowledge.*
- *In spite of the above, the doctor was allowed to continue operating and the following harm has happened to patients since March 2018.*

181. There was a core service inspection for surgery (which the local team were present at), and a well-led inspection. However, CQC did not speak to Mr Kumar or his fellow orthopaedic consultant(s) who had raised concerns during these visits. Mr Kumar's reflection was that, despite having raised concerns, he felt like he was being avoided by CQC; on the other hand, the CQC inspectors said that they were available on site, and he could have come to find them.

182. Bearing in mind that Mr Kumar had raised the concerns that had (in part) prompted the inspection, it was another obvious missed opportunity not to have contacted him (once the inspection was announced to the Trust) and informed him that the team would be happy to meet him to hear his concerns; or if there was a need for confidentiality, a meeting outside of the Trust could be arranged if required.

183. As for the inspection of surgery, the lead inspector for surgery who led the inspection was aware of the whistleblowing issues, but did not observe any problems on site; his view was that specific orthopaedic clinical issues (in terms of outcomes and specific data) would be something that would be addressed as part of the well-led part of the inspection. I return to this as a 'Catch 22' below at §188.

184. I note that initially it was intended that a SpA (in particular a consultant with surgical expertise) would be available at the inspection, but then there was no one available on the day. Again, I consider that this was an obvious way to probe the issues at stake and was another missed opportunity. They could have assisted CQC on the cases of concern that had been raised and/or the data so far available – the "deep dive" mentioned above. My view was that bearing in mind the red flags raised and the reasons for the inspection of surgery, this would have been sensible. This seemed to be a resourcing issue (no one was available on the day). Also, it was said by some that a specialist would not necessarily have had the correct expertise (i.e. orthopaedic, raising the theme already noted above); but that should have been requested, and if not possible, then the involvement of the NPA or SpA to review the data and/or the various reviews at a later stage would have been helpful.

Inspection outcome

185. In fact, I cannot see any specific concerns about orthopaedic surgery in the inspection report at Royal Lancaster Infirmary, in terms of patient outcomes or in terms of governance and duty of candour. This was published in May 2019, along with the evidence annex which runs to over 350 pages for the overall Trust.

186. Overall, the Trust (taking account of the three hospital sites) was rated as Requires Improvement, but the reasons for this do not touch on specific orthopaedic issues or outcomes. The hospital in question, Royal Lancaster Infirmary, was rated as Requires Improvement overall, but Surgery was rated Good under Safe, Effective, Caring and Well Led, and Responsive was rated requires improvement (on the basis

primarily of data on referral to treatment pathways). I could not see any reference in the evidence Annex to the issues about Dr X issue or the cases under internal or external review, or the patient safety issued identified. It may be that this is hidden somewhere in the underlying data, but a) there is no audit trail that I can see which shows it and b) none of the interviewees were able to identify this. In short, I could not ascertain what the outcome was at the inspection on the orthopaedic concerns raised by Mr Kumar, despite this being one of the factors that had prompted the inspection.

187. There were four requirement notices issued by CQC following the inspection but none of these related to orthopaedic surgery issues (specifically or generally), nor did any of the specific areas of improvement which were recommended by CQC. So, in short, no regulatory enforcement action was taken.

188. Thus, there is somewhat of a Catch 22 here: if the main response to the concerns was an inspection, but these issues were not focused on at either the surgical inspection nor the well-led inspection (and there was certainly no positive conclusion that the problems had been resolved), then the focus returns to the ongoing scrutiny of the Trust's actions by CQC at engagement meetings and/or information requests.

Follow up by CQC?

189. In summary, the audit trail does not show any meaningful engagement by CQC to follow up in regulatory terms on the problematic orthopaedic incidents raised by Mr Kumar in or around the period 2018-2019. The Trust's internal review (which was previously recorded, prior to it even being concluded, by CQC on CRM as having shown no concerns) was not provided until January 2019, some six months after it was due. It was entitled the Theme Review of Trauma and Orthopaedics. It was a short (1 ½) page report with no Annexes or data. Even by then it stated that 10 cases were still in progress and 3 were overdue. It is not clear to me how at the time CQC could have been assured as to quality of the Trust's review of historic incidents on the basis of this review, nor that the Trust had complied with its duty of candour to patients.

190. The external review (that had been sent to Wrightington, another Trust) was never received by CQC. This was supposed to be the external assurance that the Trust and CQC were waiting for. The Theme Review in fact stated *"no concern was found…"* in the external review, but CQC did not see it for themselves. I was told that

it was requested at engagement meetings, but this is not minuted nor any there any emails which show it being requested. I cannot see any scrutiny or follow up even of the Theme Review despite it containing some concerning findings (even on its own merits).

191. I have not seen any questioning by CQC as to whether there was scope for any further review and/or a RCoS review, as Mr Kumar had said to CQC several times (and to the Trust) from the outset. Regulatory action could have been taken on governance or candour grounds; data or other information could have been properly requested and if not provided (such as the external review) could have been requested under s.64 of the 2008 Act. The data and the reviews could have been the subject of a "deep dive" by CQC's NPA or an appropriate SpA. All this would have applied regulatory pressure on the Trust to seek and obtain proper external assurance at an earlier stage. This continued even once the Tulloch review had been obtained (see below). In fact, a proper review did not occur until March 2021 when the RCoS review was requested (following the involvement of Members of Parliament and NHS England).

192. CQC's position overall in interviews was that the Trust was doing all that could reasonably be required of it at that stage. I do not see that CQC can have been properly assured of that in the circumstances set out above.

The Tulloch review

193. Mr Kumar continued to raise this with the Trust in particular via a letter dated October 2019. At this stage, the Trust commissioned Chris Tulloch, an orthopaedic surgeon and deputy medical director from the North East to undertake a further external review. However, his terms of reference were to look at the incident reporting and management systems in place within trauma & orthopaedics, and to undertake a review of behaviours / cultures, and to provide recommendations; he was also asked to respond to the questions asked in Mr Kumar's letter. This was not a full external clinical review of the series of cases of concern[38].

194. Nonetheless, Mr Tulloch, who reported in January 2020, reached a number of important conclusions showing concern about the quality and scope of the Trust's

[38] as was subsequently acknowledged by the investigation commissioned by the Trust itself: see the summary in its letter of 7 June 2022 – Chronology at Annex II.

reviews so far. His view that the Trust's review so far had been a case of 'marking your own homework.' In particular, his view was that the 7 cases selected for external review initially were not those of greatest concern, and that several patients had continued to suffer whilst Dr X continued in practice between March 2018 and August 2018; more robust action should have been taken. He made some management recommendations and provided answers to questions raised about the process by Mr Kumar.

195. At this stage, the management of the UHMB Trust had transferred to a different CQC Relationship Owner and management team. This brought some changes in terms of regulatory meetings: the team ensured that the CQC meetings were separate from the other stakeholder body meetings (such as the Clinical Commissioning Group (**CCG**)).

196. Further, it is clear that the Trust was under close regulatory scrutiny at that time – under what is called an Enhanced Support Programme including for Trauma and Orthopaedics. There were a number of issues going on with a number of services.

197. Despite this, CQC did not even request or receive the Tulloch review until several months later in November 2020. It was only requested once it had been referred to in a Health Service Journal article. An action plan about what steps the Trust were taken to implement the findings was also provided by the Trust upon request, and the Inspection Manager and Head of Inspections were made aware. This included improved data analysis for incidents but did not suggest that a further external clinical review of cases was being proposed.

198. It is fair to recall that the pandemic intervened at this stage (March 2020 onwards) and that may explain the break in normal proceedings. Further, an inspection was planned for May 2020 including for surgery, in the context of this enhanced scrutiny of the Trust. However, this did not take place on account of the Covid pandemic.

199. Nonetheless, at no stage did CQC appear to recognise the deficiencies of the reviews so far carried out nor hold the Trust to account about these; even once the Tulloch report was belatedly requested and received. I can see no evidence in the subsequent engagement that the CQC ever called the Trust's approach into question or scrutinised it in any meaningful way.

The Royal College of Surgeon's review and CQC's role

200. I started above at §155 with the end of the story: the RCoS review. My view is that, had there been proper engagement with the information Mr Kumar raised with CQC at an earlier stage, and had the value of his information been recognized, then it is likely that the failings that were identified by the RCoS would or could have been revealed sooner. In my view the CQC failed to use its regulatory powers to ensure that the Trust was undertaking a proper 'look back' exercise which was properly externally assured. The various ways it could have done this are set out above (see §191).

201. In basic terms, and at the very least, CQC needed to obtain the relevant reviews, read them properly, and question whether they were fit for purpose. Moreover, at no stage did CQC find any regulatory breach: it did not issue a requirement notice, or warning notice, or even an advisory action under regulation 17 or 20, nor was information ever requested under s.64, and at no stage did CQC itself seek any clinical input to enable it to probe or understand the historical incidents at issue. CQC seems to have failed to engage properly or robustly with the importance of the orthopaedic incidents which had occurred.

202. This is obviously not a case where nothing was done: there was engagement with the Trust and there was an inspection in 2018, there was then further engagement (and plans for an abortive inspection in May 2020). However, this was a case ultimately about patients who had been operated on when they should not have been, or without appropriate clinical supervision, and who had developed, or who risked developing, complications as a result and were entitled to know that. That was something which CQC should have been focused on as part of its regulatory role.

Other points

203. <u>Reliance on other bodies</u>: One theme which was apparent in some of the material I saw (as above) was over reliance on the role of the (then) CCG and/or NHSE, something warned against by Sir Robert Francis in 2013 after Mid Staffs (see Section 5 above). Obviously assurance from other stakeholders such as commissioning bodies will be evidence which CQC can and should look at, and a group of stakeholders will share knowledge and views. But CQC is the regulator and it is for CQC to ensure that it is maintaining its regulatory independence and exercising its own judgment. If

another stakeholder 'assures' a review report which, looked at objectively, is not fit for purpose, CQC cannot and should not rely on that assurance to discharge its regulatory role. There was a visible shift in this perspective from October 2019 (at which point CQC began to hold meetings with the Trust alone so that their roles were not blurred).

204. Lack of managerial oversight / resource: There was a lack of involvement from senior managers in these issues over time, and this has been fully acknowledged by those I spoke to. It is clear with hindsight that such oversight was required. Partly, this seems to have arisen because of a series of changes going on in the region at the time (in 2018 – 2019), with merging of areas and vacancies among staff teams. The Relationship Owner in had a series of different managers over time and this meant that there was lack a continuity in terms of management of the issues. Often the RO was attending engagement meetings alone without managerial support, and alongside this was already dealing with another intensive whistleblowing issue in urology at UHMB. This goes some way to explaining the lesser focus which Mr Kumar's concerns received. It also may explain how other senior stakeholders at these meetings seemed to be taking the lead on issues, rather than CQC. One further reflection was that having a Relationship Owner who becomes 'embedded' within a trust can create difficulties in terms of regulatory challenge and scrutiny. Senior managers I spoke to agreed that this was sometimes a risk to be borne in mind and that regular changes in Relationship Owner can be effective to ensure a 'fresh' approach.

The role of ethnicity

205. It is difficult to draw any concrete conclusions about this issue in the UHMB context. There was obviously an issue as between Dr Y and Mr Kumar which was related to ethnicity (as described above) and involved Dr Y making a race-related allegation against Mr Kumar. However, I cannot see any evidence that this played any specific role in how CQC considered Mr Kumar's concerns from a regulatory perspective. None of those I spoke to within CQC gave me any reason to consider that this was the case. They were clear that they considered this was unacceptable and contrary to their values and those of CQC. In circumstances where no one from CQC ever met him, it is difficult to draw any real conclusions based on his ethnicity as to the way he was treated. It is difficult to make any assumptions or deductions about what, if any, unconscious or other biases may have been at play.

206. The most I can discern is that when Dr Y raised an issue about Mr Kumar, which touched on the effect on BME doctors, this created a nervousness or sensitivity towards the overall issue, and precipitated a clear response in Dr Y's favour (without having engaged with Mr Kumar's position as a whistleblower or his email to the RO about the forthcoming focus group). This is consistent with, and supported by, my reflection (see Section 7 section) that there is a lack of confidence or nervousness more generally within CQC in dealing with issues of race discrimination when raised in different contexts. This is something which I return to in my Recommendations in Section 9.

Overall

207. CQC did not respond appropriately to Mr Kumar. The failure to engage properly with, or ever meet, Mr Kumar himself at any stage was a real missed opportunity. Although CQC took some action in relation to the orthopaedic concerns which he raised, there was no meaningful or focused regulatory engagement or response by CQC. CQC could and should have applied robust scrutiny and pressure to the Trust in its regulatory role, informed by what Mr Kumar was telling them. Had it done so, it is likely that the RCoS review or a similar resolution on the problematic clinical cases would have been elicited earlier. Further, the Trust should have been held to account by the regulator on these issues. Moreover, had Mr Kumar been treated appropriately by CQC from the outset, he would have felt valued and heard, rather than ignored and ultimately disengaged from CQC altogether.

(3) East Lancashire

208. A full chronology of events for this set of concerns can be found at Annex III.

Background

209. Mr Kumar attended an inspection over 3 days as a SpA providing input for the surgery part of the core service inspection. He was required to cover both sites for the Trust: Burnley and Blackburn hospitals. He was the only consultant covering the surgical specialties for both sites.

210. Mr Kumar had emailed the inspector during the inspection asking them to get hold of some documents. Following the inspection itself, he followed up by email with the inspection manager and copied in the inspector involved at the Blackburn site. In this email he set out his observations from the inspection:

a) concerns around increases in return to theatre/infection rates,
b) concern around alleged high infection rates in hepatobiliary surgery, and
c) alleged bullying and harassment of doctors in surgery – he said that the latter was of particular concern and was impacting patient care.

211. He also raised a resourcing concern – that there was no way he could have proper input into the number of areas of surgery he was required to cover. Mr Kumar indicated in this email that these issues had also been recorded in his hand-written notes of the inspection which he handed in at the end.

212. As emerged from discussions, this was in part a concern on the part of Mr Kumar that as an orthopaedic surgeon he was not easily able to comment on the clinical practice for other surgical specialisms (i.e. other than orthopaedic surgery). As noted above, this was a concern that he had raised more widely within CQC (including with the NPA in other conversations). He discussed it both with the inspection manager and the inspector at Blackburn during the inspection itself. This is a wider theme I look at later in my findings.

213. However, he was also raising a specific concern that in basic terms, the inspection was not sufficiently resourced (Mr Kumar recalls raising this at the inspection itself also). This was a concern which was shared by the inspector who had raised it in advance with the inspection manager; the response was that 'additional'

resource had already been requested (albeit less than would previously have been allocated under the old system), and that this would have to do (see Chronology 29 Aug 2018).

214. It seems that due to changes around that time, inspections were being planned and run with fewer inspectors over fewer days, and with fewer days of SpA input, than had previously been the case. The impression both from this example and the other inspections I have looked at was that this placed significant pressure on the inspectors, managers and SPAs to try to cover a wider remit with less time and resource. In turn it seems there were shorter gaps in between inspections and thus less time to process the administration and paperwork – which was said to explain at least in part why there was no response to Mr Kumar himself. Overall, there was a sense that CQC was straining under this pressure and that inspectors were struggling at times to deliver the quality of scrutiny on inspections that they wanted to. The pressure on inspectors (particularly those inspecting and managing acute trusts) was also evident from the UHMB example.

215. I was also told that the normal corroboration process at the end of the inspection – where SPAs, alongside inspectors from across disciplines, have a discussion as a group to report back and share emerging themes – was truncated and did not occur in this inspection, under the direction of the inspection manager. This may well have been because of the resource and timing pressures. The inspection manager's position was that they would still capture all the feedback from all inspectors at the end of each day and then share it at the final session (albeit this would not involve everyone speaking directly to each other).

216. I was told anecdotally that there was a high turnover of inspection staff around this period – and this is consistent with the pattern I have seen in terms of the departure of many of the staff involved in the various inspections I have looked at (both here and in the sample cases). Many of the staff involved in 2018 and 2019 had now moved on (and indeed had moved on shortly thereafter).

217. Mr Kumar's complaint about resourcing was therefore consistent with an overall picture which seemed to be shared both by the inspector and the inspection manager to whom he addressed his email. He also followed this up by sending it to the NPA.

Response

218. The inspection team did not respond to Mr Kumar at this stage. The inspector did not think that it was for her to reply (as she was copied in for information and would have received these points at the close of the inspection already). There was also a sense that it was not usual to follow up with SpAs because once the SpA had completed their inspection, they went back to their 'day job' (and were not paid for any further time). In my view, that was not apt for Mr Kumar who had taken the time to follow up; and it also raises an issue about follow up with SpAs more generally. Moreover, in fact the inspector had followed up to chase the documents Mr Kumar had requested, both with the relationship owner and then with the Trust directly when they were not initially available; the inspector then reviewed the Root Cause Analysis documents and was satisfied they were adequate, and did not raise any further issues. However, Mr Kumar was not made aware of this (nor of how the wider issues were addressed).

219. The inspection manager to whom the email was addressed did not acknowledge the email nor reply. They recognized that this was an omission and expressed regret for this (and explained it by reference to the pressures mentioned above). In terms of following up on the specific issues raised, they considered that this was for the inspector themselves to do because of their role in managing the detail of the core service inspection at that hospital site. The inspection manager did forward on the email to the Relationship Owner for the Trust about two weeks later in advance of the well-led inspection which the inspection manager was responsible for co-ordinating (and as explained below, the cultural concerns Mr Kumar raised did flow through into the well-led inspection). However, Mr Kumar was not specifically told this.

220. This initial lack of communication was unfortunate, and was made worse by the fact that Mr Kumar was not involved in the draft report stage so he did not see those issues which did flow through: firstly it was unfortunate, in terms of basic courtesy; secondly, because Mr Kumar was raising his concerns in a professional context as the output of the inspection, and these were relevant to the inspection outcome and also the follow up well-led inspection (later in September) and he was entitled to know that these points would be taken on board; and finally, the lack of response created a doubt in Mr Kumar's mind that his SpA's input was being taken on board; whereas in fact (as the interviews and documents showed), most of his points at least were considered and followed up.

221. I think the difficulties in this instance were therefore largely down to a lack of communication with Mr Kumar (as well as the broader resourcing / SpA role issue).

222. Those involved in the inspection whom I spoke to accepted that in hindsight there should have been a response to him, as above. The inspection manager's reflection was that it would have been sensible to have a proper audit trail and/or record of the points raised and how they had been addressed.

223. I agree – a proper audit trail would have been helpful, but also Mr Kumar was entitled to a response and to know that his input was valued and being taken on board. There seemed to be an artificial disconnect between inspectors'/ managers' roles and SpAs' roles: this seems to be an issue about the CQC's culture, as opposed to the responsibility of those involved in this case (and is evident from the wider evidence). Overall this seems unhelpful and counter-productive to the overall regulatory process, and involves excluding the valuable input of a specialist with clinical expertise and an external perspective. There was also a sense of shifting accountability for following up on these issues from the managers involved, albeit this was only one of a wide range of issues for which the managers were responsible amid increasing workload pressures.

224. Mr Kumar also wrote to the NPA on 8 September to raise the same concerns, and followed this up regarding the bullying issues on 17 September. The NPA did respond initially and said that he would pass the issues onto the Deputy Chief Inspector (**DCI**), noting that there was quite a lot of unhappiness from the inspectors regarding allocation of SPAs (which chimes with the wider picture described above). However, although the NPA told me that he thinks he would have passed this on, probably by telephone, he could not recall specifically and there is no documentary evidence that this did occur (nor was it logged on the system). There was no follow up by the DCI (who has since left CQC). The later internal correspondence in response to Mr Kumar's complaints refers to there being 'no evidence that this was escalated,' (albeit it was a different DCI involved by this time).

225. Again it is unfortunate that there was no engagement at this stage with Mr Kumar's concern.

Regulatory response

226. As noted above, in fact it does appear that Mr Kumar's input was taken on board, at least in part. I was told that increases in return to theatre/infection rates were looked into at the inspection, the documentary requests were responded to (as explained above), and the alleged bullying and harassment of doctors in surgery was reflected in the 'well led' element of the surgical inspection and recorded in the final report, as well as at the well-led inspection itself (where I understand that there was a specific focus group).

227. It is true to say that this is difficult to decipher from the CQC's overall inspection report. That is partly because the Trust is looked at as a whole overall and then by hospital, with each service looked at and rated separately. Thus, the Trust is rated Good overall (no change from previously). The well led domain was rated Good overall (noting not all staff were positive about the culture in their service and recording that in some areas pockets of staff did not feel valued supported or engaged (p 5)). As to the specific hospital to which Mr Kumar's concerns here related, this was rated Good overall (no change), and as for surgery, this was Good overall, but under Well led (for surgery), this was downgraded from Outstanding to Good (with mention of a concern about culture). The evidence Annex which sits behind the inspection report makes multiple references to CQC looking in some detail at the bullying and discrimination issues (see e.g. pages 196-7, 230, 267-8).

228. Thus, the picture overall is a relatively nuanced one, and there does not appear to be any major concern to my mind here that the issues Mr Kumar had concerns about were not otherwise captured by the inspection team and/or ignored, with the exception of alleged high infection rates in hepatobiliary surgery. However, it is clear that the lack of communication with Mr Kumar was a real problem here and created doubts and a lack of trust and confidence in the process.

229. Mr Kumar's position was that he had previously been involved in checking his part of the draft report (e.g. surgery and/or specific services), at least in relation to his input. That would seem to be sensible and to reflect the role of the SpA, at least in principle. He has provided at least one example where this is what occurred. However, CQC's position was that this was not routine.

230. This may be correct and it is difficult for me to judge what the practice of individual inspection teams is. However, it is clear that excluding the SpA from i) the proper corroboration process, and ii) the draft report stage creates an artificial disconnect which is not helpful to the regulatory process, still less to the communication with the professionals involved. The value of their work is undermined and gives rise to a risk that their input is lost / not followed up. I think that this raises a wider cultural issue about the role of SpAs in the organisation and how inspection teams engage with them (and how the SpAs themselves are trained and involved within CQC) to which I return later in my report.

Complaint to Chief Inspector

231. The upshot of this was that Mr Kumar's concern was not taken seriously even when he raised it with the Chief Inspector (see Chronology 15 March 2019). The correspondence shows that this was treated as a 'spin off' from his disengagement (which had happened by then); but the letter Mr Kumar wrote was not addressing these issues.

232. This was another missed opportunity by CQC to put things right and resolve the communication breakdown at this stage; instead the CQC chose not to engage, and the matter ended up progressing to the Parliamentary & Health Service Ombudsman and this was forwarded onto the Secretary of State for Health (by Kate Hollern MP). It was only at this stage that Mr Kumar got the beginnings of a substantive response (see Chronology 4 & 13 September 2019). Even then, the correspondence was couched in careful terms and it was not candidly acknowledged that in fact this feedback had not been included in the evidence Annex (and/or that it was otherwise difficult to trace his input through) and/or that he had not been responded to or kept in the loop.

233. This reiterates the importance of respectful communication from the outset.

Ethnicity

234. I did not observe any suggestion that Mr Kumar's concerns were not properly engaged with on the grounds of his ethnicity. Those I spoke to were clear that that was fundamentally contrary to their values and those of CQC, and this seemed genuine. Mr Kumar did not suggest otherwise at any stage. Again it is difficult to draw any further conclusions from this one example.

Section 7: the Sample

235. My findings on the 18 sample cases are set out in full in Annex V. I have prepared a summary chronology for each instance, explaining what occurred and what the response was. I have then set out my individual findings under each sample.

236. I summarise these key findings for each example below, but this should be read in conjunction with Annex V for the full explanation. In this section I use the following abbreviations: **WB** - Whistleblower; **MRM** – Management Review Meeting; **RO** – Relationship Owner; **IM** – Inspection Manager.

Sample 1

237. Issues (no interviewee):

a) Concern raised regarding a stroke unit. Contact with the Trust to pass on concerns, but no challenge or scrutiny to the Trust on the answers it gave, despite serious issues regarding patient safety and quality of care on the stroke unit at the Trust;
b) No evidence the information fed into monitoring or engagement any further, or that any further action was taken, including in safeguarding terms.
c) Problematic audit trail.
d) Follow up required.

Sample 2

238. Issues (spoke to RO):

a) Concerns about a specific ward. Problematic audit trail but outcome was a very positive one.
b) Example of a quick responsive bespoke focus group which prompted Trust to take action to improve arrangements with staff and structure on the ward.
c) After Covid, the RO was able to go back and see the improvements made.
d) Good practice in terms of i) strong open relationships with RO and Trust, ii) strong open communication between RO and their IM, iii) real empathy and good communication with the WB.
e) Positive outcome on both sides: see quote from interview below:

"It's nice to remember that you made a difference….So working with somebody…an unqualified member of staff who was absolutely brilliant. She helped to bring about more rapid change and improve working conditions and patient safety on the ward."

Sample 3

239. Issues (spoke to RO):

a) Concern raised regarding appropriate staffing of A&E ward in terms of paediatric nurses.
b) Good practice in terms of communication and swift engagement with the whistleblower and the Trust. This built trust with CQC and improved the culture of openness at the Trust. The person felt able to raise concerns directly again, and to believe that this would be raised and taken seriously with their managerial team.
c) This team (South East) had developed a policy and template for whistleblowing issues. However, based on that, there is no real explanation of why the second set of concerns did not prompt a different response; a focus group, more engaged monitoring and/or a responsive inspection. This was not a course of action indicated by template used (see below) and no evidence of any discussion with IM about this.
d) The template helped with consistency but is very focussed on immediate risk of harm to patients – which is obviously a key issue, but not the only issue.
e) The use of the template resulted in no further action in this case– rather than a full decision-making discussion with RO's manager. No evidence of an MRM or any wider discussion to see whether the Trust were doing enough and/or any challenge to Trust's answers, or to pick this up for future inspections or engagement.
f) Shows the need for guidance / templates to assist, but these need to be audited and standardised to assist people properly; otherwise potentially narrow and inflexible. Suggest review of template.
g) Good practice in terms of supportive culture between inspectors and managers (see below quote from the interview):

"I always used to discuss these issues, because it used to give me quite a bit of anxiety when you received them, not being quite sure always what to do with my

regulatory hat on. But my manager and all the managers were always there (to support), and there was never any push back from them or anything to assist me with talking it through and deciding what to do and to discuss them very promptly."

Sample 4

240. Issues: (no interviewee)

a) Serious issues including regarding patient safety and unsafe staffing levels from two staff members at a Cardio Thoracic Centre (CTC)
b) Audit trail not good; no entry which shows action taken once worrying conclusions identified. Unclear whether WB got any response at all (unclear whether second WB did either)
c) No evidence of proactive action to investigate concerns or any real action at all.
d) The hospital in question is now Requires Improvement and various inspections have occurred but no indication as to whether CTC was looked at.
e) <u>This case should be followed up.</u>

Sample 5 (linked to two other samples, Sample **8** and Sample **15** (Inspection 4))

241. Issues (spoke to RO and IM):

a) Good level of engagement with Trust about a series of repeated whistleblowing enquiries, including allegations of patient neglect and racist comments and immediate action taken to put action plan in place.
b) Good level of managerial involvement within CQC team
c) Unfounded issue when viewed at the responsive inspection which followed (after a period where CCG monitoring visits were relied upon)
d) Difficult audit trail – hence three sample examples came through but it was not clear that they were all linked. This can be labour intensive for the inspector so a suggestion was that this could be an administrative function.

Sample 6

242. Issues (spoke to RO):

a) Serious issue about alleged assault on patient and staffing problems addressed promptly by RO and Trust

b) Once Trust responded to say that internal investigation showed no indication that assault had occurred, the available records appear to show that CQC accepted these assurances without evidence of challenge. No record of having seen written statements or evidence of the internal investigation, although I was told it was discussed by telephone in more detail and at engagement meetings, and with local authority (**LA**) safeguarding team. The Trust's response appeared somewhat defensive. It appears that there was an incident but there were differing explanations as to what occurred.

c) There was a safeguarding inquiry (**SFR**) that was closed down. There was no evidence of a referral being made; it was not initially clear why it was closed down i.e. whether this is because it was just closed down because they found no evidence to substantiate inquiry.

d) The RO recognised that the rationale for closure should have been recorded. They explained that the SFR records were quite difficult to work with and there was an internal pressure to close records (within 3 days). They explained that they would have taken the Trust's word that they reported the incident to the local safeguarding authority.

e) Basic audit trail was reliable, save for the above. <u>It should be checked whether the safeguarding referral was made.</u>

Sample 7:

243. Issues (no interviewee):

a) This is a potentially concerning example because there is no audit trail to show that the information was passed onto the Trust or what action (if any) was taken. No documents are linked. There are no MRMs or other documents.
b) The concern was potentially serious and included an allegation of racism, but does not appear to have been investigated or monitored, so far as system shows.
c) The safeguarding record is also confusing. It states that there has been contact with provider and that the information has been noted for next

planned inspection. But that appears to be wrong in terms of a safeguarding entry. It should have been an error. It was not referred to the LA as safeguarding authority.

d) There do not appear to have been any inspections of the Trust from this date until August 2022. This showed Good overall.
e) There are two other information reports of concern for the Trust in March 2019 but not the same issue and they are not linked.
f) <u>This should be followed up.</u>

Sample 9:

244. Issues (no interviewee):

a) Audit trail is not good, because it took further investigation to find the relevant inspection details. There were two concurrent inspections. There is also very little detail on the form as to why the inquiry was closed or what occurred thereafter.
b) But in fact details show that response to the issue was already in train, the information was taken on board and action taken immediately to check and confirm it. Not clear whether WB was informed; no records on CRM which indicate either way.
c) It shows that the Well Led inspection (which was ongoing) revealed that the rating was inadequate. Trust was placed into special measures after the inspection.

Sample 10:

245. Issues (no interviewee):

a) There is very little information here. No related inquiries, no linked management review. There is no linked inspection. However, we found that there had been a full inspection in April 2018 over 2 days. It is a single site hospital.
b) The outcome of the inspection was: Safe, Responsive and Well Led were rated as Requires Improvement. Effective and caring were Good. Overall, the hospital went from Good overall to Requires Improvement.

c) Although there is a bad audit trail but it seems that the inspection had overtaken events and these issues had been looked at.
d) It is difficult to see how the issues raised by the WB tracked across specifically into the inspection findings. There are some findings about medicines being safe and in line with trust policy. The MRI section identifies problems with medicine but everything else was found to be acceptable and in line with processes. I cannot see how the issues were traced through. It is difficult to know which ward was being mentioned by the caller, albeit A&E was mentioned.
e) No response to WB as far as I can see.

Sample 11:

246. Issues (no interviewee):

a) There are no related documents or inquiries, MRMs or other notes. There are no linked engagement meeting notes.
b) The hospital was deregistered voluntarily on 18/4/2018 – so shortly after the WB.
c) It is impossible to track what happened here.
d) Bad audit trail, and no real evidence of any action, albeit any risk ended shortly after with the de-registration of the service.

Sample 12:

247. Issues (spoke to RO and IM):

a. Serious allegations made including patient neglect and racism to patients from staff.
b. From the letter from the Trust, it appears that there was a wider HR investigation including on Diversity & Inclusion (**DoI)** issues ongoing but the final report was not yet available. Therefore, there were wider cultural issues ongoing.
c. The team (the RO with oversight by the IM) asked for the Trust's response and accepted it, apparently without challenge. Investigation seems to be based on what Matron and ward manager thought; not clear whether wider staff were spoken to. Allegation of racism was just denied. No detailed investigation on this.

d. In light of the wider ongoing issues, it is concerning that this was just left to the Trust and not joined up with the other issues and/or pressure put on Trust to bring forward that report. The RO did not receive the further report from HR/DoI. There was oversight from the IM (who was aware of the situation and was included in all emails and decision making) and the RO's usual practice was to alert IM to these sorts of concerns.
e. The audit trail here is not good. There are no linked documents or summaries which indicate any internal discussions following receipt of trust's response, and no information relating to decision to close the enquiry. No engagement details or meetings were available on request which showed how this issue tracked through and/or was monitored or followed up.
f. There was, however, a subsequent inspection in July 2018, six months after this information of concern came in – I was provided with the report and evidence appendix by the inspector. This is not linked in the Enquiry.
g. That inspection explains the context for it was an earlier May 2017 inspection and s.29A warning notice – based on staff shortages, lack of escalation of deteriorating patients and nutritional and hydration needs not always met – requirement notices, and action plan put in place. So this covered some of the issues; however I could not specifically see the discrimination /D&I issues addressed. It was followed up in Oct 2017.
h. The overall rating was Requires Improvement. The trust was Requires Improvement for Safe, Responsive and Well Led. Effective and Caring were Good.
i. The inspectors suggested more consistency and training in terms of how to deal with whistleblowing information would be useful.

Sample 13:

248. Issues (no interviewee):

a) Information about short staffing, patient in soiled bedding, bullying behaviour.
b) There is no link to the MRM here, and no further detail on record. It appears that the safeguarding entry was opened and then closed (said to be in error). No referral was made.
c) We located the MRM by date, but it was prompted (primarily) by a different WB report on 8.8.2017 regarding power failures in theatres and risk to patients (which was available). This MRM mentions the above WB in

passing (as summarised above), but does not cover the detail of that concern in any detail (e.g. concern about patients being left in soiled bedding).

d) Unclear the extent to which that issue was investigated.
e) Good immediate engagement with Trust, and management meetings, but not clear whether specific issues of concern were investigated.
f) Audit trail is not good.

249. The following inspection samples are, by definition, examples where the whistleblowing enquiries prompted an inspection as their response. They show good practice and management oversight, but it is difficult to draw too much from them in terms of comparison because they are all examples where a certain regulatory response was necessarily taken.

Sample 14 (Inspection Sample 1):

250. Issues (spoke to RO):

a) The whistleblowing information came in, a focussed inspection on the same service (gynaecology) had already been completed. The detail underlying that inspection (which I looked at from the MRM / decision tree prompting that inspection) was information of serious concern e.g. incorrect instruments used, perforations leading to major haemorrhage and hysterectomy. The general concerns that came it had already been subsumed within that recent inspection and the Action plan already in train. The findings were inadequate under Safe and Requires improvement in terms of Well led.
b) Good example of a responsive inspection at an earlier stage and proportionate response given outcomes of inspection.

Sample 15 (Inspection Sample 2):

251. Issues (spoke to senior manager):

a) Major issues regarding safety in operating theatre (never events and unsafe processes);
b) Immediate MRM and responsive inspection undertaken, following which enforcement action was taken (warning notices).
c) Good practice example.

Sample 16 (Inspection Sample 3):

252. Issues (spoke to IM):

a) Issue raised with RO about mental health service (rather than acute);
b) An example of good practice. Problems raised and inspection swiftly followed.
c) However, difficult audit trail, as discussed during interview. Inspection is not obvious from WB inquiry itself. There is no link from inquiry to inspection, but does link from inspection back to inquiry. That requires one to know that there is an inspection, itself dependent on free text included.

Sample 17 (Inspection Sample 4):

253. Issues (spoke to RO and IM):

a) Serious concerns raised about paediatric service at two hospital sites within Trust including a death of a baby;
b) Immediate MRM, and swift responsive inspection within 1 week.
c) Enforcement action taken under various regulations; information sought about the alleged instance relating to the baby, indication that section 64/65 notice would be sent requiring information from Trust. Information then provided prior to notice.
d) Good practice: immediate response to serious concerns, clear regulatory action.

Sample 18 (Inspection Sample 5):

254. Linked to Samples 5 and 8 above.

Conclusions on the Sample

255. The sample shows a mixed picture.

256. There is evidence of **good practice** across a number of the sample cases, where quick responsive action was taken, and good engagement and communication with both the trust and critically with the person raising the concerns: e.g. Sample cases 2 and 3 above. This made a real difference to the outcome and to the sense of the information being valued.

257. Similarly, all four inspection examples (which are self-selecting as explained above) show how **good management and focused action** has worked well, alongside a **range of enforcement action** where needed: section 64 information notices, warning notices and so on. Good managerial relationships within CQC were present in all the cases where prompt action was taken, and the ability to escalate the issue immediately where necessary (e.g. Sample 17: Inspection case 4).

258. On the other hand, there is a consistent **process problem** with the audit trail in the majority of cases, even those where things went well (e.g. Inspection Sample 1, Sample 2, Sample 5 (where three samples were linked but this was unclear)). The cross linking of documents and relevant inquiries was inconsistent and in many cases non existent. Therefore, I was unable to use the CRM tool and documents saved there to review these cases in any meaningful way. This is a concern not only in understanding CQC's actions but in terms of CQC's ability to report in line with its statutory reporting duties[39], which includes a requirement to explain the action taken in response to the information provided. In these examples, it was very difficult to see what (if anything) had occurred. This is largely a problem with CRM and is linked to the need for consistency, more detailed guidance and training on how to deal with whistleblowing information being received generally.

259. More fundamentally, there are cases where **specific follow up** is needed because it is unclear whether appropriate action was ever taken (Sample cases 1, 6, 7, 13). It may be that the audit trail is the problem, but it is very difficult (even after interrogating CRM and searching against the Trust's details elsewhere within CQC) to establish what occurred.

260. I have identified a lack of follow up in two cases where **allegations of race discrimination** by staff towards service users were made, which raises an issue under reg 13(4)(a) of the 2014 Regulations specifically: Sample cases 7 and 12. There seems to have been a lack of proper investigation of these issues in both cases and/or of scrutiny by the CQC of the answers provided by the Trust. I sensed an overall lack of confidence as to how to address these issues properly, and I did not get a sense that the function of reg 13 was properly understood.

[39] Under the Prescribed Persons Regulations made under section 43FA ERA 1996, inserted by PIDA. See Section 4 above.

261. The other overarching theme in some of the cases where problems arose was an **overall lack of scrutiny or challenge by CQC of the answers provided**; assurance was too readily accepted. It may be that further challenge was made / would be visible in other forms of engagement with the Trust; but the CRM records only provide one part of the picture.

262. Another issue was **inconsistency** of approach, not just in terms of CRM / recording information, but across various regions and teams. Template guidance was developed in one region (Sample 4) which was useful but potentially too narrow in terms of the decision pathways it created. This should be reviewed and consistent guidance (and training) provided.

Section 8: Conclusions

Summary of my conclusions

263. In summary, my conclusions (which have been set out in detail under each section) are:

a) **South Tyneside:** Mr Kumar received no response at all to his complaint in 2015, and this is unacceptable. The position as to whether his concerns were taken on board in terms of CQC's regulatory functions is nuanced, because various regulatory steps were taken following the inspection. However, there is no audit trail as to what CQC's view was about the clinical issues within orthopaedics and whether that was taken any further. This example raises i) an issue about communication, and taking concerns and complaints seriously, and ii) the tension between CQC's need to deliver on inspections and ensuring it has access to the correct clinical expertise on inspections when the SpA involved is a specialist in one (but not other) aspects of surgery.

b) **UHMB**: CQC did not respond appropriately to Mr Kumar as a whistleblower; no one ever met him or spoke to him once his detailed and important concerns had been raised. That was a major missed opportunity and once which reflects poorly on CQC, as many of my interviewees recognised. It ultimately precipitated his disengagement which has already been found to be unlawful by the Employment Tribunal. In regulatory terms, although CQC took some action (i.e. a focused inspection, but without a consultant as a SpA), neither this nor the subsequent engagement gave rise to any meaningful regulatory response. My view is that CQC could and should have applied robust scrutiny to the Trust's actions in reviewing the orthopaedic incidents that had occurred. It could and should have taken appropriate regulatory steps to hold the Trust to account when the deficiencies in the various reviews became (or should have become) clear. Had it done so at the right time, resolution on the problematic clinical cases would have been likely to have been elicited earlier.

c) **East Lancashire**: This is another example of a communication breakdown, and raises similar issues as South Tyneside. There were real resourcing

issues at this inspection, both generally, and specifically as far as SpA resource was concerned. Mr Kumar as the surgical SpA was working across two hospital sites covering all of surgery in only 3 days, in areas where he did not feel professional competent to provide input. The failure to respond to him at the time was an omission (which those on the team regretted) and the subsequent failure to respond to his complaint meaningfully was overtaken by the issues around his disengagement, which again was unfortunate because those were separate to the regulatory issues he was raising. Most of the issues he raised did flow through into CQC's inspection report, but he was not made aware. This case raises the need to ensure that SpAs are treated as valued parts of the team and enabled to have input after an inspection (in the drafting of the report). Otherwise the value of SpAs' expertise is diminished, as well as their own sense of being a valued member of the inspection team.

264. On the issue of ethnicity, I have not seen any specific evidence that this played a part in how Mr Kumar's concerns were responded to in a) and c) above. This is similar in relation to b), in circumstances where no one from CQC ever met him. It is difficult to draw any real conclusions based on his ethnicity as to the way he was treated under b). The most I can discern is that there was a lack of confidence or understanding as to how to deal with the interaction between Mr Kumar and Dr Y which involved issues of ethnicity. This is consistent with my reflection (see below) that there is a lack of confidence more generally within CQC in dealing with issues of race discrimination when raised in different contexts. This is something which I return to in my Recommendations at Section 9.

265. As to my conclusions on the **Sample**:

a) The sample shows plenty of examples of good practice in dealing with whistleblowing information. I was impressed with the examples I saw of quick responsive action, inspectors who had good positive and empathetic relationships with the person raising concerns, as well as the trust they were regulating. I also saw positive examples of management relationships which were supportive and flexible, so that people felt able to get appropriate support with dealing with difficult issues. These examples showed that when whistleblowing concerns are raised and acted upon

promptly, this improves both the results for patients and staff, and also the culture in an organisation; genuinely building openness and trust. The CQC should be proud of this good practice which is a positive advert for CQC's values and the supportive culture I have witnessed across CQC. This made a real difference to the outcome and to the sense that the information provided and people involved were being valued.

b) The good practice examples also showed CQC using a range of regulatory and enforcement measures (bespoke focus groups, responsive inspections, meetings and phone calls, section 64 information notices, warning notices and so on).

c) However, the CRM system for managing and accessing whistleblowing information is seriously problematic, even as a snapshot of what has occurred. The detail inputted and linking of relevant inquiries and inspections was inconsistent and in many cases non-existent. I was unable to use the CRM tool and documents saved there to review these cases in any meaningful way. This is a concern not only in understanding CQC's actions but in terms of CQC's ability to report in line with its statutory duties[40], which includes a requirement to explain the action taken in response to the information provided.

d) I identified four cases (of 18) where specific follow up is required to ensure that appropriate measures have been taken (albeit most of the examples are from some years ago). It may be that the audit trail (i.e. via CRM) is the problem, but it is very difficult (even after interrogating CRM and searching against the Trust's details elsewhere within CQC) to establish what occurred.

e) I identified a lack of proper follow up in two cases where allegations of race discrimination by staff towards service users were made. I sensed an overall lack of confidence on the part of some CQC staff as to how to address these issues properly, and I did not get a sense that the function of reg 13(4)(a) of the 2014 Regulations, or the CQC's Memorandum of

[40] Under the Prescribed Persons Regulations made under section 43FA ERA 1996, inserted by PIDA. See Section 4 above.

Understanding (**MoU**) with the EHRC and its role under the EA 2010, was properly understood.

f) The other overarching theme in some of the cases where problems arose was an overall lack of scrutiny or challenge by CQC of the answers provided by trusts, which was also a theme which came through in the UHMB case. Assurance was too readily accepted and no real challenge by CQC was visible from the records I had.

g) Another issue I saw from these cases, as well as Mr Kumar's, was inconsistency of approach, not just in terms of CRM / recording information, but across various regions and teams. There is a need for consistent guidance and ongoing training on how to deal with these often difficult and sensitive issues.

Section 9: Recommendations

266. In light of my findings, I make the following recommendations for CQC's Board to consider.

Recommendation 1: **full apology to Mr Kumar and acknowledgment of his input**

267. Mr Kumar has always acted in good faith and in the interests of patient safety, and in line with his professional duties. It is never easy to raise concerns, and it takes courage. On any view, Mr Kumar's experiences over the past few years have been very difficult. He has felt dismissed, diminished and under-valued by CQC, and his reputation has been put at risk. There has been a personal and professional toll. CQC should provide him with a full apology for the failings identified above: i) in terms of how it communicated with him, ii) how he was treated and iii) how his concerns were (or were not) investigated and addressed.

268. It is hoped that the seriousness with which CQC has responded to the outcome of the Employment Tribunal by commissioning this review and CQC's other work will demonstrate to Mr Kumar that his actions have nonetheless had a positive impact.

Recommendation 2: integrating the role of SpA properly within CQC

269. The role of SpAs is vital to enable CQC to meet its regulatory functions by providing the right clinical expertise. This case shows that in many cases SpAs are not properly utilised and do not feel valued or properly involved within CQC. In particular there should be:

a) A new management structure for SpAs reporting to a senior (permanent) CQC leader;
b) A new process of induction, training and integration for SpAs, to include a clear understanding of the CQC's Freedom to Speak Up process (and how they should raise concerns), training on inspections, and updated ongoing training, including on equality and discrimination, as per the other recommendations below;
c) A transparent process of feedback (about and from SpAs) and appraisal, including where issues arise on inspections;
d) A transparent process for disengagement of SpAs with a right of appeal;

e) Involvement of SpAs in post-inspection corroboration and reviewing draft sections of reports to ensure their input has been correctly reflected.

270. As part of this, I would suggest a two way work-shadowing or mentoring programme, so that SpAs and inspectors can develop an understanding of each others' constraints and skills.

271. I would also suggest a working group of SpAs should be involved in 'workshopping' the details of Recommendations 2 and 3 below, in the style of 'co-production,' to build confidence in the system and ensure it meets the needs of all concerned. This should include SpAs of all disciplines.

272. CQC may want to invite Mr Kumar, whether as an individual or as part of a wider professional body or group, to consider contributing to this process in some way, in conjunction with recommendation 1.

Recommendation 3: improved access to appropriate clinical expertise (via SpAs)

273. Without this, CQC is at risk of not being able to fulfil its regulatory functions effectively.

274. The intelligence-led matching model which has been being developed by the NPA team needs to be prioritised and adapted to ensure that appropriate clinicians with the correct expertise are available for inspections and matched to the right ones.

275. This needs to include training of both SpAs and inspectors to ensure that their respective roles and expertise are understood (see Recommendation 2 above). As for training of inspectors, this should emphasise the need in regulatory terms for CQC to engage with clinical issues, and how to access the correct expertise (whether on inspection or as part of engagement) to do that.

Recommendation 4: improved processes, policies and training for staff dealing with whistleblowing information, and for managers in supporting staff

276. This needs to encompass:

a) A new system for logging and monitoring whistleblowing information which is standardized, clear and includes sufficient (mandatory) detail on actions, mitigations and next steps. This should allow uniform tracking of this information across from entry to engagement to inspection and thereafter, as part of the wider intelligence system. This should be easy for managers to regularly review on a 'dashboard' system, and should be added to the agenda for all regular team meetings. Any system must ensure linking of records and documents (such as inspections, engagement meetings, emails) which is essential to allow follow up and accurate statutory reporting.

b) A new and improved policy and training system on whistleblowing, as part of a continuing professional development system (not a one off induction training), covering:

    1. the importance of engagement and communication with whistleblowers and the importance of follow up, and why this matters to people and improves outcomes. All too often this is avoided because of confidentiality concerns but there are ways around this (meetings outside of the provider and/or direct contact with the inspector by telephone).
    2. details and/or case examples of the range of actions which might follow in response to whistleblowing information (e.g. focus groups, meetings, information requests, informal visits, inspections, enhanced monitoring etc, and the importance of challenge and scrutiny of the information provided – linked to Recommendation 3 where need be)
    3. development of standardised templates for record keeping and whistleblowing decision-trees.
    4. clear basic training on the role of whistleblowers and their protected status in employment law.
    5. specific training on handling allegations of discrimination (including race discrimination) raised by whistleblowers, and the role and importance of the EA 2010 and CQC's MoU with the EHRC, and reg 13 of the 2014 Regs, to build confidence.

277. I would suggest that those involved in the Sample review should be invited to present their cases as live examples of good practice, and lessons learned.

278. In addition to these formal recommendations, I would also suggest that CQC considers:

a) Race awareness and anti-racism training for all its staff (in addition to the specific training above) to build confidence across the organisation, Input should be sought on this from the Race Equality Network within CQC who have a positive role to play and an important voice.

b) Ensuring that all involved in Mr Kumar's case have a reflection and learning process in relation to the outcome of the proceedings, to ensure that the precise issues that arose are properly understood.

279. Thank you for involving me in this important and interesting piece of work.

ZOE LEVENTHAL KC

Matrix Chambers

22 March 2023