Transcript of an all staff briefing by CQC Chief Executive Ian Trenholm 8th September 2022

There have been a couple of stories about us in the media recently. I thought would be worthwhile to talk about them now.

I was thinking about writing a blog but after consideration I thought it would be worth just talking directly on one of these calls

I know some of you will be listening live to this, some of you will be listening back.

There has been some coverage, some recent coverage, of an Employment Tribunal following the disengagement of one of our special advisers who'd raised some whistleblowing concerns

Special advisers as some of you know, particularly our inspectors will know, are practicing clinicians and managers who play a really important role with us out on inspections, helping us to bring a practitioner voice and an expert voice to the work that we do

And in this particular case we disengaged Mr Kumar from our special adviser panel some years ago, and this process of disengagement of Mr Kumar from his role as a specialist adviser was handled badly and I have written to Mr Kumar and apologised to him for that.

Separately, however, there was a question about how we handle information of concern that he shared with us. And this is a really important question and one that goes to the heart of what we do really

My understanding is that we used that information to inform our regulation and there have been inspections around the information Mr Kumar gave us. There have been three inspections linked back to Mr Kumar's information

However I do want to be 100% assured that we did all we could at the time that he gave us his information some years ago. I also want to understand what we could have done differently then and whether our procedures today still need any further work.

I'm conscious that sometimes with long running cases our procedures and our processes do change but we need to make sure that we can do a compare and contrast in terms of where we are today

I am still working through the details of how we best assure ourselves on this with our Exec team but I wanted to let you to know how seriously I'm taking this and we'll do some sort of review very shortly, and quite a relatively quick piece of work, I hope, to make sure that we are absolutely… we absolutely can learn the lessons we need to learn

When we talk to providers we talk about openness and honestly and learning and I think we need to do the same internally which is why we are going to do this short review and we are going to review our other processes as well

There have been posts on social media and some comments in internal meetings which have, I think, expressed views on some elements of this pretty complex case and I am deliberately not going to get into a public argument with anyone as that is somewhat pointless

I would ask colleagues though just to be a little bit more thoughtful about the way they express their views on this topic in meetings

We want to get to the bottom of how we could improve and look at all the facts not just the version of events that's been reported in the media.

And I've heard examples of some inconsiderate comments to colleagues about decision making – decisions that were made some years ago – and that is not how we should conduct ourselves. I want make sure that we can be respectful and thoughtful about the way that we learn our lessons.

And I am concerned though that these comments that are on social media and so forth could cast doubt on both how we and the National Guardians Office, who are completely unrelated to this case, how we both support whistleblowers when we both have a good track record of supporting people in some very complex circumstances.

People who are courageous enough to whistle blow on unsafe practice are often nervous and I want to do everything we can to give them confidence to speak up and talk about what they have seen

Last year we received over 18,000 concerns about poor practice from people who work in services right across health and social care organisations – that was an increase of 44% on the previous year

And our inspectors have been reviewing each one and working through what to do next whether that be to carry out an inspection or raise with another agency for them to act. For each and every concern we work through it and consider it very carefully in trying to make sure that our actions are the right ones and are proportionate and sensible

I recognise that sometimes we may get the specifics of a case wrong but I think 18,000 people last year will have seen us act clearly and in the public interest

I want to just take the opportunity to say unambiguously that if you have a patient safety concern or if you are told about one by someone we work with then you must raise it. You must raise it. It is as simple as that.

I think that there's sometimes a bit of a danger of getting tied up in a bit of a theoretical discussion around complex processes and all of that kind of stuff but I am very clear that if we see things or are told about things that impact on patients or people who use services we all need to act on it. It is as simple as that really.