

The Care Quality Commission: an essential guide to its powers and processes

By Tim Green and Hazel Jackson

The Care Quality Commission (“CQC”) is the independent regulator of health and adult social care in England at a time when this sector faces unprecedented scrutiny. However, the CQC’s role and purpose is not well understood. This note provides an essential guide to H&S and regulatory practitioners on the CQC’s powers and procedures in anticipation of widespread enforcement action as the COVID 19 emergency eases.

What is the CQC?

1. The CQC is an executive non-departmental public body, established in 2009 under the Health and Social Care Act 2008 (“**the 2008 Act**”), which regulates all health and adult social care services in England. Its role is to make sure care services provide people with safe, effective, and high-quality care, and to encourage those providers to improve. The CQC currently regulates approximately 15,500 care homes, 1400 hospitals, 590 ambulance services, 8700 GP services, 11,000 dentists, 11,000 care services in the home, and other community care services. Its management structure is headed by a Board and supported by an executive team. Its Board – the senior decision-making body – is accountable Parliament through the Department of Health and Social Care (“**DHSC**”).
2. The CQC’s role is to: (i) register care service providers; (ii) monitor and inspect services to see whether they are meeting the CQC’s fundamental standards of quality and publish what they find, including quality ratings; (iii) take enforcement action where they identify poor care; and (iv) speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice. The main tools used for

monitoring and inspection are: (i) collecting and examining data through an ‘Insight’ model; (ii) inspections of all new services; (iii) follow-up inspections for services where the risk is greatest or quality is improving; (iv) publishing its inspection reports and quality ratings; and (v) listening to people who use the services e.g. the CQC’s registration and inspection teams include Experts by Experience having had personal experience of care, the CQC works with local Healthwatch and looks at information received from other local groups, and it uses data gathered nationally by other organisations including patient survey data and information from the NHS.

3. In 2018/2019, the CQC had an annual budget of £234m, comprised of 87% from fee income, 12% from grant-in-aid from the DHSC, and under 1% from reimbursement for services and other income. The operating expenditure (£227.7m) was allocated across its activities as follows: 10% for registration, 35% for monitoring, 41% for inspection, 3% for enforcement, 3% for independent voice, and 8% for other activity (such as thematic reviews).
4. The CQC’s enforcement powers (outlined in more detail below) are: (i) regulatory, which includes the use of requirement notices or warning notices to set out what improvements the care provider must make and when, or placing the provider in special measures where the CQC closely supervises the quality of care; (ii) civil which includes making changes to a care provider’s registration to limit what they may do, for example by imposing conditions for a given time; and (iii) holding the care provider to account through criminal powers by issuing cautions, fines, and prosecuting cases where people are harmed or placed in danger of harm.

The CQC's duties and powers in the care sector and why it matters

5. The CQC is the primary regulator for standards in the healthcare sector. The CQC's main objective in performing its functions is to “*protect and promote the health, safety and welfare of people who use health and social care services*” (section 3(1) of the 2008 Act). By section 3(2), it is required to perform its functions for the purpose of encouraging the improvement of health and social care services, and the provision of those services in a way that focuses on the needs and experiences of service users, and makes efficient and effective use of resources. It broadly achieves these aims through the processes summarised below.

6. By section 4 of the 2008 Act, the CQC must have regard to *inter alia*: (i) the views expressed by or on behalf of members of the public about health and social care services; (ii) experiences of people who use health and social care services and their families and friends; (iii) views expressed by Local Healthwatch organisations or Local Healthwatch contractors; (iv) the need to protect and promote the rights of service users (including, in particular the rights of children and those detained under the Mental Health Act 1983); (v) the need to ensure that any action taken by the CQC is proportionate to the risks against which it would afford safeguards; (vi) any developments in approaches to regulatory action; and (vii) best practice amongst persons performing functions comparable to those of the Commission (including the principles under which regulatory action should be transparent, accountable, and consistent). By section 5 of the 2008 Act, the Commission has a duty to publish an informative statement on how it intends to carry out its functions, post consultation with the relevant persons. The statement is to include how it proposes to promote awareness among service users and carers of its functions, ensure that proper regard is had to views expressed by service users and carers, and arrange for any of its functions to be exercised by, or with the assistance of, service users and carers.

a. Register care service providers

7. Before a care provider can carry out any of the activities regulated by the CQC (which includes the provision of primary care services), they must register with the CQC.¹ It is the responsibility of the care provider to identify the regulated activities and register them and satisfy the CQC that they meet a number of requirements.
8. These requirements include the CQC's fundamental standards of quality and safety which are set out regulation 9 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/2936 ("**the 2014 Regulations**"). They are *inter alia*:
 - a. The place where care is received, and the equipment used in it must be clean, suitable, and looked after properly.
 - b. The patient must have care or treatment tailored to them and their needs.
 - c. The patient must have safe care and treatment and not be put at risk of harm that could be avoided.
 - d. The patient must be respected, involved in their care and support, and told what is happening at every stage of their treatment.
 - e. The patient must be cared for by suitably qualified and experienced staff.
 - f. The provider of care must have plans to meet these standards and must display their CQC rating publicly.²
9. The CQC is thus the gatekeeper to the healthcare sector. It will look at information about applicants and the services they intend to provide and make judgments about:

¹ See sections 10 and 11 of the 2008 Act and regulation 3 of the Care Quality Commission (Registration) Regulations 2009/3112 ("**the 2009 Regulations**").

² The CQC produces guidance notes describing how providers and managers can meet the regulations. These include the fundamental standards of care:
https://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf.

whether the service provider is suitable; whether the provider has enough staff (and staff with the right skills, qualifications and experience); the size, layout and design of the places they intend to provide care; their policies, systems, procedures and how effective the provider will be; and how the provider is run and how they plan to make decisions. Granting the registration application is delegated to the CQC's Registration Manager other than some matters (e.g. Learning Disability Services) where the Head of Registration must be consulted.

10. By section 12(3) of the 2008 Act, the registration application can be granted unconditionally or subject to such conditions as the Commission thinks fit. Conditions may limit the types of services that a service provider may provide and where they may be provided. For example, the Commission could impose conditions on the provision of care in residential homes, the effect of which would be to specify the categories of users of services and the number of residents that may be accommodated. The Commission can change the conditions of a service provider's registration at any time, which would allow for additional conditions to be imposed (section 12(5) of the 2008 Act). See below for further information on the CQC's regulatory power in relation to registration.
11. Anyone registered by the Commission to carry on regulated activities will receive a certificate of registration. Provision of a regulated activity without being registered with the CQC, or if the provider's registration has been suspended or cancelled,³ is an offence punishable by a fine.

b. *Monitor, inspect and rate services*

12. Once a service is registered with the CQC, the CQC monitors them continuously. By section 46 of the 2008 Act, the CQC is required to conduct periodic reviews of the carrying on of regulated activities of service providers, including for example

³ Section 34 of the 2008 Act.

English NHS bodies, to assess their performance and to publish reports of its assessments (or “ratings”). Section 60 empowers the Commission to carry out inspections of the manner in which service providers carry on their functions. This includes first, ‘comprehensive inspections’ which are regular checks on health and social care services; and second, ‘focused inspections’ which are to look at something the CQC is concerned about or if there is a change in a care provider’s circumstances (e.g. they were involved in a takeover). In accordance with section 46 of the 2008 Act, the CQC publishes sector-specific Provider Handbooks which describes its approach to regulating, inspecting and rating service providers.

13. In order to carry out such inspections, the CQC has the power to enter and inspect any regulated premises,⁴ and may require the provision of documents, information, or explanations to be given of relevant matters.⁵ Such inspections will be unannounced but more often they are pre-arranged, whereby the regulated body is normally given two weeks prior notice in writing and may be informed of certain things that the inspectors wish to see. The CQC’s inspection teams include specialists such as clinicians or pharmacists, and ‘Experts by Experience’ who have personal experience of care through using care services or being a carer of another.
14. The CQC rates most providers for their quality of care overall and assesses them against five key questions: are they safe, effective, caring, responsive, and well-led? The inspection teams answers these questions by taking evidence from senior staff and services users.
15. The CQC awards ratings on a four-point scale: Outstanding, Good, Requires Improvement, or Inadequate.⁶ In relation to some inspections, namely NHS GP

⁴ Section 62(2) of the 2008 Act.

⁵ Sections 64 and 65 of the 2008 Act.

⁶ By section 46(3) of the 2008 Act, the “assessment of the performance of a registered service provider is to be by reference to whatever indicators of quality the Commission devises”. The Commission must publish these indicators of quality and can revise them provided the Commission before doing so consults the Secretary of State any other persons it considers appropriate (section 46(6), (7) and (8)). In the last month, the

practices, the Commission will also examine how services are provided to six specified population groups, including older people and people with long-term conditions. Judgments and ratings will be 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. The CQC does not give ratings to dental practices.

16. The 2008 Act provides no right of appeal against an assessment or rating. There is only a limited two-stage procedure for challenge. First, *prior* to publication, service providers can challenge the evidence taken into account by the CQC within 10 days of reviewing the draft report (but no further evidence may be submitted). Second, *after* publication, a review of ratings may be sought on the sole ground the CQC *failed to follow its process* for making rating decisions. Otherwise providers must use the Parliamentary and Health Services Ombudsmen or apply for judicial review.
17. Collecting and using information. A key part of the CQC's role is gathering and analysing information and data about providers when they register, through continual monitoring, when the CQC inspect them, and through listening to people's views and experiences of care. Making greater use of intelligence in the way the CQC regulates services is a priority in its strategy for 2016 to 2021. The ways in which data is used, and from where it is collected, includes: (i) an Insight model to monitor the quality of care; (ii) gathering information before any inspection of a provider such as that received internally by the CQC and through its designated feedback form;⁷ (iii) local⁸ and national⁹ data; and (iv) partnerships with charities.

ratings given to care providers have spanned the entirety of the CQC's scale and include: 12 Outstanding, 62 Good, 67 Requires Improvement, and 32 Inadequate.

⁷ <https://www.cqc.org.uk/give-feedback-on-care>.

⁸ By working with Local Healthwatch and other groups.

⁹ By organisations including patient survey data, information from the NHS, patient opinion feedback, and the NHS Friends and Family Test.

c. **Enforcement action**

18. The CQC has two primary purposes when using its enforcement powers, namely: 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 to hold providers and individuals to account for failures in how the service is provided. The CQC seeks to use a structured decision process to help decide which cases should result in enforcement action and what option should be used. It has an Enforcement Policy¹⁰ and an Enforcement Decision Tree,¹¹ which should be read alongside the CQC's provider handbooks and guidance for providers on meeting the regulations. Practitioners will be familiar with similar enforcement models used by the HSE and EA.
19. **Regulatory action.** The CQC can use the following enforcement actions to require a provider to protect people who use regulated services from harm and the risk of harm, and to ensure providers improve so that people receive health and social care services of an appropriate standard. The types of action include:
- a. **Requirement notices.** Where a provider is in breach of a regulation, but people using the service are not at an immediate risk of harm, the CQC may require a report from the provider by serving a requirement notice on it under section 26 of the 2008 Act. The response from the provider must show how it will comply with its legal obligations and its proposed remedy. Failure to send the CQC a report in the timescale set out in the requirement notice is an offence. These notices are akin to improvement notices issued by the HSE.

¹⁰ CQC Enforcement Policy (February 2015):

https://www.cqc.org.uk/sites/default/files/20150209_enforcement_policy_v1-1.pdf.

¹¹ CQC Enforcement decision tree (January 2017):

https://www.cqc.org.uk/sites/default/files/20170217_enforcement_decision_tree.pdf.

- b. Warning notices. These can be issued by the CQC under section 29 of the 2008 Act to notify the provider that they are in breach of their obligations. There is an additional provision in section 29A for a warning notice addressed to NHS trusts or foundation trusts where the CQC judges that it requires significant improvement.
- c. Special measures. The CQC can place a provider in special measures. This is an administrative framework which helps the CQC to manage providers who are failing to comply with their legal requirements and require a higher than usual level of regulatory supervision within a particular timeframe. For NHS Foundation Trusts, the CQC can require NHS Improvement to appoint an administrator and place a foundation in “*special administration*”. This is a time-limited, rule-based administration which results in an administrator making recommendations designed to ensure the NHS body improves its standards. These powers are set out in the Care Act 2014 and the CQC must have issued a section 29A Warning Notice (see below).

20. **Civil enforcement action.** The CQC’s civil enforcement powers include:

- a. Imposing removing or varying conditions of registration,¹² suspending registration,¹³ and cancelling registration.¹⁴ The CQC will consider using these powers where it assesses that people receiving regulated services have suffered harm or are at risk of harm because a registered person is failing to comply with legal requirements; or are receiving care services that substantially fail to meet the standards set out in the regulations. Imposing conditions on registration is one of the more frequently used powers of the CQC. It will use this power if it assesses that by imposing a condition, it is likely to result in the provider addressing the matters of

¹² Section 12(5) and 15(5) of the 2008 Act.

¹³ Section 18 of the 2008 Act.

¹⁴ Section 17 of the 2008 Act.

concern within an acceptable timescale. Suspension and cancellation are less often used and usually follow considerable efforts to get registered persons to meet legal requirements. Cancellation will occur where the CQC considers the registered person does not have the capability or capacity to substantially comply with the regulations or is likely to fail to do so.

- b. Urgent procedures. The CQC can impose conditions or suspend a registration on an urgent basis under sections 30 and 31 of the 2008 Act if the thresholds set out in the 2008 Act are met.¹⁵ Providers are entitled to appeal but this does not prevent the condition or suspension taking effect.

21. **Criminal enforcement action**. The HSE has a key role in prosecuting serious safety incidents. In addition the 2014 Regulations gave the CQC power to prosecute where people using a registered service are harmed or placed at risk of harm.¹⁶ Criminal enforcement action will be taken if a service provider fails to meet prosecutable fundamental standards or for failing to comply with conditions of, and limitations on, registration.
22. When deciding whether to prosecute, the CQC considers clear prosecution criteria including, *inter alia*: the gravity of the incident, persistent breaches, the service is breaching fundamentals of care (i.e. it is being carried out significantly below the

¹⁵ The CQC will only use urgent procedures where the CQC believes that: (i) unless there is an urgent use or amendment of conditions, or urgent suspension of registration, a person will or may be exposed to harm; or (ii) unless the CQC applies to a Justice of the Peace for the urgent cancellation of registration, a person will be exposed to serious risk to their life, health or well-being.

¹⁶ The HSE and local authorities are the lead inspection and enforcement bodies for health and safety matters involving patients and service users who are in receipt of health or care service from providers **not** registered with CQC. A memorandum of understanding has been published between the CQC, HSE and local authorities to set out their respective roles and principles for managing cases where people using a registered service are harmed or place at risk of harm:

<https://www.hse.gov.uk/aboutus/howwework/framework/mou/mou-cqc-hse-la.pdf>.

standards required for compliance with the regulations and is giving rise to a significant risk), and the CPS's Code for Crown Prosecutors.

23. Under s.90(2) of the 2008 Act, proceedings for an offence set out under Part I of the Act may be brought within 12 months from the date on which there is sufficient evidence to warrant a prosecution. No such proceedings can be brought over three years after commission of the offence. The offences are specific to the registration process including: (i) a failure to comply with any condition in relation to registration (section 33) and (ii) providing or managing a regulated activity where the provider's registration (and/or a manager of the service provider) has been suspended or cancelled (section 34).
24. The range of options of enforcement includes simple cautions, fixed penalty notices and prosecution.
25. Most of the enforcement activity is directed towards providers as the body carrying on regulated activity. However, the CQC can also use its powers to hold certain individuals who work for providers to account. If prosecuted for a breach of regulation 22 of the 2014 Regulations, as mentioned above, the maximum fine is unlimited. Examples of previous prosecutions include:
 - a. In *CQC v Southern Health NHS Foundation Trust*, 12 October 2017, the NHS Foundation Trust was fined £125,000 after being prosecuted for failing to provide safe care and treatment resulting in avoidable harm to a patient under regulations 12(1) and 22 of the 2014 Regulations.
 - b. Two owners of a Liverpool care home were fined £60,000 in March 2017 for failing to provide safe care and treatment contrary to regulation 23 of the 2008 Act and fined a further £20,800 following a guilty plea to 13 offences under regulation 25 of the 2009 Regulations.

26. In relation to unregistered providers, the CQC will either advise the provider to register, where there is no immediate risk of harm to people or take enforcement action against individuals where the breach is continuous. This can include prosecution or other actions such as obtaining an injunction.

The impact of Covid-19 on the CQC

27. On 4 March 2020, the CQC announced that most of its inspections would continue as planned following the outbreak of coronavirus and that this position would be kept under review.
28. The CQC's chief executive, Ian Trenholm, stated that the CQC's role was to give the public assurance that health and social care services are safe, and that this role continued to be important as coronavirus emerged. As a result, the CQC were to concentrate its activity *“where it is needed most to ensure people receive safe care, going where we can make the biggest difference, and offering a front line perspective across the whole health and social care system”*.
29. However, subsequently on 16 March 2020, the CQC announced that its routine inspections for hospitals, GP surgeries and care homes were being paused where there are no immediate safety concerns. This means that health and care workers could concentrate efforts on battling Covid-19.
30. Ian Trenholm added that during this period, the CQC's priority was to support those who deliver health and social care in order to keep people safe during this emergency. Only in a *“very small number of cases when there is clear evidence of harm, such as allegations of abuse”* would it be necessary to use the CQC's inspection powers. In addition:
- a. In adult social care, the CQC's inspectors will be acting as a support for registered managers, providing advice and guidance throughout the

lockdown period in the absence of a single national body equivalent to NHS England.

- b. The CQC are talking to social care providers about how to collect information most effectively from them to ensure the Government has a clear picture of the impact that Covid-19 is having on the sector.

Will the CQC investigate and take enforcement action due to the pandemic?

31. Inspections, unless absolutely necessary, were suspended on 16 March 2020, and it is unclear when and how they will resume. Dr Richard Vautrey emphasised that, even once infection rates have peaked and the Covid-19 pressures subside, GP practices will “*go through a difficult recovery phase, which could take many months for them to return to normal activity*”. He urged that this point must not be lost on the CQC as it reviews its plans in the upcoming months.
32. On 30 April 2020, the CQC issued a statement on their regulatory approach during the pandemic. It was reinforced that CQC’s regulatory role has not changed. The Commission launched an Emergency Support Framework (“**ESF**”) to be rolled out sector by sector from 4 May 2020. Three key elements involve: (i) using and sharing information from new and existing sources to target support where its most needed; (ii) having open and honest conversations with providers, health and care staff, and wider stakeholders such as local authorities; and (iii) being transparent about the action taken and how the CQC will approach the recovery phase of the pandemic. The information gathered from the ESF is to aid CQC in better understanding the impact of coronavirus on staff and people using services. The conversations provide a “*forum for providers to talk through tough decisions...and for inspectors to offer targeted local advice where appropriate*”.
33. The CQC stated they will “*continue to inspect*” where “*there is evidence of a risk of harm, deliberate abuse, systematic neglect, or a significant breakdown in leadership*” and

use their powers “to take action against those responsible where we find unsafe or poor care”. However, given each sector will be affected by the pandemic in different ways, the CQC committed to adapting its approach and any regulatory action taken to the users and providers in each sector: “there is no one-size-fits-all approach”.¹⁷

34. Notwithstanding routine inspections are now paused, the CQC are continuing to inspect in response to risk and concerns raised and services have remained subject to close monitoring using a range of intelligence resources, including the ESF. During the pandemic there has been an increase in calls to CQC’s national contact centre from staff raising concerns about care. Between 2 March and 31 May 2020, there was a 55% increase in calls from adult social care staff, 26% related to the lack of PPE, and 32% concerned infection control or how social distancing was being practiced. In response, the CQC followed up with the provider directly, predominantly by telephone. Since 17 March, 17 physical adult social care inspections have been conducted (11 due to concerns raised by staff); and 12 hospital inspections (7 due to concerns raised by staff). If an inadequate response to Covid-19 has been taken, it is open to CQC to take enforcement action.
35. So far, the CQC has been silent on the key question as to the scope and nature of CQC enforcement action arising as a result of the emergency. It has emphasised it will deal with alleged failings on a case by case basis. In practice, it is hard to see how the public appetite for investigation and accountability into the treatment of vulnerable persons in care home during the pandemic can be met without a sharp increase in an enforcement activity in the sector.

¹⁷ From 19 May 2020, CQC are publishing ‘insight’ documents intending to highlight Covid-19 related pressures on the sectors that CQC regulates. The first was published on 19 May 2020 and the second published on 16 June 2020.

How can the care sector respond?

36. On 16 June 2020, Ian Trenholm issued a statement emphasising that the collaboration between services is integral to meeting people's needs and stressed how important it was that positive transformational changes are not lost, and efforts to improve system working become widespread. In addition, on 17 June 2020 the Chief Inspector, Kate Terroni said that staff from care providers must be able to speak freely and not be prevented from raising their concerns about quality and safety – all providers must support this.
37. The sector could then respond and treat the conditions created by the emergency as transformational moment and catalyst for improved services and change. It might try and adopt a collaborative stance and present this to the CQC as an alternative to enforcement. In any event, it seems almost inevitable that far reaching change to how the sector is managed and regulated is highly likely to follow.

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