How CQC regulates
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**Introduction**

This document provides a summary of how CQC regulates healthcare and adult social care services in England. It is designed to accompany our Business Plan for 2012/13. More detailed information on how we regulate can be found on our website at www.cqc.org.uk and particularly in the following documents available on our website:

- *Scope of registration*
- *Guidance about compliance: Essential standards of quality and safety*
- *Judgement framework*
- *Enforcement policy.*

CQC is the independent regulator of healthcare and adult social care services in England. We make sure the care provided by hospitals, dentists, ambulances, care homes and home-care agencies meets government standards of quality and safety.

We register health and adult social care services across England and we inspect them to check whether or not standards are being met. Our inspections take place regularly and at any time in response to concerns. They are almost always unannounced.

During our inspections we ask people about their experiences of care, talk to care staff, and check that the right systems and processes are in place. We judge whether the standards are being met or not and we publish reports of our findings on our website.

In between our inspections we monitor all the information we hold about a service. The information comes from our inspections, the public, care staff, care services and from other organisation.

We put the views, experiences health and wellbeing of people who use services at the centre of our work, and we have a range of powers we can take if people are getting poor care.
What does CQC regulate?

We regulate healthcare and social care services.

Our powers to regulate are set out in the Health and Social Act 2008 and the regulations made under the Act.

Any service providing care that is defined in the Act as a ‘regulated activity’ has to be registered with us to be legally allowed to provide care.

The legislation makes it an offence to provide these activities without being registered with CQC.

Regulated activities

Regulated activities are all the types of care that require a service to be registered with CQC in order to be legally allowed to provide them.

They correspond to the types of care usually provided by hospitals, care homes and dentists and include things such as treatment of illness or injury, nursing care, personal care and support, surgery, medical advice and care for people with mental health problems.

There are 15 registered activities in total. You can read the detailed description of each activity in our Scope of registration publication, available on our website.

Types of care that we regulate

The following care ‘providers’ routinely provide care that falls under one or many of the regulated activities and are regulated by CQC:

- **Adult social care** (such as care homes, nursing homes, and agencies that provide care in the home – also known as domiciliary care). These are the greatest number of services registered with CQC.
- **NHS services** (including hospitals, trusts and community health services).
- **Independent healthcare** (including private hospitals and clinics).
- **Dentists**
- **GP out-of-hours services** (GP cover during the night and at weekends; we will cover all GP practices from 1 April 2013).

Where health and social care happens: providers and locations

Care ‘providers’ must register for the regulated activities they provide and each ‘location’ in which they carry out regulated activities is agreed by CQC as a condition of their registration.

This ensures that the CQC and the public are clear about where and when regulated activities are taking place. For example, a care home company may run
several different care homes across the country. In this instance the company would register as the ‘provider’ and the individual care homes would be ‘locations’.

Locations are important because generally each location gets its own separate inspection from CQC.

**CQC’s additional powers and responsibilities**

In addition to our regulatory work under the Health and Social Care Act, we have a number of other powers and responsibilities. Most notably, we are responsible for protecting the interests of people whose rights are restricted under the Mental Health Act. We make sure that mental health law is used correctly and that patients are cared for properly while they are detained in hospital or are on a community treatment order. You can read more about our responsibilities under the Mental Health Act on our website.

**The four key parts of our regulatory work**

The four key parts of our main regulatory work are:

1. Registration
2. Inspecting and monitoring
3. Enforcement
4. Publication

1. **Registration**

Providers that want to provide care that is regulated under the Health and Social Care Act 2008 have to apply to be registered with CQC. As part of the application process they have to provide evidence that shows they will be able to provide care that meets the government standards.

We consider each application on the basis of risk. By this, we mean the risk that they will not be able to provide care that meets government standards. This may be different according to specific issues related to the service that’s going to be providing care, or to risks within particular sectors.

We make a judgement as to whether or not to register a provider. If we have information that suggests it won’t be able to provide care that meets the standards, we can refuse the application.

The staff involved in deciding whether or not an application should be approved are experts in the field of registration.

An application can be approved, rejected or approved subject to certain conditions, which have to be met within a certain time frame.
2. Inspecting and monitoring

Once we have approved a provider’s registration application, we monitor them to check that the care they are providing at each of their locations meets government standards.

By ‘government standards’ we mean the regulations made under the Health and Social Care Act 2008.

Inspections are part of our monitoring process.

Inspections

We have three main forms of inspection:

- **Scheduled inspections**, which are planned by CQC in advance and can be carried out at any time.
- **Responsive inspections**, where inspectors inspect because of a specific and immediate concern.
- **Themed inspections**, where we look at a particular type of care or issue across one or more care sectors, for example dignity and nutrition in NHS hospitals, or care for people with a learning disability in both care homes and hospitals.

In scheduled inspections, we routinely inspect hospitals, care homes and agencies that provide care in the home at least once a year and we inspect dental services at least once every two years.

Our inspections are almost always unannounced which means we don’t tell the service we are coming.

We carry out these inspections across all services because they:

- Identify poor care quickly and effectively.
- Act as a deterrent. Our experience shows that where services know that they will be inspected routinely, they are more likely to ensure that standards are maintained. This experience is borne out by the research in this area.

We have found that there is no substitute for an inspector visiting services, talking to people who receive them and the staff who provide them. This is not a ‘tick box’ system, but a way of enabling a skilled and experienced inspector to observe care, listen to people’s views and experiences and analyse what they see. Where they have concerns in particular areas, they can investigate in more detail, by examining systems and records.

In addition to scheduled inspections, we inspect at any time where there are concerns that a service may no longer be meeting one or more of the standards – these are the responsive inspections.
How we inspect

Each inspector is responsible for monitoring whether the services in their portfolio are meeting the standards.

There are 16 main government standards and when they inspect an inspector will examine a minimum of five. There is no maximum number of standards that an inspector can look at, and so they may make a judgement to inspect all the standards depending upon risk. The minimum five are drawn from the five key areas most relevant to the quality and safety of care being provided.

Experience has shown that it is more effective to allow inspectors the discretion to inspect whichever standards they feel are most appropriate given the information they have available when planning their inspections, providing they ensure broad coverage by selecting at least five of the standards that are most indicative of the quality and safety of care being provided.

When they are on site, their direct observation may lead them to look at other areas that require greater scrutiny, which is why it is important they have the freedom to use their professional judgement to ensure they target their activity where it is most needed.

Our inspections are focused on identifying where services aren’t meeting the government standards, but inspectors are encouraged to ‘describe what they see’, which includes evidence of where a service has met the standards, to give a balanced picture.

Most of an inspector’s time during inspection is spent talking to people. However, in some services it can be difficult for the inspector to talk to people using the service due to problems they may have with communicating, for example people with dementia or complex learning disabilities. In these settings our inspectors can use SOFI2 (Short Observational Framework for Inspection, a specific methodology for observing the care of people with dementia or complex learning disabilities).

We have found that the three processes of ongoing scrutiny and review, analysing information, and directly observing services and talking to those who use services and work in them, are the most effective ways of monitoring whether services are meeting the government standards of quality and safety.

Specialist inspections

Most inspections are conducted using a standard ‘model’. By this we mean the same approach is used across different healthcare and adult social care services.

However, there are certain areas where we conduct specialist inspections. These include visiting patients detained under the Mental Health Act, pharmacy inspections, inspections relating to specific regulations on ionising radiation, and joint inspections relating to children.
There are occasions where more specialist clinical and social care professional advice and involvement is necessary in our regular inspections. On these occasions, our National Professional Advisors – a group of eight professionals including a GP, a cardiac surgeon, a radiologist, a nurse, a dentist, a senior social care manager, a psychiatrist and an ambulance and emergency care manager – are available to consult and, if necessary, accompany the inspector on an inspection. To strengthen this approach, we are developing a bank of clinical and professional associates who we can call on.

Professional experts are also routinely involved in our themed inspections. An example of this is the involvement of senior nurses as part of the dignity and nutrition inspections.

**Using the expertise of people who use services in our inspections**

As well as using what people tell us about services in deciding where and how to target our regulatory activity, we use the expertise of people who use services in our inspections.

They are known as ‘Experts by Experience’. Our experts by experience are trained and supported to accompany our inspectors. They have a range of experiences and knowledge. We ensure that Experts by Experience are used in all types of our inspections. We have found their involvement in themed inspections particularly useful. They support us in developing our inspection methods, to make sure we take into account the views and experiences of people who use services. In mental health visits there is a programme of joint inspections with people who have experience of using services. These are known as ‘Acting Together’ visits.

**Monitoring services outside inspections**

In between our inspections, we continually monitor all the information we hold about a service. We use a range of information to help us identify where there is a risk that a service is no longer meeting one or more of the standards.

This information comes from members of the public, from partner organisations like the local authority and the complaints ombudsmen, from the service (as they are required to tell us when certain things happen) and from care staff. When a member of care staff tells us information about a service in confidence, this is called ‘whistleblowing’.

We gather information from a number of sources. These include:

- **Individual concerns** from the public and care staff received direct by CQC.
- **Statistical information**, for example on the number of deaths at a service (which can be compared against other services).
• **Information from local organisations** – we receive information from Local Involvement Networks (LINks), the Overview and Scrutiny Committees of local authorities, local authority commissioners and strategic health authorities, third sector organisations, people who use services and groups that represent them, the Governors of Foundation Trusts, and other local bodies with an interest in health and social care.

• **Information from thematic reviews** – our thematic reviews are projects that look at particular themes in health and social care. They look at what happens to people across different services or at issues in a particular type of organisation.

• **Information from our work under the Mental Health Act** – as part of the work we do under the Mental Health Act, we have specialist staff, known as ‘Mental Health Act Commissioners’ who visit hospitals that are able to detain people under the Mental Health Act. Where the Mental Health Act Commissioner identifies an issue that might indicate a hospital is not meeting the regulations under the Health and Social Care Act, they will share that information with inspectors.

3. **Enforcement**

If we find that a service is not meeting the standards, we take action against them. We call this ‘enforcement’ because we are enforcing the standards. We are always proportionate in the action we take.

We have a variety of enforcement powers available to us where we find a service is not meeting one or more of the standards.

Whatever action we take, we always share our findings with those who commission services and with others with responsibility for ensuring quality and safety in health and social care systems (such as other regulators).

We have the ability to set **compliance actions as a precursor to enforcement action** where a service is not meeting the standards but the impact on people using the service is minor. We sometimes ask services to send us an action plan and we check whether they have done what they said they would do. If after this time we judge that the service is now meeting the standards again, we will take no further action.

However, if the service continues to not meet the standards we will consider further action. We have the ability to escalate our action where necessary.

In our communications with services, we use the term ‘non-compliant’ to describe when a service is not meeting one or more of the standards.

If the way in which a service is not meeting a standard is very serious, we have a range of actions we can take using the civil and criminal procedures contained in the Health and Social care Act 2008 and the relevant regulations.
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The range of enforcement actions we can take include:

- Issuing a warning notice requiring improvements within a short period of time.
- Restricting the type of care that the service can offer.
- Stopping admissions into the care service.
- Issuing fixed penalty notices.
- Suspending or cancelling the service’s registration.
- Prosecution.

When we exercise these powers we do so in a proportionate way, considering the effect on the public and those who use services. This suite of powers enables us to take swift, targeted action where services are failing the people who use them.

4. Publication

We publish the results of our regulatory work to help the public make informed decisions about which care services to use.

We do this by:

- Publishing inspection reports on our website.
- Publishing summaries of our inspection findings on our website, through a care directory of every service we regulate.
- Issuing local media releases when we have taken enforcement action against a service because they are non-compliant with one or more of the regulations.

As well as publishing information about our inspections, we also publish wider information including:

- The guidance and documents we use in making our regulatory judgements, so that the public and services providing care are clear about the criteria we use. We think this is an important element of our transparency as a regulator. There should be ‘no surprises’ in terms of the criteria we use in reaching our judgments.
- Broader national reports that arise from our themed inspections.
- Quarterly ‘Market Reports’ that highlight strong and poor performance in meeting the standards in each care sector.
- Information on our monitoring of the use of the Mental Health Act, in the form of an annual report.
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- Information on the use of Deprivation of Liberty Safeguards in the form of an annual report
- Our report to Parliament describing the state of healthcare and adult social care services in England (often known as the ‘State of Care’ report).
How to contact us

Phone us on: 03000 616161
Email us at: enquiries@cqc.org.uk
Look at our website: www.cqc.org.uk
Write to us at:
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Please contact us if you would like a summary of this document in another language or format (for example, in large print, in Braille or on audio CD).

Registered office:
Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG