Care Quality Commission (CQC) approach to Covid-19

1. Summary

Our core purpose is to provide assurance to the public, Government and Parliament that Health and Social Care services provide people with safe, effective, compassionate, high-quality care and to encourage services to improve.

Our public facing role has always been to enable the public to use health and care services and assume they are safe, and to provide parliamentarians and executive leaders in the sector with assurance of safe care, alongside highlighting good practice and innovation.

As the only organisation that has a front-line picture of the 30,000 providers of health and social care, we are able to provide a perspective of what is actually going on the ground day to day.

Our role and purpose remains as important during the Covid-19 outbreak as during normal times. However, the way in which we carry out that role will be quite different. Our approach of Register, Inspect and Rate will change as follows:

- **Register** – we will continue to Register new providers and providers who need to vary their existing service, and where necessary, this will be in parallel to them being set up. Our design approach is that we need to provide assurance that we know where healthcare is happening, and basic safety and quality care is in place. In addition to our normal business we have put in place measures to support fast, safe and effective registration of new and additional Covid-19 related services.

- **Inspect** – we have cancelled a number of scheduled inspections.

    - The decision to cancel is based on an assessment of risk and the sector. This decision-making process is personally overseen by the three Chief Inspectors daily.
    - We have written to providers and told them what we are doing and explained we will be adopting a pragmatic approach to inspection.
    - Full inspections rely on the use of Specialist Advisors (SpA), many of whom are clinicians. They are increasingly telling us they are needed in their home medical setting, which in turn has caused some cancellation of inspection.
    - We are developing a targeted methodology which will enable us to provide assurance of the ‘absolute basics’ during the outbreak, and for a period of about 6 months afterwards. Our revised inspection methodology can be delivered remotely if

necessary. The methodology is being developed as a purely digital product, at pace, in conjunction with 70 of our team and Microsoft. We hope to have a product being live tested during w/c 16th March.
    - We don't expect to be taking significant enforcement action during the outbreak as in the main it will not pass the public interest test. However, we are concerned that some incidents may take place, such as direct abuse, which we would expect to act upon.

- **Rate** - We don't believe that formal rating will be necessary during the height of the virus outbreak. However, in the very short term it makes sense to rate where we can carry out inspections. Many providers across all sectors have been asking us to continue to provide rating and carry on our work.

Additionally, we are linking with DHSC to offer communications channels to all providers, notably in social care where all accept preparedness is least well developed.

Alongside the work we are doing with Microsoft on a targeted methodology we are rapidly building a survey app which again we hope to have in test next week to enable us to get a real time picture of the issues facing social care in particular. We would expect to be able to ask about staffing levels, stocks, food, medicines, etc.

Our business continuity plan is now fully stood up with a Gold and Silver command group working through five operational cells. We have moved to a resilient model with a seven-day rotation of leaders to ensure we can maintain the current tempo for the duration the emergency.

Offers of mutual aid have been made to NHSE, PHE and DHSC. Colleagues have been working on secondment for over a week and we are actively matching people to requests coming from other bodies.

These measures are in addition to the release of qualified staff to the frontline response, which is already taking place.

We have been refreshing all of our internal technology infrastructure over the last year and are confident we can move to a fully work from home model if needed. We have tested redeploying our National Customer Service Centre (NCSC) team to work from home and are confident we can offer a normal service. We are actively discussing with NHS 111 services how we can provide overflow support to them.

Given the pace at which events are unfolding it would not be either practicable or desirable to undertaken normal statutory consultation on our plans, including how we intend to support implementation of the forthcoming emergency legislation.

We are committed to supporting the delivery of the emergency legislation in any way that we reasonably can and are also discussing how we can support DHSC's on temporary easement on DBS and mandatory vaccinations.

2. Detail

We have created three operational principles that drive our decision making:

- We will focus our activities on ensuring the ***public receive safe care*** by responding where we believe risk is highest and where we can make a difference.

    - By safe care, we mean that services are meeting the fundamental standards and protecting people's human rights including those subject to the Mental Health Act or Mental Capacity Act or in other vulnerable situations
    - We will act where our actions help services to improve, e.g. by prompting a system response and ensuring learning is shared
    - We will focus on developing our understanding of risk as the situation develops, e.g. encouraging people who use services and health and social care workers to share information with us, working more closely with our partners to understand risk across an area.

- We will ***support providers*** in this challenging time by reducing what we ask of them wherever we can without compromising people's safety, and by ensuring we are not contributing to the risk of spread of infection.

    - We have in place clear decision-making criteria to guide whether to proceed with routine activity (see below) – bearing in mind our core role to ensure people receive safe care
    - We also have a role in understanding and sharing good practice in terms of emergency preparedness and where we can we will seek to continue activities to enable this
    - We will minimise the likelihood that CQC staff spread infection by following guidance from Public Health England and reducing/stopping visits to services if advised
    - We will make CQC staff available to support frontline and system-wide work beyond CQC where they can have greatest impact.

3. We will prioritise the health, ***safety and wellbeing of our staff*** and reduce the risk they are exposed to

- Following PHE guidance, we may restrict service visits, travel, attendance at events etc.

2.1 Areas of Risk

Our operational response, detailed below is a reflection of where we see risk across the health and social care system:

- Whilst most providers and their teams will wish to do the best they can in these extraordinary circumstances we know that this does not always happen in reality. Our role in calling out issues and drawing down support remains important.
- There are some environments which present inherently more risk in terms of the opportunities for people to suffer unseen harm. For example, social care settings, domiciliary care, closed mental health wards and geriatric ward in hospitals will need to be monitored carefully – especially if this emergency extends for up to 6 months
- It is clear today that some settings are very prepared for Covid-19 and others are not. There is a need for the central messages to be carried to all providers and regularly reinforced
- Whilst the focus is rightly on Covid-19 planning we are concerned about people who have pre-existing medical conditions who need treatment, e.g. for cancer, etc, so we believe we have a role in understating and reporting on what is happening to those people at a provider-level to try and ensure as normal service as possible is resumed after the emergency, and the right prioritisation decisions are made.

2.2 Action underway at present

- Developing an interim inspection methodology to help deploying a targeted risk-based approach to direct our efforts at areas of specific safety concern
- Using our unique position to act as a communication channel with providers; this is a two-way information flow. We plan to feed into the centre issues that we identify on inspections
- We are developing an app to help provide real time intelligence in the ASC sector about resources and supplies
- Monitoring the impact of the outbreak across the health and social care sectors, to inform national response and planning
- Working on business continuity plans and ensuing our colleagues remain safe, limiting the risk of spreading infection
- Prioritising our Registration activity to ensure we can focus on those requiring urgent attention and support to make changes to their current registration details.

2.3 CQC and safe staffing

Staffing is covered under Regulation 18. Safe, effective staffing is about having enough staff with the right skills, in the right place, at the right time.

We have never used staffing ratios as the sole determinant of a rating or the need for enforcement action and see no reason to change that position now.

CQC does not prescribe any specific numbers of staff to deliver safe care. We expect that:

- Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards)
- Providers should have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe
- We expect providers to demonstrate that they are making the most effective use of the staffing resources available to them. This will need to reflect the context in which they are working including shortages of key staff and should consider current legislation and guidance where it is available. In determining the number of staff and range of skills required, they should consider the different levels of skills and competence required to meet people's needs, the registered professional and support workers needed, supervision needs and leadership requirements
- Staffing levels and skill mix must be reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service
- There should be procedures to follow in an emergency that make sure sufficient and suitable people are deployed to cover both the emergency and the routine work of the service.

2.4 Activity already stood down or amended ***(valid on 11/3/20 only and subject to ongoing change)*:**

Seven NHS hospital or ambulance trusts:

- Cambridge University Hospitals (a core service inspection)
- South East Coast Ambulance Service (a well-led inspection)

- Great Western Hospitals (a well-led inspection)
- Clatterbridge Cancer Centre (we have moved it back by three weeks and will review again)
- Torbay and South Devon (we have amended our focus and removed two core services from the planned inspection – we have undertaken the remainder)
- George Eliot Hospital NHS Trust (cancelled last week)

It is important to note that whilst we have started to cancel some scheduled inspections, we have received feedback from some trusts that they would prefer CQC to continue with our programme of inspection; to help them understand how well prepared they are in relation to Covid-19.

Primary Medical Services

- 12 GP locations, including one at the request of the provider with no risk, one where staff are self-isolating and three due to practices being under pressure with either their vulnerable patient group or supporting local response.
- 12 dental practices, due to the inspector being part of a high-risk group (people with pre-existing health conditions for example, asthma, diabetes or cancer, a disability or those who are pregnant), four as the inspector is self-isolating, four at the request of the provider with no risks identified. One provider requested as a staff member is in a high-risk category and would only be attending the practice for the inspection.
- One urgent care NHS 111 service under significant pressure.
- One SEND inspection – at the request of system leaders
- Two slimming clinics, due to an inspector self-isolating.

Adult Social Care

- Two ASC locations. One due to staff at the service that were self-isolating and one due to an CQC inspector self-isolating.

Registration

- We have “fast tracked” four registration applications/changes to the register to ensure provision of additional/new support to providers relating to support to Covid-19.

Requests for postponement denied

- One GP request for postponement but as a warning notice was being followed up the risk to patients was deemed to great and the request was denied.
- One independent ambulance request for postponement denied as clear information suggestive of risk.

2.5 Support to the wider sector

As referenced above, in addition to offering resources to PHE we have been in discussion about how we can take some pressure off NHS 111 services and what this would look like alongside our own planning and risks.

We understand that NHSBSA are taking 20% of the daily 111 calls to the non-clinical Covid-19 line. This equates to around 1,200 calls per day based on the volumes last week. As a result, we feel it would be sensible to offer CQC to take 10% of daily calls equating to around 600 calls per day. We have a 320FTE office-based team in our National Customer Services Centre (NCSC) who manage all our contacts from the public and providers and provide administrative support to the wider organisation. We are confident they can all work from home and we are actively working with NHS 111 to offer 25FTE support to manage up to 600 non-clinical calls per day, subject to technology permitting.

2.6 External communications to date

Ian Trenholm issued a letter to the sector, detailing CQC's position on Covid-19 on 4 March 2020: https://www.cqc.org.uk/news/stories/how-were-responding-outbreak-coronavirus

- This highlighted that we will be focusing our activity where it is needed most to ensure people receive safe care – this means concentrating on those areas where we see that the risk to the quality of care is the highest and where we can make the biggest difference.
- We will support providers by looking at how we can act flexibly and proportionately to reduce the asks that we make of you – including reducing what you need to do to prepare for inspection and looking at what we can do to limit our need to be on site.
- We will honour our duty of care to our colleagues at CQC.

We will write again to providers as the situation develops.

We are also in regular contact with trade associations that represent large section of the health and social care landscape. This allows us to gain insight into the local challenges faced by providers across the sectors. We are feeding this information in to DHSC to help plan for and mitigate the associated risks.

We are also in regular contact with NHSE, PHE and other system partners to share information and align and support activities.

2.7 Internal communications

We have established a daily update to all colleagues and the senior team have been running regular leaders' briefs, driven by the outputs from the Gold and Silver command decisions.

A deep cleaning protocol has been established for all 7 offices. Trigger points for office closure are also being picked up in the Operational readiness workstream.

2.8 Operational support

A programme with the supporting governance structure has been established and filled with leads for the 5 workstreams:

- Engagement
- Operational readiness
- Operational resilience
- Regulatory response
- Intelligence & data collection

2.9 Special Advisors (SpAs), MHA reviewers and SOADS

We wrote to all the above-mentioned colleagues detailing our interim approach and principles as highlighted above, adding that there is a current requirement for support within PHE for clinical skills primarily to support tracing and containment activity and providing details should SpAs want to help in that regard.

We also acknowledge that majority of our SpA workforce may be drawn upon to support frontline services and other pressures in the system which will impact on their availability to support CQC activity. We asked to be made aware should this be the case to allow us to continue to understand the SpA resource.