

Lord Alton of Liverpool
Acting Chair
Joint Committee on Human Rights (JCHR)

13 January 2026

Dear Lord Alton of Liverpool,

Thank you for your letter of 18 December regarding progress being made by the Care Quality Commission (CQC) following the Joint Committee on Human Rights (JCHR) 2022 report on 'Protecting human rights in care settings'.

In your letter you refer to publicly reported stories about inadequate service provision in care settings and about the ability of CQC as the independent regulator, since the Committee's report.

I hope it is helpful for me to set out that over the last year, CQC's key focus has been on returning to our core purpose: providing effective regulation of health and adult social care services. This is in response to concerns raised in external reviews of our current ways of working by Dr Penny Dash, myself prior to my appointment as Chair, and the Care Provider Alliance. The reviews were clear that problems when implementing our new assessment approach and issues with our new technology mean we have been unable to fully deliver on our purpose.

We have taken urgent action to improve and ensure we are carrying out more assessments, publishing more reports, and have the right skills in our teams aligned to sector expertise. We have appointed four new Chief Inspectors to lead on regulation of each sector, and recently consulted on developing a clearer, simpler, and more trusted assessment framework, built through engagement, collaboration, and codesign with those who deliver services and the public.

We have been focussing on making changes to our existing technology, in line with the recommendations of the independent IT review we commissioned. Improving our data to make it more accurate, accessible and useful across CQC has also been a priority, so that we have strong foundations for ensuring our new systems are a success.

To be clear and accountable with the public we serve and the providers we regulate, we have been sharing [regular updates](#) with stakeholders on our progress. To uphold our accountability to parliament, we have been sharing quarterly updates with the Health and Social Care Select Committee which are published and available on their website.

Chair: Professor Sir Mike Richards Interim Chief Executive: Dr Arun Chopra

We continue to use our independent voice to highlight where we see concerns and trends in health and social care. In October 2025, our [State of Care report](#) was published which is our annual assessment of health care and social care in England. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve. The report found, among other things, that we continue to see significant unwarranted variation and inequalities in care. This persists in how people access and experience care, and their outcomes from it.

In your letter you ask that I set out progress CQC has made on areas identified in the Committee's report as well as concrete actions we have taken to identify and monitor care failures in a timely and effective way. I have provided responses to these questions against the relevant recommendations in the report in an appendix to this letter.

I hope this update provides assurance to the Committee, care providers and the public as we continue to move forward with improvements in the way we work, and in continuing to protect human rights in care settings.

I look forward to continuing to engage further with the Committee as we progress the improvements being made at CQC.

Should it be helpful to you, I would welcome a discussion regarding the content of this letter alongside my colleague Chris Badger, our Chief Inspector of Adult Social Care.

Yours sincerely

**Professor Sir Mike Richards,
Chair,
Care Quality Commission**



CC:

Chris Badger, Chief Inspector of Adult Social Care, Care Quality Commission (CQC) (chris.badger@cqc.org.uk)

Professor Meghana Pandit, Interim Medical Director, Department for Health and Social Care (DHSC) (meghana.pandit@dhsc.gov.uk)

Appendix

Provision of care

1. Recommendation: The CQC must adequately monitor providers' compliance with expected standards and hold providers accountable in a timely way. (Paragraph 26)

Timely monitoring and oversight

A key element of strengthening human rights protections in health and social care is ensuring greater regulatory oversight of sectors by increasing the rate at which we carry out assessments. This ensures that provider ratings are kept up to date and that the public can have confidence in the quality of care.

In April 2025, we set a target to publish 9,000 assessments by September 2026. We have made good progress completing 4,590 assessments between 1 April 2025 and 31 December 2025, putting us ahead of target. In November 2025, we had completed 50% more assessments than in November 2024. This activity supports us to monitor provider's compliance and hold them to account where standards are not met.

To ensure that the public and people who use services are kept informed in a timely manner, we have introduced a new timeliness metric, intended to reduce the time taken between commencing an assessment and completion. For Adult Social Care, Primary and Community Care and Oral Health Services, the target is a median of 50 working days. For Mental Health and Secondary Care Services, the target is a median of 85 working days. We are currently meeting both targets.

Alongside this operational progress, over the last year we have engaged colleagues, providers, stakeholders and the public across England to inform development of improvement proposals. The proposals were across 2 areas of focus:

- developing our frameworks and guidance for assessing providers
- changing our methods for inspecting, assessing and awarding ratings to health and care services.

Embedding human rights in regulation

In 2023 we published our [human rights approach to regulation](#) which states clearly that care that does not respect and promote human rights is neither safe nor high-quality. We consulted regularly with external stakeholders including people who use services to shape our human rights approach. These stakeholders support a check and challenge function in evolving projects whilst also supporting on specific

elements of work critical to advancing rights based practices in CQC – for example bespoke learning and development of staff.

Our human rights approach is based on fundamental (FREDA) principles of Fairness, Respect, Equality, Dignity and Autonomy which are foundational elements in the Human Rights Act itself. These elements are illustrated through the areas of work described below.

In September 2025, the CQC Board approved [4 new equality objectives for 2025–2029](#), strengthening equity and human rights across our regulatory work and within our workforce. Three of these objectives focus on the people who most need our protection, supporting equal access to care, fair experiences, and better outcomes across health and social care (the fourth relates to our internal workforce). They are:

- **Equality objective 1:** Amplify the voices of those at risk of poor care.
- **Equality objective 2:** Develop systems to gather equality data to better understand and respond to equality risks.
- **Equality objective 3:** Improve equity by using our regulatory and monitoring activities e.g. via the Patient and Carer Race Equality Framework (PCREF).

A further key pillar in our human rights-regulatory based work is our Anti-Racism Policy and Strategy approach first approved by our board in September 2024 and aligned to the [Race and Health Observatory Anti Racism Principles](#). This work is now nearing the end of phase 1– “naming racism” and has included within it the delivery of co-produced foundational learning and development for all staff. This initial phase has also included a Participation Action Research piece as a key strand. This research approach is being developed by a group consisting of CQC staff, providers, lay people and third sector partners with lived experience. This work will culminate in a coproduced published position statement and high-level action plan which will inform our ongoing work in phase two of our approach.

Consultation on our future assessment framework

Our consultation, [Better regulation, better care](#), received over 1,600 responses, which we will use to refine our current assessment approach. We are committed to this change, especially in relation to clarity of reporting, consistency of approach, and the timeliness of our assessments.

Monitoring the Mental Health Act

CQC delivers statutory functions under the Mental Health Act (MHA). We monitor the use of the formal powers of the MHA through our MHA monitoring visits and MHA complaints investigations. The Mental Health Act (2025), which was formally introduced to Parliament as a Bill on 6 November 2024, became law in December 2025. We worked closely with stakeholders to review the provisions of the Bill and will continue to work with stakeholders and the government during the implementation period of the Act.

From 1 January to 23 December 2025, we visited 675 inpatient mental health wards to monitor the use of the MHA and the experience of people detained under the MHA. Our MHA monitoring visits are almost all unannounced and are focused on the rights of people subject to the formal powers of the MHA.

We raise concerns in our MHA monitoring reports, including those shared with us directly by detained patients, to mental health service providers who are required under the MHA to tell us of the action they will take to address those concerns. We also ask all mental health service providers to inform us of how they have involved people who use their services in developing their action plans. Information and intelligence gathered in our MHA monitoring activity is shared with regulatory teams to inform their ongoing monitoring of providers' compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

National Preventive Mechanism

CQC is one of 21 statutory bodies that make up the [UK's National Preventive Mechanism \(NPM\)](#), which fulfils the UK's obligations under the Optional Protocol to the Convention against Torture (OPCAT) to protect people's human rights connected with ill-treatment when detained by the state. CQC carry out this role through our inspections and visits to health and social care services in England where people may be deprived of their liberty—such as under the MHA or Mental Capacity Act—as well as through joint inspections in criminal justice settings.

Countries that are signatory to OPCAT recognise that the protection of people deprived of their liberty is strengthened through a preventive system of visits to places of detention. A preventive approach by NPM bodies means being proactive, flexible and grounded in human rights when monitoring places of detention, intervening where needed, and promoting continuous improvement.

Over the past year, we have strengthened our preventive work and engagement with NPM by raising staff awareness about NPM through internal communications, embedding learning on the NPM in inspector induction, and providing significant content to the UK NPM annual report which is laid before parliament. Countries that ratify OPCAT also permit periodic international visits to places where people may be deprived of their liberty, creating a dual system of national and international oversight.

The patient and carer race equality framework (PCREF)

In our refreshed Human rights approach, we emphasise the importance that epistemic justice has to play in ensuring a rights-based lens is utilised in our regulatory work. This concept describes how people and their views can be silenced, ignored or discredited on grounds of prejudice or biased assumptions. People whose voices are less heard, valued and understood are the people whose human rights need protecting the most.

The patient and carer race equality framework (PCREF) is an important part of advancing rights-respecting care and it sits firmly within our assessment framework.

As part of our commitment to tackling inequality and promoting and protecting human rights, we now look to see how providers implement PCREF. In November we published a [brief guide](#) illustrating what inspectors and Mental Health Act reviewers look for in checking how providers are implementing PCREF. Evidence from PCREF also helps us prevent ill-treatment, a core function of our role within the National Preventive Mechanism.

MHA reviewers carried out focused MHA monitoring activity between 1 January and 31 March 2025 to look at how well PCREF was understood and its impact at mental health ward level. This work is being repeated between 1 January and 31 March 2026 to understand the impact of PCREF at ward level in its first year of full implementation. The outcomes of this work are reported nationally in our annual Monitoring the Mental Health Act report.

Independent Care (Education) and Treatment Reviews [IC(E)TRs]

Another important element of rights protections in our work, monitoring providers' compliance with expected standards and hold providers accountable, is our delivery of Independent Care (Education) and Treatment Reviews [IC(E)TRs]. IC(E)TRs form part of NHS England's commitment to improve the care of people with a learning disability and autistic people in hospital, and ultimately, to reduce the number of people with a learning disability and autistic people in hospital. IC(E)TRs are independent, in-depth reviews into the care and treatment of relevant people in long term segregation in hospitals, including children, young people and adults. They are modelled on Care, (Education) and Treatment Reviews (C(E)TRs).

IC(E)TRs review the individual's care to ensure people are receiving safe and effective care and treatment in the least restrictive setting and that there is a clear plan for discharge and future care. By focusing on ensuring people's individual needs are assessed and action is taken to meet those needs, as well as raising concerns when people's rights are not respected or upheld, the IC(E)TRs promote the reduction of restrictions and discharge from hospital of people with a learning disability and autistic people.

IC(E)TRs are chaired by our Mental Health Act reviewer colleagues, supported by a designated MHA operations manager. We have this year refreshed human rights specific guidance that sets out what an Independent Care (Education) and Treatment Review is and the overarching principles underpinning how we conduct each review. It also prescribes how concerns arising from IC(E)TRs should be escalated to regulatory colleagues and appropriate action taken by them. It references the specific requirement of IC(E)TR chairs to ask whether staff have had training in human rights-based care and to look for evidence of the impact of the training.

2. Recommendation: Specific training on human rights and its effects on the provision of services must be given by all registered providers to staff. The CQC should work with all stakeholders to ensure this is happening in practice. It is crucial that training programmes go beyond simply stating rights or obligations, and effectively demonstrate the relevance of and use of human rights in making decisions regarding care and treatment. (Paragraph 61)

Our [assessment framework](#) enables us to focus on people's human rights when they receive health and care services. It helps us prevent failures in care that are often related to risks to human rights and to ensure people receive good care.

Our human rights approach to regulation has ensured that the quality statements in our assessment framework are aligned to human rights principles of fairness, respect, equality, dignity and autonomy.

As we review feedback from our consultation on the assessment framework, human rights will continue to be a key part of our regulation as we continue to move forward in the future. Our consultation activity has included engagement directly with people who use services with a particular focus on those people more likely to experience poorer care and health inequalities. It has also included a specific question in the formal consultation document and at the supporting engagement events encouraging stakeholders to consider and share their views on any potential equality and human rights implications of our proposals. As part of the work we are doing to improve our assessment approach, we are scoping a specialist human rights review of the sector specific assessment frameworks currently under development.

As the independent regulator of health and adult social care in England, we cannot specify the training a provider must deliver in human rights, however we can ensure that providers of services are effectively considering human rights in their care delivery. A key part of this is ensuring staff have the right skills, knowledge and experience to deliver effective rights respecting care. There is an opportunity to look at strengthening this element further when we build our proposed sector level assessment frameworks.

The [Care Certificate](#) is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with the non-regulated workforce in mind, the Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

We believe it is good practice for health and social care workers' to use the updated [Care Certificate](#) standards. One of these standards is Equality, diversity and human rights. As we build guidance for our future assessment frameworks, we will further promote our expectations that staff have the skills and knowledge to deliver rights-respecting care, for example by referencing Care Certificate standards, the Level 2 Adult Social Care Certificate qualification and the role of higher-level qualifications in promoting rights-respecting care.

Complaints mechanisms

3. Recommendation: In its regulatory and monitoring role, the CQC must take proper account of how complaints are being handled by providers, and how decisions made by the Ombudsman bodies are being implemented. The CQC must also routinely look at how health and care contracts between individuals and providers are being terminated and work alongside the Ombudsman

bodies and providers to ensure that individuals are not suffering retaliation after lodging complaints. (Paragraph 108)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16 sets out our powers and duties relating to complaints. This regulation makes sure that people can make a complaint about their care and treatment.

To meet this regulation providers must have an effective and accessible system for identifying, receiving, handling and responding to complaints from people using the service, and people acting on their behalf or other stakeholders. All complaints must be investigated thoroughly and any necessary action taken where failures have been identified. In our [Regulations for service providers and managers guidance](#) we are clear that people's care and treatment must not be affected if they make a complaint.

When requested to do so, providers must provide CQC with a summary of complaints, responses and other related correspondence or information.

CQC can prosecute providers for a breach of the part of this regulation that relates to the provision of information to CQC about a complaint within 28 days when requested to do so. CQC can move directly to prosecution without first serving a Warning Notice. In addition, CQC may take any other regulatory action in response to breaches of this regulation. More information can be found on the [offences section](#) of our website.

As part of our Provider Information Return, we continue to ask providers how many people have been served notice in the preceding 12 months solely because of a change in their care needs, as well as for any other reasons. We may follow up with providers to gather more information when required. However, as noted in the government response to the report we are limited in the action we can take in relation to contractual issues which is outside our remit.

As mentioned earlier in this letter, we are currently awaiting the outcome of the consultation on our assessment framework, however it is highly likely that we will continue to assess the procedures providers have in place for complaints under the key question of responsive.

Mental Health Act Complaints

CQC also receives [complaints from, or concerning individuals, about their care and treatment under the MHA](#). Between 1 January and 23 December 2025, we received 3,216 individual complaints relating to care and treatment under the MHA. The vast majority of these complaints are, with the consent of the complainant, referred back to providers to investigate and to respond to complainants. When complainants are not satisfied with providers' responses, they can ask for CQC to investigate further. MHA complaints investigations are carried out by MHA reviewers as part of our MHA monitoring duties to keep under review the use of the formal powers of the MHA, and to promote the rights of detained patients. Intelligence gained from our MHA complaints work is shared with inspection colleagues to inform their ongoing monitoring of providers.

Information sharing between CQC and Local Government & Social Care Ombudsman (LGSCO)

LGSCO routinely share information with CQC about investigations and outcomes which our Data & Insight team can then make available to operational teams. With further developments to our regulatory platform being made, we hope to improve how we can utilise this sort of information to inform our planning and activities with providers. Since we began our assessment of local authorities and our duties under part 1 of the Care Act, we also now utilise LGSCO information about councils where that can inform our work in this area too. LGSCO is frequently listed as an evidence source in the “Feedback from Partners” evidence category.

Further progress to note

Please see progress towards other recommendations as highlighted in your report:

1. The Government must work with providers, the CQC, and other stakeholders to take steps to raise awareness and prevent inappropriate use of DNACPR notices. (Paragraph 36)
2. In its monitoring, assessing, and inspecting activities, the CQC must continue to seek assurances that care users are placed at the centre of DNACPR notices, in a way that protects their human rights. (Paragraph 38)

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) recommendations

Our [assessment framework](#) includes a focus on capacity, consent, and DNACPR/ Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) rights. Under the *effective* key question, we check that people or their lawful representatives are involved in care planning. The *responsive* key question, particularly the Planning for the Future statement, focuses on end-of-life care and advanced planning.

Following our [thematic review](#) on DNACPR, we strengthened GP practice assessments. GP specialist advisors review care plans and DNACPR decisions using a standard template for consistency. Five random patient records are checked remotely and DNACPR is discussed during GP interviews. Additional guidance is being developed to support inspectors’ judgments. and we are reviewing training to include DNACPR in induction. Senior specialists have delivered upskilling sessions on mental capacity, DNACPR, ReSPECT, and Advanced Decisions to Refuse Treatment, referencing PHSO recommendations.

For adult social care and hospital inspections, internal guidance for staff ensures DNACPR decisions uphold human rights and align with end-of-life quality statements. Staff also have access to guidance on **ReSPECT**.

We have published a [GP mythbuster](#) most recently updated in October 2024 aimed at helping providers manage and maintain effective oversight of DNACPR decisions. Our thematic review established a Ministerial Oversight Group, though we believe this has not met since 2022.

Restrictive practices should only be used where strictly necessary, as they could amount to a breach of the prohibition of torture and inhuman or degrading treatment (Article 3 ECHR) and the right to liberty and safety (security) security (Article 5 ECHR). The Government must work with the CQC and the Ombudsman bodies to review existing guidelines to ensure that they comply with the requirements of human rights law, and to take appropriate steps to ensure that providers only have recourse to restrictive practices as a last resort. This is of particular importance for people with dementia and people with a learning disability and/or autism, who may be more likely to be subject to restrictive practices, due to their specific health and care needs. (Paragraph 41)

Restrictive Practices

Restrictive practices should only ever be used when absolutely necessary, and only as a last resort. They must never breach people's human rights, including the right to be free from inhuman or degrading treatment and the right to liberty and security.

Since our report [Out of Sight — Who Cares?](#), we have repeatedly called for providers to act immediately to reduce the use of restrictive practice, and to ensure they provide person-centred, trauma-informed care at all times. In 2023, we heard clearly from members of our expert advisory group for people with a learning disability and autistic people that we needed to address the issue head on and develop a clearer and stronger position on the use of restrictive practice. Later that year we published our [policy position on reducing restrictive practices](#). We have since developed training for inspectors in association with the British Institute of Learning Disabilities (BILD), and the Restraint Reduction Network (RRN). Guidance for inspectors was updated to reflect the policy position.

Our 'Out of Sight, who cares?' report called for us to be notified when seclusion or segregation is used. In 2024, the Department of Health and Social Care consulted on a change to our regulations that would require mental health units to notify CQC when restrictive interventions are used. DHSC's response to the consultation asked CQC to do further work before the requirement could be introduced. This work is ongoing. We are developing guidance for inspectors and MHA Reviewers on psychological and cultural restraint, in line with recently published NHSE guidance on restrictive practice

Further, our Independent Care (Education) and Treatment Reviews [IC(E)TRs], promote the reduction of restrictions and discharge from hospital of people with a learning disability and autistic people by focusing on ensuring whether people's individual needs are assessed and associated actions then implemented, as well as raising concerns when people's rights are not respected or upheld.

Targeted work also continues specifically on other approaches to monitoring the use of Restrictive Interventions, their impact on individuals, and groups affected by inequalities, within CQC and in collaboration with other organisations. For example, in our recent report into [Good practice in relation to access, experience and outcomes for Black men in mental health services](#) we highlight the need for improved ethnicity data, anti-racist practice, and shared learning as essential for reducing inappropriate or avoidable restrictive interventions.

Furthermore, as part of our [new Equalities Objectives](#), we have an objective between 2025-2029 to develop systems to gather equality data to better. This is to ensure that our inspections are insight informed, and where there are inequalities in the application of interventions such as restrictive practices, these are identified and addressed as part of our assessment processes.

3. The Government must legislate to give the CQC the power to require care settings to inform them of any changes to their visiting status, and to report live data on levels of visiting and restrictions. The CQC must make compliance with visiting restrictions a key consideration when undertaking its regulatory and monitoring roles. (Paragraph 84)

In April 2024 a new fundamental standard on visiting (Regulation 9A) came into effect to ensure that care homes, hospitals and hospices registered with CQC respect the right of each person to receive visits and to be accompanied, following an assessment of their needs and preferences.

Providers registered with CQC must comply with Regulation 9A, and we may refuse registration if providers cannot offer evidence that they are able to meet all parts of the regulation. Information people share with us about visiting is also used as part of wider monitoring of services.

In drafting guidance for [Regulation 9A: Visiting and accompanying in care homes, hospitals and hospices](#) we took an approach aligned with human rights decision-making for qualified rights, so aligning the guidance with European Convention on Human Rights (ECHR) Article 8. The structure of the guidance specifically includes whether any restriction to visiting is lawful, has a legitimate aim and is proportionate, i.e the least restriction possible. In addition, there are requirements that consideration of restricting visiting rights must be in exceptional circumstances only and consider the preferences of the person receiving care, the impact on each individual affected including impact on their human rights and their wellbeing. Decisions must be recorded and reviewed regularly, including reviewing mitigations to reduce restrictions.

In early 2025 the government commenced a post-implementation review of Regulation 9A seeking views from people who use services, families, providers, carers and others impacted to understand their experiences of visiting and accompanying since the regulation came into force.

We have engaged closely with the Department of Health and Social Care throughout the duration of the review. We await publication of the review findings and any recommended actions to improve the rights of visiting and accompaniment in care homes, hospitals and hospices. We will closely consider how we carry out work to address any recommendations for CQC alongside the wider changes we are making to our assessment framework and ways of working.

4. Complaints mechanisms that involve care settings must be clarified and streamlined. All complaints relating to care settings should be investigated either by the LGSCO or by the PHSO, and not by the CQC. Section 120(4) MHA 1983 should be amended accordingly to transfer the duty to investigate complaints related to the Mental Health Act 1983 in England, along with the CQC's enforcement powers for such investigations and decisions, from the regulator to the LGSCO or the PHSO. This change would help minimise some of the confusion as to which body one should direct complaints, and could better enable the CQC to focus on its monitoring and regulatory role. (Paragraph 105)

In their response to the report, the Government decided not to accept this recommendation, outlining that there are clear benefits to CQC maintaining responsibility for complaints made under the MHA. This recommendation was therefore not taken forward as part of the MHA 2025. A full evaluation of our MHA monitoring and complaints service has been commissioned following which, with sufficient funding, we hope to implement recommended changes.

5. The LGSCO, the PHSO, and the CQC must have a "no wrong door" policy for complaints. If a complaint is out of scope of one body, they must direct it to the appropriate organisations in an adequate timeframe. (Paragraph 107) 26.

Signposting and redirection of complaints to the correct organisations where necessary is ingrained in the work we do. We continue to work closely with the LGSCO, meeting quarterly, to monitor how we signpost relevant queries and complaints to each other in an efficient and timely way. We signpost to the LGSCO website directly from our own pages on how to make complaints, to help raise awareness and understanding of what the Ombudsman's role is and how to contact them. Upon request and on an ad hoc basis, we review the traffic from our website to the LGSCO pages and can see that people do click through.

6. While Liberty Protection Safeguards (LPS) are not fully implemented, the Government must work with the regulator and all stakeholders to ensure that providers fully understand the functioning of the Deprivation of Liberty Safeguards (DoLS) and comply with statutory requirements. (Paragraph 54)

As part of our assessments of hospitals and care homes, we routinely review providers' operation of the Deprivation of Liberty Safeguards (DoLS). An internal working group has been established to provide assurance on the effectiveness of CQC's duty to monitor the operation of MCA and DoLS in England as set out in the Code of Practice, which sets expectations for CQC to monitor them through inspections, and to report annually. Much of this work is focused around ensuring good practice in carrying out MCA functions and subsequently effective

implementation of DoLS by providers. We are also working to ensure our workforce is confident in the application and implementation of MCA/DoLS through strengthened induction, upskilling sessions and guidance.

In successive State of Care reports, we have raised strong concerns about the operation of Deprivation of Liberty Safeguards (DoLS), including delays in processing applications and the variable knowledge of staff about the safeguards. Across both health and social care services, we continue to find that many of the issues outlined in the House of Lords MCA post-legislative scrutiny report are still relevant and have been exacerbated by the stark increase in the volume of applications, bringing new challenges for the DoLS system.

CQC has continued to liaise with the Department of Health and Social Care and ministers in past and present governments about these concerns, highlighting the need for system reform. We welcomed DHSC's announcement in October confirming the introduction of changes to the current DoLS system in the form of the Liberty Protection Safeguards (LPS) following a consultation. We will continue to liaise with DHSC throughout the implementation process.