

Written evidence from the Care Quality Commission (CQC) (HCS0045)

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Introduction

1. The Care Quality Commission (CQC) is the independent quality regulator of health and adult social care in England. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage these services to improve.
2. Section 4(1)d of the Health and Social Care Act 2008 states that CQC must “*have regard to the need to protect and promote the rights of people who use health and social care services*”. This includes but is not limited to people’s human rights.
3. We do not have regulatory powers to take legal action directly under the Human Rights Act 1998. However, human rights are embedded into the regulations we use, which include the Fundamental Standards¹. These are the standards which care must never fall below, set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
4. Our remit covers a wide range of topics related to this inquiry, and we have summarised many of them in the below written submission. These include:
 - CQC’s human rights approach to regulation
 - Our regulatory activity
 - Our role in supporting patients and residents who make complaints
 - Changes to the regulation of care settings due to the pandemic
 - Our future regulatory approach
 - An overview of our findings in care settings
 - Human rights issues during the pandemic
 - Restrictions on visiting in care settings
 - Infection, prevention and control (IPC)
 - Improving our regulation of services for people with a learning disability and autistic people
 - Reducing avoidable segregation, seclusion and restraint
 - Encouraging people to be supported in the community
 - Protecting human rights through our Mental Health Act monitoring duties
 - Deprivation of Liberty Safeguards as a human rights protection
 - The use of Do Not Attempt Resuscitation (DNACPR)
 - Modern slavery in staffing in adult social care settings
 - Sexual safety in care settings

¹ <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards>

CQC's human rights approach to regulation

5. Human rights are at the heart of our approach to regulation. We first published our Human Rights approach to Regulation² in 2014, alongside our strategy “Raising standards, putting people first”.
6. Through our enforcement powers as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we consider enforcement action if services do not meet the Fundamental Standards.
7. As part of our regulatory decision-making process, when there is a breach of our regulations, we consider whether there was an infringement of any person’s rights or welfare or reduction in their quality of life. Where appropriate this includes consideration of a potential infringement of a person’s human rights.
8. We make a safeguarding referral to the relevant local safeguarding authority if we believe abuse or neglect is occurring, or there is a risk of serious or significant harm to a person or people and we are the first organisation to become aware of this information.
9. If there is a situation where we think the Equality and Human Rights Commission (EHRC) has more suitable regulatory powers to address the issue, we use our Memorandum of Understanding³ with the EHRC. This enables both ourselves and the EHRC to share information and refer cases where the other regulator has more suitable regulatory powers.
10. In 2019 we reviewed⁴ our human rights approach to support improvement of our regulatory model and adapt to significant changes in the way that health and adult social care services are delivered.
11. We have made good progress in embedding human rights into our assessment framework and the tools that inspectors use. We have also delivered a major learning programme on human rights for all inspection staff and developed an Equality and Human Rights Network for our staff, which has over 500 members.
12. We have used our equality objectives⁵ to develop work which protects the human rights of specific groups of people, for example how we consider care quality for people with a learning disability using acute hospital services and on how providers meet the NHS Accessible Information Standard.

Our regulatory activity

13. Human rights issues are embedded throughout our assessment framework and regulations, rather than being assessed separately. As human rights form a significant part of the enforcement action we take, for example addressing breaches of regulations on staffing or good governance could have a preventative or actual impact on human rights, it is not possible to separate out the enforcement action we have taken in response to human rights issues.

² <https://www.cqc.org.uk/guidance-providers/all-services/our-human-rights-approach>

³ <https://www.cqc.org.uk/about-us/our-partnerships/memorandum-understanding-equality-human-rights-commission-ehrc>

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https://www.cqc.org.uk/sites/default/files/20200922_Our_human_rights_approach_post_consultation_document_FINAL_WEB_accessible.pdf

⁵ <https://www.cqc.org.uk/about-us/our-strategy-plans/our-equality-objectives-2021-2025>

14. In the last year where we have published figures (2019/2020)⁶ we carried out more than 16,000 inspections across all sectors. This includes our public commitment to re-inspect services based on their inspection rating, as well as inspection of newly registered services and those that we inspected due to intelligence we receive.
15. On re-inspection a total of 2,332 services improved their ratings from inadequate or requires improvement. 79% of the services that we re-inspected, and were previously rated inadequate, improved, compared with 74% in 2018/19. We continue to have regular conversations with key stakeholders, which includes inspection outcomes, risks identified and ongoing monitoring.
16. We use safeguarding alerts to quickly inform local authorities of the most urgent and serious information of concern that we receive. In 2019/20, 96% of alerts were referred within one day, just ahead of our target of 95%.
17. When we took urgent enforcement, 75% were served within three days against our KPI target of 70%.
18. We record enforcement activity by regulated activities, rather than by locations. This means that there may be more than one record of enforcement activity for a regulatory breach in a particular service. For adult social care services, in 2019-2020 we recorded 7,156 regulatory actions, the majority of these actions (6,097) were requirement notices, but we also issued 521 warning notices, took 367 civil enforcement actions and 171 criminal enforcement actions in relation to regulated activities. In 2020-2021, the volume of inspections was lower as we varied our activity types in response to the pandemic, with a total of 2,612 regulatory actions of which 2,083 were requirement notices, 275 warning notices, 242 civil enforcement actions and 12 criminal enforcement actions.
19. Our data for hospitals covers both NHS and independent hospitals providing acute, mental health and community-based healthcare. In hospitals, in 2019-2020 we recorded 1,363 actions in total, of which 1,186 were requirement notices, 72 were warning notices, 78 were civil enforcement actions and 26 were criminal enforcement actions. In 2020-2021 we recorded 443 actions of which 307 were requirement notices, 47 were warning notices, 82 were civil enforcement actions and 7 were criminal enforcement actions.

Our role in supporting patients and residents who make complaints

20. We can investigate complaints when people are sectioned under the Mental Health Act 1983 (MHA) but do not have the remit to investigate or resolve individual complaints where people experience or know about poor care not related to the MHA. This is the role of providers and the ombudsmen.
21. However, concerns raised by people using services, their families and friends, and staff working in services all provide vital information that helps us to understand the quality of care. We also use positive experiences to highlight and share examples of good and outstanding care.
22. Feedback from people who share their experience is used in many ways, including to help us decide when to inspect a service, to raise concerns with providers and seek a response, and to help shape our lines of enquiry before an inspection.

⁶ [Care Quality Commission \(2021\) care Quality Commission Annual Report 2019-2020](#)

Give Feedback on Care

23. We launched our updated Give Feedback on Care (GFOC) service in January 2020, to capture information about people's experiences of the care services they or their loved ones use or that they have experience of through their work. People can give feedback on the phone or online.
24. The new service was designed around the needs of users and a full accessibility audit (carried out by the Digital Accessibility Centre) was completed, which involves testing by people with physical, sensory and mental impairments.
25. Concerns raised by people who use health and social care services and their families will be considered earlier in CQC regulatory processes, along with a strengthening of our engagement with advocates for people who use services.
26. We have had a 75% increase in contacts from the public via Give Feedback on Care in the period April-August 2021 compared to the same period in 2020.
27. We have also seen a 17.7% increase in concerns raised with us by staff this year (2021) as compared to last year (April to September).
28. We use these concerns and others to help inform inspections. In September 2021, of those inspections that have a recorded risk trigger (not regulatory history), 53% are triggered by information of concern.
29. We run public behaviour change campaigns to encourage and enable people to share their experiences of care direct with CQC through our GFOC channels. Our 2020/2021 campaign – Because We All Care was delivered in partnership with Healthwatch, the consumer champion for health and social care, with support from health and social care charities representing people who use services, providers of services and commissioners.
30. In addition to our time-specific behaviour change campaigns, we have also partnered with a small number of national charities who hear from and have direct trusted reach to some of the key populations we wish to hear from. These partnerships are known as Tell us about your care partners and involve Disability Rights UK, Relatives and Residents Association, Mind, Carers UK and Patients Association.

Complaints about providers

31. How well health and social care providers identify, receive, record, handle and respond to complaints is within the remit of our regulation, under Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014⁷. This is also incorporated into our assessment frameworks that inspectors use to rate services.

Role of the Ombudsmen

32. Beyond that set out above, we do not have the remit to investigate individual complaints on people's behalf. Where an individual complaint can't be resolved with the provider, the Local Government and Social Care Ombudsmen (LGSCO) has a role in reviewing certain types of complaints.
33. LGSCO looks at individual complaints about councils, all adult social care providers (including care homes and home care agencies) and some other organisations providing

⁷ <https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-16-receiving-acting-complaints>

local public services. They make decisions and recommendations on complaints they investigate but do not have legal powers to force organisations to follow these recommendations.

Changes to the regulation of care settings due to the pandemic

34. In response to the pandemic we suspended our routine activity. This was to limit the risk of transmission of COVID-19 and to enable providers to focus on care delivery during the unprecedented challenges of the pandemic. We continued to cross the threshold where we were concerned about the safety of people using services.
35. In parallel we made real progress in our ability to monitor services. The introduction of the emergency support framework gave us a structured way to have conversations with providers to help monitor risk and support them during the pandemic. We built on this with our transitional monitoring approach (TMA). The TMA app will soon be integrated into the regulatory platform. This will become the one-stop-shop for all inspector activity. We are now moving out of transition and evolving our approach again.
36. Since May 2020, we have carried out online monitoring calls to provide support to providers during the pandemic and to help assess risk of poor care, that might require further regulatory action. Overall, up to 24 October 2021 we have carried out 19,553 calls to adult social care services, 2,887 calls to hospitals and 4,080 calls to primary medical services.
37. These conversations include questions that focus on how providers protect people from abuse, ensure that any restrictions imposed on people meet best practice standards and legal requirements and how families are involved in people's care and treatment. We also include people's experience of care.
38. We gather people's experience of care through multiple channels, for example through feedback we receive directly from people who contact us or through contact we make with people to seek their views. It also includes a review where appropriate, of notifications the provider must make to us about specific events in their service and other information we hold.
39. Our Experts by Experience⁸ are members of the public from diverse backgrounds who play a vital role in our regulation of health and care services. They bring their personal knowledge and experience of services to help us with our inspections and other key aspects of our work. Experts by Experience talk with people who are using services and their carers during inspections. This helps inspectors to assess and rate the quality of care being provided. We are currently evaluating the results of a pilot study in which we used Experts by Experience to make targeted telephone calls to family members of people who live in care homes. In these calls the Experts by Experience used a series of prompts to explore these family members' experiences of care home visits.
40. Where concerns are identified we may take further regulatory action, including an inspection.
41. In our regulation of Adult Social Care, questions which cannot be resolved by an inspector can be escalated to the Adult Social Care transitional response panel. These were often enquiries from providers but also from people using services or their families.

⁸ <https://www.cqc.org.uk/about-us/jobs/experts-experience>

42. Between March 2020 and October 2021, 2,351 questions were escalated to the panel and the responses published internally so they could be used as a source of reference.
43. A key terms search analysis of the panel log shows that the most common human rights issues that we responded to were concerns about disproportionate visiting restrictions (including from providers about national guidance), application of Deprivation of Liberty Safeguards and, less frequently, concerns about DNACPR decisions being made without consultation with the person.
44. We considered every single query and followed up. We responded using current available guidance, such as the DHSC Ethical framework for decision making⁹ and, where necessary, with reference to human rights principles such as least restriction to achieve a legitimate aim.

Our future regulatory approach

45. We are currently developing our future regulatory approach, which will be based on a single assessment framework that covers all health and social care services. The new single assessment framework remains underpinned by the Fundamental Standards, with a strong emphasis on providers ensuring that the human rights of people using services are upheld. It also includes specific projects aimed at embedding human rights into regulation for learning disability services.
46. We will improve how we hear the voices and experiences of people using the services we regulate, including a focus on reaching out to those at risk of human rights breaches. This commitment is set out in our strategy published in May 2021.
47. Poor experience and outcomes from care are likely to engage human rights breaches. The strategy also contains a cross cutting ambition to tackle inequalities and further details about how our action to hear from people more likely to have poor access, experience and outcomes from care is given in our Equality Objectives, published in July 2021¹⁰.
48. We are now reviewing our response to the pandemic in order to learn lessons and support our programme of improving and transforming the way we regulate services. This work considers how we have protected people's human rights – including, but not limited to the role of our COVID-19 Equality and Human Rights Impact Assessments¹¹.
49. Our new strategy is also built on these principles and learning to date. There is a commitment to reaching out to people who are most likely to have their human rights breached and to including human rights when we look at our safety theme in the strategy. There is an Equality and Human Rights Impact Assessment¹² of the strategy which will help us to ensure that equality and human rights are central to our future development as a regulator.

⁹ Responding to COVID-19: the ethical framework for adult social care - GOV.UK (www.gov.uk)

¹⁰ <https://www.cqc.org.uk/about-us/our-strategy-plans/new-strategy-changing-world-health-social-care-cqcs-strategy-2021>

¹¹ <https://www.cqc.org.uk/about-us/equality-human-rights/coronavirus-regulatory-response-equality-impact-assessment>

¹² <https://www.cqc.org.uk/about-us/accessibility/cqc%E2%80%99s-strategy-2021-equality-impact-assessment>

Health and Care Bill

50. The Health and Care Bill sets out a new duty for us to assess how local authorities are meeting their social care duties, and a proposed role for us in reviewing Integrated Care Systems.
51. We are working with people who draw on care and other stakeholders to develop our approach and to ensure that the promotion of people's human rights remains a central theme.

An overview of our findings in care settings

52. The pandemic has been intensely damaging for some people who use health and social care services, and many struggled to get the care they need. Unless consideration of human rights principles is built into decision making at every level, then it is less likely that human rights will be upheld during times of pressure.
53. For an organisational approach to protecting and respecting human rights to be successful, there has to be a skilled and motivated workforce, with good training in person-centred care and human rights. Individuals need the attitude, knowledge, skills and confidence to protect human rights.
54. There also must be good leadership, including oversight of how human rights are being upheld in practice for people. This applies to both providers and commissioners of care.
55. These issues cannot be seen in isolation from the wide scale challenges in health and social care – especially that the workforce is exhausted and depleted.
56. In our 2021 State of Care report¹³, we express the need for urgent action to tackle staffing issues and the increased pressures and stresses caused by staff shortages, especially as we approach winter.
57. Monthly data from information submitted to us by providers of residential care shows their staff vacancy rate increasing steadily from 6.0% in April 2021 to 10.2% in September 2021.
58. The £5.4 billion of government investment, with £500 million committed to support the adult social care workforce is welcome. However if the funding for social care is to have any impact, there must be a sharp focus on developing a clearly defined career pathway for social care staff – linked to training and supported by consistent investment, higher overall levels of pay to increase the competitiveness of the market, and good terms and conditions to ensure employers can attract and retain the right people. A new deal for the care workforce needs to be developed. This should consider recruitment and retention, training, pay and rewards, the professionalisation of the workforce, and workforce resilience.
59. Health and social care staff are exhausted, and the workforce is depleted. They have worked tirelessly in times of sustained pressure to help those who needed care. The negative impact of this way of working, including anxiety, stress and burnout, cannot be underestimated. They need support to work differently, without which there could be implications for the quality of care including whether people's human rights are upheld in care settings.

¹³ https://www.cqc.org.uk/sites/default/files/20211021_stateofcare2021_print.pdf

Human rights issues as a result of the pandemic

60. We issued several guidance statements when we became aware of increasing human rights risks during the pandemic, such as our statements on DNACPR decisions¹⁴, on access to hospital care and treatment for older and disabled people¹⁵ and on care home visiting¹⁶.
61. We also supported adult social care providers with guidance on culturally appropriate care¹⁷ due to the increased risks that people's cultural needs would not be met with less family or community contact. Where there was evidence of increased risk, we also built this into our monitoring of services during the pandemic, including through our Mental Health Act monitoring activity. Additionally, we shared instances of good practice picked up through adult social care inspections to provide examples of services that are proactive in providing care that respects people's culture.

Restrictions on visiting in care settings

62. An awful consequence of the pandemic, particularly during its height, has been the separation of families and carers from their loved ones. Visiting is a central part of care home life. It is crucially important for maintaining the health, wellbeing and quality of life of residents.
63. Although the measures that have caused this separation were introduced to keep people safe, this does not reduce the impact on people's wellbeing – both for those using health and care services as well as those who love and care for them. This means that providers need to balance competing human rights.
64. We have previously submitted evidence to the Committee on visitors to care homes during the pandemic.¹⁸
65. We have taken decisive action throughout the pandemic to help keep people safe in care settings, and making absolutely clear to providers that blanket approaches to visiting are unacceptable and may trigger an inspection. We have been clear throughout the pandemic that the individual must be at the centre of decisions around visiting. We expect providers to follow government guidance on visiting where people are entitled to have designated visitors, and where we are made aware that this is not happening we follow up with the provider and inspect if we consider that there is risk. Where we have any evidence that this is not happening, we will continue to take action.
66. We continue to monitor information where there are concerns about blanket bans. Concerns have been raised with us about 51 potential blanket bans, 16 of which have been raised in the last 6 months. The last concern we received in relation to visiting bans was raised in September 2021¹⁹. We have taken action in every case, including following up with providers, inspecting, raising safeguarding alerts where applicable and following up with local authorities.

¹⁴ <https://www.cqc.org.uk/news/stories/joint-statement-advance-care-planning>

¹⁵ <https://www.cqc.org.uk/guidance-providers/adult-social-care/access-hospital-care-treatment-older-disabled-people-living>

¹⁶ <https://www.cqc.org.uk/news/stories/rights-individual-must-be-paramount-when-deciding-visiting-plans>

¹⁷ <https://www.cqc.org.uk/guidance-providers/adult-social-care/culturally-appropriate-care>

¹⁸ <https://committees.parliament.uk/publications/5977/documents/67715/default/>

¹⁹ Data correct as of 4 November 2021

67. Since the visiting guidance was amended on 8 March 2021, we have completed 2,348 care home inspections which included an Infection Prevention and Control review. 96.6% of these inspections confirmed that the care homes were enabling visiting to happen, and action was taken following the 79 inspections (3.4%) where we had outstanding concerns.²⁰
68. Even before the pandemic, there were concerns raised in some circumstances about care homes not allowing visitors – usually barring particular visitors rather than a “blanket approach” to restricting visiting.
69. In 2016 we published information on visiting rights in care homes which we updated in 2019²¹ to incorporate new guidance on consumer law.

Infection, prevention and control (IPC)

70. IPC is an essential part of safety in care settings. It became even more important during the COVID-19 pandemic in protecting people using services and staff by preventing the spread of infection.
71. We have enhanced our approach when inspecting care homes to include a mandatory question, in our IPC tool for care homes, on whether the service is ‘facilitating visits to people living at the home in accordance with current guidance’. We assess whether all types of visitors are prevented from catching and spreading infection.
72. The questions help us gather information about the service; where the strengths are and if there are any gaps or concerns about infection prevention and control. Where there are gaps, we aim to signpost the service to resources that could help.¹²
73. For each area, we state whether we are assured, somewhat assured or not assured by the provider of the service. We use the ‘somewhat assured’ judgement where there are minor issues we have identified with the provider. For example, where we have not taken regulatory action but have shared information with the people running the service to help them improve their handling of IPC.
74. During the period 24 July 2020 to 26 October 2021, there have been 6,638 IPC inspection forms completed. Of these, 89.2% (5,920) of services were assured or somewhat assured for all eight questions we look at. Of the completed forms, the visiting domain was assured or somewhat assured in 6,452 cases (97.2%).
75. In our State of Care Report this year, we report further on the way most care providers we have inspected have demonstrated that they have faced challenges relating to infection and prevention control well.

Improving our regulation of services for people with a learning disability and autistic people

76. In our recently published State of Care report for 2020/21, we describe that a closed culture is ‘a poor culture that can lead to harm, including human rights breaches such as abuse’. In these services, people are more likely to be at risk of deliberate or unintentional harm. This risk has been further exacerbated during the pandemic by more services becoming closed environments due to a lack of visitors, and from the potential

²⁰ Data up to 31 October 2021

²¹ https://www.cqc.org.uk/sites/default/files/20191017_visiting_rights_information_2019_update.pdf

impacts of staffing and management pressures. Our closed cultures guidance²² extends beyond services for people with a learning disability and autistic people and applies to all services which might be a closed culture.

77. When we have concerns about a closed culture in a care setting, we use our closed cultures guidance to help ensure that we are able to assess the quality of care in the care setting. Fundamental to this approach is a focus on gathering the experiences of people using the service and their families. This guidance also has a more specific focus on identifying regulatory breaches which may infringe on any person's rights or welfare, including a potential infringement of a person's human rights.
78. We continue to take action against unsafe and dangerous care. Currently, 8 inpatient services for people with a learning disability and autistic people are rated inadequate and 19 as requires improvement, out of a total of 76 services.
79. We are improving the way we regulate services for people with a learning disability and autistic people to make sure they receive a good quality of care. As part of this, we have been working on and piloting an approach which is more in-depth and centered around people's experiences of care, to help us get to the heart of a culture of a service.
80. The key to this is specialist skills and increased observation. Some practical changes we have made include visiting services more regularly and at telling times, like handover periods, mealtimes, and evenings to better understand the whole culture of a service. It also includes spending more time speaking to people who use services and their families.
81. We have been trialing ways of ensuring we put people's experience at the heart of our inspections. This includes the 'Quality of Life tool', which looks at how well people with a learning disability or autistic people's care plans are delivered in practice.
82. The quality of life tool was developed in order to address recommendations from Glynis Murphy [REDACTED] and recommendations in our restrictive practices review²⁴. It was developed in collaboration with the University of Warwick and best practice in care planning for people with a learning disability and or autistic people.
83. The primary purpose of the tool is to improve our ability to consistently identify and take appropriate regulatory action in services that fail or are failing to meet the needs, aspirations and skills development of people with a learning disability and/or autistic people.
84. The quality of life tool has not replaced our published methodology for assessing and evaluating the performance of registered providers. The quality of life is a tool for inspectors to assist them in emphasising good and poor care in line with our published methodology.
85. In addition, we are trialing the use of 'Talking Mats'TM to support our interactions with people who have difficulty in expressing themselves verbally.
86. We have also developed and delivered training to all inspection staff on learning disabilities and autism, and the various types of communication tools that are used to support people to express themselves. This has included training on Makaton, British Sign Language and Picture Exchange Systems.

²² <https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures>

²³

²⁴ <https://www.cqc.org.uk/publications/themed-work/rssreview>

87. We want to encourage providers to think more about supporting people to live their best lives when in a service.

Providers using surveillance

88. The use of surveillance techniques, including CCTV in health and social care settings by providers is increasing. Although CQC does not have the authority or powers to regulate the use of CCTV by the provider, the use of CCTV can impact on people's liberties and human rights and CQC is required to comment on equality and human rights in health and social care.
89. We have introduced a new approach and guidance²⁵ on the providers use of surveillance/CCTV to ensure any surveillance is not used for anything other than the best interests of the people using the service. The guidance provides a framework and a level of knowledge to enable us to assess how people's human rights are protected when CCTV is used.
90. The guidance is supported by a site visit tool, enabling inspectors to ask key questions to identify lawful and appropriate use of surveillance.
91. CQC has the powers to view and seize surveillance recordings made by providers and where appropriate use these to support our regulatory functions, such as enforcement.

Reducing avoidable segregation, seclusion and restraint

92. Restrictive practice is a human rights issue. In our 'Out of Sight – Who Cares report?'²⁶, we found too many examples of undignified and inhumane care, in hospital and care settings where people were seen not as individuals but as a condition or a collection of negative behaviours. The response to this has often been to restrain, seclude or segregate them.
93. The report outlines recommendations for organisations across the health and social sector to progress in this area.
94. Where services have a good culture and staff are engaged, we have seen people leading their best lives. However, we have found:
- that getting the right staff with the right skills has become increasingly difficult during the pandemic, resulting in people's needs not always being well met by staff who respect and value them.
 - cultures where restrictive practice is frequently used – people are observed and followed rather than interacted with and given opportunities to develop skills and a meaningful life.
 - that some people have become stuck in services and are not able to move on to a community place.
 - some people have moved into care services during the pandemic without good planning and support, which has stopped them settling in – this is distressing for them and disruptive to others.

²⁵ <https://www.cqc.org.uk/guidance-providers/all-services/how-we-check-use-surveillance>

²⁶ <https://www.cqc.org.uk/publications/themed-work/rssreview>

- fewer face-to-face visits from families, commissioners, professionals and providers has made it more difficult to identify when closed cultures could be developing.
 - that quality assurance systems, which check that good care happens around the clock, supported by every member of staff, has never been more important.
95. In winter 2021/22, we will publish a progress report on the ‘Out of Sight- who cares?: Restraint, segregation and seclusion review’ by reporting on progress and working with colleagues and external partners to engage, involve and ultimately ensure the recommendations in the report are actioned appropriately.
 96. This work will help ensure that we drive through changes to meet the needs of people with mental health conditions, people with a learning disability and autistic people. It will help to ensure they have good quality of life, are able to receive the right support at the right time and ensure they are not subject to restrictive practices such as segregation, seclusion and unnecessary restraint.
 97. The work will also help to drive forward the goals in the NHS Long Term Plan, including plans to increase community health provision.

Encouraging people to be supported in the community

98. We know from national guidance that in the majority of instances, the community is the best place to care for people with a learning disability and/ or autistic people in a way that protects their human rights. If people have to stay in hospital this should be for the shortest period possible and to receive clearly defined specialist treatment.
99. We recently updated our policy which describes what we expect good care to look like for autistic people and people with a learning disability.
100. The guidance ‘Right Support, Right Care, Right Culture’²⁷ says that people should be cared for on an individual basis, and have the choice to pick their care and support. They should be cared for as close to home as possible. It covers good care from registration through to inspection of a service. It is about ensuring people have the right model of care and are going into a service that meets their individual needs, whether that’s in adult social care, a community service or a hospital.
101. We published the Home for Good report²⁸ in September 2021 which demonstrates through case studies that good community support can be provided for people with a learning disability, a mental health need and or autistic people.
102. The report finds that it is possible for people who have previously been in ‘long-stay’ mental health hospitals to live well in the community – with the right care in place.
103. Good quality housing provision needs to be expanded and this requires investment upfront, because people need to have the choice of accommodation and care provider to meet their specific needs so that their human rights are protected.
104. The report also finds that providers need to better collaborate with clinical and health professionals, and community teams and that family involvement in all aspects of service planning and delivery (where the person wants this) increases the chance of a good outcome.

²⁷ <https://www.cqc.org.uk/sites/default/files/20200929-900582-Right-support-right-care-right-culture-FINAL.pdf>

²⁸ <https://www.cqc.org.uk/publications/themed-work/home-good-successful-community-support-people-learning-disability-mental>

Access to ICU/ITU treatment for disabled people during the pandemic

105. During the early part of COVID-19, NICE updated guidelines for access to ICU/ITU treatment in a way which could have had an adverse impact on people with a learning disability and people with long term but stable physical impairments, such as cerebral palsy.
106. Upon reviewing the evidence, we identified concerns that the guidelines potentially excluded some disabled people from gaining access to the care they needed. We encouraged NICE to revise their guidelines which were subsequently amended.

Protecting human rights through our Mental Health Act monitoring duties

107. We have a duty, under the Mental Health Act 1983 (MHA), to monitor how services exercise their powers and discharge their duties when patients are detained in hospital, subject to community treatment orders or guardianship. We do so primarily by visiting and interviewing people whose rights are restricted by the MHA, and we require actions from providers when we find issues or concerns.
108. We also have duties to review and powers to investigate MHA complaints raised by or on behalf of individuals, and to provide a Second Opinion Appointed Doctor Service (SOAD) to review or certify treatment. In 2020/21, SOADs provided second opinions for 14,146 patients with 30% resulting in some change to the treatment plan.
109. In addition, we act as the primary National Preventive Mechanism²⁹ (NPM) for England in relation to mental health detention. The NPM coordinates across the four nations of the UK to focus attention on practices in detention that could amount to ill-treatment, and works to ensure its own approaches are consistent with international standards for independent detention monitoring.
110. In 2020/21, we received 2,280 MHA enquiries, mostly from people who use services and carers, the majority by telephone. We opened only seven of these to be investigated as complaints³⁰.
111. Most enquiries are resolved through provision of information or signposting to local complaints procedures. We undertake a small number of complaints investigations each year, usually where local complaints procedures have been exhausted and we feel that intervention may resolve the complainant's continued dissatisfaction or pick up on matters that have been inadequately addressed.
112. During the pandemic we prioritised calls from detained patients, so that MHA Reviewers contacted patients directly and in many cases were able to resolve matters or ensure that services address any complaint in that contact.
113. In March 2020, inpatient services made wide organisational and procedural adjustments for infection management and to cope with staff shortages due to the pandemic. In response we put in place digital processes to carry out MHA monitoring duties and engage people who use services without having to physically visit a site. In 2020/21 we carried out 628 MHA monitoring reviews of services using digital processes

²⁹ <https://www.nationalpreventivemechanism.org.uk>

³⁰ <https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-201920-mental-health-act-coronavirus-covid-19>

and spoke with 1,916 patients and 1,113 carers. We were able to maintain contact with detained patients, carers, advocates and staff through digital access to maintain oversight. We continued to inspect mental health services in person in our regulatory role, based on risk throughout the pandemic.

114. We returned to site visits in July 2021. We retained some aspects of the above review methodology, in particular continuing to contact carers and advocates by telephone or video link outside of the physical visit, providing a more rounded picture of services.
115. Our revised methodology used during the pandemic is ready to be re-imposed if necessary, in line with the ongoing pandemic situation.
116. The Coronavirus Act carried amendments to the Mental Health Act 1983 in recognition of the difficulties in providing face to face support, and in particular prepared for the suspension of independent SOAD certification of treatment without consent. Due to our adoption of a SOAD review process using digital technology, this suspension did not have to be invoked and the power to do so now has been revoked.
117. Using our contacts with patients, families and staff, we identified and responded to new and significant challenges to human rights due to the pandemic - such as increased restrictions as result of blanket bans in services. We also influenced new national policy.
118. We successfully trialed and adopted digital tools at real pace, and where possible we involved people who would benefit from them, such as lived experience representatives who sat on project groups or supported testing and activities.
119. In past *Monitoring the Mental Health Act* annual reports, we have raised concerns over the compatibility of certain aspects of the Mental Health Act 1983 with European Convention on Human Rights.
120. In particular, we have been concerned that the three-month period in which medication for mental disorder can be initially administered without legal procedure to a detained patient's consent is unjustifiably long³¹.
121. The lack of patient choice in the identification of a 'nearest relative' under the MHA is also problematic in terms of Article 8 compliance.
122. We are pleased to note that proposals in *Reforming the Mental Health Act* White paper and subsequent consultation summary address these concerns and indicate measures to improve the law in a forthcoming Bill.³²

Deprivation of Liberty Safeguards as a human rights protection

123. There are specific protections for people in care settings through the application of the Mental Health Act and authorisation of deprivations of liberty under the Mental Capacity Act (MCA).
124. The Deprivation of Liberty Safeguards (DoLS) legislation is in place to protect people in care homes and hospitals who may need to be deprived of their liberty and therefore provides protection for rights under ECHR Article 5. The safeguards help to ensure that the correct process is used to protect people's human rights if they lack the mental

³¹ https://www.cqc.org.uk/sites/default/files/20190108_mhareport2017_amend_1.pdf

³² <https://www.gov.uk/government/consultations/reforming-the-mental-health-act/outcome/reforming-the-mental-health-act-government-response>

- capacity to consent to the arrangements for the care they need, are under continuous supervision and control, and are not free to leave.
125. In our report 'Monitoring the Mental Health Act 2018/2019'³³ we stated that taking away a person's liberty so that they can be treated in hospital has a major impact on that person's life, work and family. It is therefore essential that this is carried out in a manner that respects their fundamental rights. Our report found that the reality is that this is frequently not the case.
 126. It is difficult for patients, families, carers and professionals to navigate the complexity of the interface between the MHA, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
 127. In our 2018/2019 State of Care report, we highlighted our concerns about the level of services' awareness and understanding of the DoLS legislation, and that this was a primary reason for poor practice. We found some improvements before the pandemic³⁴ after the publication of our State of Care report.
 128. In this year's State of Care report we found that while services have largely maintained levels of DoLS during 2020/21, they need to have a continued focus on people subject to a deprivation of liberty.
 129. We continue to have concerns about delays in authorisations, which mean that individuals are deprived of their liberty longer than necessary, or without the appropriate legal authority and safeguards in place.
 130. Many of the issues we have reported on previously have continued and/or have been exacerbated in the context of the pandemic and associated pressures on the system.
 131. Providers are required to notify us without delay when the outcome of an application for a DoLS authorisation is known, including when authorisation has not been granted.
 132. Numbers of notifications from adult social care services and hospitals reached their lowest point during the early months of the pandemic. In adult social care, we saw a sharp fall in the numbers of notifications received between March and April 2020. In hospitals, numbers were lowest in May 2020.
 133. During the pandemic providers faced significant challenges in balancing adhering to government guidelines on infection prevention and control and managing the risk presented by COVID-19, with ensuring that they met any existing individual's DoLS conditions or new DoLS needed.
 134. We saw good examples of providers thinking creatively to support social distancing and isolation in the least restrictive way possible – for example, allowing multiple individuals who had tested positive to socialise in one area of the care home.
 135. However, in some cases, we were concerned that providers' focus shifted away from DoLS towards managing COVID-19 restrictions. When conditions on DoLS that are there to support the person, such as being able to go out, are not followed, this has a significant impact on the person.
 136. Our inspectors have had concerns that social distancing and other restrictions have made it more difficult to meaningfully implement the DoLS process in a way that supported people's human rights. In particular, they have had concerns around a lack of visits from Relevant Person's Representatives (RPRs), families and other professionals, and the move to online assessments.

³³ https://www.cqc.org.uk/sites/default/files/20201127_mhareport1920_report.pdf

³⁴ https://www.cqc.org.uk/sites/default/files/20201016_stateofcare1920_fullreport.pdf

137. Better training is needed to improve staff knowledge and understanding of DoLS and the MCA, and their importance in protecting people's human rights.

Liberty Protection Safeguards

138. Liberty Protection Safeguards (LPS) were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system. There will be an initial one-year period where DoLS and LPS are in operation at the same time, with full implementation expected to come into force in April 2022.
139. LPS will provide a legal framework for the lawful deprivation of liberty of those individuals receiving care and treatment, where they do not have capacity to consent to the arrangements for the care they need, are under continuous supervision and control, and are not free to leave.
140. The safeguards under LPS will have some significant differences to the those provided under DoLS, including the extension of scope to protect the rights of 16- and 17-year olds. LPS will apply to hospitals and care homes and will expand the system of administrative authorisation of deprivations of liberty to all settings where care is provided including private homes, residential schools and domiciliary care arrangements.
141. Under draft regulations currently being considered by the government, CQC, as a named monitoring body, will have a statutory duty to monitor and report on the operation of Liberty Protection Safeguards of those aged 18 or over.
142. A public consultation on the draft regulations and codes of practice is expected to be announced soon. During that consultation, we will engage with the DHSC to ensure that the codes and secondary legislation fully support our statutory duty to protect and promote the rights of people who use health and social care services, including their human rights, as well as its obligations under the National Preventative Mechanism.

Do Not Attempt Resuscitation

143. In our 2021 review 'Respect, protect, connect' about Do Not Attempt Resuscitation (DNACPR) decision-making during the pandemic, we found a worrying picture of poor involvement of people using services, poor record keeping, and a lack of oversight and scrutiny of the decisions being made.
144. We made it clear that all health and care providers must assure themselves that any DNACPR decisions have been made appropriately, in discussion with the person and in line with legal requirements and best practice.
145. These shortfalls in governance must be addressed if providers are to assure themselves that decisions were, and are, being made on an individual basis, and in line with the person's wishes and human rights.
146. A key finding was that the issues uncovered in the report – including limited understanding of the importance of good conversations around what should happen if someone was to become very ill, and the need for proper and consistent processes around this – pre-date the pandemic.
147. A lack of understanding of the Mental Capacity Act can lead to issues such as people being assessed as having capacity for a relevant decision when they no longer do. It can also prevent health and care workers, particularly those in care homes, from being able to

identify and raise concerns. This means that people may not be protected from unsafe care or treatment and may be at risk of having their human rights breached.

148. To help address concerns around DNACPR which arose during the pandemic and which we identified in our report, we have updated guidance for inspectors on quality and safety and DNACPR, developed new a new alert for enquiries that include DNACPR, updated our inspection frameworks for adult social care and Primary Medical Services and developed new training for inspectors. We followed up with providers where we had found DNACPRs of concern in our report.

Modern slavery in staffing in adult social care settings

149. Though outside our regulatory remit, where we have come across concerns that modern slavery is operating, we are able to refer these to relevant bodies.
150. Since 2016 we have made 25 referrals to other bodies where we have concerns that there may be modern slavery, illegal trafficking, illegal working, labour exploitation, or financial irregularities indicative that there may be labour exploitation or modern slavery. Of these 20 were in adult social care settings, 1 was in primary medical services and 4 were other.
151. We worked collaboratively with the Home Office and other relevant stakeholders to ensure safe houses for victims for trafficking and modern slavery were subject to our oversight, so we could ensure appropriate support was being provided to those living there. Following a successful pilot, the Home Office requested that we routinely inspect these services from January 2021.

Sexual safety in care settings

152. In 2020 we published a review³⁵ on sexual safety and supporting people's sexuality in social care settings. We set this in the context of expressing sexuality as a basic human right, alongside being free from sexual abuse.
153. We found that sex is often seen as a 'taboo' subject in adult social care settings and staff, providers and families can be reluctant to raise issues.
154. We identified a lack of guidance for providers and have since published guidance³⁶. We believe people are better protected when they are empowered to speak out about unwanted sexual behavior and can speak openly about their sexuality.
155. Effective adult social care leaders develop a culture, an environment, care planning and processes that keep people and staff safe, and support people's sexuality and relationship needs.

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³⁵ https://www.cqc.org.uk/sites/default/files/20200225_sexual_safety_sexuality.pdf

³⁶ <https://www.cqc.org.uk/sites/default/files/20190221-Relationships-and-sexuality-in-social-care-PUBLICATION.pdf>