Joint Committee on Human Rights Inquiry into 'The Government's response to COVID-19: human rights implications':
Response from the Care Quality Commission

Introduction

1. The Care Quality Commission (CQC) is the independent 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 them to improve.

CQC's role in regulating closed cultures

2. We use our independent evidence gathered through inspection and other regulatory activity to comment on and raise issues about the state of health and care, which we share with the public, providers and wider stakeholders including Parliament and Government. This allows us to shine a light on issues and suggest ways forward through our recommendations.

3. One year ago, we published interim findings from our review of restraint, segregation and seclusion (RSS), which said that certain types of services are "not fit for purpose" and do not adequately protect people's human rights. The Secretary of State for Health and Social Care commissioned this review and accepted these recommendations in full. The final report is due later this year.

4. Closed cultures are services that may be at increased risk of harm – including abuse and human rights breaches - deliberately or unintentionally. A closed culture can develop anywhere but we know that there are certain services and groups of people that will be at greater risk. This includes services that provide care for people with a learning disability and autistic people, and older people living with dementia who may not have regular contact with families.

5. COVID-19 has exacerbated the risk of a service becoming 'closed' as it reduces the likelihood of external professionals and others entering a service and reduces contact with people's families.

6. People's human rights must be protected during COVID-19 and these are central to our Mental Health Act reviewer and inspection approaches. The voice of people who use services is fundamental to what we do, and we continue to engage with people and their families on how we can improve what we do.

7. We have developed a programme of work to look at how we improve our regulation of closed cultures, which is now underway.

Our concerns with the mental health sector (inpatient units)

8. For some time, we have made it clear that hospital is an absolute last resort.

9. We're finding mental health services are under pressure and ratings deteriorating. Our review of restraint, segregation and seclusion, and what happened at Whorlton Hall, show the scale of challenge for those with highest need.

10. Health and social care leaders need to look beyond traditional service and commissioning barriers to recognise their shared responsibilities for the outcomes of people that use services. Good, person centred care, is possible – and there are good services. We need to see faster progress in the availability of these services that put the care of people first.

Our response to COVID-19

11. Throughout the pandemic our regulatory role and core purpose to keep people safe has been at the heart of all decisions we have made. This role has not changed.

12. Our approach to working with the system has allowed us to raise national issues with government, such as on PPE shortages and other concerns.

13. **We have continued and will continue to cross the threshold** through inspections where we have significant concerns, including serious concerns about people's care and where there are human rights breaches.

14. CQC has committed to a full programme of responsive inspections for certain settings, including unannounced focussed inspections for these services.

15. We have a bespoke approach to people detained under the Mental Health Act in hospital[1]. This approach includes conducting visits to services where we are concerned there are significant human rights breaches.

16. We expect services to continue to do everything in their power to keep people safe and we will continue to inspect where we see evidence of risk of harm, deliberate abuse, systematic neglect or a significant breakdown in leadership.

How we are improving what we do

17. <u>Unannounced inspections</u>

    17.1. The percentage of unannounced inspections in hospitals with wards for people with a learning disability or autism has increased from 62% in Q1 2019/20 to 77% in Q4 2019/20.

[1] https://content.govdelivery.com/accounts/UKCQC/bulletins/2854377

17.2. CQC undertakes shorter, unannounced inspections, which can take place at weekends. We have used out of hours inspection visits to uncover regulatory and human rights breaches and taken action as a result.

17.3. Mental Health Act Visits are almost entirely unannounced visits to wards. Around 1200 visits are completed per year – they may be carried out during weekends or evenings although this is not a regular approach due to the reduced access to patients and clinical staff out of normal hours.

17.4. Our guidance[2] to inspectors says inspectors should look at all the evidence to assess the truth of people's experience in using the service by always carrying out unannounced inspections; always using an Expert by Experience; and carrying out evening and weekend inspections.

17.5. We are currently rolling out training to all inspectors on closed cultures, given their new prevalence in all settings. As of the 1 July 2020, 804 colleagues have completed this. All operational colleagues will have completed this training by the end of August 2020 and there will be follow up sessions throughout the year.

18. Give Feedback on Care

18.1. CQC's new Give Feedback on Care service launched in January 2020. It captures 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.

18.2. 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.

18.3. Concerns raised by patients and their families will be considered earlier in CQC inspection processes, along with a strengthening of our engagement with advocates for people who use services.

19. Responding to concerns

19.1. CQC is conducting a review of its methodology for how we respond to concerns in co-production with inspectors and people who use services.

19.2. CQC has developed a decision-making tool for inspectors about taking regulatory action where there are inherent risks or warning signs of a closed culture. This means also that a focussed inspection should be triggered more consistently when there are concerns raised.

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[2] https://www.cqc.org.uk/sites/default/files/20200623_closedcultures_guidance.pdf

19.3. CQC has developed a new insight monitoring tool to draw together information and analysis about independent mental health and learning disability healthcare services which was launched in December 2019.

19.4. CQC has introduced guidance for colleagues in our call centre to help ensure we are collecting as much information as possible, and to help identify safeguarding and vulnerable groups, and signs of closed cultures.

19.5. The number of concluded successful prosecutions has risen from 5 cases a year for 2017/18 and 2018/19 to 14 cases this year so far, with further prosecutions underway.

19.6. CQC is supporting DHSC in its review of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, looking at whether the scope and extent of CQC's enforcement powers is sufficient.

20. Family visits

20.1. We expect services to ensure that they are supporting people to stay in touch with family members in line with national guidance.

20.2. Our new closed cultures guidance highlights that it is important for services not to put in place blanket restrictions such as restricting all family visits and this should be considered on a case by case basis. We will be highlighting good practice where this happens.

21. Progress on implementing independent review recommendations

21.1. The independent reviews commissioned by CQC in the wake of the Panorama on Whorlton Hall in May and June 2019 have produced important and valuable recommendations which we accept in full and we are in the process of implementing them entirely, via a dedicated 'closed cultures' team. The Noble review[3] published in January 2020, and the Murphy review[4] published in March 2020. Phase Two of the Glynis Murphy review will be presented to CQC Board next year.

21.2. We started a major organisational transformation programme in 2019 which will deliver significant benefits for people who use services, providers, stakeholders and our colleagues. It will strengthen our technology, processes, capability and culture to ensure we can successfully deliver our future strategy from 2021 and be an efficient and responsive regulator.

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[3] https://www.cqc.org.uk/news/stories/cqc-publishes-independent-review-its-regulation-whorlton-hall
[4] https://www.cqc.org.uk/news/stories/cqc-publishes-independent-review-its-regulation-whorlton-hall-between-2015-2019

21.3. Strengthening our regulation to improve how we keep people safe, particularly those who are in the most vulnerable circumstances, is part of that programme – so that CQC can better identify and respond to services that might be at risk of developing a closed culture.

21.4. We have been working to strengthen how we collect intelligence from people who contact us with information of concern. We will now be able to report against population groups and protected characteristics as well as the location of care.

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