HOUSE OF COMMONS LIBRARY

BRIEFING PAPER

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# The Care Quality Commission

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Contents:

# Contents

# Summary

This House of Commons Library briefing explains the statutory role and powers of the Care Quality Commission (CQC)

The CQC was established in April 2009 and replaced three former regulatory bodies. The CQC is responsible for the registration, inspection and monitoring of health and adult social care providers, including independent providers, under the *Health and Social Care Act 2008*.

All providers of health and adult social care who carry out "regulated activities" are required to register with the CQC and demonstrate they meet fundamental standards. The scope of regulated activities includes treatment of disease, disorder or injury, surgical procedures, maternity and midwifery services, personal care, nursing care and assessment or medical treatment for persons detained under the *Mental Health Act 1983*.

The CQC inspects and monitors the services that it registers. Following an inspection, services receive a rating on a four-point scale: outstanding; good; requires improvement; and inadequate. There is no set interval for inspections; inspections are carried out at variable frequency according to the CQC's judgment of risk. Highly performing services – i.e. those with an outstanding rating – can expect inspections at a five-year interval, while services rated as inadequate are normally inspected within 12 months of their last report.

The CQC made major changes to its inspection and regulatory approach from 2013, primarily following concerns raised in the independent Francis review of failures in care at the Mid Staffordshire NHS Foundation Trust. Key changes included the introduction of regulatory "fundamental standards", including a new specific 'duty of candour'; asking five questions of all services (are they safe? effective? caring? responsive to people's needs? and well-led?); strengthening how the CQC acts on concerns and complaints raised by the public; and the introduction of chief inspectors for hospitals, adult social care and primary medical services and integrated care.

In April 2015, the CQC introduced a new enforcement policy. This enhanced their powers to act where they identify poor care, including acting on breaches of regulations and a new power to prosecute providers directly. The CQC also introduced a special measures framework, which applies to providers that have major failures in quality of care and/or serious financial problems.

In January 2020, the CQC set out changes following an independent review into how it dealt with concerns about the regulation of Whorlton Hall (an independent hospital providing assessment and treatment for people with learning disabilities and complex needs). The review made recommendations to improve the CQC's processes, including its internal whistleblowing process, all of which were accepted by the CQC. A second upcoming review will make recommendations for how CQC's

regulation of similar services can be improved, in the context of a raised level of risk of abuse and harm.

The CQC publishes an annual State of Care report to Parliament, which is its assessment of health and social care in England. The most recent report – an assessment of 2018/19 – found that although across England the state of care is generally good, there are widespread problems with access to care, with many people unable to access appointments. The report also raised concerns about the state of care for people with mental health problems, autism and learning disabilities. The report noted that in September 2019, 10% of inpatient services for people with learning disabilities and/or autism were rated as inadequate, as compared to 1% in 2018.[1]

The CQC has no role to investigate individual complaints made against a specific service. However the CQC highlights that it is keen to hear from the public about their experience of care to help inform when and how it regulates and inspects particular services.

The CQC's role and remit extends to England only. There are separate bodies that carry out the regulation and monitoring of providers in the devolved nations: In Wales, the Healthcare Inspectorate; in Scotland, the Care Inspectorate and Healthcare Improvement Scotland; and in Northern Ireland, the Regulation and Quality Improvement Authority.

1 Care Quality Commission, Growing pressures on access and staffing risk creating 'perfect storm' for people using mental health and learning disability services, 15 October 2019

# 1. Key functions

The Care Quality Commission (CQC) is responsible for the registration, inspection and monitoring of health and adult social care providers, including independent providers, under the *Health and Social Care Act 2008*.

Since April 2010, all health and social care providers of "regulated activities" (see box 1) are legally required to register with the CQC in order to provide services. Activities the CQC regulates include:

- Treatment, care and support provided by hospitals, GPs, dentists, ambulances and mental health services.
- Treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care).
- Services for people whose rights are restricted under the *Mental Health Act 1983*.

To register, providers must show they are meeting fundamental standards of quality and safety across all of the regulated activities they provide.

Box 1: Regulated activities

"Regulated activities" are set out in the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*, and broadly cover the following areas:

- Personal care
- Accommodation for people who require nursing or personal care
- Accommodation for people who require treatment for substance misuse
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Surgical procedures
- Diagnostic and screening procedures
- Management of supply of blood and blood-derived products
- Transport services, triage and medical advice provided remotely
- Maternity and midwifery services
- Termination of pregnancies
- Services in slimming clinics
- Nursing care
- Family planning services.

The CQC carries out visits and inspections in line with its judgment of risk and publishes provider ratings on a four-point scale – outstanding; good; requires improvement; and inadequate. If services are not meeting fundamental standards of quality and safety, the CQC has

enforcement powers to issue warnings, restrict services, issue a fixed penalty notice, suspend or cancel registration, or prosecute the provider.

The CQC also carries out thematic reviews into particular themes or aspects of health and social care, including pathways of care, groups of people or services.

Additionally, the CQC has a statutory role in protecting the rights of vulnerable people, including those whose rights are restricted under the *Mental Health Act 1983.*

## History

The CQC was established by *Health and Social Care Act 2008.*[2] It took over the functions of the following three existing regulatory bodies from 1 April 2009:

- The Healthcare Commission (formally known as the Commission for Healthcare, Audit and Inspection)
- The Commission for Social Care Inspection
- The Mental Health Act Commission

In 2013, the CQC set out major changes to its inspection and regulatory model.[3] The 2013-16 strategy proposed new fundamental standards of care, risk-based inspections (rather than annual inspections), specialist inspectors and new quality ratings. All providers of NHS acute hospitals, NHS and independent residential and community based mental health services, and NHS and independent community health services were inspected and regulated under the CQC's new regulatory model from 1 October 2014, and later expanded to other providers including independent acute hospitals, and NHS and independent ambulance services.[4]

The strategy also introduced five key questions, which are now asked of all services during an inspection:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they response to people's needs?
- Are they well-led?[5]

The three-year strategy also signalled an intention to strengthen enforcement action, in order to enhance the CQC's ability to protect people and swiftly deal with failures in care. Further information is included in section 3.

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2 Background information to the legislation is available in the Library research paper on the then *Health and Social Care Bill.*

3 Care Quality Commission, Raising standards, putting people first: Our strategy for 2013-2016

4 Care Quality Commission, Care Quality Commission confirms new approach to inspecting and rating care services, 25 September 2014

5 Care Quality Commission, The five key questions we ask (last accessed 20 December 2019)

The CQC has issued a revised strategy detailing how it will inspect and rate providers, covering the period 2016-2021[6]. While this largely maintains the approach introduced in 2013, the new strategy highlights a more focused and targeted approach to inspection. This means the CQC focusing more on assessing services with poor ratings and those whose rating is likely to change, and less on services where care is consistently good. Services that are performing well can expect less frequent inspections and will be mostly trusted to manage their own performance in the short and medium term. This "intelligent monitoring" approach supports the CQC to carry out visits in line with its judgment of risk.[7]

The CQC is currently engaging on the development of its next strategy, due to be published in April 2021.

6 Care Quality Commission, Shaping the future: Our strategy for 2016-2021
7 Care Quality Commission, Using data to monitor services

# 2. Changes to the CQC's approach

## Changes following the Mid Staffordshire NHS Foundation Trust Inquiry

From 2013, the CQC changed its model in relation to the inspection of the services it regulates. This is described in the three-year strategy Raising standards, putting people first: Our strategy for 2013-2016.

Key changes included the introduction of regulatory "fundamental standards" including a new specific duty of candour; five questions asked of all services (are they safe? effective? caring? responsive to people's needs and well-led?); strengthening how CQC acts on concerns and complaints raised by the public; and the introduction of chief inspectors for hospitals, adult social care and primary medical services and integrated care.

The changes were prompted by several high-profile major failures in care, most notably at the Mid Staffordshire NHS Foundation Trust. The public inquiry, chaired by Robert Francis QC, reported in February 2013 and examined the causes of failure within the Trust.

Although the public inquiry looked specifically at the period 2005-08, during which the CQC was not in operation, it nonetheless looked at the existing regulatory framework (the inquiry began in 2009) and its effectiveness in identifying and acting on concerns about providers. The inquiry made several recommendations for strengthening the CQC's regulatory framework, which shaped its three-year strategy. An overview of key changes is described below.

## Fundamental standards

The Francis Report recommended the introduction of fundamental standards, which identify the basic standards of care. It recommended that non-compliance should not be tolerated, and organisations not able to consistently comply should be prevented from continuing to provide a service. The report also said that to cause death or serious injury to a patient through non-compliance should be a criminal offence.[8]

The CQC subsequently developed rigorous fundamental standards which were introduced by the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* and came into force for all registered providers on 1 April 2015. The standards also introduced two new requirements for providers – a duty of candour and a fitness test for directors of NHS bodies.

The Regulations prescribe 12 fundamental standards:

- *Person-centred care*: The care and treatment of service users must be appropriate, meet their needs and preferences

[8] The Mid Staffordshire NHS Foundation Trust Public Inquiry, Publication of the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 6 February 2013

- *Dignity and respect*: Service users must be treated with dignity and respect. This includes ensuring the privacy of the service user; supporting their autonomy, independence and involvement; and having due regard to any relevant protected characteristics.
- *Need for consent*: Care and treatment of service users must only be provided with the consent of the relevant person. For people who lack mental capacity, treatment should be given in accordance with the Mental Capacity Act 2005.
- *Safe care and treatment*: Care and treatment must be provided in a safe way for service users. This includes assessing the risks to the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks; ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; and the proper and safe management of medicines.
- *Safeguarding service users from abuse and improper treatment*: This regulation sets out that care or treatment for service users must not be provided in a way that includes discrimination against a service user on grounds of any protected characteristic, includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual, is degrading for the service user, or significantly disregards the needs of the service user for care or treatment.
- *Meeting nutritional and hydration needs*: This includes supplying suitable and nutritious food and hydration which meets the service user's requirements, such as those prescribed by a health professional, their preferences because of religious or cultural background, and supporting a service user to eat or drink if necessary.
- *Premises and equipment*: Premises and equipment should be clean, suitable and properly used and maintained.
- *Receiving and acting on complaints*: Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.
- *Good governance*: Services must have systems and processes in place to ensure they can meet these standards. This would include assessing, monitoring and improving the quality and safety of the services provided (including the quality of the experience of service users).
- *Staffing*: Sufficient numbers of suitably qualified, competent, skilled and experience persons must be deployed in order to meet these standards.
- *Fit and proper persons employed*: Service providers must only employ people who can provide care and treatment appropriate to their role. They must have strong recruitment procedures in place and carry out relevant checks such as on applicants' criminal records and work history.

- *Duty of candour*: Health services must act in an open and transparent way and notify the service user and relevant persons/bodies if there is a notifiable safety incident. A written notice should be given which also contains an apology.[9]

The statute accompanying the new standards gives the CQC enforcement powers to act on instances on non-compliance, including bringing criminal charges for breaches of specific regulations. Further information is available in section 3 of this briefing.

The 2013 strategy also signalled a change in the way the CQC gathers and acts on concerns and complaints, in order to better build up a picture of quality of care. The CQC currently gathers people's experiences of services through its public portal: Give feedback on care.

## Proposed changes following inspection at Whorlton Hall

In January 2020, the CQC published the findings of an independent review into how it dealt with concerns about the regulation of Whorlton Hall (an independent hospital providing assessment and treatment for people with learning disabilities and complex needs).

The review criticised the CQC for not publishing a 2015 report which raised concerns about the provider. Whorlton Hall had been inspected in August 2015 by a CQC inspector-led team but that inspection and draft report indicating concerns about the care provided to patients, with a proposed rating of "Requires Improvement", was not published. The independent review said that a published report with a "requires improvement" rating at that time would have led to closer examination of the service.[10]

The independent review made recommendations to improve the CQC's processes and procedures, on areas including the information provided to inspectors about services, quality assurance processes, the internal whistleblowing process and how the CQC investigates complaints from providers.[11]

The CQC said in a press release it has accepted all the recommendations of the independent review and will soon publish an action plan setting out how they will address each recommendation.[12]

An upcoming independent review, led by Professor Glynis Murphy, will look at the regulation of Whorlton Hall between 2015 and 2019. It will make recommendations for how the CQC's regulation of similar services can be improved, in the context of a raised level of risk of abuse and harm.[13]

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9 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Section 2, Regulations 9-20

10 Report to the Board of the Care Quality Commission ("CQC") on how CQC dealt with concerns raised by Barry Stanley-Wilkinson in relation to the regulation of Whorlton Hall Hospital and to make recommendations, 22 January 2020, page 7

11 ibid, page 13-14

12 Care Quality Commission, CQC publishes independent review into its regulation of Whorlton Hall, 22 January 2020

13 Care Quality Commission, Update on independent review into regulation of Whorlton Hall, 19 June 2019

# 3. Enforcement action

The Francis report raised concerns about limits to the CQC's powers to enforce regulations. In particular, the report raised concerns that the CQC could not prosecute providers directly, however severe the offence. It noted that the CQC could only prosecute a provider for a breach of regulations which constituted a criminal offence where a warning notice requiring action had previously been issued, and where a provider had not secured compliance within the required time.[14]

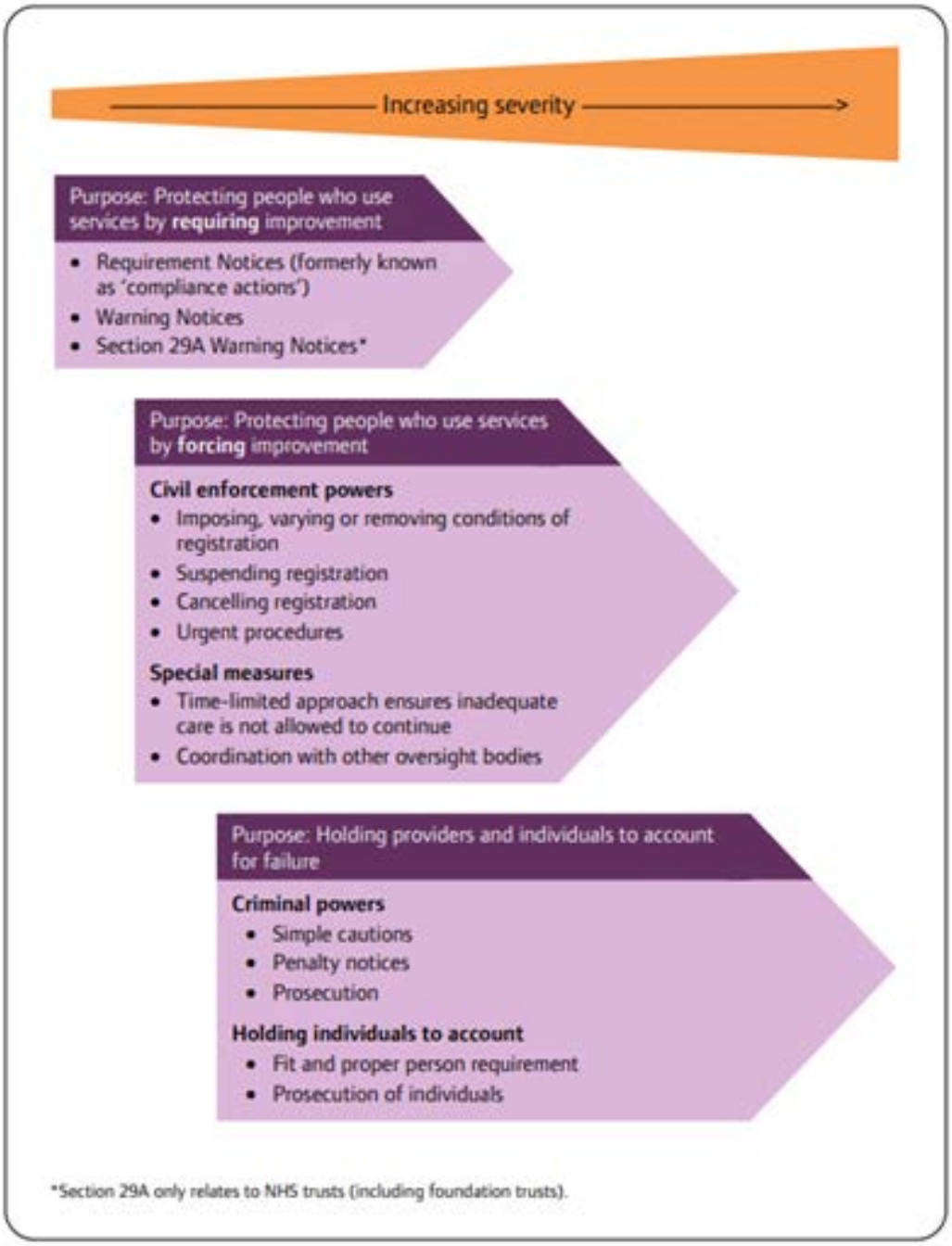
## Enforcement powers

The CQC's enforcement policy (published in 2015) set out in full their revised approach to addressing breaches of regulations. These powers are given under the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*.

The CQC explains that, where appropriate, if the provider can improve the service on their own and the risks to people who use services are not immediate, they will usually work with them to improve standards rather than taking enforcement action. The CQC will usually intervene if patients are at an unacceptable risk of harm or providers are repeatedly or seriously failing to comply with their legal obligations.

The CQC provides the following overview if its enforcement powers, relating to the severity of a breach of regulations. Further information on each of these, and the associated maximum fines or penalties, is available in sections 3- 5 of the enforcement policy.

[14] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 2: Analysis of evidence and lessons learned (part 2), February 2013, para 11.66




## Criminal powers

There are certain regulations which relate specifically to harm or the risk of harm, or are requirements imposed by the CQC. Breach of these regulations is a criminal offence and the CQC is able to move directly to prosecution without first serving a Warning Notice. These are:

- Regulation 11: Need for consent
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 14: Meeting nutritional and hydration needs
- Regulation 20: Duty of candour

- Regulation 20A: Requirement as to display of performance assessments[15]

## Special measures for failing services

The special measures framework came into force on 1 April 2015. Trusts may be placed in special measures as a result of serious failures in quality of care and/or serious financial problems.

NHS Improvement publishes a list of trusts that are currently in special measures, for quality and financial reasons: Trusts in special measures.

## Special measures for quality reasons

Special measures for quality reasons applies when there are serious and systemic failings at a trust in relation to quality of care and where it has been identified that the trust is unable to resolve the problems without intensive support. Special measures are usually triggered by a rating of "inadequate" in the well-led domain (indicating concerns that the organisation's leadership is unable to make improvements in a realistic timeframe without additional support) and "inadequate" in at least one of the other domains (safe, caring, responsive and effective). The CQC through the Chief Inspector of Hospitals, recommends to NHS Improvement that a trust is placed in special measures, and ultimately NHS Improvement will make the decision.

There are a number of different types of intervention that can take place, but the main features of the special measures regime are that:

- NHS Improvement appoint an improvement director to help a trust to turn around its performance and improve patient care;
- NHS Improvement will appoint partner organisations – often high-performing trusts - to provide expert advice and support;
- Each trust is required to develop a detailed action plan, which it must update regularly.

In addition, NHS Improvement reviews the leadership of trusts in special measures and, if necessary, it can use its powers to ensure trusts have the right leadership in place.

Special measures will include a time-limit in which to make improvements, usually a maximum of 12 months, so that poor care is not allowed to continue. The CQC will also set clear criteria for providers to exit special measures, relating to improvement in ratings. NHS Improvement will only take a trust out of special measures for quality reasons following a recommendation from the Chief Inspector of Hospitals.

While a Trust is in special measures, the CQC may at any point use their urgent powers to safeguard patients if there is any immediate risk of harm, and the CQC will usually re-inspect a trust within 12 months.

Further information is available in the guidance issued by CQC and NHS Improvement on Special measures for quality reasons (December 2017).

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[15] Care Quality Commission, Enforcement policy, February 2015, page 12

## Special measures for finance reasons

Special measures for finance reasons applies to trusts facing significant financial challenges. This includes trusts that are forecasting or have recently delivered a substantial deficit or have had an exceptional financial governance failure such a major fraud.

As a result of being placed in special measures, NHS Improvement will usually appoint a financial improvement director to the failing trust. During their process of financial improvement, trusts are required to demonstrate that there has been no negative impact on quality of care. Further information is available in NHS Improvement guidance on Special measures for finance reasons (March 2018).

# 4. Inspections

The current way that the CQC inspects is set out in its guidance on What we do on an inspection.

## Frequency of inspections

If providers are registering with the CQC as a new provider, the CQC will normally aim to inspect within 12 months of registration. Providers will receive their initial rating at this inspection. The CQC use a provider's existing rating to determine when next to inspect the service.

The following principles apply regarding re-inspection:

1. Inadequate – Normally within 12 months of publishing the last comprehensive inspection report;
2. Requires improvement - Normally within two years of publishing the last comprehensive inspection report;
3. Good - Normally within three and a half years of publishing the last comprehensive inspection report; and
4. Outstanding - Normally within five years of publishing the last comprehensive inspection report.

These are maximum inspection intervals, therefore the CQC may inspect more frequently, particularly if there is a risk.[16]

## Types of inspections

The CQC carries out regular checks on health and social care services. The CQC calls these *comprehensive inspections* and they use them to make sure services are providing care that's safe, caring, effective, responsive to people's needs and well-led.

Some things – such as how frequently the CQC inspects, the size of the inspection team it uses and whether or not CQC tells the service that it is coming – depend on what type of service being inspected.

The CQC also carries out *focused inspections*. These are smaller in scale than comprehensive inspections, although they follow a similar process. The CQC carries out focused inspections for two reasons:

- To look at something the CQC is concerned about, which might have been raised during a comprehensive inspection or through CQC's monitoring work.
- If there is a change in a care provider's circumstances. This might mean they've been involved in a takeover, a merger or an acquisition.

A focused inspection does not always look at all five of the key questions. The size of the team and who's involved depend on what the inspection is looking at.

There are differences between the things the CQC looks at when it inspects different types of service. For example, when the CQC inspects NHS trusts, it looks at eight core services:

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16 Written Question HL17299, 25 July 2019

- Urgent and emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatient services and diagnostic imaging (such as x-rays and scans)

When the CQC inspects GP practices, the CQC looks at how the practice provides services to particular population groups. For hospitals, the CQC also undertakes well-led inspections that focus on assessing the leadership and culture of the organisation.

## Factual accuracy

When a provider is inspected by the CQC, the provider has the opportunity to go through the "factual accuracy process"; prior to the publication of a CQC report the provider is sent a draft copy of the report and has 10 working days to submit a response, including relevant evidence, which may challenge the content of a report.

When the report is published the provider can ask for a review of individual and overall ratings and may also challenge by way of judicial review. The CQC explains that this is "the opportunity for providers to challenge the accuracy and completeness of the information in the draft inspection report on which the ratings are based. Any factual accuracy comments that are accepted may result in a change to one or more rating".[17]

The CQC has also established quality assurance panels to look at samples of rating judgements to check consistency of inspection reports.[18]

[17] Care Quality Commission, Factual accuracy guidance [last accessed 5 February 2020]
[18] Care Quality Commission, What we do on an inspection: Inspection reports [last accessed 5 February 2020]

# 5. State of Care

The State of Care is the CQC's annual report to Parliament of its assessment of health and social care in England.

The 2018/19 report found that although across England the state of care is generally good, there are widespread problems with access to care and many people unable to access timely appointments. The CQC raised concerns that patients are reaching crisis point rather than accessing care sooner, meaning "immediate and costly" intervention; some patients end up in inpatient services because of a lack of local, intensive community services. The report noted particular concerns for people with mental health problems, autism or a learning disability:

> Some people are struggling to get access to the mental health services they need, when they need them. This can mean that people reach a level of 'crisis' that requires immediate and costly intervention before getting the care they need, or that they end up in inappropriate parts of the system. Some people are detained in mental health services when this might have been avoided if they had been helped sooner, and then find themselves spending too long in services that are not suitable for them.[19]

The CQC concluded that the care given to people with a learning disability or autism is "not acceptable", and highlighted that between October 2018 and September 2019, 14 independent mental health or learning disability hospitals had been rated as inadequate and put into special measures. Additionally, as of September 2019, 10% of inpatient services for people with learning disabilities and/or autism were rated inadequate, as compared to 1% in 2018.[20]

The report also highlighted pressure on services throughout the health system, highlighting that waiting times have continued to increase, such as for cancer services, and performance in hospital emergency services has worsened. Of particular concern is that the usual lull in activity seen during the summer has not occurred this year – trusts have essentially been facing "winter pressures" all year around.

The report also raised concerns about the future of adult social care services:

> The stability of the adult social care market remains a particular concern. There is still no consensus on how adult social care should be funded in the future. Twice in 2018 we had to exercise our legal duty to notify local authorities that there was a credible risk of service disruption because of potential failure of a provider's business. An estimated 1.4 million older people (nearly one in seven) do not have access to all the care and support they need.[21]

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19 Care Quality Commission, The state of health care and adult social care in England 2018/19, 14 October 2019, page 6

20 Care Quality Commission, Growing pressures on access and staffing risk creating 'perfect storm' for people using mental health and learning disability services, 15 October 2019

21 Care Quality Commission, The state of health care and adult social care in England 2018/19, October 2019, page 4

# 6. Major reports

## 6.1 Mental health

The CQC has statutory duties under the *Mental Health Act 1983* to protect patients by reviewing, and where appropriate, investigating powers under the Act, in relation to detention, community treatment orders and guardianship. The CQC also has a duty to appoint second opinion appointed doctors.[22]

### Monitoring the Mental Health Act

The CQC publishes an annual report to Parliament on monitoring the *Mental Health Act*. The 2018/19 report (published February 2020) highlighted five key areas of concern:

- Services must apply human rights principles and frameworks. Their impact on people should be continuously reviewed to make sure people are protected and respected.
- People must be supported to give their views and offer their expertise when decisions are being made about their care.
- People who are in long-term segregation can experience more restrictions than necessary. They also may experience delays in receiving independent reviews. This is particularly true for people with a learning disability and autistic people.
- People do not always get the care and treatment they need. Some services struggle to offer appropriate options, both in the community and in hospital.
- It is difficult for patients, families, professionals and carers to navigate the complex laws around mental health and mental capacity.[23]

The 2017/18 report (published February 2019) raised significant concerns that many of the wards, in which people are detained under the *Mental Health Act*, are unsafe and provide poor quality care. This was also raised in the NHS Long Term Plan (January 2019) and the independent review of the Mental Health Act (December 2018). The CQC has welcomed the statement in the Long Term Plan that capital investment from the forthcoming Spending Review will be made available to upgrade the physical environment for inpatient psychiatric care.[24] The CQC has also said that it will act on the recommendation of the report of the independent review of the Mental Health Act that it revises the criteria used to assess the physical and social environments of mental health wards.[25]

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22 Department of Health, Mental Health Act 1983: Code of Practice, 2015, page 14
23 Care Quality Commission, Monitoring the Mental Health Act in 2018/19, 11 February 2020
24 Care Quality Commission, Monitoring the Mental Health Act in 2017/18, 26 February 2019, page 4
25 *ibid*

### Mental Health Act: Code of Practice

Following a request from the Department of Health and Social Care, in June 2019 the CQC published its evaluation of how the Mental Health Act Code of Practice (the Code) is being used. It found that the Code is not being used as it was intended, and raised key concerns about providers' understanding and application of the guiding principles, engagement and involvement of patients and local area working:

> We found that:
>
> - Providers lacked understanding about how to promote, apply and report on the guiding principles in the Code of Practice.
> - Providers did not support staff well enough to enable them to have meaningful and productive conversations with patients so that they can better understand patients' goals and how patients can take ownership of their recovery. Independent Mental Health Advocates (IMHA) offer an additional safeguard and support for patients, but our review of MHA reports shows ongoing difficulties with providing IMHA support.
> - Local areas, including commissioners, local authorities, police and providers, should work together better to make sure that people receive the right care across organisations, including making sure that people in need of urgent care have timely access to a bed that is close to home, in line with the expectation of section 140 of the MHA.[26]

The CQC made several recommendations for the Department of Health and Social Care, to consider as part of their forthcoming review of the *Mental Health Act*. This includes developing standard resources on the Code, to help patients, carers and staff understand how the Code applies to them.

The independent review of the *Mental Health Act*, chaired by Professor Sir Simon Wessely, published in December 2018, highlighted that consecutive CQC reports have found that many staff lack sufficient knowledge of the Code of Practice and the rights of people detained under the Act.[27]

The Government has said it will publish a White Paper in early 2020, which will set out the Government's response, in full, to the independent review. It has also said it remains committed to reforming mental health law, developing and bringing forward legislation when Parliamentary time allows.[28]

### Sexual safety on mental health wards

The CQC published a report in September 2018 on sexual safety on mental health wards, considering a high number of reported incidents.

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26 Care Quality Commission, Mental Health Act Code of Practice 2015: An evaluation of how the Code is being used, June 2019, page 3

27 Modernising the Mental Health Act: Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983, December 2018, page 216

28 For further information, see the House of Commons Library briefing paper on Mental health policy in England, 7 January 2020

The CQC made recommendations such as national guidance on sexual safety on mental health wards that can be adapted to specific inpatient settings. The Sexual Safety Collaborative was established by NHS Improvement in October 2019, in response to the report. In a debate on the Mental Health Act in July 2019, then Health Minister Jackie Doyle-Price said that the Government is rolling out new guidance on sexual safety on mental health wards.[29]

## 6.2 Local system reviews

In July 2017 the Secretaries of State for Health and Social Care and for Communities and Local Government asked the CQC to carry out targeted reviews of local health and social care systems. The local reviews looked specifically at how collaboration between services can improve people's experience of care, with a focus on older people.

The CQC's Beyond Barriers report (July 2018) found often there were barriers to effective coordination of health and care services, which meant that people's experience of care was fragmented. In summary:

- Organisations intended to work together but mostly focused on their own goals
- Although there was good planning between services, the way services were funded did not support them to work together
- Organisations:
  - were prioritising their own goals over shared responsibility to provide person centred care
  - did not always share information with each other which meant they weren't able to make informed decisions about people's care
  - were not prioritising services which keep people well at home
  - planned their workforce in isolation to other services
- The regulatory framework focuses only on individual organisations.[30]

The CQC made recommendations to improve collaboration, such as joint action plans across health and social care and funding reform to enable pooling of budgets between providers.

In the context of key NHS objectives to increase collaboration, the reviews were considered to provide timely insight into coordination across health and care services. The Five Year Forward View (2014) and the NHS Long Term Plan (2019) set out how the NHS will move towards integrated health and social care, with all local areas expected to have an "integrated care system" by April 2021. The CQC intended to expand the programme of local reviews, to areas such as cancer, maternity, mental health, learning disability services and respiratory conditions, in order to assess how well system partners are working

29 HC Deb 25 July 2019 c694WH
30 Care Quality Commission, Beyond barriers: how older people move between health and care in England, July 2018

together. However, in a letter sent in January 2019 the CQC said it was forced to disband the programme due to a discontinuation of funding from the Department of Health and Social Care. The CQC said:

> this is [a] disappointing outcome given the benefits the LSR [local system review] programme has demonstrated and given how such reviews could help ensure the NHS Long-Term Plan and any future adult social care reforms have a demonstrable impact for people who use services.[31]

The Department of Health and Social Care have since committed to exploring the possibility of commissioning further system reviews, and discussions are ongoing between CQC and the Department for a future programme of work.[32]

## 6.3 Restraint

In 2018, the CQC was commissioned by the Secretary of State for Health and Social Care to undertake a review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism.[33]

An interim report was published in May 2019 and presented the CQC's initial findings on the use of long-term segregation on mental health wards for children and young people and wards for people with a learning disability or autism. The CQC visited and assessed the care of 39 people in segregation, most of whom had an autism diagnosis.

The CQC found that sixteen people had been in segregation for a year or more –one person had spent almost a decade in segregation. It found that reasons for extended time in segregation included delayed discharge from hospital due to a lack of suitable package of care available in the community. The CQC also found that some of the wards were unsuitable environments for people with autism and many staff lacked the necessary training and skills to work with people with autism who have complex needs and challenging behaviour.

The interim report recommended that there should be an independent review of the care and discharge plan for each person in segregation on a ward for children and young people or on a ward for people with a learning disability or autism. It also recommended that safeguards are strengthened, including the role of independent advocates.[34] The recommendations have been accepted in full by the Government.[35]

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31 Letter Re: CQC update on Local System Reviews from Chris Day, Director of Engagement, Care Quality Commission to Dr Sarah Wollaston, then Chair of the Health & Social Care Committee, 23 January 2019

32 Health Service Journal, CQC given green light for more local system reviews, 13 February 2019

33 Care Quality Commission, Interim report: Review of restraint, prolonged seclusion and segregation for people with a mental health problem, a learning disability and or autism, 21 May 2019

34 Care Quality Commission, Segregation in mental health wards for children and young people and in wards for people with a learning disability or autism, May 2019 page 6

35 Care Quality Commission Thematic Review of Restrictive Practices, Seclusion and Segregation :Written statement - HCWS1569, 21 May 2019

A full report will make recommendations for the Department of Health and Social Care and is expected in spring 2020. The recommendations will be focused around what the health and care system needs to do to improve care for people with mental health problems, learning disabilities and autism. The CQC will also be reviewing and revising their approach to regulating and monitoring hospitals that use segregation.

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