Identifying and responding to closed cultures

Supporting information for CQC staff

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Contents

About this supporting information

This document includes advice on:

- Identifying services where there may be a high **inherent risk** of a closed culture that might lead to abuse or breaches of human rights.
- Identifying **warning signs** that there may be a closed or punitive culture, or risk of such a culture developing.
- How to **use existing regulatory policy, methods and processes** when there is a high inherent risk and/or warning signs.

1. Background

In May 2019, BBC *Panorama* exposed the culture of abuse and human rights breaches of people with a learning disability at Whorlton Hall. It reinforced how important it is for everyone involved in the care of people with a learning disability or autistic people to identify closed cultures, where abuse and human rights breaches may be taking place.

Providers have the primary responsibility for making sure that people receiving care are free from abuse and that they have their human rights upheld. As the regulator we monitor, inspect and regulate these services to ensure this is happening. In services where abuse and breaches of rights are deliberately concealed by managers or groups of staff there are additional challenges in identifying these.

Following the programme, we have commissioned two independent reviews into our regulation of Whorlton Hall. We have taken practical steps ahead of the findings of these reviews to improve our regulation and to ensure that all our hospital and social care inspectors have a consistent and shared understanding of the potential risk factors for abusive cultures, and can use this information to take action where necessary.

Policy context

Protecting people's basic human rights is at the heart of good care. Everyone involved in the care of people has a duty to act where there is a risk that a person's human rights are being breached. To prevent breaches of human rights, we would expect to see the following elements in place in a service:

- **Right model of care** (including pathway of care): people are receiving care in an appropriate place at the appropriate time. This includes models of care for specific services, such as the national service model for adult social care for people with a learning disability or autism and behaviour that challenges.
- **Right staff**: services have an appropriate number and mix of trained and skilled staff. There may be a higher risk of human rights abuses where:
    - a high proportion of staff do not have adequate training. This might include a higher use of agency staff who do not have the right skills and/or are not well supported. However, agency staff can sometimes feel more able to speak up when a service is providing poor care or the culture is poor.
    - there are recruitment challenges. For example the location or reputation may make it harder for services to maintain a staff team with the right mix of skills.

  It is important to note that abusive behaviour or human rights breaches can be carried out by permanent and/or trained staff. Ensuring that staff are trained or reducing usage of agency staff is not a solution on its own.
- **Right culture**: managers are responsible for building a culture that consistently respects human rights, which prevents abuse. This culture must be consistent from leadership through to frontline practice. This will be more challenging in some settings, but it is not impossible in any setting. A culture that respects human rights culture includes dignity, respect, zero tolerance of abuse, person-centred care and least restrictive practice. There is a large weight of evidence that a poor culture that contributes to the abuse of people using services is also more likely to be a poor

working environment for staff working in those services. Similarly, ensuring a good culture in a service, will have benefits for both people using services and for staff.

Where the culture of a service has led to abuse, this is a breach of Health and Social Care Act 2008 regulations.

Which services is this information relevant to?

This supporting information is particularly useful for regulating services for people with a learning disability or autistic people. However, the principles apply to all settings where people may be less able to self-advocate, or are less likely to have their communication needs supported or to be listened to and believed than others.

- **For CQC mental health teams:** this includes mental health wards for children and young people, mental health rehabilitation wards and wards for people with an acquired brain injury or dementia.
- **For adult social care services:** this could include services for people with dementia, mental health conditions or acquired brain injury.
- **For acute and community hospitals:** this could include wards for people with dementia or frail older people that are essentially closed environments at night time.
- **For other services:** this includes services where by nature they are more 'closed', for example healthcare services in criminal justice settings.

Why are we publishing this?

We are committed to improving our regulation of services where there is a risk of a closed, or punitive culture. This document builds on the discussion guides produced for inspection staff in July 2019. It brings together our current understanding of, and methodology for, inspecting these types of services and provides further detail to support their identification and regulation.[1]

We will be continuing to review and update this supporting information. If you would like to provide feedback, please contact closedcultures@cqc.org.uk.

[1] This supporting information is a learning resource for CQC inspectors. It provides information, references, links to professional guidance, legal requirements or recognised best practice guidance about particular topics in order to assist inspection teams. It does not provide guidance to registered persons about complying with any of the regulations made pursuant to section 20 of the Health and Social Care Act 2008 nor does it include further indicators of assessment pursuant to section 46 of the Health and Social Care Act 2008.

2. Inherent risk factors

From our experience of regulating services, the likelihood that a service might develop a closed or punitive culture is higher if one or more of the inherent risk factors described in this section is present.

Experience of people receiving care

Inherent risk	Description
People who use the service are highly dependent on staff to meet their basic needs	This includes people with impaired or fluctuating capacity and/or limited ability to communicate their needs and wishes, or ability to communicate what they do not want to do, or to be done to them.
People stay in hospital for months or years rather than a shorter time	This includes, for example, wards for people with a learning disability or autism. Though this usual for adult social care services, risks in health services appear higher when people stay for longer.

Leadership and management

Inherent risk	Description
Weak or poor management of the service	Weak management can enable a culture to be set by individual staff with poor values or malign intent. It can also lead to different cultures on different shifts, for example day and night staff. Signs of risk include: • Significant changes in management over a short period of time, which may lead to less oversight. • High use of non-permanent staff at a team leader level, which may lead to less consistent role modelling in a team. • A failure to provide regular, good quality staff supervision that can have an impact on ensuring the service has a consistently good culture. • Poor response to complaints, for example from families. • **Adult social care services** that mainly employ family members in management roles. These may be prone to weak management as there can be less oversight or internal challenge.

Skills and experience of staff providing care

Inherent risk	Description
Characteristics of staff working in the service	• A high proportion of staff providing direct care that do not have enough or appropriate training. This includes, for example, understanding how to provide good support for people with a learning disability or autistic people. • Limited access to professional staff with the specialist skills to meet the specific needs of people, or little working connection between professional staff and those providing direct care. • High staff turnover, even if there is a small core of longstanding staff. • Staff suspensions or dismissals, changes in management or management absences (including of the registered manager). • High use of agency or bank staff. This may be a risk in terms of creating a consistent culture, or the level of training provided to staff. For example staff being given training on the specific communication needs of particular people using the service. • **In hospitals:** high ratios of healthcare assistants or non-registered roles with a failure to provide regular, high-quality supervision. • Staff working long hours with excessive amounts of overtime.
Feedback from staff working in services or ex-staff or people using the service, their family or friends or others who have visited the service	People sharing concerns with us such as: • an unhealthy culture within the staff team, for example, bullying, presence of cliques, disrespectful language about people using the service or about colleagues. • disrespectful treatment of people using the service. • staff spending much of their time in 'unproductive activities' rather than with people using the service, for example in the staff room. • people who 'speak up' are at risk of reprisals. • staff are encouraged to be other than totally honest when recording or reporting information about care. This includes, for example, by minimising the severity of incidents involving staff or people using the service or by presenting performance data in a manner that reduces the likelihood of external scrutiny by senior managers or outside agencies.

External oversight

Inherent risk	Description
There is a lack of meaningful external scrutiny	• The service is geographically isolated or staff in the service have little contact with other services so they are not exposed regularly to a wider, healthy culture. • People using the service are a long way from home. This may reduce how often family members or staff from their local area are able to visit them. • People using the service are isolated, rarely leaving the grounds of the service for example, to engage in meaningful activities within the local community. If they do, much engagement is with other similar services and the people in them. • Effective and independent advocacy services are non-existent. • Multiple bodies fund places, with no single commissioner taking the lead. • Commissioners do not carry out monitoring or review people's care annually or reviews are carried out remotely, by phone. • There is poor reporting of concerns, and little contact from local authority safeguarding teams.

3. Warning signs

Through our monitoring and inspection of services, we must be alert to the presence of warning signs that indicate a service might have or might be developing a closed or punitive culture.

Where warning signs are present, inspectors should follow the CQC Risk management framework, making enquiries or carrying out a responsive inspection as appropriate. Where the warning signs are caused by specific incidents, inspection staff should refer to the guidance on specific incidents.

The absence of warning signs on inspection, particularly in relation to staff behaviour, does not indicate that this type of behaviour never occurs. For example, the presence of a CQC inspection team is highly likely to change the behaviour of staff. This highlights the importance of using other intelligence, such as information from concerns raised about the service, or where abuse is being deliberately concealed. This section outlines the different types of warning signs, and what to look out for when monitoring or inspecting services.

Leadership and management

Warning sign	What to look out for	When?
Whether senior staff know what is actually happening	• Do the senior staff spend a substantial proportion of their working day interacting directly with people or are they dealing with 'management tasks'? • Is feedback from people who use services regularly gathered and used to improve the service? • Are members of the senior management team and other professionals a regular presence in the service? • **In hospitals:** are members of the senior multidisciplinary team (for example, doctors, occupational therapists, and clinical psychologists) a visible and daily presence on the ward? • **In hospitals:** are there limited or no examples of managers using information and data to monitor progress and improvement against outcomes. Is this used to identify where there may be potential changes in the quality of care?	Inspection
Willingness to acknowledge potential signs of poor culture or potential abuse	• Do managers and/or staff ignore or play down, or encourage others to ignore or play down, the significance of concerns (for example, the severity of incidents, allegations or complaints made by staff, people using the service, their family, friends or advocates)? • Do managers recognise the impact of violence on staff as well as people using the service, including the cumulative effect of violence on empathy and judgements, and what have they put in place to address this?	Inspection

	• How do managers respond to allegations of staff bullying either staff (as there is often a link between staff bullying and poor treatment of people using the service)?	

Experience of people receiving care

Warning sign	What to look out for	When?
A high proportion of people who are cared for in some form of isolation from other people using the service	• **In hospitals:** are patients subject to de-facto isolation, where there is a high staff-to-patient ratio? For example because there are many patients on 2:1 or 3:1 observation? ***Note:*** *In adult social care services, there is no mechanism for notifying use of isolation to us, but we may have other intelligence about this.*	Monitoring and inspection
Whether people using the service are comfortable with staff	• Do people using the service appear comfortable with staff or do they appear anxious? • What do people tell us about their relationships with staff? • What do we find from use of the Short Observational Framework for Inspection (SOFI)?[2]	Inspection
How people using the service behave towards one another	• Do staff tolerate abusive language by, or inappropriate physical contact between, people using the service?	Inspection
How staff behave towards people using the service	• Do staff tease, make fun of or play jokes on people who are under their care? • Do staff touch people in inappropriate ways – overly rough or too intimate? • Do staff ignore people using the service or prioritise 'routine' tasks over time spent interacting with them? • Do staff appear impatient or intolerant of people's behaviour, rather than seeking to understand the causes of the behaviour? • Do they sometimes use physical restraint when it is not absolutely necessary to protect the person or others? • Do they understand the impact they have on people's behaviour and how this can escalate it?	Inspection

[2] Note that we have further development work planned on assessing the experience of people using services who do not use verbal communication

	• Are medical interventions carried out in the least restrictive manner appropriate? For example, are people with epilepsy are only given rectal diazepam instead of Buccal Midazolam if there is a clear clinical reason? • Is the focus behaviour control or therapeutic interactions? • **In hospital settings:** is there low level of engagement with people using the service when under observation. For example, members of staff sitting outside the person's room for long periods of time observing them with no interaction with the person? • Are punitive measures taken? For example, in inpatient care are personal possessions confiscated or people put into hospital clothing, without a legitimate reason to do so, such as protecting people from harm? Is an assessment made about whether this is the least restrictive option?	

Skills and experience of staff providing care

Warning sign	What to look out for	When?
Whether the staff who provide the majority of direct care know what they are doing	• Do the staff know the people that they are working with on that shift well? • Do they know what is in the person's care plan/positive behaviour support plan, and exactly how to act when situations arise that are covered by the plans? • Have they had the training required to work with the group and particular individuals to undertake the tasks they have been given? For example, in autism, positive behaviour support, basic/intermediate life support). • Is there an emphasis on creating a communicative environment for people who use the service? For example, appropriate use of personalised communication aids?	Inspection
How staff talk about people with a learning disability or autistic people	• Do they use disrespectful language and talk as if people with a learning disability or autistic people are of less value than other people? • Do staff talk about people in terms of the problems they pose to staff; rather than as individuals? • Do written care records indicate that staff view people with respect and treat them as individuals (for example shift handover notes)?	Inspection

Whether staff have done all in their power to help/enable people to attend to their basic needs	• Are people using the service poorly dressed? • Are they wearing their own clothes? Is their personal hygiene poor? • Are there signs of poor physical healthcare (including poor dentition)? • Would you be willing to eat the food?	Inspection

Use of restrictions (including blanket restrictions)

Warning sign	What to look out for	When?
Imposed restrictions	Are there imposed restrictions in place? Are these reviewed to see if they are for a legitimate reason and the least restrictive option? I.e. are they a proportionate response to a risk, especially blanket restrictions. Examples include: • kitchen locked, other rooms locked and off limits so people have limited control over their living space. • Is access to equipment, such as books, activities, CDs, restricted for people using the service as it is locked away and staff have the key? • Are there restrictions on leaving the building that are not the least restrictive option? For example, leaving the building to smoke. • Are physical restrictions of individual people to prevent self-harm are not regularly reviewed? • Are people in segregation restricted to “finger food” or denied access to phone calls, music, the internet or other activities without assessment of whether this is proportionate response to risk? • Is application of the Mental Capacity Act poor? For example, failing to apply for a deprivation of liberty safeguards (DoLS) or not meeting the conditions within a DoLS.	Inspection

Use of restraint

Warning sign	What to look out for	When?
High, or increasing, recorded or reported use of restraint, seclusion or segregation	• **In hospitals:** as well as looking for an increase in notifications, is there is a complete absence of these notifications? Or is there evidence in the national data of potential under-reporting about the use of restrictive interventions? • **In adult social care services:** currently there is no mechanism for notifying these to us, unless the restraint triggers another notification such as serious injury, but we may have other intelligence about the level of restraint, seclusion or segregation.	Monitoring

Physical environment

Warning sign	What to look out for	When?
Whether the condition of the building shows that people using the service are respected.	• Is it dirty or in a poor state of repair? • Would you be prepared to live there? • But be aware that unhealthy cultures can also take place where the physical environment of the service is good. • Have people been allowed to personalise their own rooms?	Inspection
Physical factors	• What is layout of the service like? Does it have lots of small rooms or rooms leading off rooms, areas that could pose greater risk of abuse going unobserved?	Inspection

External oversight

Warning sign	What to look out for	When?
A high, or increasing, number of safeguarding incidents, complaints or other notifications[3]	This is especially of concern if the incidents, complaints or notifications are: • any form of inappropriate behaviour by staff towards people using the service. • injuries to people that cannot be fully explained, even when safeguarding investigations do not find any abuse. • an increase in incidents where people using the service are violent towards staff • involvement of the police. • complaints by people using the service, their family and friends, including those that are withdrawn subsequently. • complaints that family members, or others such as advocates, are being prevented from visiting or receive a hostile response from the service. • complaints that family members or visiting professionals are not enabled to see someone in private (unless there is a legitimate reason why this would be a risk and this is the least restrictive option to enable the person to receive a visitor). ***Note**: if notifications specifically refer to people previously having made "false allegations" then these people may be vulnerable to deliberate abuse, as perpetrators know that the complainant is less likely to be believed.*	Monitoring

[3] The caveats are that:

- low numbers, and particularly an absence of notifications and reported incidents, might indicate poor recording or failure to notify or submit data externally as required; this can be checked by operations colleagues through the available Insight tools
- services that have a healthy culture may have a low threshold for reporting and so be high reporters and vice versa,
- a step change in the patterns or frequency of reports could indicate a change in process, management and reporting culture.

4. Responding to closed cultures

The presence of one or more inherent risk factors is not proof that there is an abusive or punitive culture, but could be a sign that there is an increased chance of one developing. This section highlights potential areas of concern that inspectors need to consider when monitoring, planning an inspection, and inspecting services. These refer to all types of services unless otherwise indicated.

Monitoring

Area of concern	Action
Are people able to self-advocate?	Where people are in circumstances where they are not able to advocate for themselves, pay particular attention to how we can get evidence of people's experience of care and how their human rights are protected, regardless of whether there are other inherent risk factors or warning signs.
Is there a high inherent risk?	Pay particular attention to services where all or most people cannot communicate their basic needs.
	Look at the information that we have about management and leadership, staffing and external oversight to monitor the inherent risk of a closed culture developing in the service. This includes looking at staff turnover including leadership turnover.
	Consider current regulatory compliance and breach history.
	If you are unclear on the level of inherent risk for a service, use support from others through the escalation process in the risk management framework to help come to a decision. Inspection managers should offer support to inspectors to help make these decisions, as inherent risk may not be a clear-cut issue.
Are there any warning signs?	Be alert to the warning signs that the service is developing an abusive or punitive culture or is at risk of one developing. Focus particularly on the nature and volume of whistleblowing, complaints, safeguarding incidents and other notifications.
	Where you have concerns, handle these through our usual decision-making processes, including the risk management framework and our safeguarding guidance, especially the inspector's safeguarding handbook. Where there is a high inherent risk in a service and warning signs are developing, there should be a low threshold for deciding to carry out a responsive inspection.
	Prioritise gathering evidence that could provide additional information about the areas of concern. Consider whether there is a need to trigger the emerging concerns protocol, a strengthening and formalising of existing arrangements for sharing emerging concerns between regulators.

Inspection and Mental Health Act review visit planning

Area of concern	Action
Is there an inherent risk?	Carry out a desktop review of evidence about the culture. This includes a review of available Insight tools such as concerns raised with CQC by whistleblowers, safeguarding notifications and notifications of deaths. Look at the provider's response/actions taken and themes from the evidence. This review might flag both inherent risks and warning signs.
	Look at the previous three years' inspection reports (and the previous two Mental Health Act (MHA) monitoring reports for mental health services) to identify breaches and action points. Look at whether these have been met and if there are any recurrent themes.
	Speak with inspection colleagues who have visited the service, and for mental health inspection, recent MHA reviewers.
	Contact other professionals, commissioners and Healthwatch Enter and View. If possible, talk to commissioners, so that their views and any concerns can influence can influence our course of action and inspection planning, also other professionals who might visit the service more regularly.
	Adult social care for people with a learning disability or autistic people only: • A large number of people using adult social care services are highly dependent on staff to meet their basic needs, which is one factor in inherent risk. • **If, in addition, a service has a high inherent risk in relation to management, staffing or lack of external scrutiny then carry out a comprehensive inspection**. Do not use the 'return to good' methodology, regardless of whether any warning signs are present. This is a matter of judgement based on the factors in the section on inherent risk above.
	Mental health hospitals for people with a learning disability or autistic people: • Consider carrying out a focused inspection, focused MHA visit or increasing the frequency of MHA visits. • If a decision is made to carry out a focused inspection, plan the resource for the site visit to include Experts by Experience to talk to patients and family members, meeting access requirements of patients and whether the inspection team needs people with particular skills, such as a specialist advisor or inspector trained in SOFI methodology. • Talk to any relatives where we have contact details, so that their views, experiences and any concerns can influence our course of action and inspection planning.

Area of concern	Action
Are there warning signs?	Ensure that you have an up to date picture of any concerns raised by any staff or ex-staff in the service or others such as relatives, so that this can influence inspection planning. Where necessary and possible, contact people to ensure that you have the most recent information.
	Prioritise gathering evidence that could provide additional information about the areas of concern.
Focus of the inspection or MHA review?	Plan the inspection or review to focus on the culture of the service, how this impacts on the quality of care and experience of the people using/living in the service. Focus on whether human rights are being upheld and promoted. The Equality and human rights FAQ page on the intranet gives more information about human rights in our regulation. **This is the key point for planning MHA reviews**.
Resourcing for the inspection?	Consider the skills and competencies needed in your inspection team and whether you are the right person to lead the team. Agree the team with your inspection manager.
	Make gathering the experiences of people who use services a priority. Request an Expert by Experience join the team, either a person with a learning disability or an autistic person or a family carer. ***Note:*** *Depending on the urgency of the inspection or the availability of an Expert by Experience this may not always be possible, but a request should always be made*.
	Plan for the communication needs of people using the service, for example by booking interpreters.
	Adult social care services for people with a learning disability or autistic people only: Inspectors can request an additional team member if there are warning signs, even if it is a small service. For example, a second inspector could also be involved either on the same day or a different day if having two people in the service at the same time might not work well. If the warning signs have been uncovered during an inspection, then additional resource may be required for another inspection day which includes a second inspector.

On inspection

Area of focus	Action
Gathering the views of people who use services and their family	It is very important to have adequate time to speak informally with people using the service, so that they are at their ease, alongside time for general observations of the care given in the service. This might mean that more time is needed for the inspection. MHA review visits are also a valuable way of gathering general observations and more informal feedback from staff as well as patients.

Area of focus	Action
	All discussions with people should take place in private wherever possible. For example, staff should not be present when asking people using the service or their relatives and friends about their experiences. We have powers under the National Preventive Mechanism and Health and Social Care Act 2008 to do this, with the individuals' consent.
	Use the Expert by Experience to support talking to people using services and families on the day of the inspection wherever possible, as well as before and after the inspection. This ensures that any concerns from families can be followed through by gathering additional evidence on site.
	If there are known, specific concerns that might need corroboration or follow up by talking to families or people using the service, it might be more appropriate for the inspector carry out the interviews. If an Expert by Experience flags an issue of concern from an interview, then an inspector may need to do a follow-up interview.
	Ensure contact is made with any advocates working with people in the service, where these are known.
	Adult social care and mental health hospitals for people with a learning disability or autistic people only: • If there are blanket restrictions or restrictions in place for particular people, check compliance with human rights-related responsibilities. Questions to ask include: o Is the restriction for a legitimate aim? o Has the provider considered different options to meet that aim? o Is there evidence that the restriction in place is the least restrictive option? o Have decisions been made in line with requirements of Mental Capacity Act, if this applies? o Pay particular attention to any assessments or best interests decisions under the Mental Capacity Act, are staff observing principle 1 of the Act, to assume capacity? o Are the decisions regularly reviewed? • Review medication management, including how the service is reducing overmedication through STOMP aims and practice.
Staff	All staff interviews should take place in private. Under section 63 of the Health and Social Care Act 2008 we have powers to interview in private anyone working in the service. Interviewing support staff, such as domestic staff, housekeepers and porters, is also important as they have observed what is going on in a service day-to-day.
	Ask follow up questions, especially when staff give reasons for why people are restricted. For example, if a member of staff says "a person doesn't go out because they get anxious", a follow-up

Area of focus	Action
	question could be “what are you doing to support them to go out if they want to?”
	For mental health hospital inspections of services for people with a learning disability or autistic people: see appendix B for key themes to explore for different staff groups.
Observation	Case tracking should be used to see whether care plans are delivered in practice in frontline care delivery. Inspection teams should also check that the care plan is personalised and need to be alert to ‘copy and paste’ in plans. Care plans should include what gives the person joy or meaning in life and not be over focused on behaviour control. Inspection teams should choose who to case track, rather than asking the provider to select people. Prioritise case tracking of people who might be more vulnerable to human rights breaches. This includes: • anyone currently in long-term segregation • people a long way from home or without regular visitors • people who have been abused in other settings or have ‘allegation risk assessments’ in place • people who face significant barriers in giving feedback themselves, for example people who are non-verbal. (***Note:*** *In some services, this might be the majority of people using the service. In this case inspectors should use their judgement about who might be most vulnerable to human rights breaches.*) Case tracking should include speaking to or communicating with the person if possible and to their relatives or friends, advocates and commissioners either during or after the inspection visit.
	If anyone using the service is autistic, consider whether the service specifically considered reasonable adjustments and meeting the needs of individual autistic people, for example in relation to communication, sensory overload and reducing distress? Does the service meet the Accessible Information Standard? The National Autistic Taskforce (comprised entirely of autistic people) has produced an independent guide to the quality of care for autistic people which highlights many relevant issues. If the needs of autistic people are not met, there is a higher risk of a culture reliant on excessive restraint developing.
	Adult social care services for people with a learning disability or autistic people only: • Always use SOFI where this will work, including in case tracking. There may be services where SOFI is not the best observation method, for example if the service is provided to small numbers

Area of focus	Action
	of people in small rooms. In these situations, a similar time should be allowed for other ways of observing care.
	Mental health hospital services for people with a learning disability or autistic people only: • Consider using SOFI and general observations, including for case tracking. MHA review visits are also a valuable way of gathering general observations and more informal feedback from staff as well as patients.

5. After the inspection or MHA visit

- Following the inspection or MHA visit, if you have concerns about the safety of individuals using the service, report this using safeguarding procedures and consider taking urgent action (see responses section below).
- The inspection team needs time to reflect on evidence gathered, in an open and responsive way that allows the team to challenge each other about what was found. This could include someone from CQC, who is independent of the inspection, facilitating these discussions. Additional time may be needed, beyond the usual corroboration and management review meeting processes.
- Mental Health Act (MHA) reviewers visit services on their own. Reflective practice after a visit is therefore particularly important. If you are an MHA reviewer and the service has a particularly high inherent risk, or you have concerns after a visit, managers should support you to have a reflective practice discussion.
- Line managers need to check the wellbeing of all those associated with the inspection or MHA visit, if the inspection or visit has dealt with particularly difficult issues.

Responses to consider if concerns are identified on inspection

When we have identified closed cultures where there is a high risk of abuse, human rights breaches or poor care, the following should be considered:

- Is there is a need to raise a safeguarding alert?
- Where concerns are serious, do concerns need escalating within CQC management structures, in line with enforcement and risk management processes?
- Is a multi-agency strategy meeting is required? If so, discuss with the local authority and police. If there are concerns that there is a criminal element involved, this needs to be reported to the police as well as the local authority. Decide how quickly a multi-agency strategy meeting is required to ensure the welfare and safety of people.
- If not already triggered in monitoring, is there is a need to trigger the emerging concerns protocol?
- Do any issues need to be taken forward into ongoing engagement activity? For example, with commissioners or at a local area level, including providing briefings for other CQC staff who attend these meetings if necessary.
- Does any regulatory activity need to be taken at a provider-level? Further information can be found on the intranet about Reactive provider level well-led assessments. Criteria for reviewing concerns about a provider include, but are not limited to the following:
    - a significant number of the provider's locations were rated as 'inadequate' across the provider as a whole
    - on location inspections, risks were identified that appear to have stemmed from a failing in or an issue with, corporate policies, procedures, or governance arrangements

- whistleblowing concerns were raised, which were of a serious nature and suggested systemic failings at provider level
- there has been a lack of active engagement post location inspections from the provider.

If there are other issue(s) that suggest a reactive provider level well-led assessment may be required, contact the Policy and Strategy team to discuss.

6. Enforcement

When warning signs are identified, and evidence is found of breaches of the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, consider whether enforcement action is required. This action may be civil, criminal or both. It could include taking urgent action under section 31 of the Health and Social Care Act 2008 to impose, vary or remove conditions or suspend registration if people are, or may be, at risk of harm. In some cases, it could include taking urgent action under section 30 to cancel a provider's registration if there is a serious risk to life, health or wellbeing.

Where urgent action needs to be considered, it is important to schedule a management review meeting including the Legal Services team as soon as possible.

Abuse does not need to have occurred for us to take enforcement action. A failure to have systems and processes in place giving rise to risks that might lead to abuse or human rights breaches could be a breach of regulation 17 – good governance (see appendix C). There may also be a breach of regulation 12 – safe care and treatment.

To meet the requirements of regulation 13 – safeguarding service users from abuse and improper treatment, providers must have a zero-tolerance approach to abuse, unlawful discrimination and restraint. This includes:

- neglect
- subjecting people to degrading treatment
- unnecessary or disproportionate restraint
- deprivation of liberty.

Providers must have robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors. Abuse and improper treatment includes care or treatment that is degrading for people and care or treatment that significantly disregards their needs or that involves inappropriate recourse to restraint.

Enforcement subsequent to any regulatory breaches should follow our enforcement guidance, including our enforcement handbook, enforcement decision tree and enforcement policy. See appendix C.

If there have been regulatory breaches, we should not rely simply on asking the provider to give assurances about how they will address concerns, we should seek assurance by way of independent verification for ourselves. In relation to closed cultures, providers and managers may be part of the problem. Rather than relying on what they tell us, we need to be asking the provider to demonstrate change or improvement objectively, in a way that can be measured, or we should be assessing change or improvement in a different but independent way.

Potential breaches of human rights should be considered in enforcement decision making, in line with the enforcement decision tree. This includes breaches of specific rights such as

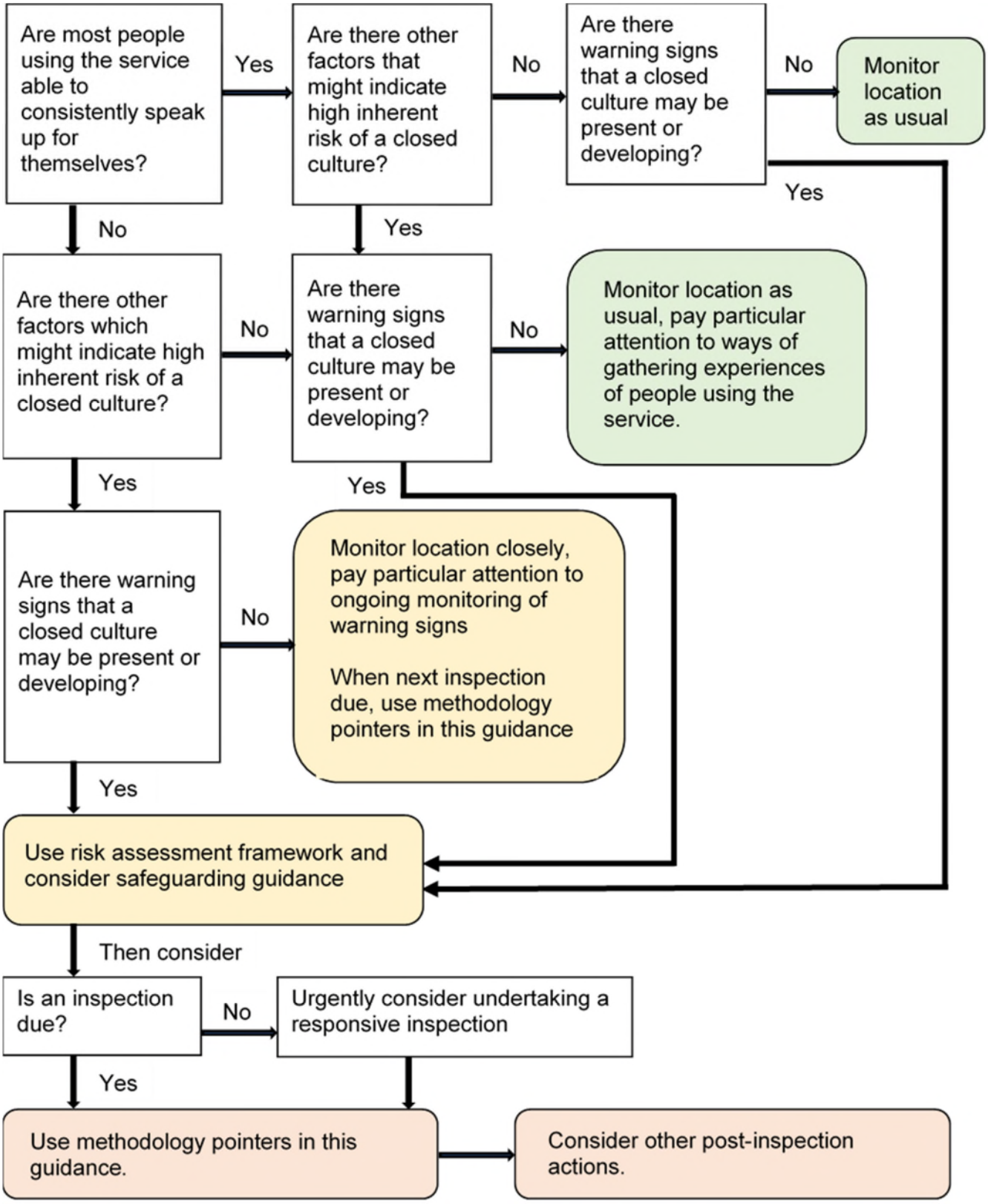
rights under the Mental Capacity Act or Mental Health Act. It also includes rights under the Human Rights Act such as:

- the right to be free from inhuman or degrading treatment (Article 3)
- the right to home, private life and correspondence. (Article 8) This is a wide-ranging right. Where people have restrictions placed on them without these being lawful, for a legitimate aim and the least restrictive way of meeting that aim, this may breach Article 8. These restrictions go beyond restraint and could include, for example, restricted access to visitors or other people, to food and drink, to their own possessions, to moving around within a service or to going outside. Any restrictions should be regularly reviewed to ensure that they meet these criteria.

Further guidance on the links between our regulations and human rights law is available the Equality and human rights FAQ page on the intranet.

7. Appendices

Appendix A: identifying and responding to closed cultures (summary)



Appendix B: additional prompts for mental health services

Prompt	Action
Desktop review in monitoring or pre-inspection	Consider the following intelligence: • safeguarding notifications – look for actions, provider response and themes. • whistleblowers – actions taken, provider response and themes. • involvement of police – links to safeguarding, whistleblowing. • deaths – actions, provider response including Mental Health Act (MHA) deaths notified through regulation 17 • previous two MHA monitoring reports and provider action statements • MHA complaints received for the service over last three years • Second Opinion Appointed Doctor Service (SOAD) – activity including notification of concerns from visiting SOADs • staff interviews on inspection – key themes to explore • talk to local advocacy provider service to identify any concerns • Look for any recent Local Healthwatch reports
On inspection or MHA visit	Follow up areas identified as themes or requiring follow up from pre-inspection or pre-MHA visit review. • If there are known, specific concerns that might need corroboration or follow up by talking to patients or families, it might be more appropriate for the inspector or MHA reviewer to lead the interviews. If an Expert by Experience flags an issue of concern from an interview, then an inspector or MHA reviewer may need to do a follow up interview. • **Cross reference safeguarding notifications** with local authority and against provider records. • **Ward tour** – including look for the potential indicators of closed cultures listed above. • **Review staffing rotas** for last 3 months – agency use, skill mix, length of shifts, weekly total hours, shifts not covered etc. • **Review of restraint/safeguarding/serious incidents** – select incidents: cross reference notification, incident report, care notes entry and consider whether to look at CCTV footage where available, in line with our existing guidance on this. • Look at **Long term segregation safeguards**.

Prompt	Action
Staff interviews	**Care assistants/support workers** • Focus on care plan of an individual patient (for example, someone from case tracking). Talk through the care plan and their understanding of what they do and examples from practice. Build in questions regarding training and support. • Talk through understanding of restrictive practices and talk through recent restraint being used, for example, why, when, who provided oversight, and debrief. • Explore their knowledge of how to raise concerns.
	Registered nurses • Focus on development of care plan/positive behaviour support (PBS) plan, evidence used, involvement of patient, families and staff – including complying with the Accessible Information Standard (identify, record, flag, share and meet the information and communication needs of each person using the service). Explore knowledge of PBS approach. How are staff aware of care plan. When are care plans reviewed and who is involved. How are patients enabled to maintain contact with family and friends? • For people in assessment and treatment settings, ask: What is the end goal of this person's assessment and treatment? What are they doing to make sure this person can leave hospital? How often do people see their consultant? (also check in case tracking) • Incident analysis, review of use of restrictive practices and learning, how do they ensure that any restrictive practice is lawful, for a legitimate aim and the least restrictive option (this is a requirement to avoid breaches of the Human Rights Act). • How do they ensure compliance and good practice with MCA and MHA, including access to advocacy?. • How do they ensure staff are following plans? • Training provided to them, supervision and professional development.
	Other members of multidisciplinary team • Involvement in care planning. • Time with team delivering care, observing practice. • Similar themes to registered nurse and managers - approach dependent on role. • Where possible, case tracking should also include MDT meeting notes to see the involvement of different people, including families.

Prompt	Action
	Managers • Staffing levels, skills and training, agency use, supervision, support and appraisal. • Presence on ward, assurance regarding quality of care delivery. • MCA and MHA. Restrictive practices (see questions above). Restraint reduction – overall strategy and concrete examples of restraint reduction for individual people at high risk of being restrained. • Incident, concerns monitoring, analysis and monitoring. Safeguarding incidents on ward, actions and learning. Understanding of Duty of Candour. The number of people with "allegations risk assessments/ plans" and how allegations made by these people are followed through.
Supporting information	There are several Brief Guides that relate to topics covered in this appendix, including guides on inspecting safeguarding, long term segregation, restraint, rapid tranquilisation, seclusion rooms, assessing how providers use the MCA, use of blanket restrictions on mental health wards, discharge planning in Learning Disability services, good communication standards for people with a learning disability or autism, positive behaviour support for people with behaviours that challenge.

Appendix C: Link to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Each situation of a closed and punitive culture must be assessed to determine whether there are any breaches of regulations. The following are examples of where certain evidence may indicate a breach, but you should always consider the wording of the regulation itself when determining if a breach has occurred.

Regulation	Description
Regulation 9: Person-centred care	This can be used if people are not receiving person-centred care. For example, if frontline staff are not following care plans (including Positive Behaviour Support plans) or care planning has not been carried out appropriately to meet needs and preferences.
Regulation 10: Dignity and respect	This can be used if care is not being provided with dignity and respect or there is not due regard to people's equality characteristics. One example would be where observations of people in seclusion are undertaken in a way which breaches rights to privacy, when this is not the least restrictive way of ensuring people or staff remain safe.
Regulation 11: Need for consent	This can be used if lawful consent to treatment is not obtained – this includes correct use of the Mental Capacity Act and Mental Health Act
Regulation 12: Safe care and treatment	This can be used if the care and treatment of people using the service is not safe, including where the culture has an impact on the safety of the care or treatment and if the failure to follow care plans results in unsafe care.
Regulation 13: Safeguarding service users from abuse and improper treatment	This can be used if the service does not protect people from abuse or improper treatment, such as verbal abuse and psychological abuse, including taunting people, ill-treatment, unnecessary or disproportionate restraint or inappropriate deprivation of liberty, such as using seclusion as a punishment.
Regulation 16: Receiving and acting on complaints	This can be used if complaints from patients or their families and informal carers have not been adequately investigated or addressed – and also where a provider does not give information to CQC about complaints, when requested, within a 28-day limit.
Regulation 17: Good governance	This can be used if there is inadequate management oversight of the culture in a service, where there are inadequate systems and processes to ensure compliance, including where the registered person does not have adequate assurance that risks to the health, safety and welfare of patients are being mitigated or that other regulations are being met.
Regulation 18: Staffing	This can be used if there are not enough staff with the skills and competencies required to meet the needs of people on the ward or staff are not provided with adequate training.

Regulation	Description
Regulation 19: Fit and proper persons employed	This can be used if the provider employs, or continues to employ people who are unfit to carry out their role – for example if they are not suitably qualified or experienced, or are not of good character. This could put people at the risk of harm or abuse.
Regulation 20: Duty of candour	This can be used if the provider is has not acted in an open and transparent way in relation to providing care and treatment, in particular when something has gone wrong and caused physical or psychological harm to someone using the service. The provider must follow a specific set of duties as outlined within the regulation.