**Analysis of responses to CQC Visiting Consultation**

Draft guidance for providers on how to meet Regulation 9A: visiting and accompanying in care homes, hospitals and hospices

Contents

[1 Executive Summary 4](#_Toc162258446)

[2 Introduction 7](#_Toc162258447)

[2.1 Background 7](#_Toc162258448)

[3 Method statement 9](#_Toc162258449)

[3.1 Consultation Process 9](#_Toc162258450)

[3.1.1 Survey 9](#_Toc162258451)

[3.1.2 Focus groups and workshops 10](#_Toc162258452)

[3.2 Report Structure 11](#_Toc162258453)

[3.3 Reading the Report 12](#_Toc162258454)

[3.4 Respondent Categories 14](#_Toc162258455)

[3.4.1 Breakdown by respondent 14](#_Toc162258456)

[3.4.2 Breakdown by respondent (individuals) 15](#_Toc162258457)

[3.4.3 Breakdown by respondent (organisations) 16](#_Toc162258458)

[3.4.4 Breakdown by respondent (sectors) 17](#_Toc162258459)

[4 Visits in 18](#_Toc162258460)

[4.1 Level of agreement 18](#_Toc162258461)

[4.2 Discussion 23](#_Toc162258462)

[4.2.1 Survey 23](#_Toc162258463)

[4.2.2 Focus groups and workshops 25](#_Toc162258464)

[5 Visits out 27](#_Toc162258465)

[5.1 Level of agreement 27](#_Toc162258466)

[5.2 Discussion 32](#_Toc162258467)

[5.2.1 Survey 32](#_Toc162258468)

[5.2.2 Focus groups and workshops 34](#_Toc162258469)

[6 Accompaniment 35](#_Toc162258470)

[6.1 Level of agreement 35](#_Toc162258471)

[6.2 Discussion 40](#_Toc162258472)

[6.2.1 Survey 40](#_Toc162258473)

[6.2.2 Focus groups and workshops 42](#_Toc162258474)

[7 Meeting preferences 43](#_Toc162258475)

[7.1 Level of agreement 43](#_Toc162258476)

[7.2 Discussion 48](#_Toc162258477)

[7.2.1 Survey 48](#_Toc162258478)

[7.2.2 Focus groups and workshops 50](#_Toc162258479)

[8 Exceptional circumstances 51](#_Toc162258480)

[8.1 Level of agreement 51](#_Toc162258481)

[8.2 Discussion 56](#_Toc162258482)

[8.2.1 Survey 56](#_Toc162258483)

[8.2.2 Focus groups and workshops 58](#_Toc162258484)

[9 Other feedback 59](#_Toc162258485)

[9.1 Discussion 59](#_Toc162258486)

[9.1.1 Survey 59](#_Toc162258487)

[9.1.2 Focus groups and workshops 62](#_Toc162258488)

[Appendices 64](#_Toc162258489)

[Appendix 1: Survey text 64](#_Toc162258490)

[Appendix 2: Closed question data tables 70](#_Toc162258491)

[Respondent breakdowns 70](#_Toc162258492)

[Question 1 72](#_Toc162258493)

[Question 2 73](#_Toc162258494)

[Question 3 74](#_Toc162258495)

[Question 4 75](#_Toc162258496)

[Question 5 76](#_Toc162258497)

[Appendix 3: Glossary 77](#_Toc162258498)

# Executive Summary

Context

Following the Government’s consultation on its secondary legislation and the publication of Regulation 9A, CQC drafted proposed guidance to help providers and other stakeholders understand the new standard on visiting and their roles and responsibilities under it. In January and February 2024, it then held a six-week consultation on this proposed guidance.

This report

PPL were commissioned to conduct an independent analysis of the response to the consultation and to generate this report which sets out a summary of the responses. The findings are set out below.

Respondents

**There were 553 unique responses to the survey, of which 287 were from individuals and 266 were on behalf of an organisation.** Of the responses from individuals, 125 were from health or social care employees and 71 were from carers of somebody using health and social care services. 41 were from members of the public or people who use health or social care services. Of the responses from organisations, 217 out of 259 were from health or social care providers. The sector breakdown showed that 277 out of 361 respondents who stated their sector were from adult social care, compared to 23 from hospice services and 19 from acute NHS hospitals.

Visits in

**78% of respondents to Question 1 agree or strongly agree that the guidance clarifies the requirements on providers to facilitate visits**. Several respondents link this to their experience in the Covid-19 pandemic or argue that visits are important for the wellbeing and quality of life of people who use services. However, several respondents challenge the use of specific phrases which they say are unclear or subjective, suggesting that this could lead to providers imposing restrictions on visiting. Nonetheless, some respondents believe that limitations or restrictions may be necessary to control infections and limit disease transmission.

Visits out

**85% of respondents agree or strongly agree that the guidance clarifies the requirement not to discourage people from going out on visits**. Several respondents relate their support for the guidance to their own experiences, whilst some say the guidance is clear on providing pragmatic support and avoiding discouragement of visits out. However, several respondents question whether additional staffing could be needed and how this would be funded, whilst some ask where responsibility for risk assessment and safeguarding would sit. Meanwhile, some respondents express concerns about the guidance leaving scope for providers to restrict or limit visiting opportunities.

Accompaniment

**82% of respondents agree or strongly agree that the guidance clarifies requirements around enabling accompaniment**. Several relate this to their own experiences of accompanying people who use services, whilst some suggest that being accompanied is beneficial for wellbeing, comfort or stress reduction. However, several express scepticism that hospitals would allow people to be accompanied. Furthermore, several raise concerns about the potential staffing impacts for homes if they were required to accompany people to appointments and some suggest this would have financial implications for providers.

Meeting preferences

**73% of respondents agree or strongly agree that the guidance clarifies the requirement to meet preferences.** Several say that an individual’s personal choices should be respected provided they have the capacity to make that decision. However, several say that the guidance is too subjective and open to interpretation and that providers may not accommodate the preferences of people who use services. Several also express concern about how the preferences of people who use services would be determined if people are unable to freely express them or do not have capacity.

Exceptional circumstances

**79% of respondents agree or strongly agree that the guidance is clear around exceptional circumstances.** Most of those who comment positively are supportive of the principle of only putting restrictions in place in exceptional circumstances. However, many respondents argue that the guidance is subjective or open to interpretation, often specifically referring to the phrase ‘exceptional circumstances’. Several argue that providers might exploit this ambiguity to put restrictions in place. Conversely, some respondents say the guidance does not sufficiently emphasise safety and wellbeing or that measures may be needed for infection control.

Other findings and suggestions

In response to Question 6, respondents often echo their earlier comments from previous sections, with several reflecting positively whilst many reiterate previous issues. Some say that the guidance is too wordy or difficult to read, whilst some feel it does not sufficiently recognise the distinction between settings such as hospitals, hospices, care homes and supporting living. Meanwhile, some question what appeals or dispute resolution process would be in place. Many seek clarification around specific areas of the guidance, often particular words and phrases, whilst several make suggestions which include:

* Sharing the guidance with providers and statutory agencies, as well as families, carers and friends, to maximise awareness of the legislation
* Providing examples to help clarify key points in the guidance
* Outlining processes for dispute resolution

Further suggestions can be found in Section 9.1.1.

Next steps

CQC will use this summary report, alongside the full response data, to gather a detailed picture of all the consultation responses. This will inform CQC’s formal consultation response and influence the development of its regulatory approach and guidance.

# Introduction

## Background

The Government has developed and introduced a new fundamental standard: secondary legislation designed to ensure that visiting is protected and prioritised in settings registered by CQC.

In summer 2023, the Government invited comment and feedback on its proposed legislation via a consultation. The consultation, which received approximately 1,400 responses, found that most people supported the proposal to introduce a new fundamental standard.

Following that consultation process, the Department of Health and Social Care (DHSC) published a new regulation, Regulation 9A, which sets out the terms of the new fundamental standard on visiting that will apply to those in care homes, hospices, and hospitals.

Regulation 9A establishes obligations for:

* providers to facilitate people using their services to receive visits from family and friends.
* providers to enable people using their service to go out on visits.
* hospitals or hospices to enable people to be accompanied by a family member, friend or advocate on outpatient appointments.

These are necessary for people’s health and wellbeing.

As such, any restrictions to people’s visiting rights must be the exception and be time limited. They should only be put in place where there are thoroughly assessed risks to health and safety.

Regulation 9A will also enable CQC to specifically include visiting considerations as part of its wider regulatory assessment of providers. This could include using civil enforcement powers in line with its published enforcement policy when it is necessary and proportionate to do so.

DHSC proposes the regulation will come into force in April 2024.

As the independent regulator of health and social care in England, CQC has a legal duty to issue guidance on compliance with the new fundamental standard.

CQC has therefore drafted proposed guidance to help providers and other stakeholders understand the new standard on visiting and their roles and responsibilities under it. The guidance also sets out what people using health and social care services, and their families, friends or advocates, can expect.

CQC has since held a consultation (over a 6-week period in January and February 2024) **focused on the clarity of its guidance** – and not on the legislation itself. PPL were commissioned by CQC to independently analyse and summarise the responses received from the public, providers, and other organisations to the consultation questions.

CQC will use this summary report, alongside the full response data, to gather a detailed picture of all the consultation responses. This will inform CQC’s formal consultation response and influence the development of its regulatory approach and guidance.

# Method statement

## Consultation Process

There were two strands to the consultation: a survey and a series of focus groups/workshops. PPL were commissioned to undertake an independent analysis of the consultation survey response, whilst another organisation was commissioned to conduct the focus groups and workshops. Their findings were shared with PPL and a summary is provided in this report.

The approach for each of these strands is set out in the sections which follow.

### Survey

The survey was available online via CQC’s website from Tuesday 9th January to Tuesday 20th February. Easy Read formats were available as part of the consultation and other reasonable requests for accessible documentation (including translations) could be submitted to CQC.

Responses to the survey were collated and any references to personally identifiable information removed by CQC prior to sharing this data with PPL. The majority of responses were submitted via the webform but handwritten Easy Read responses and emails/letters were also accepted.

Where a response did not conform to the structure of the survey – for example, where a respondent submitted an email or letter without directly answering the survey questions – this was regarded as a ‘non-fitting’ response and processed as a response to Question 6 of the survey. This was the question which asked:

*‘Do you have any other suggestions for improving our guidance?’*

For all of the closed questions in the survey, data was aggregated and presented for respondents as a whole, but also subdivided into various categories. These are outlined in further detail in Section 3.

Please note that for Question 4, the ‘strongly agree’ and ‘strongly disagree’ options were erroneously placed at opposite ends of the Likert scale compared to other questions. Some respondents may have adjusted their responses due to the error and this should be borne in mind when interpreting the data for Question 4. The impact of this on the findings cannot be quantified but there is no reason to believe that this has significantly altered the overall findings. Some respondents commented on this issue and provided additional comments to clarify their feedback.

For all of the open questions in the survey, all data submitted to the consultation was reviewed by analysts who applied a thematic coding framework. This framework was devised using an approached based in Grounded Theory (meaning it was driven by the data received) and was iterated throughout the analysis as required.

Responses which did not answer any of the consultation questions (i.e. responses which only provided respondent information and did not answer Questions 1 to 6 in the survey in any way) were not considered as part of the analysis, nor were they counted in the response tallies in Section 3 and in Appendix 2.

### Focus groups and workshops

CQC identified particular groups of people in their equality impact assessment who may have been less able to access the consultation due to accessibility needs and for whom the guidance may have a particular impact, as well as other stakeholder groups. Another organisation was commissioned to conduct focus groups and workshops with these groups.

Online focus groups were conducted with 4 different groups:

* People aged over 65 years old;
* People with caring responsibilities;
* People from ethnic minority backgrounds; and
* People with a disability, impairment or long-term health condition.

Each focus group lasted 1 hour and 15 minutes and there were 6 or 7 participants in each group (25 in total). Participants were from a mix of geographic locations, ethnic backgrounds and socioeconomic groups.

Findings were shared with PPL and they have been summarised in this report alongside the consultation findings.

## Report Structure

The main body of the report (Sections 4 to 9) set out the findings of the analysis of consultation responses.

Sections 4 to 9 are grouped thematically. Within each of these Sections, the report is subdivided into different parts which cover:

* ‘Level of agreement’ – A summary of the closed question responses which correspond to that theme.
* ‘Discussion’ – A summary of the qualitative feedback submitted to the consultation. This is further subdivided into:
* ‘Survey’ – A summary of the open text responses to the relevant survey questions; and
* ‘Focus groups and workshops’ – A summary of feedback gathered through the convened groups outlined in Section 3.1.2 above.

The differences between ‘open’ and ‘closed’ questions are explained in Section 3.3 which follows below.

The themes for each of the Sections are derived from the questions in the survey. This means that the closed questions from the survey each correspond to a specific theme – e.g. Question 1 about visits in corresponds to Section 4 in the report (Visits In) and this is where responses to this question are summarised.

However, responses to the open questions have been summarised thematically. This means a response to Question 1 which discusses exceptional circumstances would be summarised in Section 8 (Exceptional Circumstances) rather than in Section 4 (Visits In), even though they were answering a question in relation to the latter. Nonetheless, the question to which they were responding did inform the analytical process as a key piece of context – eg. a response to Question 1 was be assumed to be about Visits In unless it explicitly raised another issue.

## Reading the Report

Tense

Responses have been summarised in the present tense. This is because, although the survey was conducted in the past, it is assumed that the views expressed remain the views held at the current time by those respondents. The same approach has also been applied to the summaries of the focus groups and workshops.

Naming conventions

People who took part in the survey element of the consultation are referred to in this report as ‘respondents’. People who took part in the focus groups and workshops are referred to in this report as ‘participants’.

Open and closed questions

Closed questions are questions where the respondent can select a response from a limited range of options. Open questions allow respondents to submit any response they choose (subject to character limits).

Limitations of the report

This consultation was open to anybody who chose to respond and is therefore a self-selecting sample. The findings cannot be held to be necessarily representative of the views of a wider population and do not necessarily constitute a representative sample. However, CQC has held meetings with groups identified as being less able to access the consultation and has promoted the consultation through their website and on social media, as well as through emails and bulletins to members of the public, providers and other stakeholders.

Use of percentages

Throughout the report, percentages given are of those who have answered the relevant question. E.g. A reference to “50% of respondents” in relation to question 1 would mean half of those who answered question 1, rather than necessarily meaning half of those who responded to the consultation. Wherever these percentages are used in a chart the base number (e.g. n=500) is given in the caption or legend.

Use of quantifiers

For closed questions, numeric quantifiers are used – either a whole number or a percentage of respondents.

Vast majority

Most

A majority

Many

Several

Some

A few

A small number

However, due to the nature of qualitative analysis and the subjectivity of the analysis process, the open text questions and focus group discussions have been summarised using verbal quantifiers. These give an indication of the weight of sentiment without necessarily using number or percentages to do so. The spectrum of quantifiers used is shown here, ranging from ‘vast majority’ (the largest quantifier) to ‘a small number’ (the smallest).

Glossary

A glossary covering a small number of acronyms used in the report is set out in Appendix 3.

## Respondent Categories

### Breakdown by respondent

There were a total of 553 unique respondents to the consultation.

536 responses were submitted online, 12 were submitted as Easy Read responses (which includes scanned handwritten responses) and 5 were submitted as emails (or letters attached to emails).

Respondents were also asked to identify themselves based on whether they were responding as an individual or on behalf of an organisation. Responses received by email did not necessarily identify as an individual or an organisation but were assigned to one of these categories based on engagement with the respondent. There was a slightly larger proportion of responses by or on behalf of individuals than organisations.

|  |  |
| --- | --- |
| **Respondent type** | **Responses** |
| Individual | 287 |
| Organisation | 266 |
| **Total** | **553** |

Figure 1: Breakdown by respondent

### Breakdown by respondent (individuals)

Respondents who were speaking on behalf of an individual were asked to self-identify into further categories. Those with over 10 responses are displayed in the table below. If fewer than 10 responses were received for any given category then these responses were included in the ‘Other’ category. Some respondents did not provide an answer to this further question, hence the total of the responses in Figure 2 is lower than that shown in Figure 1. One response where two selections were made was excluded as an invalid response.

|  |  |
| --- | --- |
| **Respondent type** | **Responses** |
| Carer of somebody using health and social care services | 71 |
| CQC employee | 12 |
| Expert by Experience | 16 |
| Health or social care employee | 125 |
| Member of the public/person who uses health or social care services | 41 |
| Other | 20 |
| **Total** | **285** |

Figure 2: Breakdown by respondent (individuals)

### Breakdown by respondent (organisations)

For respondents who indicated that they were responding on behalf of an organisation, they were then asked to categorise said organisation. Those with over 10 responses are displayed in the table below, whereas those with fewer than 10 responses were included in the ‘Other’ category. Again, not all respondents who identified themselves as responding on behalf of an organisation gave an answer for this question, hence the total in the table below is lower than that in Figure 1. The vast majority (over 80%) of responses were from representatives of health or social care providers. The only other category with over 10 respondents was ‘Voluntary and community sector organisation representative’.

|  |  |
| --- | --- |
| **Respondent type** | **Responses** |
| Health or social care provider | 217 |
| Voluntary or community sector organisation representative | 20 |
| Other (including Trade body or membership organisation for service providers) | 26 |
| **Total** | **263** |

Figure 3: Breakdown by respondent (organisations)

### Breakdown by respondent (sectors)

Separate to the previous questions, respondents were also asked to identify which sector they work in, or are most closely associated with.

361 respondents provided an answer to this question. This was comprised of 246 organisations and 122 individuals, meaning 92% of organisations provided this information compared to 43% of individuals.

The two most common responses were both subgroups of the adult social care sector, collectively making up over 75% of the total responses.

|  |  |
| --- | --- |
| **Respondent type** | **Responses** |
| Acute Hospital – NHS | 19 |
| Adult social care – community based/homecare | 49 |
| Adult social care – residential or nursing care home | 228 |
| Hospice service | 23 |
| Other (including ambulance services and community health services) | 49 |
| **Total** | **368** |

Figure 4: Breakdown by respondent (sectors)

# Visits in

Question 1 asked:

**‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to facilitate people using their services to receive visits from people they want to see?’**

Respondents could select one of five options ranging from ‘strongly agree’ to ‘strongly disagree’.

They were then invited to provide any further comments in a free text box.

## Level of agreement

As shown in Figure 5, overall, most respondents to question 1 (78%[[1]](#footnote-2)) agree or strongly agree that the guidance clarifies requirements on providers to facilitate visits.

Figure 5: ‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to facilitate people using their services to receive visits from people they want to see?’ (n=541)

Question 1 is answered by 284 respondents who identify themselves as an individual and 258 who are responding on behalf of an organisation. Organisations are more likely to strongly agree, whilst individuals are proportionally higher across all other responses, including disagree and strongly disagree, as shown in Figure 6.

Figure 6: ‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to facilitate people using their services to receive visits from people they want to see?’ broken down by respondent type

When further broken down, the responses from individuals show that carers are least likely to agree or strongly agree. However, that still leave almost two thirds of carers (63%) who agree or strongly agree (as shown in Figure 7). CQC employees are the most likely to disagree or strongly disagree (17%) but the relatively small number of responses in this category means the variance between this group and others is unlikely to be significant.

Figure 7: ‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to facilitate people using their services to receive visits from people they want to see?’ broken down by individual

Figure 8 shows the breakdown of responses from organisations: 17% of voluntary and community sector representatives disagree or strongly disagree that the guidance clarifies requirements on providers to facilitate visits, compared to 4% of health or social care providers and 4% from the ‘Other’ category.

Figure 8: ‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to facilitate people using their services to receive visits from people they want to see?’ broken down by organisation

Looking at the sector breakdown (Figure 9*)*, 95% of those who work in or are most closely associated with hospice care agree or strongly agree that the guidance clarifies requirements on providers to facilitate visits, whilst the remainder neither agree not disagree.

Meanwhile, 10% of those from ‘Other’ sectors disagree or strongly disagree – this compares to no more than 5% in any of the named sectors.

Figure 9: ‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to facilitate people using their services to receive visits from people they want to see?’ broken down by sector

## Discussion

### Survey

Positive views

Reflecting the pattern observed in the quantitative data, many respondents comment positively on the proposed guidance. Many do so in general terms, offering support for the principle that people who use services should be able to have visitors, whilst several say that the guidance provides clarity around allowance of in-person visits. Several also link this to their own experiences, including their experiences of the restrictions related to the Covid-19 pandemic, whilst several say that visits are important for the wellbeing and quality of life of people who use services.

A few respondents suggest that this guidance could reduce providers’ use of blanket rules to restrict visiting. Small numbers of respondents say that the guidance supports person-centred care, enables standardisation of practice around visiting, is transparent and supports personal choice and the right of people who use services to make their own choices.

Concerns

Several respondents challenge the use of specific words or phrases within the guidance, including ‘reasonably practical’, ‘end of life’, ‘safe visiting’ and, most notably, ‘exceptional circumstances’ (see Section 8.2). They say that these terms require further clarification. A few respondents, meanwhile, say that elements of the guidance are subjective or open to interpretation without necessarily commenting on specific words of phrases. Furthermore, several respondents argue any ambiguity or lack of clarity could enable providers to restrict visiting, or otherwise expect scepticism that providers would comply with a requirement to enable visiting in all but exceptional circumstances.

However, some respondents feel that limitations or restrictions are necessary in order to control infections and limit transmission of disease. Some also say that allowing an increased level of visiting could lead to a negative impact for other people who use services due to increased disturbance or reduced privacy.

Meanwhile, some respondents say that the guidance has not been written in a way that is clear or uses clear English, whilst a few say that the guidance does not adequately recognise the difference between different care settings, including care homes, hospices and hospitals.

A few respondents say the guidance is unnecessary or redundant as there is already existing guidance in place.

Other concerns that small numbers of respondents raise include:

* Inconsistency within the guidance, including inconsistent use of the term ‘visitor’;
* A need for safeguarding considerations to protect people who use services;
* A need for safeguarding considerations to protect visitors, including young children;
* The stated exclusion of accommodation for substance misuse treatment from the guidance and the restrictions which could be placed on those being treated for substance misuse;
* Potential gender considerations – e.g. concerns about male visitors to a female ward or bay;
* Who will fund the implementation of this guidance;
* How to ensure patients are not accepting restrictions because of a concern over their place within a home;
* Whether organisations will keep proper records; and
* How disputes between different parties could be resolved at speed.

Clarifications and suggestions

Several respondents say that people who use services should be able to choose who visits them, whilst several others seek clarification or further information in specific areas, which include:

* Clarification of what would happen if a local authority made a safeguarding recommendation to restrict visiting;
* Examples of what constitutes ‘reasonably practical’;
* Clarification of arrangements for those who lack capacity;
* Clarification of arrangements for learning disabled visitors;
* The responsibilities of visitors and what could be required of them;
* Clarity on whether providers retain the right to limit visiting;
* How the safety of people who use services can be the focus of this guidance;
* Additional training for staff which recognises cultural considerations;
* Provision of Easy Read guidance or a helpline to improve accessibility;
* Whether staffing levels constitute a basis for restricting visiting; and
* Alignment of the guidance with the NHS’s evolving care partner policy.

### Focus groups and workshops

In terms of their experiences to date, participants say that visiting people in hospitals and care homes is beneficial, both for patients or residents and their visitors, reflecting the views of survey respondents. For some carers taking part in the focus groups the ability to visit cared for people is seen as a necessity, whilst some younger participants say they have engaged with other patients on wards where their family members have been staying, precisely because they recognise the value between patients and visitors.

Where participants have positive experiences these generally involve services being flexible and facilitating privacy, particularly in ICU or hospice settings. However, participants say that visiting rules often vary and staff do not always adhere to these rules. Some participants had experienced a perceived lack of flexibility, including visiting rule restrictions. At times these visiting rule restrictions are not perceived to make sense, but at other times this is not the case. Some carers report that staff gave them more flexibility as they became familiar with both patient and visitor needs. However, a small number of participants from ethnic minority backgrounds feel they lost confidence in hospitals due to their experience of trying to visit relatives in hospital during Covid-19 restrictions – they welcome the guidance but do not automatically trust NHS services to follow it.

More broadly, participants say that the wording of the guidance is not always felt to be strong enough, with words like ‘should’ giving providers ‘get outs’. Some feel that asking services to follow the guidance could place additional pressure on staff, but some carers argue that facilitating visiting arrangements with carers could reduce staff workload. Participants believe there is a need to strike a balance between implementing the fundamental standard but also allowing staff to provide the care patients need.

SURP members want to understand how the guidance should be implemented in practice and what people should expect from providers. They think there should be tools to support providers in making this happen and some scenarios which demonstrate what good looks like in this context. They also say that there are instances in a mental health context where visitors can be part of a patient’s care plan and question whether the guidance addresses this or arrangements for DOLS representatives making visits.

# Visits out

Question 2 asked **‘Do you agree that the guidance clarifies the requirements on care homes to make sure people using their service are not discouraged from going out on visits from the care home?’**

Respondents could select one of five options ranging from ‘strongly agree’ to ‘strongly disagree’.

They were then invited to provide any further comments in a free text box.

## Level of agreement

Overall, most respondents to Question 2 (85%) agree or strongly agree that the guidance clarifies the requirement not to discourage people from going out on visits (as shown in Figure 10).

Figure 10: ‘Do you agree that the guidance clarifies the requirements on care homes to make sure people using their service are not discouraged from going out on visits from the care home?’ (n=532)

Question 2 is answered by 285 respondents who identify themselves as individuals and 253 who are responding on behalf of an organisation. Organisations are more likely to strongly agree, whilst individuals are more likely to agree (as shown in Figure 11).

Figure 11: ‘Do you agree that the guidance clarifies the requirements on care homes to make sure people using their service are not discouraged from going out on visits from the care home?’ broken down by respondent type

When further broken down (see Figure 12), respondents who identify as ‘Experts by Experience’ are least likely to agree or strongly agree (69%) and the most likely to disagree or strongly disagree (19%).

Figure 12: ‘Do you agree that the guidance clarifies the requirements on care homes to make sure people using their service are not discouraged from going out on visits from the care home?’ broken down by individual

The breakdown of responses from organisations (see Figure 13) shows the highest level of disagreement or strong disagreement amongst voluntary or community sector organisations (17%). No other organisation category is above 5% for this metric. Voluntary and community sector organisations are also the only group below 90% for agree or strongly agree (83%).

Figure 13: ‘Do you agree that the guidance clarifies the requirements on care homes to make sure people using their service are not discouraged from going out on visits from the care home?’ broken down by organisation

Looking at the sector breakdown (see Figure 14), the greatest proportion of disagree and strongly disagree (11%) is seen amongst the ‘Other’ category respondents.

Figure 14: ‘Do you agree that the guidance clarifies the requirements on care homes to make sure people using their service are not discouraged from going out on visits from the care home?’ broken down by sector

## Discussion

### Survey

Positive views

Reflecting the pattern observed in the quantitative data, many respondents comment positively on the proposed guidance. Most often they do so in general terms, suggesting that the guidance is necessary, or otherwise express support for the principle of visits out being encouraged. Several relate this support or positivity to their own experiences, past or present, often suggesting that this is already their experience of visiting and should continue, or describing in negative terms their experience of restrictions put in place during the Covid-19 pandemic.

Furthermore, some say that the guidance provides clarity on the principle of pragmatically supporting visits out and avoiding discouragement of this, including indirect forms of discouragement such as prolonged isolation upon return. Meanwhile, a few say that visits out support improved wellbeing or quality of life and a small number suggest that this supports personal choice and the principle that someone should have the freedom to go out should they so wish.

Concerns

Several respondents, mostly adult social care providers or employees, mention financial considerations, particularly around the question of how to fund staffing if additional support is required to facilitate visits out. Of these, some specifically mention a need to charge 1-to-1 support or escort fees to cover these costs. A few respondents argue that the proposed legislation and guidance places additional pressure on providers in terms of workload, whilst some express concerns about where responsibility sits for risk assessment and safeguarding considerations covering the period of the visit out.

Conversely, some respondents express concern that the guidance gives providers opportunities to restrict or limit visiting opportunities and access to the community. An example would be one Covid-19 positive resident within a home preventing other residents from being allowed to participate in visits out. One respondent says that restrictions may be put in place ‘accidentally’ due to deprivation of liberty considerations.

Meanwhile, a few respondents say that the guidance is not necessary as it describes practices which already exist or which are covered by existing legislation and regulation.

Other concerns that small numbers of respondents raise include:

* The potential for visits out to confuse or otherwise negatively impact a resident;
* The willingness of residents to take part in visits out or the willingness of family members to support visits;
* A perceived lack of oversight or clear path for dispute resolution in the event of disagreement over appropriate action;
* Areas of the guidance which could be considered unclear or which would benefit from illustrative examples – e.g. what forms ‘discouragement’ of visits might take and what would constitute an ‘unnecessary restriction’ on returning from a visit;
* Specific wording choices which could be amended or strengthened to better reflect the legislation or remove opportunities to limit visits out – e.g. ‘should not’ changing to ‘must not’; and
* Whether staff have sufficient training to support visits out.

Clarifications and suggestions

Respondents make various suggestions around how the guidance could be improved or address additional areas. This often includes requesting clarifications around particular issues, such as:

* Best interest decisions where a person does not have capacity;
* Where national guidance would supersede this guidance (e.g. pandemic lockdowns) and where it should be viewed in conjunction;
* What would constitute a reasonable level of risk when facilitating visits out;
* Whether nursing homes are included in the categories of setting covered by the guidance;
* Whether or when residents or providers have the right to refuse visits out; and
* Commissioners’ roles and duties in supporting visits out.

A small number make broader suggestions, which include:

* Using a more positive wording and framing in the guidance – e.g. supporting and encouraging visits out;
* Ensuring individual circumstances are taken into account;
* Dedicated staff teams to support visits;
* Timetabling and advance notification of visits out;
* Enabling late returns to homes after social events;
* Consideration of cultural factors; and
* Seeking UK Health Security Agency guidance on infection control and visiting restrictions.

### Focus groups and workshops

None of the focus group participants have experience of making visits out of residential care homes.

Nonetheless, in relation to the guidance, they say that visits out could potentially raise safeguarding issues and there could be a tension between individual freedom and protecting individuals from risk of harm. Participants say every case should be assessed individually. However, some express an expectation that family should be included in decision-making whilst others assume that service providers would be liable for protecting residents from risk and should therefore retain decision-making responsibility.

One participant raises the question of capacity, and says there is a difference between risk assessing and assessing mental capacity which should be borne in mind. In general, participants find it difficult to understand how decision-making would work in these circumstances. They would like to understand the role of providers and families and, in particular, individuals with power of attorney.

Some SURP participants say that the guidance in this area shows an ambition to empower people and provides a better structure to support residents and patients. They say it is important that families and carers are involve in discussions and decision-making in all areas of visiting.

# Accompaniment

Question 3 asked **‘Do you agree that the guidance clarifies the requirements on hospitals and hospices to enable people to be accompanied by a family member, friend or advocate to appointments that do not require an overnight stay?’**

Respondents could select one of five options ranging from ‘strongly agree’ to ‘strongly disagree’.

They were then invited to provide any further comments in a free text box.

## Level of agreement

Overall, most respondents to question 3 (82%) agree or strongly agree that the guidance clarifies the requirements around enabling accompaniment (as shown in Figure 15).

Figure 15: ‘Do you agree that the guidance clarifies the requirements on hospitals and hospices to enable people to be accompanied by a family member, friend or advocate to appointments that do not require an overnight stay?’ (n=528)

Question 3 is answered by 283 respondents who identify themselves as an individual and 248 who are responding on behalf of an organisation. In line with previous questions, organisations are more likely to strongly agree whilst individuals are more likely to agree (as shown in Figure 16).

Figure 16: ‘Do you agree that the guidance clarifies the requirements on hospitals and hospices to enable people to be accompanied by a family member, friend or advocate to appointments that do not require an overnight stay?’ broken down by respondent type

When further broken down (see Figure 17), the responses from individuals show the lowest levels of agreement (agree and strongly agree) and the highest levels of disagreement (disagree and strongly disagree) amongst Experts by Experience (69% and 13% respectively) and carers (76% and 10%).

Figure 17: ‘Do you agree that the guidance clarifies the requirements on hospitals and hospices to enable people to be accompanied by a family member, friend or advocate to appointments that do not require an overnight stay?’ broken down by individual

The breakdown of responses from organisations (Figure 18) shows that providers are most likely to agree (85% including strongly) whilst voluntary or community sector organisations are most likely to disagree (12% including strongly).

Figure 18: ‘Do you agree that the guidance clarifies the requirements on hospitals and hospices to enable people to be accompanied by a family member, friend or advocate to appointments that do not require an overnight stay?’ broken down by organisation

Looking at the sector breakdown (Figure 19), there is wide variation in levels of agreement, ranging from 95% amongst hospice services to 75% for community-based adult social care services. The highest proportion of disagreement comes from sectors falling into the ‘Other’ category.

Figure 19: ‘Do you agree that the guidance clarifies the requirements on hospitals and hospices to enable people to be accompanied by a family member, friend or advocate to appointments that do not require an overnight stay?’ broken down by sector

## Discussion

### Survey

Positive views

Reflecting the pattern observed in the quantitative data, many respondents comment positively on the proposed guidance. Most often they do so in general terms, or otherwise express support for the principle of family members or other individuals close to the people who use services being able to accompany them to appointments. Several relate this to their own experience or the experience of people who use services, carers and relatives of accompanying or being accompanied to appointments. Some say that the guidance makes the requirements of the legislation clear.

Meanwhile, some respondents suggest that having a person to support with appointments is beneficial for wellbeing, comfort or stress reduction. Furthermore, a few argue that having someone to support with an appointment is important for accurate information sharing.

A small number of respondents suggest other potential benefits, including:

* Freeing up staffing as family members can accompany people;
* Providing familiarity for those with complex needs; and
* The guidance covering multiple settings, including care homes, hospices and hospitals.

Concerns

Several express scepticism that hospitals will allow people who use services to be accompanied to appointments, and therefore whether the guidance can be put into practice, sometimes referring to their personal experiences. One respondent suggests it is not clear what hospitals’ and hospices’ responsibilities are in this respect. Similarly, a few respondents say that hospital transport would not allow an accompanying person to travel, or they suggest that specialist transport might be needed.

Meanwhile, several respondents raise concerns about the potential impact of the guidance on staffing levels in care homes if they are required to accompany people who use services to appointments, or suggest that it is unclear if this would be expected. Relatedly, some respondents outline potential financial implications, including the cost of providing staffing, as well as who would be responsible for funding this and through what mechanism.

A few respondents also say that family members may not be in a position to provide accompaniment, or that they may not constitute an appropriate responsible person. Other concerns raised by a small number of respondents include the need to consider cultural factors such as language, the need to make providers aware of the regulations and guidance, and a lack of examples in the guidance.

Clarifications and suggestions

A few respondents request specific clarifications on particular points of the guidance, including the accompaniment of people who use services in specific circumstances (e.g. young people who turn 18 and whether they require parental accompaniment, learning disabled people who require spousal support, or those under the care of mental health services whose disorders may be exacerbated without accompaniment) or circumstances where accompaniment may not be appropriate (e.g. safeguarding those at risk of domestic abuse). Other specific queries relate to:

* What is meant by the use of the term ‘advocate’;
* Which individuals can accompany people who use services (and whether these people can by under 18);
* The circumstances in which it might be appropriate for multiple people to accompany an individual;
* The difference between accompaniment as a preference and essential support and how this is represented in the guidance;
* The reason for a differentiation between overnight stays and stays which are not overnight, whether the guidance applies to the former circumstances and how overnight stays can be facilitated for those providing accompaniment;
* The strength of wording around the extent to which providers are obligated to enable accompaniment;
* Whether the scope of the guidance includes ensuring private rooms for confidential conversations; and
* Whether the guidance applies across all care settings.

Other suggestions include:

* Updated leaflets and appointment letters, and provision of accessible information;
* Use of Hospital Passports and Communication Passports;
* Highlighting conditions where accompaniment is particularly important – e.g. those with dementia or communication difficulties;
* Ensuring staff provide accompaniment where no family member or other appropriate person is available; and
* That the guidance should not be mandatory.

### Focus groups and workshops

Accompanying someone to appointments is perceived to be straightforward at present, with participants only reporting a small number of restrictions, such as not being able to accompany a family member in an ambulance during Covid-19 restrictions or not being able to accompany a family member during a tooth extraction. Positive experiences involve services being flexible, and SURP participants feel there are significant benefits in being accompanied for appointments.

Due to the fact that accompaniment is perceived by participants to be relatively straightforward at present, there are few comments on the guidance around accompaniment. One participant with experience of restrictions says that any limitations should be clearly explained, whilst most of the SURP participants say that the language should be strengthened from ‘should’ to ‘must’.

SURP participants also say the guidance should clarify whether being accompanied means being supported by a member of staff from a residential setting or by a family member or carer. They raise instances when they would have preferred a family member but were not given that option.

# Meeting preferences

Question 4 asked **‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to meet the preferences of the person using the service when facilitating visits?’**

Respondents could select one of five options ranging from ‘strongly agree’ to ‘strongly disagree’.

They were then invited to provide any further comments in a free text box.

## Level of agreement

Overall, most respondents to question 4 (73%) agree or strongly agree that the guidance clarifies the requirement to meet preferences (as shown in Figure 20). This is less than the proportion of respondents who agree or strongly agree with other questions, but this may be due to some extent to the labelling error on this question in the survey (see 3.1.1). Similarly, 14% disagree or strongly disagree – almost double any other question.

Figure 20: ‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to meet the preferences of the person using the service when facilitating visits?’ (n=534)

Question 4 is answered by 281 respondents who identify themselves as an individual and 257 who are responding on behalf of an organisation. In line with previous questions, organisations are more likely to strongly agree whilst individuals are more likely to agree (as shown in Figure 21).

Figure 21: ‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to meet the preferences of the person using the service when facilitating visits?’ broken down by respondent type

When further broken down (see Figure 22), the responses from individuals show that half of Experts by Experience agree or strongly agree, compared to 82% of CQC employees and 76% of the public. The highest level of disagreement also comes from Experts by Experience.

Figure 22: ‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to meet the preferences of the person using the service when facilitating visits?’ broken down by individual

The breakdown of responses from organisations (see Figure 23) shows the highest level of agreement (80% including strongly) amongst providers. 28% of voluntary or community sector organisations disagree or strongly disagree that the guidance clarifies the requirement to meet preferences.

Figure 23: ‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to meet the preferences of the person using the service when facilitating visits?’ broken down by organisation

Looking at the sector breakdown (see Figure 24), NHS hospitals are least likely to agree (61% including strongly) and the joint most likely to disagree (22% including strongly) that the guidance clarifies the requirement to meet preferences.

Figure 24: ‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to meet the preferences of the person using the service when facilitating visits?’ broken down by sector

## Discussion

### Survey

Positive views

Reflecting the pattern observed in the quantitative data, many respondents comment positively on the proposed guidance. Several do so in general terms, whilst several say that an individual’s personal choices should be respected provided they have capacity to make that decision. A few respondents say that the guidance is clear that the preferences of individuals should be supported and a few say that this is a person-centred approach, whilst a small number describe negative experiences they have had around this in the past.

Concerns

Several respondents say that the guidance is too subjective and open to interpretation. Furthermore, several argue that providers, particularly hospitals but also care home settings, may not accommodate the preferences of people who use services. They say that providers could put restrictions in place that would allow them to limit visits in, visits out, and accompaniment to appointments.

Several respondents also express concerns about how the preferences of people who use services would be determined. They suggest that people who use services may not be able to freely express what their preferences are, may not have capacity to make that decision, or may not make decisions in their own best interest. One such respondent believes that an individual may have to be asked for their views more than once as they may change their mind, whilst another says that determination of capacity can be decision-specific, citing the Mental Capacity Act.

Meanwhile, a few respondents feel that services are currently understaffed and may not be able to support the provisions laid out in the guidance, whilst a few believe that the guidance does not sufficiently emphasise person-centred and individualised care. However, a few suggest that the guidance covers areas already covered by existing guidance, or outlines practices which already take place.

Other concerns raised by a small number of respondents include:

* How the preferences of children and young people who are Gillick competent should be accommodated and whether parental accompaniment is required;
* What considerations would be required for infection control purposes and whether the guidance could be implemented safely;
* How the preferences of one individual may conflict with the wishes of another (e.g. where visiting may be disruptive to other people who use a service within a ward setting);
* How disputes could be resolved and decisions documented;
* The costs to providers of assigning staff to accompany people who use services, or the costs which may be passed on to service uses if they do not have anyone to accompany them;
* Concerns about the clarity of the wording of the guidance; and
* Potential variability in the operating circumstances of different care settings.

Clarifications and suggestions

A few respondents request clarifications or make specific suggestions about the guidance, which include:

* Clarification of the difference between accompaniment as a preference and essential support, and ensuring the former is supported in addition to the latter;
* Specific stated role for a ‘family carer’ within the guidance;
* How best to ensure decisions around visiting preferences are fully documented (including use of care plans, risk assessments and best interest decisions);
* Clarification of human rights-based decision-making as a term;
* Inclusion of illustrative examples;
* Clarification of arrangements for people who use services who do not have capacity;
* Setting-specific guidance;
* Consideration of cultural factors as part of understanding preferences;
* Providing staff with additional training;
* Ensuring integrated care systems (ICSs) engage and communicate with care providers to ensure preferences and needs are being met; and
* Circulating guidance to all hospital staff.

### Focus groups and workshops

SURP participants say that scenarios or examples would help providers and the public understand what good looks like, and also say there should be more clarification of who visitors might be (i.e. family and friends but also advocates, solicitors, and those supporting with care plans). They would like more detail for mental health patients in psychiatric settings, and also raise how alternatives can be explored if first choice visiting arrangements are not possible, as well as ensuring people are informed about how long it will take for decisions to be made.

A small number of other participants raise the issue of Power of Attorney (POA) and the role of those with POA in any decision-making process. They say the guidance should recognise that people may have to speak on behalf of loved ones if necessary.

# Exceptional circumstances

Question 5 asked **‘Do you agree the guidance makes clear that decisions on exceptional circumstances must be based on the health, safety and welfare of people using the service and other people on the premises?’**

Respondents could select one of five options ranging from ‘strongly agree’ to ‘strongly disagree’.

They were then invited to provide any further comments in a free text box.

## Level of agreement

Overall, most respondents to question 5 (79%) agree or strongly agree that the guidance is clear around exceptional circumstances (as shown in Figure 25).

Figure 25: ‘Do you agree the guidance makes clear that decisions on exceptional circumstances must be based on the health, safety and welfare of people using the service and other people on the premises?’ (n=530)

Question 5 is answered by 280 respondents who identify themselves as an individual and 255 who are responding on behalf of an organisation. In line with previous questions, organisations are more likely to strongly agree (as shown in Figure 26).

Figure 26: ‘Do you agree the guidance makes clear that decisions on exceptional circumstances must be based on the health, safety and welfare of people using the service and other people on the premises?’ broken down by respondent type

When further broken down (see Figure 27), the responses from individuals show that the lowest levels of agreement and the highest levels of disagreements are amongst Experts by Experience (63% and 13% respectively) and carers (67% and 15%).

Figure 27: Do you agree the guidance makes clear that decisions on exceptional circumstances must be based on the health, safety and welfare of people using the service and other people on the premises?’ broken down by individual

The breakdown of responses from organisations (see Figure 28) shows that there is a greater level of agreement amongst providers (86%).

Figure 28: Do you agree the guidance makes clear that decisions on exceptional circumstances must be based on the health, safety and welfare of people using the service and other people on the premises?’ broken down by organisation

Looking at the sector breakdown (see Figure 29), the level of agreement with question 5 is broadly consistent across the different sectors, ranging from 78% for acute hospitals to 86% for hospice services.

Figure 29: Do you agree the guidance makes clear that decisions on exceptional circumstances must be based on the health, safety and welfare of people using the service and other people on the premises?’ broken down by sector

## Discussion

### Survey

Positive views

Reflecting the pattern observed in the quantitative data, many respondents comment positively on the proposed guidance. Several do so in general terms or otherwise say that restrictions should occur only in exceptional circumstances, whilst some say that the guidance provides clarity on this question. A few respondents base their support in their own experience, typically referencing the Covid-19 pandemic. Meanwhile, a few feel the approach could be beneficial for the wellbeing or safety of people who use services, and a small number are positive about the guidance including information on how to record decisions. One respondent specifically says that it is positive that the guidance references a person’s mental capacity and ability to give consent, as well as the Mental Capacity Act and Mental Health Act.

Concerns

Many respondents suggest that the guidance is subjective, ambiguous, unclear or open to interpretation, often specifically referring to the ‘exceptional circumstances’ phrasing, which is commonly felt to be too broad. Several respondents, around half of whom are carers, argue that providers may exploit this perceived ambiguity in order to restrict visiting or to avoid acting on the preferences of people who use services where it is in the interests of providers to do so. A few respondents reference how providers interpreted national guidance during the Covid-19 pandemic and lockdowns, whilst a small number of respondents express concern that the ‘exceptional circumstances’ phrasing could lead to restrictions being placed on those with physical, mental or learning disabilities. Respondents also challenge words or phrases including ‘risk’ and ‘end of life’ and suggest that these require further definition or clarification.

Conversely, some respondents express concern that the guidance does not sufficiently emphasise the safety and wellbeing of people who use services, relatives, carers and staff. Similarly, a few respondents comment on infection control measures, suggesting that providers should be able to bar unwell visitors or that the Health Protection Agency should provide advice to families. A few respondents question the dispute resolution process which would be in place if there were conflicts between different people who use services or between people who use services and providers.

Other concerns which a small number of respondents raise include:

* A perceived lack of clarity over what happens if a person lacks mental capacity;
* How benefits are weighed against risks when personal preferences come up against safeguarding considerations;
* A perceived lack of distinction between different care settings in the guidance;
* Possible duplication within this legislation and guidance of the contents of the Mental Capacity Act;
* The extent to which visiting may affect other people who use services;
* Potential restrictions which the guidance may place on family visiting;
* The possible insurance implications of not following government guidelines; and
* The practicality of implementing the guidance when individuals face potentially long waits for DOLS assessments.

Clarifications and suggestions

Several respondents request examples of what would constitute ‘exceptional circumstances’. Some also request specific clarifications around particular wording or the potential impact of the guidance on particular groups (including those with disability or those detained under the Mental Health Act).

Other suggestions which a small number of respondents raise include:

* Additional training to support HCPs undertaking risk assessments;
* Allowing families to access care home residents on the same basis as staff;
* Reviewing the guidelines on an annual basis;
* Making all decisions subject to regular review;
* Risk assessing all visits out or appointments;
* Referring to the Patient and Carer Race Quality Framework in the guidance;
* Creation of a contract between a provider and person who uses that service which sets out expectations around visits and accompaniment;
* Explaining in the guidance that ‘exceptional circumstances’ may vary by setting and that examples may therefore not be appropriate; and
* Records being kept to support decisions, and made available to families.

### Focus groups and workshops

SURP participants in particular raise the language used in the guidance and feel strongly that the phrase ‘exceptional circumstances’ is ambiguous and could be used by providers to restrict visiting unnecessarily. This reflects a concern which is expressed in responses to the survey. They are concerned that where controls are used to protect everybody, individual needs and preferences can get lost, and say there should be a focus on mitigating risks rather than eliminating them completely. In terms of the guidance, they suggest:

* More specificity around the term ‘exceptional circumstances’;
* Use of examples or scenarios to make this clear; and
* Inclusion of requirements around how often a provider would have to review any restrictions on visiting.

More widely, participants believe that services should have the power to manage visiting in the interests of infection control. This view is influenced by experiences of Covid-19 restrictions.

One participant expresses concern about potential safeguarding implications of restricting visiting.

Record keeping is viewed as an important part of the process, but some participants express concern about whether this could create an additional burden for staff.

# Other feedback

Question 6 asked **‘Do you have any other suggestions for improving our guidance?’**

A free text box was provided for respondents to complete.

## Discussion

### Survey

Positive views

Several respondents comment positively on the proposed guidance. They sometimes do so in general terms, or say that the guidance has helped provide clarity on issues such as visiting. Some respondents relate this to their own experiences, often around visiting family members during the Covid-19 pandemic, whilst some respondents set out the importance of visiting for the wellbeing and quality of life of people who use services.

A few respondents say that the guidance is person-centred or focused on the needs of the individual, whilst a small number believe individuals should have autonomy or control over their lives. One respondent says that removing individuals’ rights to make choices about risks or be involved in decision-making would run contrary to Article 8 of the Human Rights Act 1998 and Section 4 of the Mental Capacity Act 2005.

A small number of respondents raise other potential benefits, including increased standardisation or consistency, a clear expectation around record keeping, and an explicit statement that visits should always be permissible for those at end of life. One respondent welcomes the guidance that mental capacity should be taken into account in any assessment.

Concerns

Several respondents make wider criticisms of CQC or of government policy which sit outside the scope of this consultation. Of the remainder, many echo concerns which are covered in earlier sections, but do so in more generalised terms. For example, some respondents say that they feel the guidance is unclear, wordy or difficult to read, whilst some feel that is does not sufficiently recognise the distinction between different settings, including hospitals, hospices and care homes. A few respondents believe there is a gap in the guidance for supported living settings, with one specifically suggesting that the guidance does not go far enough on Extra Care, Supported Living Schemes and Shared Lives.

Some respondents also challenge the decision-making process or question what appeals or dispute resolution process will be in place. Meanwhile, a few respondents question whether providers have sufficient staffing to be able to implement the guidance, or raise concerns about the potential impact of any additional paperwork on staffing, with a small number relating this to funding constraints.

A few respondents raise other concerns, which include:

* The guidance being unnecessary as it mirrors existing best practice or is ‘common sense’;
* Providers failing to abide by the guidance;
* Guidance not being compulsory;
* Potential negative impacts of visitors, including disruption for other people who use services or threats and intimidation towards staff;
* Possible need for nighttime visiting restrictions (for reasons including security of controlled drugs and availability of staff);
* Considerations for people who use services without family or friends;
* A lack of provisions in the guidance around equity for ethnic minorities;
* Absence of the Human Rights Act (HRA) from any statements of relevant related legislation;
* A need to balance visiting against any infection control risks;
* Clarity around ‘virtual’ visiting options such as telephone or online conversations;
* How to resolve family disagreements over visiting;
* Lack of information sharing preventing preferences or needs being properly understood; and
* Use of the term ‘gender’ rather than ‘sex’ in the equality impact assessment.

Clarifications and suggestions

Many respondents seek clarifications on specific areas of the guidance. These often echo clarifications summarised in earlier sections of this report. Requested clarifications include:

* Details of the responsibilities which sit with providers;
* Clarity over any paperwork requirements associated with this guidance;
* Specificity over what constitutes ‘safe’;
* An outline of how this guidance would interact with government guidance – e.g. in the event of a pandemic;
* Clarification of whether this guidance supersedes protected mealtimes;
* More detail on where someone might be part of a care plan and not just a ‘visitor’;
* Further information about the role of commissioning; and
* Use of the term ‘reasonable adjustments’ rather than ‘reasonable steps’ to reflect the language of the Equality Act.

Several respondents request that the guidance and any additional information should be shared with providers and statutory agencies as well as with families, carers and friends, in order to maximise awareness of the legislation around visiting. Several respondents also say that illustrative examples would help with understanding of the guidance and provide further clarity. Furthermore, several respondents make suggestions around potential processes for oversight and dispute resolution, which include provision of information about complaints procedures and PALS.

Some respondents feel that the guidance should reflect the language and principles of the Mental Capacity Act (MCA) and should specify the need for collaborative working between people who use services, providers and carers or trusted others. One respondent says the MCA is often misused in order to place restrictions on people who use services, whilst another says the guidance refers to the Mental Capacity Act 2006 and suggests this is an error.

Some respondents feel that staff may require additional training or upskilling to support the implementation of this guidance, whilst some respondents make suggestions around equalities considerations. They say impact assessments should be carried out or that the guidance should refer to the public sector equalities duty, the Equalities Act and the Human Rights Act.

Other suggestions put forward include:

* A helpline to discuss the changes;
* An explicit requirement to make visitors feel welcome;
* Unrestricted visiting at all times for named relatives;
* Provider use of accreditations schemes such as ISO9001;
* Removal of visiting times and replacement with an appointment system;
* Visiting times to coincide with doctors’ visits to enable family support;
* Creation of Easy Read versions of the guidance;
* Including carers in decision-making, especially for people with dementia;
* Making requirements related to Power of Attorney clear for the public;
* Dissemination of the CQC whistleblowing policy;
* Ensuring accompanying staff members can facilitate improved communication;
* Specific references in the guidance to the role of ICSs;
* Creation of a Visiting Plan for all people who use services;
* Recognition of staff wellbeing;
* Hospital facilities for overnight stays for relatives or carers;
* Publication of statistics covering the number of times providers have restricted visiting; and
* Further information around closed cultures.

### Focus groups and workshops

Participants have relatively little experience of restrictions to visiting or to accompanying people to appointments, and are therefore surprised the guidance is being issued. Older participants in particular have experience of greater levels of restriction in the past. However, most participants understand the rationale for the guidance once they have had it explained. They question whether the guidance would be superseded by restrictions like those seen in the Covid-19 pandemic, and whether the public could use the guidance to challenges or report providers who are not following it.

Participants suggest that if the guidance is partly intended to help people using health and social care services and their families, friends or advocates know what to expect, then a simplified version is required. They say a simplified version could help hold services to account.

Participants also suggest that they guidance may need to differ for different services (e.g. hospitals and care homes) and that it could touch on the value of providing visitors with privacy.

# Appendices

## Appendix 1: Survey text

**About you**

For the following questions ‘about you’ we understand that more than one option may apply. However, please select the one that best describes how you are responding today.

Which of the following best describes the capacity in which you are responding today:

* I am responding as an individual
* I am responding on behalf of an organisation

*If responding on behalf of an organisation:*

I am completing this form as a:

* Health or social care commissioner
* Health or care service provider (go to list of service types)
* Regulator or arm’s length body
* Trade body or membership organisation for service providers
* Voluntary or community sector organisation representative
* Other

If you selected ‘Other’ please give a short description of your organisation if possible

Please tell us the name of the organisation you are responding on behalf of:

*If responding as an individual:*

* Carer of somebody using health and social care services
* CQC employee
* Health or care service employee (go to list of service types)
* Expert by Experience
* Member of the public/person who uses health or social care services
* Parliamentarian/Councillor
* Student/researcher
* Other

If you selected ‘Other’ please give a short description of your role if possible

Please check the box below if you do not want us to publish any of your comments (we will not include any personal details).



Service type list (only for those selecting provider/employee above)

Which of the following best describes the sector you work in or are associated with

* Acute Hospital – Independent
* Acute Hospital – NHS
* Ambulance service – Independent
* Ambulance service – NHS
* Adult social care – community based/homecare
* Adult social care – residential or nursing care home
* Community health service – NHS and independent
* Dental practice
* GP service
* Hospice service
* Independent consulting doctor/independent clinic
* Substance Misuse Service
* Other

If you selected ‘Other’ please give a short description of the sector you are associated with

**Consultation questions**

**Question 1**: Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to facilitate people using their services to receive visits from people they want to see?

Strongly disagree/Disagree/Neither agree nor disagree/Agree/Strongly agree

Please provide any further comments (free text)

**Question 2**: Do you agree that the guidance clarifies the requirements on care homes to make sure people using their service are not discouraged from going out on visits from the care home?

Strongly disagree/Disagree/Neither agree nor disagree/Agree/Strongly agree

Please provide any further comments (free text)

**Question 3**: Do you agree that the guidance clarifies the requirements on hospitals and hospices to enable people to be accompanied by a family member, friend or advocate to appointments that do not require an overnight stay?

Strongly disagree/Disagree/Neither agree nor disagree/Agree/Strongly agree

Please provide any further comments (free text)

**Question 4:** Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to meet the preferences of the person using the service when facilitating visits?

Strongly disagree/Disagree/Neither agree nor disagree/Agree/Strongly agree

Please provide any further comments (free text)

**Question 5:** Do you agree the guidance makes clear that decisions on exceptional circumstances must be based on the health, safety and welfare of people using the service and other people on the premises?

Strongly disagree/Disagree/Neither agree nor disagree/Agree/Strongly agree

Please provide any further comments (free text)

**Question 6:** Do you have any other suggestions for improving our guidance?

(Free text)

**Helping us to monitor equality diversity and human rights**

How old are you?

* 17 or below
* 18-24
* 25-34
* 35-44
* 45-54
* 55-64
* 65-74
* 75-84
* 85+
* I would prefer not to say

How would you describe your ethnic origin?

* Arab
* Asian or Asian British – Bangladeshi
* Asian or Asian British – Chinese
* Asian or Asian British – Indian
* Asian or Asian British – Pakistani
* Any other Asian background
* Black or Black British – African
* Black or Black British – Caribbean
* Any other Black background
* Mixed Asian and White
* Mixed Black African and White
* Mixed Black Caribbean and White
* Any other Mixed or multiple ethnic background
* White British: English/Northern Irish/Scottish/Welsh
* White Irish
* Irish Traveller or Gypsy
* Roma
* Any other White background
* I would prefer not to say

If you ticked any other ethnic background please specify (free text)

Do you consider yourself to have a disability, impairment or long-term health condition?

* Yes (please answer the next question)
* No
* I would prefer not to say

Which of these statements apply to you? Please select all that apply

* I have a sight impairment (I am blind or partially sighted)
* I have a hearing impairment (I am deaf or hard of hearing)
* I have a physical impairment (for example difficulty walking or using my hands)
* I have a learning disability
* I am an autistic person
* I have a mental health condition
* I have another type of impairment, disability or long term condition not listed above

If you have another type (not selected) please specify if you wish [free text]

How would you describe your gender?

* Male
* Female
* Other
* I would prefer not to say

Is your gender identity the same one you were assigned at birth?

* Yes
* No
* I would prefer not to say

Which of the following options best describes how you think of yourself?

* Bisexual
* Gay man
* Heterosexual
* Lesbian
* I would prefer not to say
* Other

Which religion or belief do you most identify with?

* Atheism
* Buddhism
* Christianity (including Church of England, Catholic, Protestant and all other Christian denominations)
* Hinduism
* Islam
* Judaism
* No religion
* Sikhism
* I would prefer not to say
* Other: please specify

## Appendix 2: Closed question data tables

### Respondent breakdowns

#### Response channel

Table 1: Summary of responses by channel

|  |  |
| --- | --- |
| **Response channel** | **Number of responses** |
| Online | 536 |
| Easy Read | 12 |
| Email | 5 |
| **Total** | **553** |

#### Response capacity

Table 2: Summary of responses by response capacity (ie. as an individual or on behalf of an organisation)

|  |  |
| --- | --- |
| **Response capacity** | **Number of responses** |
| Individual | 287 |
| Organisation | 266 |
| **Total** | **553** |

#### Individual response categories

Table 3: Summary of responses from individuals by sub-category

|  |  |
| --- | --- |
| **Response channel** | **Responses** |
| Carer of somebody using health and social care services | 71 |
| CQC employee | 12 |
| Expert by Experience | 16 |
| Health or social care employee | 125 |
| Member of the public/person who uses health or social care services | 41 |
| Other | 18 |
| **Total** | **283** |

#### Organisational response categories

Table 4: Summary of organisational responses by sub-category

|  |  |
| --- | --- |
| **Response channel** | **Responses** |
| Health or social care provider | 217 |
| Trade body or membership organisation for service providers | 7 |
| Voluntary or community sector organisation representative | 20 |
| Other | 15 |
| **Total** | **259** |

#### Sector breakdown

Table 5: Summary of responses by sector

|  |  |
| --- | --- |
| **Response channel** | **Responses** |
| Acute Hospital – NHS | 19 |
| Adult social care – community based/homecare | 49 |
| Adult social care – residential or nursing care home | 228 |
| Ambulance service – Independent | 2 |
| Ambulance service – NHS | 1 |
| Community health service – NHS and independent | 9 |
| Hospice service | 23 |
| Other | 30 |
| **Total** | **361** |

### Question 1

‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to facilitate people using their services to receive visits from people they want to see?’

Table 6: Summary of all closed question responses to question 1

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Strongly agree** | **Agree** | **Neither agree nor disagree** | **Disagree** | **Strongly disagree** | **Total** |
| **Overall** | **238** | **187** | **78** | **18** | **21** | **542** |
| *Individuals* | *97* | *112* | *49* | *12* | *14* | *284* |
| Carer of somebody using health and social care services | 21 | 24 | 15 | 8 | 3 | 71 |
| CQC employee | 1 | 8 | 1 | 1 | 1 | 12 |
| Expert by experience | 3 | 8 | 3 | 1 | 1 | 16 |
| Health and social care employee | 48 | 50 | 18 | 2 | 5 | 123 |
| Member of the public/person who uses health or social care services | 17 | 14 | 8 | 0 | 1 | 40 |
| Other | 7 | 7 | 4 | 0 | 2 | 20 |
| *Organisations* | *141* | *75* | *29* | *6* | *7* | *258* |
| Health or social care provider | 117 | 65 | 23 | 3 | 6 | 214 |
| Voluntary and community sector representative | 8 | 7 | 0 | 2 | 1 | 18 |
| Other | 16 | 3 | 6 | 1 | 0 | 26 |
| *Sectors* | *177* | *116* | *43* | *8* | *11* | *355* |
| Acute Hospital – NHS | 9 | 4 | 4 | 0 | 0 | 17 |
| Adult social care – community based/homecare | 17 | 21 | 9 | 1 | 1 | 49 |
| Adult social care – residential or nursing care home | 119 | 69 | 26 | 5 | 7 | 226 |
| Hospice service | 12 | 9 | 1 | 0 | 0 | 22 |
| Other | 22 | 17 | 4 | 2 | 3 | 48 |

### Question 2

‘Do you agree that the guidance clarifies the requirements on care homes to make sure people using their service are not discouraged from going out on visits from the care home?’

Table 7: Summary of all closed question responses to Question 2

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Strongly agree** | **Agree** | **Neither agree nor disagree** | **Disagree** | **Strongly disagree** | **Total** |
| **Overall** | **254** | **201** | **51** | **15** | **17** | **538** |
| *Individuals* | *110* | *118* | *39* | *9* | *9* | *285* |
| Carer of somebody using health and social care services | 24 | 28 | 13 | 4 | 2 | 71 |
| CQC employee | 0 | 9 | 1 | 1 | 1 | 12 |
| Expert by experience | 4 | 7 | 2 | 2 | 1 | 16 |
| Health and social care employee | 54 | 50 | 14 | 2 | 3 | 123 |
| Member of the public/person who uses health or social care services | 18 | 16 | 7 | 0 | 0 | 41 |
| Other | 10 | 7 | 2 | 0 | 1 | 20 |
| *Organisations* | *144* | *83* | *12* | *6* | *8* | *253* |
| Health or social care provider | 125 | 67 | 9 | 3 | 7 | 211 |
| Voluntary and community sector representative | 8 | 7 | 0 | 2 | 1 | 18 |
| Other | 11 | 9 | 3 | 1 | 0 | 24 |
| *Sectors* | *177* | *116* | *43* | *8* | *11* | *355* |
| Acute Hospital – NHS | 9 | 8 | 1 | 0 | 0 | 18 |
| Adult social care – community based/homecare | 20 | 19 | 6 | 1 | 1 | 47 |
| Adult social care – residential or nursing care home | 126 | 73 | 15 | 3 | 8 | 225 |
| Hospice service | 11 | 9 | 1 | 0 | 0 | 21 |
| Other | 24 | 17 | 1 | 3 | 2 | 47 |

### Question 3

‘Do you agree that the guidance clarifies the requirements on hospitals and hospices to enable people to be accompanied by a family member, friend or advocate to appointments that do not require an overnight stay?’

Table 8: Summary of all closed question responses to Question 3

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Strongly agree** | **Agree** | **Neither agree nor disagree** | **Disagree** | **Strongly disagree** | **Total** |
| **Overall** | **245** | **189** | **63** | **18** | **16** | **531** |
| *Individuals* | *109* | *119* | *37* | *9* | *9* | *283* |
| Carer of somebody using health and social care services | 24 | 30 | 10 | 4 | 3 | 71 |
| CQC employee | 0 | 10 | 0 | 0 | 1 | 11 |
| Expert by experience | 3 | 8 | 3 | 1 | 1 | 16 |
| Health and social care employee | 52 | 46 | 18 | 4 | 2 | 122 |
| Member of the public/person who uses health or social care services | 20 | 16 | 5 | 0 | 0 | 41 |
| Other | 10 | 8 | 1 | 0 | 1 | 20 |
| *Organisations* | *136* | *70* | *26* | *9* | *7* | *248* |
| Health or social care provider | 114 | 60 | 18 | 6 | 6 | 204 |
| Voluntary and community sector representative | 10 | 4 | 2 | 1 | 1 | 18 |
| Other | 12 | 6 | 6 | 2 | 0 | 26 |
| *Sectors* | *174* | *112* | *38* | *12* | *8* | *344* |
| Acute Hospital – NHS | 12 | 5 | 1 | 0 | 0 | 18 |
| Adult social care – community based/homecare | 20 | 16 | 9 | 2 | 1 | 48 |
| Adult social care – residential or nursing care home | 108 | 72 | 25 | 6 | 5 | 216 |
| Hospice service | 13 | 8 | 1 | 0 | 0 | 22 |
| Other | 25 | 11 | 4 | 5 | 2 | 47 |

### Question 4

‘Do you agree that the guidance clarifies the requirements on care homes, hospitals and hospices to meet the preferences of the person using the service when facilitating visits?’

Table 9: Summary of all closed question responses to Question 4

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Strongly agree** | **Agree** | **Neither agree nor disagree** | **Disagree** | **Strongly disagree** | **Total** |
| **Overall** | **202** | **192** | **67** | **29** | **48** | **538** |
| *Individuals* | *84* | *111* | *46* | *18* | *22* | *281* |
| Carer of somebody using health and social care services | 20 | 23 | 16 | 6 | 5 | 70 |
| CQC employee | 1 | 8 | 0 | 0 | 2 | 11 |
| Expert by experience | 2 | 6 | 3 | 2 | 3 | 16 |
| Health and social care employee | 39 | 50 | 20 | 5 | 7 | 121 |
| Member of the public/person who uses health or social care services | 15 | 16 | 5 | 2 | 3 | 41 |
| Other | 7 | 7 | 2 | 3 | 1 | 20 |
| *Organisations* | *118* | *81* | *21* | *11* | *26* | *257* |
| Health or social care provider | 101 | 70 | 15 | 7 | 20 | 213 |
| Voluntary and community sector representative | 7 | 5 | 1 | 2 | 3 | 18 |
| Other | 10 | 6 | 5 | 2 | 3 | 26 |
| *Sectors* | *18* | *11* | *3* | *6* | *3* | *41* |
| Acute Hospital – NHS | 4 | 7 | 3 | 1 | 3 | 18 |
| Adult social care – community based/homecare | 15 | 19 | 9 | 2 | 4 | 49 |
| Adult social care – residential or nursing care home | 102 | 76 | 23 | 5 | 17 | 223 |
| Hospice service | 9 | 8 | 1 | 0 | 3 | 21 |
| Other | 21 | 14 | 4 | 6 | 3 | 48 |

### Question 5

‘Do you agree the guidance makes clear that decisions on exceptional circumstances must be based on the health, safety and welfare of people using the service and other people on the premises?’

Table 10: Summary of all closed question responses to Question 5

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Strongly agree** | **Agree** | **Neither agree nor disagree** | **Disagree** | **Strongly disagree** | **Total** |
| **Overall** | **235** | **188** | **69** | **20** | **23** | **535** |
| *Individuals* | *104* | *106* | *45* | *10* | *15* | *280* |
| Carer of somebody using health and social care services | 24 | 23 | 13 | 6 | 4 | 70 |
| CQC employee | 2 | 8 | 0 | 0 | 1 | 11 |
| Expert by experience | 4 | 6 | 4 | 0 | 2 | 16 |
| Health and social care employee | 47 | 47 | 21 | 2 | 5 | 122 |
| Member of the public/person who uses health or social care services | 18 | 14 | 6 | 1 | 1 | 40 |
| Other | 9 | 7 | 1 | 1 | 1 | 19 |
| *Organisations* | *131* | *82* | *24* | *10* | *8* | *255* |
| Health or social care provider | 114 | 68 | 17 | 6 | 7 | 212 |
| Voluntary and community sector representative | 6 | 7 | 2 | 1 | 1 | 17 |
| Other | 11 | 7 | 5 | 3 | 0 | 26 |
| *Sectors* | *167* | *120* | *44* | *8* | *12* | *351* |
| Acute Hospital – NHS | 8 | 6 | 2 | 1 | 1 | 18 |
| Adult social care – community based/homecare | 20 | 20 | 6 | 2 | 1 | 49 |
| Adult social care – residential or nursing care home | 109 | 72 | 29 | 3 | 8 | 221 |
| Hospice service | 11 | 8 | 3 | 0 | 0 | 22 |
| Other | 22 | 17 | 4 | 3 | 2 | 48 |

## Appendix 3: Glossary

A selection of acronyms and technical terminology used in the course of this report are defined below.

|  |  |
| --- | --- |
| **DOLS** | Deprivation of Liberty Safeguards – measures which allow restrictions to be put in place for people who lack capacity to consent to care or treatment in order to keep them safe |
| **ICS** | [Integrated Care System](https://www.england.nhs.uk/integratedcare/what-is-integrated-care/) – local partnerships which bring together health and care organisations (including NHS organisations and upper-tier local councils) to develop shared plans and joined-up services |
| **HCP** | Health and Care Partnership – bring all provider health organisations (such as acute hospitals, mental health hospitals, community health providers) in a given area to work as one. Each organisation within a partnership retains its own budget but will agree, with other partners, how it is spent for the benefit of the local community |
| **PALS** | [Patient Advice and Liaison Service](https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/) – a service which offers confidential advice, support and information on health-related matters |
| **POA** | Power of Attorney – a means of giving a trusted person legal authority to make decisions on behalf of another person |
| **SURP** | Service User Reference Panel – a group convened by CQC with experience of using mental health services and of being detained under the Mental Health Act |

1. Note that percentages in the text and on the Figures have been rounded to the nearest percentage point, which is why there may be minor discrepancies. [↑](#footnote-ref-2)