Department of Health & Social Care

# Government response to the consultation on visiting in care homes, hospitals and hospices

Presented to Parliament
by the Minister of State for Social Care
by Command of His Majesty

December 2023

CP 983


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# Contents

# Foreword

We know that visiting loved ones in care homes, hospitals and hospices plays a vital role in maintaining health and wellbeing. Loved ones often play an essential role as 'care supporters', providing assistance, support and advocacy for those accessing care. We also know just how upsetting and distressing it can be to have those crucial visits restricted. Since the pandemic, we have been working hard to ensure visiting restrictions that were in place during the height of the COVID-19 pandemic cannot be commonplace again. We will move forward and learn to create a better environment for all when it comes to visitation.

Guidance is clear that visiting should be encouraged and facilitated in all circumstances. End-of-life visiting should always be supported, wherever possible, regardless of the setting. While most settings comply with visiting guidance, our ambition is to ensure there is no room for individual settings to unreasonably restrict visiting. This will give everyone peace of mind that they will not be alone when receiving treatment and care.

We conducted a public consultation to capture views on introducing secondary legislation to protect visiting as a fundamental standard across care homes, hospitals and hospices. No one should be denied reasonable access to visitors while they are a resident in a care home, or a patient in a hospital or hospice. The standard will also include accompanying people to hospital as outpatients (for diagnostic visits or visiting accident and emergency departments) and hospices (outpatient appointments).

This document summarises the extensive responses to our consultation. This is undoubtedly an emotional subject and important to all of those who have been affected by visiting restrictions and/or who have a loved one or friend in a care home, hospital or hospice. We are grateful to each and every person who took the time to engage with this consultation. This is vital in helping us move forward in the best way possible to support those providing and receiving care.

It is so important to us that we get this right and determine what action should be taken. We are certain that this is a valuable policy mission, and the consultation responses have helped to cement this.

This command paper sets out how and why we must legislate, and what is required from care homes, hospitals and hospices to support visiting for the undisputable benefit of those receiving care.

**Helen Whately, Minister of State for Social Care**

**Andrew Stephenson, Minister of State for Health and Secondary Care**

**Maria Caulfield, Parliamentary Under Secretary of State for Mental Health and Women's Health Strategy**

# Executive summary

## Why we held this consultation

Visiting is a crucial part of a person's care. This includes having a loved one at a hospital bedside for a crucial diagnosis discussion, receiving assistance from a 'care supporter' or simply going for a walk with a family member or friend. The human connection is vital to the health and wellbeing of us all.

The COVID-19 pandemic taught us invaluable lessons. Restrictions were deemed necessary at the height of the pandemic to control the risk of transmission from a new virus that was not well understood. We now recognise that these restrictions affected the health and wellbeing of many of us. This includes residents, patients and their families and friends, and especially those who find it challenging to advocate for themselves.

Health and care providers recognise this and have worked hard to return to pre-pandemic levels of visiting. On 19 May 2022, Amanda Pritchard, NHS England CEO, wrote to all NHS hospital trusts reminding them that NHS England's national principles for hospital visiting remain the absolute minimum standard. No patient should be alone unless through their own choice. NHS England also introduced an explicit requirement in the NHS standard contract that providers must comply with. In social care, the government is clear that providers should support visiting, with care home residents able to have a minimum of one visitor at a time, even during an outbreak of COVID-19.

Although all health and care settings should be allowing visits, there remain reports and instances where this has not been the case. So, to protect this vital part of a person's care, the government has consulted on our proposed legislation with:

- patients
- care homes residents
- families
- providers
- staff
- representative groups

This would strengthen rules and provide the Care Quality Commission (CQC) with a clearer standard to which providers must adhere.

We launched our consultation on 21 June 2023 and received over 1,400 responses.

## Summary of consultation outcomes

The majority of responses supported the government's proposal to introduce a fundamental standard on visiting.

The government will now work with the CQC to develop and introduce a new fundamental standard. This will focus on visiting, against which the CQC will assess certain registered settings as part of its existing inspection framework. We intend to lay the necessary regulations[1] in Parliament to introduce this additional standard as soon as possible. We will also work with the CQC to publish the necessary guidance to the health and social care sector to ensure this new standard is clear and upheld.

Through this new standard, CQC will be able 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.

Of the themes we observed within our consultation, respondents cited that they found government guidance unclear, and that strict visiting times and complicated complaints processes were some of the barriers to visiting in health and care settings. Legislation will therefore help to create a consistent understanding of what is acceptable across all relevant providers. We will also seek to make guidance on the complaints process clearer for when issues do arise.

Some respondents expressed concern that through the provision of a standard and accompanying guidance, 'exceptional circumstances' or 'reasonable explanations' (where a provider may restrict visiting) may actually provide the conditions for more restrictive practices, which is contrary to our intention. We recognise that there will always be some, very limited, circumstances in which visiting cannot be facilitated by the provider to maintain the safety and wellbeing of service users and staff. However, we do not plan to include a list of these circumstances in the statutory instrument itself. We are clear that visiting is critical to the health and wellbeing of everyone.

While the majority expressed clear support for a consistent approach across CQC registered settings, we recognise concerns raised by sector representatives about the requirements for some health and care settings potentially putting individuals at increased risk. For this reason, we intend to exclude services for substance misuse and inpatient detoxification or rehabilitation services from the requirement. This reflects the complex circumstances and risk of relapse for a vulnerable person, and visiting is already carefully considered within care plans in these settings. Supported living settings and 'extra care'

[1] Phrasing and words used to describe draft regulation in this document may differ from the final statutory wording. This response aims to summarise the general aims of the proposed legislation.

housing schemes will also not be in scope of the regulation. These settings generally exercise ‘exclusive possession’, in which the individual has a tenancy agreement and they can decide who visits. All guidance will clearly set out the scope of this new regulation.

We intend to address concerns about residents of care homes being discouraged to take visits out of the home by overly burdensome restrictions upon their return. A care home is a person’s home, and we will be including a provision in regulations that residents should be encouraged to take visits out of the care home to support their wellbeing.

We have received clear support and heard the positive impact that this policy would have, particularly for service users and their loved ones, with powerful personal testimony. The range of support provided by many visitors, which often extends beyond companionship to a 'care supporter’ role and advocate, is fundamental.

Some have called for this right to be protected within new, primary legislation. Given the overwhelming support in this consultation, and the role of the CQC as the regulator in England, the government believes the most proportionate and appropriate way in which to protect and enable visiting is to now move to introduce a new CQC fundamental standard on visiting. This puts visiting on the same level as other fundamental standards, such as that which requires providers to meet the nutritional and hydration needs of service users.

A new fundamental standard on visiting provides a standard to be enforced by the CQC as part of its existing civil enforcement powers. This will highlight the importance of visiting to providers and all stakeholders and ensure that providers account for the vital role that visiting plays. We are grateful to all those who have taken the time to engage service users and wider stakeholders during this process, which has informed and strengthened the government’s policy decision.

# Background

The government's consultation, 'Visiting in care homes, hospitals and hospices', was published on 21 June 2023 with an easy read version published on 28 June 2023.

The consultation invited comments on plans to introduce secondary legislation to ensure that visiting is protected and prioritised in CQC registered settings. We proposed that secondary legislation would:

- amend the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (CQC Regulations) to make visiting a new fundamental standard
- include the accompaniment of people to outpatient appointments
- apply to care homes, NHS and independent hospitals (acute and mental health), hospices, and services for substance misuse or rehabilitation
- require that providers could only restrict visiting if they had a reasonable explanation or the reason was covered by a specific exception
- require that providers do not put restrictions on visiting out of care homes unless they had a reasonable explanation for doing so or a specific exception applies

The consultation closed on 16 August 2023 and the easy read consultation closed on 23 August 2023. We received approximately 1,400 responses, both from individuals and on behalf of organisations.

We have analysed all the responses submitted, and this report summarises the responses, including how the consultation responses influenced the final decisions regarding the policy. A full set of quantitative responses can be found on GOV.UK. This paper highlights summary analysis that supports the government's response. Values below 5 are suppressed, represented by a 'c', in line with departmental policy on disclosure control.

We received 1,008 responses to the standard online consultation and 395 responses to the easy read version of the consultation. Responses could be submitted either by individuals, acting in a personal or a professional capacity, or by an organisation. The tables below show the number of responses received from each group and the proportion received from each type of respondent. Note that respondents could identify as more than one type. For example, a respondent could be a care home resident and have visited someone in a care home as a family member or friend.

# Summary of responses

## Standard consultation

### Table 1: responses to the standard consultation by respondent group

| Respondent group | % of responses | Number of responses |
|---|---|---|
| Personal individual | 50% | 504 |
| Professional individual | 32% | 322 |
| Organisation or charity | 18% | 182 |
| Total | 100% | 1,008 |

### Table 2: responses by personal individuals to the standard consultation, by circumstance

| Personal individual's circumstance | Number of responses |
|---|---|
| I have visited someone in a care home as a family member or friend | 361 |
| I have visited someone in hospital as a family member or friend | 361 |
| I am or have been a hospital patient | 182 |
| I have visited someone in a hospice as a family member or friend | 106 |
| Other | 22 |
| I am or have been a care home resident | 8 |
| I am or have been a hospice patient | c |

### Table 3: responses by professional individuals to the standard consultation, by circumstance

| Professional individual's circumstance | Number of responses |
|---|---|
| I have visited someone in a care home as a professional | 156 |
| I work or have previously worked in a hospital | 138 |
| I have visited someone in a hospital as a professional | 134 |

| Professional individual's circumstance | Number of responses |
|---|---|
| I work or have previously worked in a care home | 125 |
| I am the registered person or manager of a care home | 69 |
| I have visited someone in a hospice as a professional | 55 |
| Other | 35 |
| I work or have previously worked in a hospice | 32 |
| I am the CQC-registered person, nominated individual, or a member of a hospital board | 27 |

Note that respondents to the easy read consultation could pick more than one category across personal, professional and organisation respondent types, therefore the totals here are higher than the overall number of respondents.

## Easy read consultation

**Table 4: responses to the easy read consultation by respondent group**

| Respondent group | % of responses | Number of responses |
|---|---|---|
| Personal individual | 77% | 570 |
| Professional individual | 21% | 155 |
| Organisation or charity | 2% | 15 |
| Total | 100% | 740 |

**Table 5: responses by personal individuals to the easy read consultation, by circumstance**

| Personal individual's circumstance | Number of responses |
|---|---|
| I have visited someone in a care home as a friend or family member | 352 |
| I have visited someone in hospital as a friend or family member | 166 |
| I have visited someone in a hospice as a friend or family member | 46 |
| I live in or have lived in a care home | 6 |
| I am or have been a hospice patient | 0 |
| I live in hospital or have lived in hospital | c |

**Table 6: responses by professional individuals to the easy read consultation, by circumstance**

| Professional individual's circumstance | Number of responses |
|---|---|
| I work or have worked in a care home | 38 |
| I have visited someone in a care home as part of my job | 29 |
| I work or have worked in a hospital | 28 |
| I have visited someone in a hospital as part of my job | 23 |
| I am the manager of a care home | 22 |
| I have visited someone in a hospice as part of my job | 8 |
| I work or have worked in a hospice | 7 |

The majority of respondents were female (60%). 58% of respondents were aged over 51. Most respondents lived in England (76%). Respondents had a relatively even spread across regions, except for slightly higher response rates in the North West and South East (where each of those regions represented 13% of respondents).

In addition to the online survey responses, we received 20 responses by email.

We also received 33 responses to verbal prompts which we circulated for health and care workers and the loved ones of service users to use with individuals who may find it challenging to respond to either the standard consultation or easy read consultation. These were short, simplified questions about current experiences of visiting and the proposed policy and have also been considered.

# Analysis and government response

## Current practice

In considering how to strengthen the requirement for health and care providers to ensure that residents and patients can receive visits from their loved ones, we first wanted to examine what the current visiting landscape looks like. We did not specifically ask about hospices as visiting in those settings has not historically been raised as a cause of concern. Respondents had the opportunity to raise any hospice-specific issues in response to later questions.

The standard consultation asked:

To what extent do you agree or disagree that there have been unreasonable barriers to visiting people in care homes in the last 3 months?

If you answered strongly agree or agree, what do you think these barriers are in care homes?

To what extent do you agree or disagree that there have been unreasonable barriers to visiting people in hospitals in the last 3 months?

If you answered strongly agree or agree, what do you think these barriers are in hospitals?

The easy read consultation asked:

In the last 3 months, do you think there have been barriers to visiting people in care homes?

In the last 3 months, do you think there have been barriers to visiting people in hospitals?

What barriers do you think stop people visiting care homes?

What barriers do you think stop people visiting hospitals?

## Analysis of views on barriers to visiting in care homes

**Table 7: standard consultation: To what extent do you agree or disagree that there have been unreasonable barriers to visiting people in care homes in the last 3 months?[2]**

| Response | Personal individual | Professional individual | Organisation or charity | All responses |
|---|---|---|---|---|
| Strongly agree | 23% | 9% | 4% | 154 |
| Agree | 14% | 11% | 8% | 119 |
| Neither agree nor disagree | 17% | 19% | 17% | 179 |
| Disagree | 11% | 24% | 21% | 173 |
| Strongly disagree | 7% | 19% | 29% | 147 |
| No response | 28% | 18% | 20% | 236 |

**Table 8: easy read consultation: In the last 3 months do you think there have been barriers to visiting people in care homes?**

| Response | Personal individual | Professional individual | Organisation or charity | All responses |
|---|---|---|---|---|
| Lots of barriers | c | 10% | c | 9 |
| Some barriers | 32% | 39% | c | 118 |
| No barriers | 65% | 52% | c | 232 |

Respondents to the standard consultation were somewhat more likely to disagree or strongly disagree (31.7%) than agree or strongly agree (27.1%) that there have been unreasonable barriers to visiting people in care homes in the last 3 months. Respondents who responded to the consultation in a personal capacity were more likely to agree that there were unreasonable barriers than those responding as a professional. This was reflected in the responses to the easy read consultation, where most respondents were

[2] Percentages are calculated as a proportion of the respondent type because respondents could identify as more than one type. That is, a respondent could be a care home resident and have visited someone in a care home as a family member or friend.

people sharing their personal views. However, the majority of respondents to the easy read consultation said that there were no barriers to visiting in care homes.

The 273 standard consultation respondents who agreed that there were barriers to visiting were asked to identify these from a range of options. Respondents to the standard consultation cited ‘concern or hesitancy from care homes’ most (68%); this was more likely to be cited as a barrier by individuals. Another common barrier selected was infection prevention control measures, for example restrictions during an outbreak of COVID-19 (51%), which was more likely to be cited by professional respondents. Other commonly selected options were insufficient staff capacity (48%), strict visiting times (47%) and unclear government guidance (47%).

Respondents to the easy read consultation most often cited the barrier ‘not enough people work in care homes’ (39%), followed by ‘people who live in care homes are worried about getting an illness from someone else’ (27%). People sharing professional views cited most ‘care homes are worried about friends and families visiting’. Additional barriers mentioned which were not listed included outbreaks of COVID-19 causing the care home to restrict visiting and concern from either care homes or visitors themselves that visitors would pass on illnesses to care home residents.

### Analysis of views on barriers to visiting in hospitals

**Table 9: standard consultation: to what extent do you agree or disagree that there have been unreasonable barriers to visiting people in hospitals in the last 3 months?**

| Response | Personal individual | Professional individual | Organisation or charity | All responses |
|---|---|---|---|---|
| Agree or strongly agree | 40% | 23% | 16% | 304 |
| Neutral | 15% | 13% | 13% | 143 |
| Disagree or strongly disagree | 16% | 20% | 18% | 176 |
| No response | 29% | 44% | 53% | 385 |
| Total respondents | - | - | - | 1,008 |

**Table 10: easy read consultation: In the last 3 months, do you think there have been barriers to visiting people in hospitals?**

| Response | Personal individual | Professional individual | Organisation or charity | All[3] responses |
|---|---|---|---|---|
| Lots of barriers | 3% | c | c | 11 |
| Some barriers | 28% | 28% | c | 108 |
| No barriers | 16% | c | c | 54 |
| No response | 53% | 50% | c | 207 |
| Total respondents | - | - | - | 395 |

30% of respondents agreed that there have been barriers to visiting people in hospitals in the last 3 months. Overall, in the standard consultation, this was significantly higher than those who disagreed or strongly disagreed that there were unreasonable barriers (17%).

Respondents who agreed or strongly agreed that there were barriers to visiting in hospitals were asked to identify what these barriers were from a range of options and could also provide their own response. Responses to the standard consultation suggested that the top 3 reasons for these barriers were concern or hesitancy from hospitals to allow visiting (66%), strict visiting times (67%) and infection control measures (54%). The easy read respondents who agreed that there were some or lots of barriers to visiting people in hospital most often cited strict visiting times (98%), that hospitals were worried about friends and family visiting (59%) and that hospitals did not have sufficient number of staff (61%) as barriers. Additional barriers mentioned which were not listed included transport issues, with some respondents referencing distance to travel to hospitals and expensive car parking.

## Government response to views on barriers to visiting in care homes and hospitals

We note the range of barriers that individuals may have experienced to visiting their loved ones in the last 3 months. By introducing a legislative requirement on visiting, we intend to create a consistent understanding of what is acceptable in care homes, hospitals and hospices, and this will be based on the underlying principle that visiting should always be positively supported.

[3] Totals include 8 responses which did not indicate whether they are a responding in a personal or professional capacity or responding on behalf of an organisation.

# Current position in guidance and legislation

As there are existing policies, guidance and legislation associated with visiting in health and care settings, we sought to understand views about the current process for raising concerns if visiting is being restricted.

The standard consultation asked:

If you have a concern about visiting care homes, how effective do you think the current routes are in resolving them?

If you have a concern about visiting hospitals, how effective do you think the current routes are in resolving them?

The easy read consultation asked:

Are you happy with what happens after you make a complaint?

## Analysis of views on current legislation and guidance

**Table 11: standard consultation: If you have a concern about visiting care homes or hospitals, how effective do you think the current routes are in resolving them?**

| Response | Care homes | Hospitals |
|---|---|---|
| Effective | 11% | 4% |
| Somewhat effective | 15% | 15% |
| I don’t know | 16% | 41% |
| Somewhat ineffective | 11% | 17% |
| Ineffective | 22% | 23% |
| Total responses | 732 | 584 |

Respondents were more likely to feel that that current routes to resolving complaints were somewhat ineffective or ineffective in both care homes and hospitals. Those responding on behalf of an organisation or charity and those responding in a professional capacity were more likely to respond that current routes to resolving complaints in care homes and hospitals were somewhat effective or effective than those who responded in a personal capacity.

Although most respondents to the easy read consultation had never made a complaint (50%), those who had were more likely to be happy with what happened after making a complaint (30%) than unhappy (20%).

Of respondents who explained their answers, the key concerns raised about routes to resolving visiting concerns in care homes were a lack of clarity on making complaints, that the rules and guidance were at times unclear due to frequent changes and inconsistency between providers, and that power imbalances between individuals and providers made it harder for some to reach a resolution. The issue of power imbalance between care home providers and residents and their loved ones is one that has been specifically highlighted in our engagement with visiting campaigners, who have raised concerns that residents and their loved ones are sometimes scared to complain about unfair restrictions or contact CQC due to worry about repercussions on their care, including being given notice to leave.

On hospitals, respondents who explained their answers felt that the key concerns raised about routes to resolving visiting concerns in hospitals were a lack of clarity on rules or unclear guidance, a lack of a clarity on appeals, a lack of flexibility, a power imbalance between staff and visitors, constrained visiting and a misuse of restrictions.

## Government response to views on current legislation and guidance

Some respondents questioned how to complain or resolve an issue with both providers and the CQC when they experienced difficulties with visiting. Furthermore, respondents considered that the existing routes for complaints are unsatisfactory and that there is a lack of awareness of complaints processes.

While complaining to the specific provider should usually be the first step if there is an issue, the Local Government and Social Care Ombudsman (LGSCO) plays a fundamental role in resolving concerns about visiting in care homes. The LGSCO can look into individual circumstances if a person thinks that their complaints to the provider have been unsatisfactory. The LGSCO shares information with CQC to help inform regulatory activity.

With hospitals, people have the right to make a complaint about any aspect of NHS care, treatment or service, and this is written into the NHS Constitution. The NHS website has information and guidance about how to make a complaint about primary and secondary care services. Complaints can either be made to the NHS service provider directly, for example a local hospital or GP, or to the commissioner of the services. The consultation highlighted that it is not always clear whether there are routes to escalate complaints and who people can escalate them to. For NHS services, if a person has reached the end of the complaints process and is not happy with the organisation's final decision, they have the right to bring their complaint to the Parliamentary and Health Service Ombudsman who are independent of the NHS and have the final decision on unresolved NHS hospital complaints.

The CQC conducts inspections to ensure that standards are being met and makes judgments informed by the experiences of all parties, including patients and residents. By introducing a new fundamental standard, CQC will have a clearer basis from which to:

- identify a breach by a provider
- be able to use their civil enforcement powers to take action when it is necessary and proportionate to do so

This won't, however, confer any additional powers on the CQC, which was outside the scope of this consultation.

The government is clear that it is unacceptable for any provider to evict a resident or in any way sanction them or their loved ones because they have made a complaint. By law, all regulated health and social care services must have a procedure for dealing efficiently with complaints.

## Introducing secondary legislation

The legislative proposal which we sought views on through the consultation was to amend the CQC regulations to include visiting, either as a new fundamental standard or as part of an existing, related fundamental standard.

The standard consultation asked:

To what extent do you agree or disagree with amending the CQC regulations to include visiting as a standard which will also include accompanying those attending hospital?

Which of the options below would you prefer?

- having 'visiting and accompanying those attending hospital' as a new and separate standard in regulations

- amending the existing 'dignity and respect' standard to include visiting

- amending the existing 'person centred care' standard to include visiting

Which of the following reflects your view on introducing legislation to amend CQC regulations to include visiting (or accompanying those attending hospital)?

- it goes too far – current visiting guidance and practice is sufficient

- it does not go far enough

The easy read consultation asked:

Do you agree with our proposed new rules about visiting?

If you ticked yes, how would you like us to make these new rules about visiting?

If you ticked no, tell us why.

## Analysis of views on introducing secondary legislation

**Table 12: standard consultation: To what extent do you agree or disagree with amending the CQC regulations to include 'visiting' as a standard (which will also include accompanying those attending hospital?)**

| Response | Personal individual | Professional individual | Organisation or charity | All responses |
|---|---|---|---|---|
| Strongly agree | 57% | 37% | 29% | 456 |
| Agree | 15% | 34% | 27% | 237 |
| Neither agree nor disagree | 7% | 9% | 15% | 89 |
| Disagree | 5% | 7% | 13% | 73 |
| Strongly disagree | 4% | 7% | 10% | 58 |
| No response | 13% | 6% | 7% | 95 |
| Total | - | - | - | 1,008 |

Most respondents to the consultation were supportive of the principle of amending CQC regulations to include visiting. Of those who responded to the standard consultation, 69% agreed or strongly agreed with the proposal. This support was reflected in responses to the easy read consultation, which asked if respondents agreed with our proposed new rules about visiting. The majority (79%) said that they were happy.

Respondents who agreed or strongly agreed with the proposal were asked if they would prefer to add visiting and accompanying those attending hospital as a new and separate standard or included as part of an amended existing standard. The preference of respondents was to add ‘visiting and accompanying those attending hospital' as a new and separate standard in regulations (31%). This was the preference for people responding in a personal capacity in particular. There was also support for ‘amending the existing ‘person centred care' standard to include visiting (18%), which was the option preferred by those responding on behalf of an organisation or charity.

This differed from the response to the easy read responses which had a more even spread of support but showed an overall preference for ‘adding new rules about visiting to rules the CQC already has about giving people care that is best for them and their needs’ (38%).

Respondents who disagreed, strongly disagreed or were unhappy with the proposal were asked why. 71% of the 131 respondents to the standard consultation who had disagreed

with the proposal felt that that the amendments went too far, and that current visiting guidance and practice is sufficient. This was reflected in the responses to the easy read consultation, wherein 83% of those stating that they were unhappy with the proposal stated that they do not think we need new rules about visiting.

The vast majority of respondents who felt that the proposed amendments to CQC regulations do not go far enough were those responding in a personal capacity and were those who had visited someone in a care home as a family member or friend.

Some of those who provided additional comments in response to this question thought that the proposal did not go far enough because there should be no exceptions to receiving visits from loved ones and care supporters. However, others raised concerns that legislation might compromise the safety of individuals receiving treatment, and that registered managers are best placed to make individual risk-based decisions. This was especially highlighted for those commenting on drug and alcohol facilities – further information is provided in the analysis of 'settings'.

## Government response to views on secondary legislation

We recognise that there are a range of views about our proposed legislation which were set out in response to the consultation. This includes views from some respondents that legislation is unnecessary and visiting is already adequately covered by existing CQC enforcement. It also includes other respondents believing the opposite; that our proposal does not go far enough and that individuals should in all circumstances have a 'right' to a visitor or care supporter.

There was, however, a general consensus that CQC regulations should be amended to explicitly include visiting, and a majority of respondents supported our proposal that visiting should be its own fundamental standard. We think that having visiting as a fundamental standard will present the clearest message to providers, visitors and service users alike that contact with loved ones is vitally important and will be protected. It will put visiting on a level with other CQC fundamental standards that providers must comply with.

# Legislative options and alternatives to legislation

We recognise that there may be a range of ways in which government, and health and care providers can ensure that individuals accessing care and treatment are able to see and receive support from their loved ones. Solutions may include both legislative and non-legislative options. Through the consultation we were keen to hear respondents' views on a broad range of options, including new ideas that we may not have previously considered.

The standard consultation asked:

If legislation was introduced on visiting, which of the following amendments to CQC regulations would you support, if any?

Do you think there are other options that would help facilitate visiting in care homes and hospitals instead of introducing legislation?

Which other options do you think would help instead of introducing legislation?

The easy read consultation asked:

Which proposed new rules about visiting in care homes do you think are a good idea?

Which of our proposed new rules about visiting in hospitals do you think are a good idea?

If we did not make new rules about visiting, which of these ideas do you think would help instead?

## Analysis of views on legislative options and alternatives to legislation

**Table 13: standard consultation: If legislation was introduced on visiting, which of the following amendments to CQC regulations would you support, if any? (multiple choice)**

| Response | Personal individual | Professional individual | Organisation or charity | Total |
|---|---|---|---|---|
| Visiting (including accompanying those attending hospital) is only restricted if there is a reasonable explanation | 16% | 17% | 10% | 386 |
| Visiting (including accompanying those attending | 19% | 14% | 7% | 362 |

| Response | Personal individual | Professional individual | Organisation or charity | Total |
|---|---|---|---|---|
| hospital) is only restricted if a specific exception set out in the legislation applies | | | | |
| If visiting (including accompanying those attending hospital) has been restricted, health and care providers should assess how they can still facilitate some form of visiting | 28% | 21% | 11% | 540 |
| Providers should notify CQC if they are imposing visiting restrictions | 24% | 16% | 7% | 434 |
| None of the above | 13% | 2% | 1% | 87 |

In the event that some visiting restrictions have necessarily been implemented, the majority of respondents to the standard consultation (60%) would like a demonstrable assessment from providers of alternative options to maintain contact between service users and their loved ones. Almost half of individual respondents supported a requirement for providers to notify CQC if they were restricting visiting.

Easy read respondents within care homes were clear, ‘care homes need a good reason to say no to someone visiting’ (78%), with the second most popular selection being ‘if it is not possible for someone to have visits, they should be able to talk on the phone or by video call’ (68%). For hospitals, 40% backed the idea that hospitals need a good reason to say no to someone visiting, with 38% supporting the idea that if it is not possible for someone to have visits, they should be able to talk on the phone or by video call. Approximately a third of respondents agreed that hospitals should have a list of all the reasons why someone cannot visit, and that if a hospital says no to visiting, they should explain their decision to the CQC.

When asked if there were other options that would help facilitate visiting in care homes and hospitals instead of introducing legislation respondents to the standard consultation were slightly more likely to say no (52%).

Of the 383 respondents to the standard consultation who thought that some non-legislative options would be helpful, there was a fairly consistent level of agreement that the 3 non-legislative options suggested would be beneficial: clearer and more accessible information for visitors to inform them of how or when to visit, produced by care providers or hospitals (69%), stronger and more consistent advice in government and/or NHS guidance (66%)

and accessible information provided by DHSC which informs visitors how or when is appropriate to visit (55%).

Several respondents to the consultation expressed a view that visiting should not be restricted under any circumstances, with some of these explicitly referencing the campaign for ‘Gloria’s law’ which calls for a specific legal right for individuals to have a care supporter when using health and care services. Some respondents highlighted the distinction between a ‘visitor’ and a ‘care supporter’ who offer additional care and support to their loved ones. Some responses mentioned practical ways in which visiting could be enabled, or made safer, including improved staff to patient ratios, mask wearing and visitor testing.

## Government response to views on legislative options and alternatives to legislation

It is important to acknowledge that practical considerations of facilitating visits will be different for different types of health and care provider, but we expect that providers should facilitate visits unless there are exceptional circumstances.

We would expect there to be exceptional circumstances where visiting might reasonably be restricted, when it would result in a significant risk to any person. This clearly would be in specific and uncommon situations, and these exceptional circumstances would exist to protect individuals living, working or being treated in a health and care setting.

We underline and recognise the desire for contact with and support from loved ones to be protected, as is reflected by respondents’ majority support for a legislative option which would require providers to ‘assess how they can still facilitate some form of visiting if it has been restricted’. In line with this, we intend to require providers to put in place appropriate precautions or measures to enable a visit to proceed safely where a risk has been identified rather than prevent visiting altogether. For example, this may include a visit where the visitors wear a face mask if there is a significant risk of infection.

We note the strong support for a potential requirement for providers to notify CQC of restrictions to visiting. After careful consideration of practical implications, we do not intend to include a requirement for providers to notify CQC if they are restricting visits, given the clear and limited circumstances in which visiting may reasonably be restricted. Accompanying guidance will affirm the positive intention of this regulation; to support and enable visiting in accordance with the preferences of the service user so far as reasonably practicable.

## Settings

The CQC regulate a whole host of health and care settings, all of which will have unique characteristics which need to be considered when creating a cross cutting standard.

The standard consultation asked:

Which settings do you think the amendment to CQC regulations should apply to, if any?

If the regulations were amended to apply to hospices, are there any special considerations that you think should be made?

The easy read consultation asked:

If our rules about visiting were also for hospices, is there anything you would like us to think about?

## Analysis of views on settings

**Table 14: standard consultation: Which settings do you think the amendment to CQC regulations should apply to, if any? (multiple choice)**

| Setting | Response |
|---|---|
| Care homes | 86% |
| NHS hospitals (acute) | 84% |
| NHS hospitals (mental health) | 81% |
| Independent hospitals (non-NHS acute) | 78% |
| Independent hospitals (non-NHS mental health) | 77% |
| Hospices | 77% |
| Hospitals or services for substance misuse or rehabilitation | 74% |
| None | 9% |
| Total | 913 |

Most respondents agreed regulations should apply to care homes (86%) and hospitals (84%), but all proposed settings had a high degree of support, across all respondent types.

In terms of special considerations for hospices, many respondents stated a view that visiting in hospices should not be restricted, and that hospices should be flexible to facilitate visiting in their inpatient units regardless of the time of day and not restrict the numbers of visitors where practicable, given patients will likely be receiving end of life care. Many respondents also noted that flexibility was required when facilitating visits during periods of higher risk of infection. Some highlighted a patient's right to choose whether to receive visitors or not and the recognition of visiting as a fundamental right.

Some representatives of the hospice sector raised concerns about the inclusion of hospices within the proposed legislation, arguing that hospices already facilitate flexible visiting arrangements, often accommodating visits at irregular hours. Currently, hospices make informed decisions on appropriate visiting arrangements for individual patients, taking account of the health and safety of the patient and health and care staff. Some sector representatives suggested that guidance specific to hospice visiting would be more effective than legislation but, if a legislative route was pursued, it was important that accompanying guidance should be clearly directed at hospices, taking account of their unique provision.

Substance misuse services received the weakest support for inclusion in the consultation. Responses to the consultation from substance misuse treatment providers commonly mentioned that it was usual for visiting to be very limited to help prevent relapse to drug and alcohol use and to keep residential rehabilitation and inpatient detox units safe for all, ensuring they are drug and alcohol free and conducive to detoxification and rehabilitation. Responses referred to the need for visiting to be risk-based and adapted to individual needs and the phase of the treatment programme, with visiting being minimal or completely prohibited at the start of treatment and increasing towards discharge. If included in regulations, respondents stressed the importance of clear and specific guidance on exceptions to visiting rights for substance misuse treatment, as limiting visits according to risk and maintaining safe drug and alcohol free environments is fundamental to their operation.

Some respondents suggested that supported living settings should come within scope, with concerns raised about the misapplication or lack of guidance during the pandemic which led to some settings being overly restrictive with visiting, despite guidance.

## Government response to views on settings

The consultation highlighted the importance of having consistent access to loved ones regardless of which health or care service an individual is using. We have considered the specific concerns raised about the inclusion of hospices and drug and alcohol facilities within the legislation.

The government considered whether for hospices, where visiting has historically not been an issue, legislation would be a disproportionate response. However, supported by the vast majority of consultation responses on this issue, we decided that legally enshrining the protection of visitation in the future was, on balance, the correct way forward and ensures consistency with other health and care settings. Given that hospices are largely independent providers of care, they would be otherwise free to locally restrict visiting to an extent beyond what might be considered reasonable. Therefore, we intend to keep hospice settings in scope of the new legislation.

Upon further review of the inclusion of substance misuse services, we have removed these settings from scope of this new standard on the basis that they pose a unique risk in relation to visiting due to patient relapse posed by risk-based exceptions to visiting rights. It is normal for an individual in a substance misuse residential rehabilitation or inpatient detoxification service to go without visitors for a period while undergoing treatment or rehabilitation. Patients are often vulnerable, both physically and mentally, and family dynamics may be complex and social networks enmeshed with dependence. Visiting arrangements therefore need to ensure the safety of the unit or service for other patients and residents, to ensure that triggers to drug and alcohol use are minimised.

Supported living settings and ‘extra care’ housing schemes will also not be in scope of the regulation, as these settings generally exercise ‘exclusive possession’, in which the individual has a tenancy agreement and they can decide who visits. CQC does not regulate the accommodation (and therefore visiting) aspect of these settings.

## Reasonable explanation and specific exceptions

In considering circumstances in which a provider might need to restrict visiting, we sought views on whether we should take a ‘reasonable explanations’ approach or an ‘exceptional circumstances’ approach. Although both approaches would depend on the facts of a case, ‘reasonable explanations’ would be a lower threshold.

The standard consultation asked:

What would you describe as an ‘unreasonable time' to accommodate visiting in a care home?

Which of the following, if any, should be included as an exception enabling visits to be restricted in a care home?

Are there any circumstances in which you think it would be appropriate for care homes not to allow one visitor at a time per resident?

What would you describe as an ‘unreasonable time' to accommodate visiting in a hospital?

Which of the following, if any, should be included as an exception enabling visits to be restricted in a hospital?

In the event that a care home, hospital or hospice is restricting visiting, are there any steps that you think they should take to continue to facilitate some form of visiting?

The easy read consultation asked:

Do you think any of these examples are good reasons for a care home to say someone cannot visit?

Do you think any of these examples are good reasons for a hospital to say someone cannot visit?

Can you think of any times when care homes should say someone cannot visit?

Can you think of any times when hospitals should say someone cannot visit?

What can care services do to help when they cannot let friends and families visit in the normal way?

## Analysis of views on reasonable explanations and specific exceptions

### Care homes

**Table 15: standard consultation: Which of the following, if any, should be included as an exception enabling visits to be restricted in a care home? (multiple choice)**

| | Personal individual | Professional individual | Organisation or charity | Total |
|---|---|---|---|---|
| If the resident does not wish to receive visitors | 28% | 31% | 17% | 573 |
| If a visitor is confirmed to have an infectious disease or is confirmed to be a contact of someone who has an infectious disease | 26% | 27% | 15% | 513 |
| If the person being visited has an infectious disease or there is an outbreak in the relevant part of the care home | 16% | 21% | 12% | 364 |
| If a visitor is a risk to the physical and/or mental health and wellbeing of residents or staff | 27% | 29% | 16% | 536 |
| If a visitor is requesting to visit outside standard reasonable visiting hours | 10% | 9% | 5% | 185 |
| If there is an unforeseen emergency occurring at the home | 20% | 18% | 12% | 381 |
| If the care home does not have the capacity to receive the number of visitors wishing to visit | 7% | 10% | 7% | 178 |
| None of the above | 7% | c | 1% | 61 |

The most common circumstance that respondents felt should be an exception to the visiting requirement was ‘if the resident does not wish to receive visitors’. Easy read respondents most commonly cited ‘if the person visiting a care home is unwell and will make other people unwell’ (84%); ‘If the person visiting a care home might hurt someone’ (79%); and ‘if someone does not want to have a visit’ (57%) as exceptional circumstances where it may be appropriate to restrict visiting.

Most respondents were clear that any legislation should not have blanket restrictions for certain times in response to the question on unreasonable times to accommodate visiting in a care home. Respondents mentioned visiting being a right, the need for flexibility and discretion to be used by providers, particularly in emergency situations, that visiting times depended on the preferences and needs of individuals in the care home and noted benefits to the patient of visitation.

Some respondents did suggest however that visits may be less suitable late at night or after 10pm and early in the morning, before 8am as these are times when residents may be preparing for personal care and staff may not be able to support visits or requests from visitors as their focus will be on the residents. However, many qualified these times by noting that there should still be flexibility and that providers should work with residents to strike a balance that works for their needs.

When asked about circumstances in which it would be appropriate for care homes not to allow one visitor at a time per resident, responses were similar. The most commonly chosen option being 'if the resident does not wish to receive visitors' (72%). Individuals responding in a professional capacity were more likely to choose this option (30%) compared to those responding in a personal capacity (26%).

The other most commonly chosen options were:

- if a visitor is a risk to the physical and/or mental health and wellbeing of residents or staff' (64%)
- if a visitor is confirmed to have an infectious disease or is confirmed to be a contact of someone who has an infectious disease (62%)

We heard from some organisations that including a list of restrictions in legislation could undermine government intention to support visiting and potentially result in new restrictions being implemented by providers. They noted that providers should assess situations on a case-by-case basis. This would consider patient or resident needs alongside specialist and safeguarding input, rather than applying blanket restrictions if one of the circumstances arises.

## Hospitals

**Table 16: standard consultation: Which of the following, if any, should be included as an exception enabling visits to be restricted in a hospital? (multiple choice)**

| Response | Personal individual | Professional individual | Organisation or charity | All responses |
|---|---|---|---|---|
| If the patient does not wish to receive visitors | 43% | 49% | 36% | 443 |

| Response | Personal individual | Professional individual | Organisation or charity | All responses |
|---|---|---|---|---|
| If a visitor is a risk to the physical and/or mental health and wellbeing of patients or staff | 39% | 45% | 32% | 402 |
| If a visitor is confirmed to have an infectious disease or is confirmed to be a contact of someone who has an infectious disease | 38% | 40% | 33% | 383 |
| If a patient's treatment plan restricts visitors in order to aid their recovery | 29% | 34% | 25% | 299 |
| If there is an unforeseen emergency occurring at the hospital | 29% | 32% | 25% | 297 |
| If the person being visited has an infectious disease or there is an outbreak in the relevant part of the hospital | 24% | 32% | 26% | 270 |
| If the hospital or ward does not have the capacity to receive the number of visitors wishing to visit | 13% | 19% | 14% | 151 |
| If a visitor is requesting to visit outside standard, reasonable visiting hours | 16% | 15% | 11% | 147 |
| None of the above | 9% | 2% | c | 50 |
| Total Standard Consultation Respondents | - | - | - | 1,008 |

Respondents selected patient choice (44%), patient wellbeing (40%) and risk of infectious diseases (38%) as the most supported exceptions in the standard consultation, which would enable visits to be restricted in hospitals. Over a quarter of people also supported the following exceptions: treatment plans requiring a restriction of visitors, unforeseen emergencies at hospitals, or the person being visited has an infectious disease or there is an outbreak in the relevant part of the hospital.

In the easy read consultation, the following exceptions were the most supported: if the person visiting a hospital is unwell and will make other people unwell (42%), if the person

visiting a hospital might hurt someone (40%) and if someone does not want to have a visit (30%). Around a quarter of easy read respondents also supported exceptions if the person living in a hospital is unwell and will make other people unwell or if something really bad or serious happens at a hospital

Commenting on ‘unreasonable times to visit’, 25% of respondents to the standard consultation and 9% of respondents to the easy read consultation supported restrictions on visiting overnight. Across both consultations 7% of respondents thought exceptions to visiting times should be made for patients at the end of their life, or who were vulnerable and required extra support.

### Steps to continue facilitating visiting

When asked about any steps that a care home, hospital or hospice should take to continue to facilitate some form of visiting, the most chosen option was ‘requiring PPE, social distancing or other additional infection prevention and control measures if there is a risk of the transmission of infectious diseases’ (75%). Individuals responding in a professional capacity (29%) and individuals responding in a personal capacity (27%) were particularly in favour of this option.

This was followed by ‘visiting only allowed to take place in specific areas that are isolated from other residents or patients’ (70%). Individuals responding in a personal capacity (27%) were more inclined to choose this option.

Where respondents selected ‘other’, some of the common points made were that:

- there should be flexibility to consider this on a case-by-case basis
- restrictions should be time limited and only be kept in place for as long as is necessary
- providers should consider all other options before restricting visiting
- where the restriction is absolutely necessary, that other means of supporting contact between service users and their family and friends are pursued

Many responses were unsupportive of restrictions to visiting entirely, especially for ‘care supporters’.

In response to the easy read question, ‘what can care services do to help when they cannot let friends and families visit in the normal way?’, the 3 most common responses were:

- ‘if it is not possible for someone to have visits they should be able to talk on the phone or by video call’ (72%)

- ‘let everyone have at least one person visit them’ (62%)
- ‘let people have visits that are away from everyone else in the care service’ (51%)

Where respondents left a comment in the open text box, the need to consider individual circumstances was a common theme.

## Government response to views on reasonable explanation and specific exceptions

We note the concerns raised regarding exceptional circumstances and reasonable explanations, and therefore the risk of unintended consequences arising from providing a ‘list of circumstances’ in which restricting visiting may be permissible. We will be taking an ‘exceptional circumstances’ approach in legislation. However, we do not intend to include a list of specific exceptional circumstances in legislation where the requirement for providers to facilitate visiting does not apply. The government will, however, work closely with CQC to ensure that these risk scenarios are appropriately understood, ensuring providers can maintain safe levels of care, which includes supporting visiting.

## Mental health inpatient settings

For those detained under the Mental Health Act (MHA), chapter 11 of the Mental Health Act 1983 code of practice sets out statutory guidance on visiting patients in hospital and circumstances where it may be necessary to consider the exclusion of visitors. Therefore, we considered whether any specific considerations needed to be made for detained patients.

The standard consultation asked:

If amendments to CQC regulations were also applied to mental health inpatient settings, would any further specific exceptions need to be considered for detained patients?

The easy read consultation asked:

If our rules for visiting were also for hospitals that help look after people who have mental health problems, is there anything you would like us to think about?

## Analysis of views on mental health inpatient settings

**Table 17: standard consultation: If amendments to CQC regulations were also applied to mental health inpatient settings, would any further specific exceptions need to be considered for detained patients?**

| Response | Personal individual | Professional individual | Organisation or charity | Total |
|---|---|---|---|---|
| Yes | 12% | 11% | 8% | 109 |
| No | 18% | 13% | 9% | 150 |
| I don't know | 39% | 31% | 23% | 340 |

There was not a significance variance by type of respondent as to whether it was felt that specific exceptions were needed for mental health inpatient settings. For respondents who thought that specific exemptions were needed, a common reason was that visitors may pose a risk of harm and/or have a detrimental impact on the mental health of an individual in some cases. Some respondents noted the therapeutic benefits of facilitating visits for people in mental health hospitals, including people detained under MHA.

In addition, we received responses from key mental health organisations who were supportive of the legalisation applying to all mental health inpatient settings and did not specify any specific exemptions for people in mental health hospitals, including people

detained under the MHA. One key mental health organisation commented that adding further blanket exceptions for detained patients could amount to discrimination against detained patients, and that this group of patients needs more protection, not more restriction, from the therapeutic benefits of visiting.

## Government response to views on mental health inpatient settings

Some respondents indicated there may need to be exemptions in cases where a visit poses a safety risk, or whether a visit would have a detrimental impact on the mental health of an individual. We don’t consider there to be a need for specific exemptions for mental health inpatient settings, given that the planned regulations will allow for this.

# 'Visiting out'

We know that, particularly during the pandemic, care home residents may have been discouraged from leaving care homes on ‘visits out’ due to restrictions that could have been placed on them upon their return, for example self-isolation. We were keen to understand views on whether this was an element which should be included in our policy.

The standard consultation asked:

Do you think that DHSC should include provision in regulations to state that care homes should allow residents to go on visits out of the care home?

If regulations stated that visiting out may be restricted if an exception applies, which of these do you think should be specifically outlined in regulations?

The easy read consultation asked:

Do you think we should have new rules about going out of the care home?

Which new rules about going out do you think are a good idea?

Do you think any of these examples are good reasons not to let someone go out?

## Analysis of views on 'visiting out'

**Table 18: standard consultation: Do you think that DHSC should include provision in regulations to state that care homes should allow residents to go on visits out of the care home?**

| Response | Personal individual | Professional individual | Organisation or charity | Total |
|---|---|---|---|---|
| Yes | c | c | 0% | 0 |
| Yes, unless a specific exception applies | 29% | 32% | 26% | 296 |
| Yes, unless the care home has reasonable explanation for not allowing it | 30% | 37% | 31% | 327 |
| No | 2% | 6% | 10% | 48 |
| Not sure | 2% | 2% | c | 18 |
| Other | 8% | 3% | 6% | 60 |

The option with the greatest support in the standard consultation was that visiting out should be facilitated ‘unless the care home has reasonable explanation for not allowing it’. Those responding in a professional capacity were slightly more likely to choose this option than people who responded in a personal capacity or as an organisation or charity.

Of the 378 respondents to the easy read consultation question ‘Do you think we should have new rules about going out of the care home?’, more were inclined to say ‘no’ to having new rules about going out of the care home (56%). Those sharing views from a company, or a charity were more inclined to say yes to having new rules about going out of the care home.

Following on from this question, respondents were asked if there were new rules about going out, ‘which new rules about going out do you think are a good idea?’. Out of the 165 responses to this question, 77% responded that ‘care homes should let people go out unless they have a good reason not to’ and 23% responded selected ‘care homes should have a list of reasons why people can’t go out’. This follows a similar trend as the responses in the standard consultation.

Respondents to the standard consultation were asked: ‘if regulations stated that visiting out may be restricted if an exception applies, which of these do you think should be specifically outlined in regulations?’. Options which considered the resident’s safety or general infection prevention and control were most commonly selected. For example, 69% of respondents to this question selected ‘If the person the resident would like to visit is a risk to the physical and/or mental health and wellbeing of the resident’. 68% selected ‘If a resident would like to visit someone who is confirmed to have an infectious disease or is confirmed to be a contact of someone who has an infectious disease’. 58% chose ‘If the resident's care needs cannot be met outside of the care home’.

Responses in the easy read consultation were similar in that the majority of exceptions selected by respondents focused on the service user’s safety. 37% responded ‘If someone wants to go out to meet someone who might hurt them’, 32% responded ‘If someone cannot be looked after or have care while they are out’, and 31% responded ‘If someone wants to go out to meet someone who is unwell and will make other people unwell’.

Several responses from respondents correctly reflected that residents cannot be restricted from leaving the care home premises unless a law such as the Deprivation of Liberty Safeguards under the Mental Capacity Act applies, and therefore any specific requirement to ‘allow’ residents to leave is unnecessary. .

## Government response to views on 'visiting out'

Some concerns were raised about our proposals to include ‘visiting out’ in the proposed legislation. To clarify, although residents cannot legally be prevented from leaving care homes (except in certain cases such as when they lack the relevant mental capacity to make the decision to leave and it is in their best interests to be prevented from leaving), we have heard that there were instances, particularly during the pandemic where residents may have been discouraged from leaving the care home directly or indirectly because of the restrictions placed on returning to the care home. Although government guidance on these measures during the pandemic aimed to prevent the introduction of infection into the care home setting, we recognise that it may have a negative effect on the wellbeing of residents and that some providers may have introduced additional or longer lasting measures.

We have heard from stakeholders about how essential visits out of the care home are for the wellbeing of residents and their loved ones. Therefore, we intend to include a provision in regulations that states that residents should be encouraged to take visits out of the care home. In practice, this will mean that providers should not impose unreasonable rules on returning after a visit out which would effectively act as a restriction, for example unreasonably long periods of isolation.

## Impact and implications of the policy

Before we make a decision about the new policy it is important that we fully understand the impact that it would have on the people and businesses most likely to be affected.

The standard consultation asked:

Do you think there will be an effect on care homes if they are legally required to facilitate visiting under CQC regulations?

Do you think there will be an effect on hospitals if they are legally required to facilitate visiting under CQC regulations?

If care homes were legally required to facilitate visiting by CQC regulations, how would these settings be affected?

If care homes were legally required to facilitate visiting under CQC regulations, how do you think this would affect residents?

If hospitals were legally required to facilitate visiting by CQC regulations, how would these settings be affected?

If hospitals were legally required to facilitate visiting under CQC regulations, how do you think this would affect hospital patients?

What do you think the effect would be on visitors (including those accompanying patients attending hospital)?

The easy read consultation asked:

How do you think our rules would affect people who live in care services?

How do you think our rules would affect the people who want to visit care services?

Do you think our rules would affect people who visit, live or work in a care service in a bad way?

How do you think our rules would affect care homes?

How do you think our rules would affect hospitals?

Tell us how else our rules would affect people who come to visit.

The standard consultation also asked a series of questions about the impact of regulations on those working in a care home or hospital, including questions about the need for additional PPE and length of time of an average supervised visit. The findings from these questions have informed the assumptions used in the impact assessment accompanying the legislation, which will be available on GOV.UK once published.

## Analysis of views on the impact and implications of the policy

**Table 19: standard consultation: Do you think there will be an effect on care homes or hospitals if they are legally required to facilitate visiting under CQC regulations?**

| Response | Care homes | Hospitals |
|---|---|---|
| Yes | 48% | 40% |
| No | 28% | 22% |
| Not specified | 24% | 38% |
| Total | 1,008 | 1,008 |

### Impact on settings

Respondents thought it more likely that there would be an impact on care homes than hospitals from being legally required to facilitate visiting under CQC regulations.

The 487 respondents who thought that there would be an impact on care homes could choose from a range of options as to what these would be, in addition to providing their own response. The most commonly selected responses by individual respondents was that it would offer ‘better opportunities to build relationships with residents and their families or friends’ (62%) and ‘care homes would have a clearer understanding of supporting visiting in relation to other care activities’ (58%). Professional respondents and organisations and charities were more likely to identify that ‘care homes would need to conduct and provide more paperwork and administration to cover the relevant regulations’ as an impact (50% of total respondents). ‘Care homes would feel more confident about allowing visiting in difficult situations such as an outbreak of an infectious disease’ was also identified by many as an impact (55%).

Respondents to the easy read consultation identified similar impacts for care homes, with the most popular impacts chosen being ‘care homes will have better relationships with the friends and family of people who live there’ (63%) and care homes will know how people can visit in really hard times like the COVID-19 pandemic (62%).

Additional responses provided were mixed in sentiment, from suggesting negative impacts relating to risk of infection for individuals in the setting, to positives such as increased dignity and better treatment of residents. While some respondents thought that there may be an increased workload for care staff, others thought that additional visitors may ease the pressure as they could assist with caring for their loved ones.

The 399 respondents to the standard consultation who thought that there would be an impact on hospitals could choose from a range of options as to what these would be, in addition to providing their own response. Respondents identified that hospitals would have a clearer understanding of the importance of visitors (70%), would be better prepared for visitors (61%) and would better explain visiting restrictions in exceptional circumstances (58%). Similar responses were identified in the easy read consultation.

Some respondents did feel that the effect on settings wouldn't all be positive. Consultation respondents identified that hospitals would be under more pressure to accept visitors (43%). Other concerns included an increased burden on staff, potentially having to employ more staff, and increased bureaucracy.

### Impact on residents and patients

The majority of respondents identified a range of positive impacts that requiring care homes to facilitate visiting would have on residents. The most commonly selected options from those provided were 'improvement in residents' wellbeing as they can receive visitors and make social plans' (78%) and 'residents who have difficulty advocating for themselves will be more able to share their wishes or raise concerns due to support from friends or family' (78%).

Several benefits to patients were identified by around half of standard consultation respondents including patients receiving treatment sooner if their health changes, having the benefit of advocacy, improvements in patient wellbeing, relationships with family, mental stimulation, a reduction in loneliness and ability to communicate. 27% thought that patients would be put under increased pressure to receive visitors if they didn't want to.

This was reflected in the responses to the easy read consultation, which asked how respondents thought that the rules would affect those who live in care settings. The majority of respondents selected a range of positive impacts. The most popular options selected were 'friends and families will be able to help notice sooner if something is wrong like if someone is unwell' (67%), 'people will feel less lonely and take part in everyday life more' (66%) and 'people will feel happier and spend more time with their friends and family' (66%).

### Impact on visitors

The majority of respondents identified a range of positive impacts of the legislation for visitors to health and care settings. Respondents were provided with a range of options to choose from, and the impacts most commonly selected were ‘friends and family would better understand the standard of care their loved one is receiving’ (73%) and ‘friends and family would have more opportunities to advocate for their loved one’ (72%). Only 6% of respondents through there would be no significant impact on visitors.

This was reflected in the responses to the easy read consultation, wherein the majority of respondents felt that there would be multiple positive impacts on visitors. The most popular option selected was ‘friends and families will understand more about the care the person who lives there is getting’ (71%).

The majority of those who responded to the question on the easy read consultation which asked whether our rules would affect people who visit, live or work in a care service in a bad way said no.

## Government response to views on the impact and implications of the policy

The impacts identified by respondents were mostly positive for the visitor and resident or patient. The impacts included direct benefits to individual wellbeing and relationships, as well as a sense that providers would have a better understanding about the rules and the importance of visiting. This reflects our confidence that the policy will have a positive effect on individuals who access care, and a particularly positive impact on individuals who have the protected characteristics of age and disability. We have conducted an equality impact assessment to understand the impact on individuals who share protected characteristics in more detail.

Respondents also identified the positive impacts that a better understanding of the rules around visiting would bring. This new standard would therefore address one of the key barriers to visiting, which was noted in consultation responses.

Some respondents noted impacts for health and care providers recognising that a new standard could increase workloads in settings that may already be short staffed. The government and CQC will work to ensure that communications and training will be clear and proportionate, to minimise these impacts, especially in the majority of settings already facilitating visiting in line with existing guidance. Further impacts on businesses are explored in our impact assessment which will be published on GOV.UK in due course.

## Further information

Respondents were asked whether they were aware of any evidence or quantitative research on the benefits to residents and/or patients from receiving visitors.

The standard consultation asked:

Is there any evidence or quantitative research on the benefits to residents and/or patients from receiving visitors that you wish to refer to DHSC?

Do you have any further comments about anything that this survey has covered?

The easy read consultation asked:

Tell us anything else you want us to know about.

We received numerous suggestions for studies and research that we will review for the purposes of the impact assessment accompanying the legislation. Many respondents used this question as an opportunity to reiterate their personal support for visiting, and the benefits of visiting.

When asked for any further comments about anything not covered by the consultation, many respondents again used the opportunity to reiterate the importance of visiting and the beneficial impact it has on patients and residents. A significant number of respondents also expressed views that overall patient safety and wellbeing should be equally as important as visitation rights. Many respondents flagged the importance of measures to manage risk.

A number of respondents referred to potential abuse of current guidance and any future legislation on visitation, with calls for clear guidance on how to implement any rules.

Respondents to the easy read consultation were asked to ‘tell us anything else you want us to know about’. Several respondents reiterated their views about the importance of visiting, particularly so that visitors can act as advocates for their loved ones.

# Next steps

We intend to progress with secondary legislation to amend CQC Regulations to make visiting a new fundamental standard as soon as possible.

# Impact assessment

We will publish an impact assessment on GOV.UK.

# Consultation principles

The principles that government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation are set out in the Cabinet Office Consultation Principles 2018.

# Contact details

Further copies of this report and the consultation paper can be obtained by contacting the ASC Visiting and Health Protection Policy team via email: visiting@dhsc.gov.uk

This report is also available on GOV.UK.

You can request alternative format versions of this publication by emailing: visiting@dhsc.gov.uk

If you have any complaints or comments about the consultation process, you should contact the ASC Visiting and Health Protection Policy team at the email address above.

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