

Health and Safety Executive Board		HSE/ 14/96	
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## Regulatory changes in health and social care: implications for HSE

### Purpose of the paper

- 1 The Board is asked to:
  - note the revised Liaison Agreement between the Care Quality Commission (CQC), HSE and Local Authorities (LAs) in England ;
  - note the support being given to CQC; and
  - note the implications of developments in health and social care for HSE's role across Great Britain.

### Background

2 In February 2013, the Board was invited to consider the implications for HSE arising from the Francis Report of the Public Inquiry into the Mid Staffordshire NHS Foundation Trust. The main issue for HSE related to closing the 'regulatory gap', which exists because HSE's health and social care investigation policy, published on our website, is necessarily restrictive and because CQC lack the powers to act to secure justice.

3 The Government's finalised response to the Inquiry, '[Hard Truths](#) – The journey to putting patients first', was published in November 2013. It:

- said that CQC is the right organisation to investigate and act where patients and service users have been seriously harmed due to unsafe or poor care.
- committed to providing CQC with the necessary powers to take action, including prosecution, where there are clear failures to meet 'Fundamental Standards'.
- recognised that more specific Health and Safety at Work legislation may need to be used in some instances,
- said that the existing CQC/HSE Liaison Agreement would need to be revised accordingly; and
- proposed that HSE support CQC in developing its role in investigation and prosecution.

When implemented, these proposals will substantially close the 'regulatory gap' identified by Francis.

4 The [Triennial Review of HSE](#) recommended that the liaison agreement arrangements should be extended to cover social care and that those being regulated (and those representing patients/service users) be consulted to ensure that the Agreement is sufficiently clear. It also said that any additional work undertaken by HSE to implement the Government's response to the Francis report should be properly resourced. These recommendations were accepted in the Government's response to the Review.

### Argument

#### *Legislative changes*

5 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 will allow CQC to prosecute for some breaches of 'fundamental standards' with effect from 1<sup>st</sup> April 2015. These will include the potential to prosecute for failures to 'deliver care and treatment in a safe way'. From this date CQC will become the lead investigator and enforcer where service users have been harmed because of poor or unsafe care. HSE will largely withdraw from these kinds of investigations save in exceptional circumstances.

6 There are some limitations in the CQC powers. CQC can only hold registered managers and providers to account; they can take no action equivalent to HSWA Section 7 against other individuals (such as care workers or doctors); and they cannot act against organisations who are not registered – beyond prosecuting for failure to register. Bodies who may be implicated in an incident, but do not need to be registered, include commissioners, contractors and those who operate facilities such as day care centres.

7 In addition, a new offence of 'ill treatment/wilful neglect' will be implemented in March 2015 and will apply to individuals as well as employers. The police / CPS will investigate / prosecute such cases in health and social care in England and Wales. If the police require support in these investigations in England, it is likely to come from CQC rather than HSE.

#### *Implications for HSE*

8 In England, HSE and LAs will continue to be the lead regulators and prosecutors for worker, visitor and contractor safety, for circumstances where CQC do not have powers to act, and where HSE's more specific legislation is appropriate (for example, in relation to the statutory examination of plant).

9 Health and social care cases involving patients or service users tend to be high profile and can be complex and time consuming. Because HSE will no longer be the lead investigator for the majority of these cases, resource should be freed up for other activities. However, in the short term, some of that resource will be redirected to providing support to CQC to help them in their new role.

10 To date, we have shared with CQC the benefits of HSE's incident selection criteria, the value of being signed up to the Work-related Deaths Protocol, and the practical applications of the Enforcement Policy Statement and Enforcement Management Model. In addition, we have provided legal support to CQC's lawyers and agreed for one of our lawyers to be seconded to them for twelve months to help with setting up their prosecution team.

11 Further help being provided to CQC in the period up to April 2015 includes organising and delivering peer review exercises; adapting and delivering some HSE training modules, and HSE inspectors acting as 'buddies/mentors' to demonstrate HSE's investigation processes in both site and office contexts. The help required after April 2015 hasn't yet been specified, but is likely to involve similar elements – although with CQC inspectors then taking the lead on their investigations.

12 Discussions are currently underway with DH and CQC on recovering HSE's costs for such activities undertaken to train or develop CQC staff. This is likely to include fixed prices for HSE delivered training modules and FFI rates for the other activities. It is intended to start to recover HSE's costs as and when these services are delivered. HSL will set their own rates for any research or support services provided direct to CQC.

#### *Development of a revised Liaison Agreement*

13 Good progress has been made with CQC, DH and LGA in creating a revised Liaison Agreement for health and social care in England. The LGA have been involved because residential homes are regulated by Environmental Health Officers.

14 FOD Legal and LAO are content with the proposals, and informal feedback has been very positive about its succinctness and clarity. It is also felt to allow a valuable degree of flexibility.

15 Public consultation on the Liaison Agreement started in November - managed by HSE on behalf of all three parties. The current draft is attached at Annex 1. Subject to responses received, we

anticipate that the Liaison Agreement can be finalised and signed off early in the New Year. HSE will then need to modify its internal instructions and published guidance accordingly.

#### *On-going work*

16 CQC will need to develop clear criteria setting out when they may and when they are unlikely to investigate health and social care incidents. It is hoped that these criteria will include the kinds of patient and service user incidents that HSE currently investigate – as well as others that currently fall into the ‘regulatory gap’.

17 Because CQC will be the lead investigator for patient and service user work-related deaths in England we anticipate that they will become signatories of the Work-related Deaths Protocol. Clear criteria and arrangements will also need to be in place to decide when the police / CPS need to be involved in cases of ill treatment or wilful neglect. DH, CPS, HSE and CQC are in discussion about setting the criteria and providing clear working arrangements.

## **Devolved Administrations**

### *Scotland*

18 There are currently no changes to HSE’s role in health and social care in Scotland. HSE will continue to apply current health and social care investigatory policies working with the Crown Office and Procurator Fiscal Service (COPFS) and the devolved health and social care scrutiny bodies that do not have the same powers as CQC. The Smith Commission is due to publish Heads of Agreement with recommendations for further devolution of powers to the Scottish Parliament by the end of November with draft clauses published by 25 January. This may result in further divergence of approach for HSE in Scotland.

19 The Scottish Government is currently consulting on proposals to introduce a new criminal offence of wilful neglect or ill-treatment in health and social care settings. Amongst other things, the consultation seeks views about whether the offence should apply to organisations providing care/treatment as well as individuals.

20 HSE Scotland recently met the Scottish social care regulator and the NHS Scotland scrutiny body and shared with them a copy of the draft CQC/HSE/LA liaison agreement. Both organisations commented favourably on it and may wish to replace existing arrangements with something in a similar style.

### *Wales*

21 There are also currently no changes to HSE’s role in health and social care in Wales. A recent Board Paper covered on-going issues in Wales. These included work with Welsh Government, Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales (CSSIW) to clarify our roles and produce suitable liaison agreements.

22 The Welsh Government has announced that they will introduce a new Bill to reform the regulation and inspection of social care in Wales in February 2015. This aims to focus the regulation of social care towards outcomes for people. It may well result in CSSIW acquiring additional powers to prosecute. An independent review into the work of Healthcare Inspectorate Wales (HIW) has also been commissioned. Although the findings of this report are yet to be known, it may well result in recommendations for further clarity of the role of HIW and legislative changes for additional powers.

### *Implications for GB as a whole*

23 Depending on how CQC exercise their new powers in England, and future regulatory developments in Scotland and Wales, the regulatory landscape for health and social care could look different across GB in the future.

## **Action**

24 The Board is asked to note the proposals in the Liaison Agreement, HSE's support to CQC and wider emerging developments

## **Paper clearance**

25 Cleared by the SMT on 11 November 2014.

DRAFT

## **Liaison agreement between the Care Quality Commission (CQC), the Health and Safety Executive (HSE) and Local Authorities (LAs) in England**

### Introduction

1. This Agreement applies to both healthcare and adult social care in England. It comes into effect on 1 April 2015, and replaces the [2012 CQC/HSE Liaison Agreement](#) that applied solely to healthcare.
2. The purpose of this Agreement is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public visiting these premises. It is one of the measures taken by Government to close the 'regulatory gap<sup>1</sup>,' identified by the Francis Report into failings at the Mid Staffordshire NHS Foundation Trust.
3. It outlines the respective responsibilities of CQC, HSE and LAs when dealing with health and safety incidents in the health and adult social care sectors, and the principles that will be applied where specific exceptions to these general arrangements may be justified. It describes the principles for effective liaison and for sharing information more generally.
4. Other organisations also have roles and responsibilities for investigation and / or prosecution of certain offences in health and adult social care settings, such as the police, the Crown Prosecution Service (CPS) and Safeguarding Adults Boards. CQC, HSE and LAs will notify such relevant bodies of incidents and coordinate activity or work with them as appropriate to protect service users, workers and the public from risk of harm.

### Respective responsibilities for dealing with health and safety incidents

5. CQC is the lead inspection and enforcement body under the Health and Social Care Act 2008 for safety and quality of treatment and care matters involving patients and service users in receipt of health or adult social care service from a provider registered with CQC.
6. HSE/LAs<sup>2</sup> are the lead inspection and enforcement bodies for health and safety matters involving patients and service users who are in receipt of health or care service from providers not registered with CQC.

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<sup>1</sup> The regulatory gap was due to the restrictiveness of HSE's health and social care investigation policy and CQC lacking the necessary powers to act to secure justice.

<sup>2</sup> HSE is responsible for enforcing health and safety at all healthcare premises as well as care homes with nursing, and public social care providers, whilst LAs are responsible for other residential care homes.

7. HSE/LAs are the lead inspection and enforcement bodies for health and safety matters involving workers, visitors and contractors.

8. Annex A contains examples of typical incidents falling to CQC and HSE/LAs respectively to illustrate the responsibilities outlined above. The response from the lead body will be in line with their regulatory approaches, and their decisions on whether to investigate will be subject to their published policies<sup>3</sup>.

#### Incidents where specific circumstances may apply

9 In a small number of cases, more specific criteria may be applied to ensure that the most appropriate body takes charge of the investigation and/or any related enforcement action. These criteria are set out in Annex B. Any such cases will be considered individually on their merits, taking these criteria into account.

#### Liaison in relation to individual incidents

10. Where there is uncertainty about jurisdiction or where Paragraph 9 applies, the relevant bodies will:

- determine who should have primacy for any regulatory action and whether joint or parallel regulatory action will be conducted;
- keep a record of this decision and agree criteria for review, if appropriate;
- designate appropriate contacts within each organisation to establish and maintain any necessary dialogue throughout the course of the regulatory action, and
- keep duty-holders / providers, injured parties and relatives (where appropriate) informed accordingly.

#### General information sharing arrangements

11 Each party to this agreement will work collaboratively by:

- notifying other parties as appropriate as soon as possible about information they receive on incidents in the jurisdiction of that body, and
- sharing relevant intelligence and enforcement data (see Annex C).

12. This agreement will be regularly reviewed – at least on an annual basis.

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<sup>3</sup> For example, HSE's Incident Selection Criteria Board<sup>1</sup> (01.10)

**Illustrative examples of cases that fall to CQC and HSE/LAs respectively**

**Examples of the types of incidents falling to CQC to consider the action to be taken:**

- a service user falling from a window of a second floor premises;
- a severe scalding of a service user in a bath/shower;
- patient deaths arising from a healthcare associated infection on a hospital ward;
- a service user with an need for assistance with eating, identified in their care plan, being given inappropriate food and dying from choking;
- a patient dying from an embolism after the venous thromboembolism (VTE) assessment indicated a high risk, but a prophylactic drug which was prescribed was not administered, and
- a service user being severely injured after being physically restrained in a way that was not in line with national guidance, by staff without training in restraint.

**Incidents falling to HSE/LAs:**

- circumstances where the commissioner, rather than the provider, seems to have been at fault (e.g. a resident with a known history of violent behaviour stabbing a fellow resident having been placed in a new care home without adequate discussion and briefing for the new home);
- circumstances where the provider is not required to be registered with CQC.
- employees developing dermatitis related to glove use;
- a manual handling injury from moving ill-maintained trolleys, and
- a contractor's tower scaffold collapse into a care home car park

**Criteria where more specific and exceptional criteria may apply**

In a small number of cases, more specific criteria may be applied to ensure that the most appropriate regulator takes charge of the investigation and/or any related enforcement action. This may be because of more applicable legislation or because of an absence of applicable legislation (CQC does not have enforcement powers, equivalent to HSW s7, in relation to individuals, for instance). In such cases the circumstances will be considered on their individual merits, and a mutually agreed decision reached. These examples are not exhaustive and do not take account of the police / CPS potential involvement.

**Factors tending towards HSE/LA taking the lead:**

- incidents involving building/maintenance contractors (e.g. scaffolding or asbestos);
- incidents involving installed plant for the use of anyone (e.g. lifts or escalators);
- incidents where specific HSW legislation can most adequately deal with the cause of the harm (e.g. related to the statutory examination of plant, or the Legionella Approved Code of practice), and
- incidents where an individual seems significantly at fault for a health or safety failing affecting a patient or service user, rather than the employer

**Factors tending towards CQC taking the lead:**

- incidents which may expose staff to some degree of harm, but the principal concern is the greater risk of harm which they create for people using the service

**Factors tending towards joint or co-ordinated investigation:**

- incidents where both commissioners and registered providers appear to be significantly at fault, and
- incidents where employers not required to be registered with CQC, as well as CQC registered providers, appear to be significantly at fault.

## **Arrangements for sharing of intelligence to support the Agreement**

The obtaining, handling, use and disclosure of such information is principally governed by the Data Protection Act 1998 and the common law duty of confidence, respectively.

This annex sets out the mechanism for sharing information with the other parties where it is clearly in the interest of the workers or patients and service users.

The following has been agreed as the operational means of information sharing over and above the normal working level arrangements:

- HSE/LAs will request intelligence from CQC, or share concerns, on a case by case basis by contacting their [National Call Service Centre](#).
- CQC will share concerns with HSE via the [Public Services Account](#).
- CQC will request intelligence from, or share information with, LAs on a case by case basis by contacting the [relevant local authority](#)
- HSE will share the outcomes of its health and social care RIDDOR and concerns investigations (including enforcement notices and prosecutions) with CQC on a quarterly basis.