Department of Health & Social Care

FAQs

Visiting and accompanying in care homes, hospitals and hospices

Regulation 9A

Relevant links

Legislation:

The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2023 (legislation.gov.uk)

DHSC Consultation Response:

https://www.gov.uk/government/consultations/visiting-in-care-homes-hospitals-and-hospices/outcome/government-response-to-the-consultation-on-visiting-in-care-homes-hospitals-and-hospices

CQC Guidance:

https://www.cqc.org.uk/guidance-providers/regulations/regulation-9a-visiting-and-accompanying

CQC Consultation Response:

https://www.cqc.org.uk/about-us/how-we-involve-you/consultations/consultation-our-guidance-visiting-care-homes-hospitals-and-hospices

Webinar recordings:

Care Homes: 19 March webinar | 3 April webinar

Hospitals: 25 March webinar | 2 April webinar

Hospices: 27 March webinar

Scope of Regulation 9A

1. When will the regulation come into force?

Regulation 9A came into force on 6 April 2024.

2. Which settings does the regulation apply to?

The regulation applies to care homes, hospitals (NHS and independent, for acute and mental health services) and hospices only.

3. Does the regulation apply to supported living, shared lives and extra care schemes?

Supported living, shared lives and extra care housing schemes (whether they are providing a registered service or not) are not in scope as the accommodation aspect of these settings (including visiting) is not regulated by CQC. People who use these services can decide who can enter their accommodation, and when.

4. Does the regulation apply to services for substance misuse and inpatient detoxification?

While there was clear support in response to the government consultation for a consistent approach across CQC-registered settings, concerns were raised by substance misuse sector representatives about the requirements potentially putting individuals receiving treatment at increased risk. For this reason, we have excluded services for substance misuse and inpatient detoxification from the requirement. This reflects the complex circumstances and risk of relapse for a vulnerable person. We recognise the positive impact that visiting can have for individuals receiving treatment in these settings, and visiting is carefully considered within their care plans.

5. Does the regulation apply to community NHS Trust services?

This regulation applies to hospital settings (as defined in Regulation 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) by reference to the definition in s.275 of the NHS Act 2006), including community NHS Trust services delivered from hospital settings. The guidance in relation to hospital visiting and accompanying applies to all hospital settings.

6. How does this regulation apply to day services?

Day services are not CQC regulated activities so whilst it would be good practice to accommodate visiting/accompanying, this would not be assessed or enforced by CQC.

7. Is the guidance the same for mental health services?

Yes, the same guidance applies for mental health services.

8. Do all maternity services across England have open visiting?

Hospitals are encouraged to adopt a person and family centred approach to visiting and where possible for this to be open and not restrictive. Visiting in maternity settings must be facilitated in line with the regulations unless there are exceptional circumstances and each case should be considered on its facts. Other factors, such as the health, safety and well-being of other women and babies in the ward, should be taken into account and where visiting may not be appropriate in that space, providers should consider alternative means of facilitating visits, such as visiting in day rooms.

9. Does the regulation apply to all age groups?

This regulation applies to anyone who receives services in the course of the carrying on of a relevant regulated activity of any age (unless they come under one of the listed exemptions such as prisoners/people who are undergoing detoxification etc.).

In relation to the age of visitors, the same rules apply and providers should facilitate visits from children in the same way as for adult visitors. As part of their risk management processes, providers should consider any precautions needed to support these visits to happen safely.

Funding and impact on providers

10. What funds are available to support individuals who wish to go out regularly but need supervision to do so safely?

Additional funding will not be provided as providers are not expected to employ additional staff to facilitate visits out. However, where this is part of a person's care plan, the provider should have arrangements in place already and should work with the individual to discuss their needs and how the home can accommodate them. This regulation is about care home providers not discouraging people from taking visits out of the home with friends and family if that's what they wish to do.

11. Will this add more burdens on providers?

CQC-registered providers are regularly assessed against current CQC regulations. The new visiting fundamental standard should not add additional burden to providers as visiting should already be being facilitated, as per existing guidance.

We have carefully considered the impact of this legislation and published a regulatory de minimis assessment.

12. Was the impact on other patients in close proximity considered?

We carefully considered the impact of this legislation on different groups. We don't expect this legislation to lead to a significant increase to the amount of visiting that already takes place and providers should have in place existing procedures to manage and mitigate this risk.

Evidence for legislation

13. What evidence is there that this regulation is necessary?

Concerns about visiting restrictions in health and social care settings were exacerbated by restrictions introduced in response to the COVID-19 pandemic.

While restrictions were in place at the time to control the risk of transmission of a virus that was not well understood and keep people safe, we understand that it was detrimental to well-being for loved ones to have been kept apart or for patients and care home residents not to have had someone supporting them.

We recognise the immense efforts that health and social care providers have made throughout and since the pandemic to facilitate visits as part of the vital care provided.

However, some restrictions continued beyond the lockdown periods, and we continue to hear of instances where care home residents and hospital patients are unable to see their family and friends for prolonged periods of time or be accompanied when they attend hospital. This can be harmful to the health and well-being of those receiving care as well as distressing for their friends and families visiting who, in many cases, provide vital care, advocacy and support.

Visiting restrictions in hospices has not historically been raised as a cause of concern. However, supported by the 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.

The regulation will help to entrench best practice and provide clarity for providers, those using services, and family and friends.

14. What if the legislation doesn't work?

We will continue to monitor the situation regarding visiting going forward. We believe this legislation will prove effective at addressing the current concerns on visiting in health and care settings, however if this is not the case or additional concerns arise, we will consider other options to resolve them.

CQC enforcement, inspections and guidance

15. How will this be enforced by CQC?

CQC can use its civil enforcement powers (for example, warning notices) to ensure compliance with this new regulation. CQC will use enforcement action, where necessary, to require, or in more serious cases, to force, a provider to protect people and ensure they receive services of an appropriate standard.

CQC's published enforcement policy sets out a robust, proportionate approach for taking action against providers who do not comply with the regulations. This will include visiting and accompanying under the regulation.

For more information, see: Enforcement policy - Care Quality Commission (cqc.org.uk)

16. How many providers are currently allowing visiting?

Self-reported data through the Capacity Tracker shows that In the week ending 14 March 2024, 99.8% of care homes in England were able to accommodate residents receiving visitors. This figure has been stable since September 2022.

Whilst providers will not be required to formally notify CQC of visiting restrictions, CQC will continue to gather information on this through its usual routes, e.g. people's feedback on care, talking to staff and leaders, information from local system partners and, for social care providers, there will be questions in the Provider Information Return.

17. What evidence do providers need to provide to the CQC assessor/inspector?

CQC would expect to be assured that providers are meeting the requirements of the regulation unless there are exceptional circumstances. CQC is not prescriptive about how to the meet the requirements of the regulation, but providers should be able to show, for example, how they have risk assessed the situation, who has been involved in the decision-making, whether mitigations can be put in place, if an exceptional circumstance means a restriction is put in place how and when this is reviewed, etc. For further information about CQC's approach to assessing the regulation, please see the CQC guidance on Regulation 9A.

18. Are CQC expecting providers to have a policy on visiting?

CQC cannot be prescriptive about how providers meet the regulation.

Many providers are likely to already have policies and procedures in place if they are already considering how best to provide care in a person-centred way. It may be sensible to review any existing policies and procedures to ensure people are clear about how providers might risk assess and make decisions about visiting and how providers are including people in the decision making. Providers may also wish to review procedures about how people can raise concerns about any restrictions.

19. Does the guidance cover what is an exceptional circumstance?

CQC does not want to 'normalise' what exceptional circumstances are by giving examples, however we are clear that restrictions should not be commonplace. The circumstances should be exceptional to each individual case, and we cannot provide a typical response for each unique situation.

What is 'exceptional' in a 6-bed service for people with a learning disability and autistic people may be very different in an acute setting. It will depend on the facts of a particular case. What will be important is the process the provider has put in place to assess the situation before reaching a decision. Generally, CQC will look at whether they done an individual risk assessment, spoken with all relevant parties, looked at possible mitigations before imposing the restriction, though this will be fact dependent.

For more information about providers' obligations under the new regulation and CQC's approach to assessments, please see the CQC guidance on Regulation 9A.

20. Does this include an expectation to provide virtual visiting (networking, Wi-Fi and devices)?

The regulation refers to visits on the premises and does not specifically cover 'virtual visiting'. However, we would encourage providers to consider alternative means of supporting patients and residents to remain connected with their friends and families, especially in the exceptional cases where visiting restrictions are required, or where family and friends may not otherwise be able to visit in person (for example if temporarily unwell, mobility issues, etc). If using virtual methods of communication and connection are people's preference, or used as an alternative means of supporting people to maintain their relationships where in person visits cannot take place, this would be encouraged.

21. Will hospitals be changing the information in appointment letters about patients needing to attend appointments alone due to COVID-19?

Since May 2022, hospitals have been expected to return to pre-COVID visiting and accompaniment as a minimum expectation. Hospitals should not be restricting visiting or accompaniment to appointments in this manner unless it is an exceptional circumstance. All decisions should be evidence based and be undertaken following a risk-assessment. Hospitals may want to review their local policies and associated documents to ensure these are updated in line with the legislative changes.

Visiting hours

22. What does this mean for visiting hours (e.g. overnight/protected mealtimes)?

This regulation will not change hospital visiting hours. However, blanket restrictions on visiting outside of those hours should not be applied and requests should be considered on a case-by-case basis.

Visiting must be facilitated in a way that is appropriate, meets the person's needs, and, so far as reasonably practicable, reflects their preferences.

It may be determined that late night and overnight visits are not appropriate, for example due to the fact it would be disruptive to other residents, but each case should be considered individually.

We would always expect a person on end-of-life care to be able to receive visitors at any time subject to the above points about visits meeting the person's needs, and, so far as reasonably practicable, reflecting their preferences.

23. We have a two-hour rest period in the middle of the day following patient and relative feedback, does the new regulation affect this?

The health, safety and well-being of people in health and care settings is paramount.

If an arrangement has been agreed based on the preferences and needs of those using the service and their friends/families, then it might be a matter of clearly recording this, and reviewing at regular intervals to ensure the arrangements still meet people's needs and wishes. If someone requests a different arrangement, then that should be considered on a case-by-case basis and supported wherever practicable, balancing their rights and needs against those of others using that service.

24. How does this align with existing NHS Hospital guidance on visiting?

Visiting must be facilitated in a way that is appropriate, meets the person's needs, and, so far as reasonably practicable, reflects their preferences.

Trusts will need to be flexible and consider requests for visiting outside of the regular arrangements on a case-by-case basis. This may include, for example, facilitating a visit during medical rounds if a patient wishes to have a relative/advocate there to hear what is said or to ask questions.

25. What is considered 'normal visiting'?

Visiting will look different in different settings. By 'normal visiting' we mean visits are facilitated unless there are exceptional circumstances.

26. How should hospital providers balance visiting preferences on wards?

The health, safety and well-being of people in health and care settings is paramount.

Providers should try to accommodate visiting when requested, however this should be balanced against the rights and needs of other residents.

Where visiting may not be appropriate in that space or might disrupt other patients, providers should consider alternative means of facilitating visits, such as visiting in day rooms or allowing fewer visitors at one time.

Accompanying residents to hospital

27. Does this regulation require providers to escort/accompany residents to hospital (appointments, emergency admissions etc.)?

This regulation does not require providers to escort or accompany residents to hospital appointments, emergency admissions etc.

It does not supersede any existing arrangements or actions a care home provider would usually take around this area of care, taking into account people's existing care plans.

The regulation requires hospital and hospice providers to facilitate anyone attending outpatient appointments, emergency department and diagnostic services to be accompanied by someone if they need or wish to be.

28. If a person lacks capacity to make treatment decisions and needs to go to the emergency department, is the care home required to provide a carer to accompany them to the hospital until family can meet them there?

This regulation does not supersede any arrangements you would usually make around this area of care, taking into account people's existing care plans and needs and the need to meet other existing regulations, such as Regulation 9 person centred care and Regulation 12 safe care and treatment, for example. It is aimed at ensuring people are permitted to have someone accompany them to appointments if they wish.

29. Does this regulation impact patient transport services?

Transport services are not in scope of this regulation.

30. Is there a requirement for paid carers to visit their residents if in hospital?

This regulation does not require paid care workers to visit residents in hospital above what is already in place under people's care plans in line with their assessed needs. This regulation is about allowing visitors if they and the patient/resident wish to visit, rather than requiring visits.

Visiting out

31. Do the rules mean that we should not discourage anyone from visiting out, even if it is unsafe?

In most cases, where a person has the relevant capacity, they can make their own decision about going out, even if this might be considered an 'unwise decision' with some risk to themselves.

If the visit out would pose a significant risk to the health, safety or well-being of the person or others which cannot be mitigated, the provider should consider whether an exceptional circumstance exists.

This should be discussed with the person and any other relevant people involved, and any alternative arrangements offered if possible. The provider should make a record of any decision-making and the decision should be reassessed at the appropriate time.

If they have a proper reason to do so, providers should assess the person's capacity to make that decision, and any safeguarding issues, as they would in any other situation. Where a person lacks capacity to make a decision about visiting, any decision about visiting should be made in their best interests.

32. How do we mitigate the risks posed to residents and staff by visits out of the care home?

Residents with the relevant capacity should not be discouraged from taking visits out of the care home unless there are exceptional circumstances which, for example, mean that going out would pose a significant risk to the health, safety or well-being which cannot be mitigated.

In most cases, residents with the relevant capacity cannot be prevented from leaving the home. Where their return may pose a significant risk to others in the home, then measures such as isolation may be risk assessed and imposed, relying on the exceptional circumstances exception.

If a resident lacks the relevant capacity, any decision about going out will need to be made in their best interests.

Infection Prevention and Control

33. What happens if there is another pandemic or an infectious disease (e.g. COVID/ D&V) outbreak in the setting?

In the event of another pandemic or infectious disease outbreak, providers would, in the absence of any legislative provision which provides otherwise, still be required to comply with this regulation and would be expected to continue facilitating visiting and accompanying wherever it is safe to do so, and in line with any relevant government guidance issued. They should implement precautions (such as PPE) which reduce risk and allows visits to go ahead.

The health, safety and well-being of people in health and care settings is paramount, so where risk cannot be mitigated and is significant, restrictions to visiting and accompanying may be justified as an exceptional circumstance. In those cases, providers should offer alternative arrangements such as virtual visits to ensure residents/patients maintain contact with loved ones.

End-of-life visiting should be facilitated in all circumstances.

34. Can we restrict visiting if a visitor is abusive to staff and/or residents or refuses to comply with IPC rules (such as wearing PPE)?

Providers are required to comply with the regulation unless there are exceptional circumstances. The regulation does not entitle a particular person to visit, but instead requires providers to ensure persons in care homes, hospitals and hospices can receive visits.

If the visitor's conduct would pose a significant risk to the health, safety or well-being of a service user or an employee of the provider, then the provider may be able to rely on the exceptional circumstance exception.

Providers should assess the risk posed and consider if the risk can be mitigated before making a decision to refuse a visit by that person.

35. If providers are asked to go into lockdown in the future, do providers still need to follow this regulation?

In the case of a national-level outbreak, providers would be expected to follow any government guidance issued in relation to the specific situation.

This regulation should help to encourage dialogue between providers and sector partners in cases where there are local-level outbreaks to understand whether restrictions are needed, or whether precautions can be put in place to mitigate risks and continue to facilitate visits safely.

Equality, Diversity and Inclusion

36. How does this work alongside the Equality Act and support visiting from an EDI perspective?

Providers must continue to work within the requirements of the Human Rights Act 1998 and the Equality Act 2010, including the Public Sector Equality Duty, where applicable, and make reasonable adjustments where necessary. The CQC guidance provides that a human rights-based approach to decision making can support providers in enabling visiting and accompaniment and when considering complex situations. This includes considering the balance between a person's rights and risk and safety. Providers must consider whether any restrictions are proportionate.

Other policies

37. What is the difference between this regulation and the NHSE Health and Care Partner policy?

This new CQC fundamental standard puts visiting and accompanying level with other requirements so that CQC can explicitly assess visiting and take action where it is not being facilitated in line with the regulation.

There is no intention for NHS England's National Health and Care Partner Policy to have any legislative basis as NHS England is focused on working with providers to achieve the necessary culture change.

38. What is the difference between this regulation and the Principles for Health Protection Teams (HPTs)?

The Principles for HPTs provide guidance for HPTs to support decision making in the event of an outbreak of an infectious illness in a care home.

The principles align with the regulation on visiting and accompanying and make clear that where restrictions are considered necessary because of an exceptional circumstance, any such restriction must be proportionate, risk based, and time limited.

39. Does this give residents a 'right' to a care partner/supporter?

The regulation introduces a new requirement on specific CQC-registered health and care providers to facilitate visiting and accompanying, rather than providing a right for the visitor to enter.

In practice, the impact will be similar as the new fundamental standard puts visiting on an equal footing with other legal standards such as 'dignity and respect', emphasising the importance of visiting to providing good care.

Complaints

40. What can I do if I have a concern about visiting?

CQC are responsible for regulating the health and adult social care sectors and a provider's approach to visiting will form part of CQCs monitoring and assessment once the regulation is live from April. They can take regulatory action where a provider is breaching regulatory requirements, such as the fundamental standards of care.

Where an individual has concerns regarding visiting or believe that a health or social care provider is not following guidance or regulations, they can, firstly, provide feedback or make a complaint to the provider. CQC registered providers must have a complaints procedure which is accessible to all and explains how to raise a complaint.

Complaints can also be made to local authorities where residential care is funded by the authority, or to the integrated care system (ICS) if a setting is funded by the NHS.

If an individual is not happy with the response from the social care provider, they can contact the Local Government and Social Care Ombudsman about the complaint and may also wish to inform the CQC.

Whilst CQC does not act on individual cases, a complaint about visiting would be considered alongside other information CQC have on the provider and may trigger regulatory action.

For NHS complaints

To make a complaint about any aspect of NHS care, treatment or service, individuals should follow the NHS complaints process.

The Patient Advice and Liaison Service (PALS) can be used for free, confidential and independent advice to help resolve issues with the hospital in the first instance.

If an individual is not happy with the response from the health provider, they can contact the Parliamentary and Health Service Ombudsman, and may also wish to inform CQC.