

Memorandum of Understanding between the Care Quality Commission, the Health and Safety Executive and Local Authorities in England

Introduction

1. This Memorandum of Understanding (MoU) applies to both health and adult social care in England. It comes into effect on 1 April 2015, to reflect the new enforcement powers granted to the Care Quality Commission (CQC) by the [Regulated Activities Regulations 2014](#). It replaces the 2012 Liaison Agreement between CQC and the Health and Safety Executive (HSE) that applied solely to healthcare.
2. The purpose of this MoU 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’¹ identified by the Francis Report into failings at the Mid Staffordshire NHS Foundation Trust.
3. It outlines the respective responsibilities of CQC, HSE and Local Authorities (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 also describes the principles for effective liaison and for sharing information more generally.
4. Other organisations also have roles or responsibilities for investigation, prosecution and/or oversight in relation to offences in health and adult social care settings – such as ill-treatment or wilful neglect. Appropriate liaison with other prosecutors/regulators/oversight bodies, such as the police, Crown Prosecution Service (CPS) and Safeguarding Adults Boards is essential. Some of these may be signatories to the [Work-related Deaths Protocol \(WRDP\)](#). CQC, HSE and LAs will notify relevant bodies of

¹ The regulatory gap was due to the restrictiveness of HSE’s health and social care investigation policy and CQC lacking the necessary powers to secure justice at that time.

incidents and agree the coordination of activity or work with them as appropriate to protect patients, 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 a health or adult social care service from a provider registered with CQC.
6. HSE/LAs² are the lead inspection and enforcement bodies for health and safety matters involving patients and service users who are in receipt of a health or care service from providers not registered with CQC.
7. HSE/LAs are the lead inspection and enforcement bodies for health and safety matters involving workers, visitors and contractors, irrespective of registration.
8. Annex A contains examples of incidents typically 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 or take further action will be subject to their guidance and published policies.

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 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;

² 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.

- 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.

Incident notifications and general information sharing arrangements

11. The existing statutory requirements for the notification of incidents will continue for the time being (e.g. [RIDDOR](#) and [CQC's notification requirements](#)).
12. Each party to this MoU will work collaboratively by:
 - notifying the 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).
13. This MoU will be regularly reviewed – at least on an annual basis.

Annex A: Illustrative examples of incidents that fall to CQC and HSE/LAs respectively

Examples of the types of incidents falling to CQC to consider and decide the action to be taken (if the premises are registered with CQC). These examples are not exhaustive and do not take account of the police / CPS potential involvement:

- a patient/service user falling from a window;
- a severe scalding of a patient/service user in a bath/shower;
- a patient/service user with a need for assistance with eating being given inappropriate food and being seriously harmed or dying from choking;
- a patient/service user who did not receive treatment in line with their care plan who died or was severely harmed as a result;
- a patient/service user being seriously injured or dying after being physically restrained by staff; and
- ill-treatment or wilful neglect of a patient/service user.

Incidents falling to HSE/LAs:

- circumstances where the commissioner of the service, rather than the provider, seems to have been primarily at fault;
- circumstances where the provider is not required to be registered with CQC;
- employees developing dermatitis related to glove use;
- a manual handling injury to an employee from moving ill-maintained trolleys; and
- a contractor's tower scaffold collapses into a care home car park.

Annex B: Incidents 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 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 [Section 7 of the Health and Safety at Work etc. Act 1974](#) (HSW), in relation to individuals, for instance). In such cases the circumstances will be considered on their individual merits, and a mutually agreed decision reached, in line with our published policies. These examples are not exhaustive and do not take account of the police / CPS potential involvement.

Factors tending towards HSE/LA taking the lead include incidents:

- involving maintenance contractors (e.g. scaffolding or asbestos);
- involving installed plant for the use of anyone (e.g. lifts or escalators);
- 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).

Factors tending towards CQC taking the lead include incidents:

- which may have exposed staff to harm, but the principal concern is the greater risk of harm to patients / service users.

Factors tending towards joint or co-ordinated investigations include incidents where:

- both commissioners and registered providers appear to be significantly at fault;
- employers not required to be registered with CQC, as well as CQC registered providers, appear to be significantly at fault, and
- providers should be registered with CQC, but are not. (In such cases CQC would consider the failure to register, and HSE/LAs the specific non-compliance issues.)

Annex C: Arrangements for sharing of intelligence to support the MoU

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 described in paragraph 12 of this MoU:

- HSE/LAs will request intelligence from CQC, or share concerns, on a case by case basis by contacting their [National Customer 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), in England, with CQC on a quarterly basis.
- CQC will share intelligence with the police and/or CPS by contacting the relevant local service.