



HOUSES OF PARLIAMENT

Joint Committee on Human Rights

Oral evidence: [Protecting human rights in care settings](#), HC 216

Wednesday 18 May 2022

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Members present: Ms Harriet Harman MP(Chair); Joanna Cherry MP; Baroness Chisholm of Owlpen; Lord Dubs; Florence Eshalomi MP; Lord Henley; David Simmonds MP; Lord Singh of Wimbledon.

Questions 68 - 80

Witnesses

[I](#): Gillian Keegan MP, Minister of State for Care, Department of Health and Social Care; Michelle Dyson, Director-General for Adult Social Care, Department of Health and Social Care; Lyn Romeo, Chief Social Worker for Adults, Department of Health and Social Care.

Examination of witnesses

Gillian Keegan MP, Michelle Dyson and Lyn Romeo.

Q68 Chair: Welcome to this session of the Joint Committee on Human Rights. I am Harriet Harman and I am Chair of the Joint Committee, which, as its name suggests, is a Joint Committee of the House of Lords and the House of Commons. Half our members are from the Lords and half from the House of Commons. We have members here in person but also remotely.

Our concern, again as our name suggests, is human rights, and this is our inquiry into protecting the human rights of those who are living in care settings. This is our fifth and final evidence session of this inquiry. During this inquiry, we have heard from those who have relatives in care and from care providers. We have heard from expert analysts and from the NHS. Today we are very grateful to be concluding this inquiry by hearing from the Minister responsible, the Minister of State for Care and Mental Health, Gillian Keegan. Welcome, Gillian—thank you for coming to give evidence to us—and two of her senior civil servants.

I do not know about the rest of the committee, but I for one think that civil servants do an incredibly important job. We hope that you and all your colleagues will remain doing your public service, and we have two such senior civil servants. We have the director-general for adult social care, Michelle Dyson, and the chief social worker for adults, Lyn Romeo. Thank you for coming.

I will kick off with the first question. In the course of this inquiry, we have heard some really disturbing, horrible evidence about people in care settings not having their most basic, fundamental human rights respected. It was felt that this was even more of a concern during the pandemic. The Government have a number of human rights to consider here. There is the right to life, guaranteed under Article 2—in a pandemic you obviously have to be protecting the right to life—but also the right not to be subjected to degrading treatment and the right to private and family life, as protected by Article 8 of the European convention. Visiting rights is an issue to do with the right to family life.

Do you feel, looking back on it, that you got the very difficult balance right between doing what you had to do in a pandemic to protect the right to life and protecting those other human rights—the right to family life and the right to be protected from degrading treatment?

Gillian Keegan: As you mentioned, that balance is incredibly difficult, and was particularly so at the beginning of the pandemic. At the beginning of the pandemic there was very little knowledge. We know that those in a care home setting are the most vulnerable in our society. We knew that was where the most vulnerable people were. We knew we had to protect them. We knew that we had to get the balance right, because obviously there were people going in to help them. There were people going in as part of their care, and there were family measures on visiting. At the beginning, the focus was very much on the right to life and trying to make sure that we protected people's lives.

I was not there, so I was watching this from the outside as a constituency MP, but I know that, right at the beginning, the focus was on making sure that people in care homes were safe. In my own area there was a lot of talk about step-down facilities, how people could go between hospitals, et cetera, and how we could best manage that. The balance changed over time. We were able to get balance so that people could go in. In the early days, there were screens and there was some outdoor visiting, et cetera, but clearly there was a focus on trying to get the visiting back as soon as possible.

The other difficulty was how to manage outbreaks in care homes. With outbreaks, there were infection control procedures that caused a great deal of distress to families, even in the later stages. Even though we do not have care home visiting restrictions, or even when the number of visitors is restricted to three visitors or essential caregivers, there are still some care homes, although it is a small number, that do not accept visitors inside when they are in outbreak.

We have been very clear all along about the guidance. We were very clear about trying to prioritise visiting as soon as the first wave was over, but it is fair to say that I have also met many families and many residents who feel very strongly that they need to be able to see their loved one in a care home.

My grandmother was in a care home. It does not take much to understand how difficult that would be, particularly with conditions like dementia. My grandmother had dementia. She would not have known. Not being able to explain what has changed and what is happening or to provide that comfort has probably been the most heart-breaking part of trying to get balance with regard to the right to life. Even the idea of a pandemic would be very difficult to explain.

Chair: Could you understand the anguish of some relatives when there was a period when workers were going in and out of the care homes, including agency workers and those perhaps who were not vaccinated, but relatives were not allowed in, even though they would be living a socially isolated life and taking great care? The agency workers would be going from home to home and might be living with teenagers who were going out, but these relatives, living a quite secluded life, were not able to go in, and that gave people the impression that the right to family life was not sufficiently focused on. What about that discrepancy?

Gillian Keegan: If you remember, at that point in the pandemic there were lots of these things that seemed illogical and did not pass the common sense test. Someone would say, "I'm going in to visit my wife. I'm in my 90s. I don't go anywhere apart from going in to visit my wife. I've a very low risk of catching it". At the beginning, elderly relatives in particular were prioritised for the vaccine. They would say, "I've not been anywhere. I've not seen anybody". There was a lot of trying to equate risk and the risk-reward benefit in the system.

Clearly, one of the things we were really worried about with care homes—as I say, I was not there, but I am sure this would have been a primary concern—was making sure that there were staff in the care homes and that they could take care of people. This applied not only to the care staff but to some of the nursing staff who would need to go into the care homes.

I, like most people, watched in horror the other countries that did not manage that balance. I lived in Spain for many years before becoming a Member of Parliament, and I spoke to people there about what had happened in care homes in Spain. They had had terrible trouble keeping staff to look after people who were elderly. That is your worst nightmare. You have to make sure that you have enough staff able to keep people safe. We know that the pressure on social care staff was there before the pandemic. It was massive during the pandemic and it is still there now. It will probably still be there all the time I am in this role, because we are dealing with a demographic shift and something that we have neglected to do over many decades: really put the foundations in place to build a very solid social care workforce. That is why we are taking a lot of steps to do that now.

I would imagine, looking at what was happening around the world, that the initial focus would have been on making sure that the staff were there and that they could go in, feed people and make sure that people were looked after and kept as well as possible. That would have been the priority at the time. They probably had a lot of examples they had seen where that had not happened.

Q69 Lord Henley: I am a Conservative Member of the House of Lords. You are quite clear about the guidance that you offered and the difficulty about getting that right. I can see, with the balance between all the different rights, that that is difficult. Are you satisfied, having got the guidance out, that it was adhered to? Did you monitor how they were doing in following that guidance? Has any data been collected as a result?

Gillian Keegan: The clue is in the name. It is there as guidance. You have heard from the CQC. Initially, it paused some of its work, as did many of the regulators, because that would have been the wrong time to go into care home settings. During the pandemic, it moved to more of a risk-based approach, which is important. Where there were concerns coming up—where a number of families had raised concerns about particular care homes, blanket bans, et cetera—it used that to inform where it looked and what questions to ask of which care homes. That was probably the right approach.

The way all our systems work, you have guidance, you have legislative frameworks, the local authorities and the care home providers have duties in this regard, and you have guidance, from the Department of Health and Social Care, to help navigate aspects when you are dealing with tricky situations like this. Then, of course, you have the regulator, which comes in at some point to check that it is all going on. So there is always the question, which is the most important question, about how

you make sure that the whole system works together. Without the regulatory enforcement and that feedback loop, you cannot improve the systems, and you cannot change the guidance or make it clearer, if it needs to be clarified. Sometimes guidance is not perfect. That is a continual feedback loop.

The whole work that we are doing with the reforms almost demonstrates that we acknowledge that we want accountability and more data. We want to have more information about what is going on. Michelle was there at the very beginning, or part way through, and we did not have much data even to make some of these decisions at the time, because care homes, unlike the NHS, are private third-party settings. There is a lot we will take from that experience to feed into our reforms.

Michelle Dyson: On the point about how we monitor this and our guidance, exactly as the Minister says we have the CQC, et cetera, but the other thing that we were using and continue to use is a tool called a capacity tracker. Providers fill that in for us daily and weekly, including on what is going on with visiting. It is not the most perfect tool and there are clearly 15,000 care homes. How regularly do they fill it in? It gives us visiting trends, and we can see how many of them say that visiting is happening, and we can see what reason they give for when visiting is not happening, which is principally outbreaks now, which is in accordance with our guidance. During the height of the pandemic, we used that tool assiduously. We have our own regional team and we could follow up where we thought that there were problems. It now feels much less of a problem. We are hearing much less noise on visiting.

Lord Henley: Lessons have already been learned, just as you fine-tune.

Michelle Dyson: Lessons were learned all the way through. In terms of this whole balance between Article 2 and Article 8, which was what we were trying to do all the way through, we were having discussions hourly with our public health colleagues about how to get that balance right. We were changing the guidance. I know this was difficult for providers, because we changed the guidance frequently, but did that because we wanted to get the balance right, and we changed the guidance more frequently than the national guidance changed. We were constantly adjusting and trying to get it right. As mass testing became available and then vaccines, that gave us more opportunity.

The big change we made was the introduction of the essential caregiver in March 2021. Now we have said, "You never completely close off visiting. Even when you are in an outbreak, there is always one person who must be allowed in".

Q70 **Joanna Cherry:** I am the SNP MP for Edinburgh South West, but I stress that my questions in this session relate to what was happening in England and Wales. The current guidance, as you have said, says that every care home resident should have one visitor who can visit in all circumstances, but we are aware from the evidence we have taken that care providers often fail to apply that guidance. Should there be a legal

right for patients and residents to nominate one person who can visit in all circumstances, subject to the same infection control measures as care staff?

Gillian Keegan: It is something that we keep under review. We are looking at whether that would make sense and could be achieved. I know there are lots of campaigns that would like to have that. However, the guidance is very clear that settings should not restrict visiting, and legislating could have a similar effect to the guidance.

One of the first things I asked was, "How many complaints have been made and where are they? Who are these complainants? Have they had their complaints looked at?" We looked, and since 1 December 2021 the CQC has received visiting concerns regarding 246 services, of which 104 contain allegations of blanket bans. The CQC is reviewing the most recent of those, but it has been through all the others too, speaking to the local authorities and raising safeguarding concerns if required.

When I first looked at this, a lot of people were tagging me, saying, "I can't see somebody in my care home", et cetera. It was a widespread problem. I think that more than 80% of the care homes were open for visiting, based on the capacity tracker, which did not exist at the beginning of the pandemic; it was developed to get feedback from care home providers in real time, or in as real time as we could make it. Of course, if you are in one of those 19% or 20% and it is your loved one who you cannot get to or the care home is in outbreak, those statistics or numbers do not help.

It is being kept under review. I know people feel that it would give them an extra layer of protection. However, we would still have to navigate managing outbreaks. That is not just in our own guidance on pandemics but in the World Health Organization guidance.

Joanna Cherry: I want to explore the answer you have given there, because you have put quite heavy emphasis on the role of the CQC. It seems to us from the evidence we have taken so far that there is a bit of a mismatch between what you and your government colleagues are confident the CQC can do and what the CQC has told us it is able to do about ensuring compliance with the government guidance.

For example, when we wrote to you previously, you came back to us refusing to accept our recommendation that you put the Government's guidance on a statutory footing, saying that you were satisfied that the CQC had sufficient regulatory powers to take evidence where providers were not appropriately or proportionately supporting people to have access visits and where their rights were being compromised.

The difficulty with that is that when Peter Wyman from the CQC wrote to us, he said, "We do not have the power, under the legislation given to us by Parliament, to compel care homes to inform us of any changes to their visiting status. Similarly under our legislation we do not have the power to require care homes to report their 'live data on levels of visiting'.

Neither do we have the power to take action against care homes that are not reporting changes to their visiting data”.

More recently, again, when we wrote to the Prime Minister about this in March, his answer was very much founded on the powers of the CQC. It seems to me that what you as a Government are saying to us is, “Oh no, the CQC can monitor this adequately”, but the CQC is saying to us, “We don’t have the powers to do that”.

Gillian Keegan: I can imagine that what happened with this experience is that, if you look at how the system was set up and what we felt we needed to add to it, we were trying to get data from capacity tracker. There was no data from the care homes. It is a very fragmented market. There are 15,000 to 18,000 participants, if you include domiciliary care. Looking at the structure of the market, with 15,000 to 18,000 players in it, it was probably set up with that in mind. We now realise that the capacity tracker was a vital part of us being able to understand what was happening in care homes.

The other side of this is that the statutory duties locally are with local authorities, so one of the things that we are looking at as we go forward is how we look at, monitor and measure the quality of what the local authorities are doing. We will be changing a lot of things with the reforms, and we will be looking at what the CQC has and whether that works well. We should keep that constantly under review, as well as looking at whether putting this in legislation adds anything.

However, you also have to make sure that you get the right balance with the system that you set up that is scalable, enforceable, works and can deal with that kind of market, because it is an extremely fragmented market and it is all private sector.

Joanna Cherry: I think we will have more questions later about the CQC’s powers, but just focusing on this issue of whether visiting rights should be put on to a statutory basis, this cross-party committee has recommended, after taking extensive evidence, that the Government’s guidance go on to a statutory footing. In Scotland, the Scottish Government have announced that they will introduce legislation to ensure that people in care homes have the right to see visitors even during outbreaks. I should pause and say that was not just the Government in Scotland. In fairness, there was also huge pressure from opposition parties to do this, so again it was cross-party.

It seems that in Scotland the Scottish Government have taken the view that they will be able to do that, that they are well advised to do that, and they will introduce this legislation, which will be known as Anne’s law in Scotland, into the national care service Bill, which will be introduced to the Scottish Parliament by the end of the parliamentary year. I am just wondering, given the cross-party support for it in the recommendations of this committee, and given that the Scottish Government, with cross-party support in Scotland, is introducing such a law, why you do not just go ahead, do it and resolve the issue. As our Chair said, we have heard

really distressing evidence. We all have examples from friends or, for those of us who are Members of Parliament, constituents who have suffered greatly during the pandemic. Why not just go ahead and put this on to a statutory footing? What is stopping you?

Gillian Keegan: Nothing is stopping it particularly, apart from the fact that we are doing a huge amount of reform in this area, and in the Mental Health Act. An awful lot of legislation is changing. There are an awful lot of moving pieces within the system. There is nothing stopping it. We just want to do what works. As I say, that is why it is being kept under review. I would not want the committee to think that I am saying that this is something that we do not think is a good idea, that we would never do and would never consider. It is not that. It is just that there are a lot of things that we are considering and it is kept under review. As soon as I have any further updates, I would be delighted to give them to the committee.

Joanna Cherry: Michelle, do you want to add anything on this question of whether we should put the guidance on to a statutory footing, or what might be problematic about doing that?

Michelle Dyson: I have nothing further to add on that point. It is worth being aware that you can make a complaint to the ombudsman. It is not just the CQC. Actually, 72% of complaints to the ombudsman are upheld. Local authorities are very good at implementing their recommendations, so that is something that you can use if you are a family member concerned about visiting.

Joanna Cherry: It takes quite a long time, though, does it not?

Michelle Dyson: Yes.

Joanna Cherry: If I am trying to get in to visit an elderly relative who may have only a couple of months left, a complaint to the ombudsman is not really going to cut it, because, based on my experiences as an MP—no offence to the ombudsman; it is just the nature of the system—the chances are that by the time they get back to me, my elderly relative will be dead, without me getting to see them and without them getting to see me.

Michelle Dyson: If you are local authority-funded, you can also complain to the local authority. That might be a quicker route.

Joanna Cherry: That is only if you are local authority-funded.

Michelle Dyson: Yes, whereas the ombudsman is for everyone, as is the CQC.

Lyn Romeo: It might be worth adding that, whether you are funded by the local authority or not, the local authority has a safeguarding responsibility to all the residents in their borough. If there were concerns that the person's human rights were being undermined or that they were not safe because they could not have that stimulation and contact with

their family, the local authority could ask a social worker to go in and look at that situation.

Certainly, from what I understand, during the pandemic social workers were going in and out of care homes to ensure that people were, hopefully, getting the right care and support if concerns were raised about those sorts of issues. It is not perfect, and I know that lots of things were in flux at the time, but that is another way in which what the local authority and social workers can do can enhance or support what the CQC should be doing about the visiting arrangements.

Q71 Chair: Taking the issue of the complaints system further, Minister, you mentioned that most of this provision is in the private sector, but it is a regulated sector even if it is in the private sector. We should be concerned that the regulatory processes protect people's human rights and it is not just left to beleaguered relatives of very vulnerable residents to enforce high standards. There has to be the protection out there through regulation.

On the issue of complaints, we heard a total absence of confidence, it is fair to say, in the ability of residents' relatives to complain and for that complaint to do anything other than make things worse. There was a real sense that, because of the vulnerability of residents and the inadequacy of levels of provision generally, they were worried that if they complained, it would make things worse for their relative or even end up with the relative being asked to leave the home with nowhere else to go.

It is of the utmost importance to have a good complaints system as a safety valve, so that Government can not only redress individual complaints and be assured they are being addressed, but hear people having the confidence to make those complaints. The CQC told us that it does not investigate individual complaints unrelated to the Mental Health Act. A lot of people who contact the CQC feel very rebuffed if they are told, "We are not interested in complaints". The Prime Minister wrote to us recently that the CQC "follows up on all visiting concerns shared with it".

Can you see that this is confusing to people who have concerns and complaints? Are you also keeping under review the issue of legislation clearly setting out duties relating to the investigation of complaints in care settings? Between the local authority, the ombudsperson and the CQC, people do not understand the complaints system and do not have any confidence in it. Perhaps putting that into law would be an opportunity to clarify it and give relatives confidence that their complaints were backed up by a legal system. What do you think about that?

Gillian Keegan: The CQC does not look at individual complaints, as Michelle outlined. However, it does have all the information about those complaints, and it uses that to inform its regulation. It does not respond to each complaint, but it can use that as information. Also, it is now using people with lived experience in the care settings to inform while it is doing its inspections. It uses that information, but it is not acted upon at an individual level. Individual complaints, where you get an individual

response back, are the ombudsman's responsibility, as Michelle pointed out.

The fundamental thing that concerned me when I was talking to relatives about this is the fact that they felt fearful that there would be retaliation, because it is trickier to understand what you do about that. There are so many things you could unpack from that, but people should be safe and have a quality of care. There is a duty on those providers to make sure that they look after people.

I do not know all the regulations off by heart—I am sure you do, Michelle—but there are many of those. These are, as we said at the beginning, the most vulnerable people in our society. I have seen this in my job, which I have had for about eight months now, with people with learning disabilities. These people are voiceless. You have to absolutely trust that they will have a good experience, and we have seen some awful cases where that is not the case.

There is more to think about. You could put something in legislation, but if you are frightened of retaliation, that will concern you, because your elderly, vulnerable person with dementia probably could not tell you what was happening all the time. I do not know if there is evidence. Some reviews have been done on safety in care homes, et cetera. I think there was one recently on sexual incidents in care homes, et cetera. That is a bigger concern. Whether it is in-patient facilities, the Mental Health Act, as you have mentioned, or care homes, you need to make sure that people are confident that they have people who are taking care of their very vulnerable loved ones. It concerns me when people say they are worried about retaliation.

There is another aspect to the retaliation of having to move care homes or whatever, which is a supply and demand issue—looking at market sustainability and making sure that there is a functioning market in every area. That is very much on our radar. In fact, the local authorities right now, as part of our reforms, are working on market sustainability reviews, reports and data inputs, which we will be getting and working on to try to make sure that we have a much more transparent, highly functioning market. That, again, could be another function of people thinking that they may be left without choice or with less choice for their loved ones.

The other overarching thing in our reforms is to try to ensure that we change aspects of how you can live safely in your own home for longer, or in a home that is better adapted for you in your final five years or whatever it is. That is another big part of the reforms, because we know right now that we are not optimising how we can help people to live well with dementia, and help people who are caring for those with dementia, in a way that is manageable at home, particularly if they are elderly themselves.

That is a big part of the focus of the reforms, as well as housing, supported living and technology. I came from the Dementia Research

Institute earlier today. What is coming is so promising. It will enable us to have a completely different social care set of choices for people in their old age. There was a lot in that, but it is not easy, because fundamental thing is that you are trusting people with your most vulnerable loved ones.

Q72 Lord Singh of Wimbledon: I am a Cross-Bench Member of the House of Lords. What steps have the Government taken to address concerns that those in care settings do not always have adequate access to medication, fluids and food? What are you doing to ensure that care users have their right to life protected and are free from what amounts to torture and inhuman or degrading treatment, as guaranteed by Articles 2 and 3 of the European Convention on Human Rights?

Gillian Keegan: Misuse of medication and failure to provide appropriate health, care and support services, and the withholding of the necessities of life, such as medication, adequate nutrition and heating, are all explicitly cited in the Care Act statutory guidance as forms of abuse and neglect. Regulation 14 of the Health and Social Care Act 2008 is designed to ensure that people who use these services can be confident that they will have adequate nutrition and hydration to sustain life and good health, and support in making sure that the risks of malnutrition and dehydration are reduced while they receive care and treatment.

The CQC considers this regulation as part of its assessment. It considers, when it goes into care home settings, how people are supported to eat and drink enough to maintain a balanced diet. This includes how people are involved in decisions about what they may eat and drink, and they look for potential sources of evidence for this. However, it is a very important point, because all of us will have been in a care home setting or a hospital to visit a relative and seen the drink too far out of reach. I have certainly had that experience and seen the impact that can have on somebody.

It is important that it has some teeth. The CQC can prosecute for a breach of the regulation and it has used this power in the past. It is an important power. I believe that there has been an increase in the number of guilty verdicts and in sentencing. It is an offence for carers to ill-treat or wilfully neglect, as you say, those they are caring for. The regulation is in place, but of course it is always incumbent on all of us to make sure that we constantly ask this question, because it is very important. I do not know, Lyn, if you have anything you want to add on how that is managed.

Lyn Romeo: As well as the CQC overseeing this and ensuring that these regulations are attended to, the local authority also has a responsibility and will be monitoring the contracts that it has with providers of care, to ensure that these things are all attended to and are reaching the quality of care and safety that they should be.

Certainly, social workers have sometimes had to go into care home settings to work with the care home and the CQC to try to drive

improvements in those settings. It is essential. The human rights of each individual, their own personal care and support plan and what is required for them according to their particular cultural and dietary needs must be attended to. That is something that the local authority, the CQC and the care provider need to attend to, absolutely. It is essential, and certainly it is a safeguarding issue from my perspective. That is what we would do. In my experience, we would ensure that we picked that up as a safeguarding issue.

Chair: Perhaps you could let us have the figures on the prosecutions that you mentioned in relation to the CQC after this meeting.

Gillian Keegan: Yes. I know it is a twofold increase, but I do not know from what to what, so I will write.

Chair: If you could just write to us with those figures, that would be very helpful.

Q73 Baroness Chisholm of Owlpen: Hello. I am a Conservative Member in the House of Lords. My question leads on from the food and drink point. There is a simpler point to be made about how much training is given to care staff to make sure that the obvious things are done. As a nurse, I discovered that quite often in hospitals the glass was put next to the patient on the wrong side, so they were not able to reach it, or the food was put in front of the person in the care home but they could not feed themselves and then it was just collected at the end. It shows how important training for staff and awareness of what each person in the care home requires is. Is that being done, and is there any way of checking up that that is done properly?

Gillian Keegan: It is fair to say that there has been a lot of training social care workers at many different levels. There is a care certificate, which is the very base level. However, we recognise that part of the reforms and part of the reason why we are investing £500 million in workforce and strengthening the workforce is that the knowledge and skills frameworks need to be strengthened.

The people in care homes do a fantastic job, by and large. All of us will have experienced that. They really are amazing. We would have been completely lost without them during the pandemic. They were a lifeline, but there is a lot of movement in the sector. There is a lot of training and retraining, and it is very difficult to progress in the sector, which is one of the features that is not normal. Some 75% are all at the same level and there are not many progression routes. That is one of the key things that the reforms will deliver: making sure that we have robust training.

We have also learned an awful lot more. You talk about nutrition. Making sure that the drink is on the right side, where you can access it, is important. If you leave someone a sandwich in the fridge, if yesterday's sandwich is there, you may want to ask a question. These things are there, but there is a lot more to do on dementia and how to help people with dementia, how to de-escalate situations, and how to help people

with learning disabilities, who may also be somebody you are caring for. A lot of training is available, but we want to help professionalise that workforce. They massively deserve it, because they do a fantastic job but do not always get the support they need in the training and the professional development.

Q74 David Simmonds: This question is about something we heard quite a lot about in the media, the “do not attempt resuscitation” notices. These should be relevant only for the purpose of deciding if resuscitation is appropriate. Are you satisfied that there are sufficient safeguards in the system to ensure that these notices are not used to affect decisions about treatment escalation or, indeed, becoming relevant to admission to places where people might receive care or to hospital?

Gillian Keegan: That is a very important question, because many concerns were raised at the start of the pandemic about inappropriate application of “do not attempt cardiopulmonary resuscitation” and those decisions. There was a lot of information going between groups and families. I have a nephew with Down’s syndrome. I got a call from my sister-in-law, who was frightened out of her mind that this could be true and that, if he ended up in hospital, these blanket decisions could be being made. We responded to those concerns by commissioning the Care Quality Commission to review how those decisions were being made during the first wave of the pandemic, and it published a report in March 2021.

Since then, we have established a ministerial oversight group that is responsible for the delivery of all the recommendations in the report. That is overseen by my colleague Maria Caulfield. They have had three meetings so far, and they are making sure that there are improvements to the system and considering how we can ensure adherence to the guidance across the system. There has also been a set of universal principles for advanced care planning. They were published just recently, in March 2022, and they were from a coalition of partner organisations across health and social care. They can be applied in all settings.

Over the last couple of years, we have done a lot. Several clinical leaders, and I think the BMA and many royal colleges, sent letters out to say that blanket policies should never be applied and that this has to be an individual decision that is made with families. There has been a lot of work, and the general medical services contract quality and outcomes framework has included a requirement for all DNACPR decisions for people with learning disabilities in particular to be reviewed.

This is important, because one of the things that we saw during the pandemic, which is heart-breaking, is that people with learning disabilities were in the top percentage of mortality. That very much concerns us, so we are making sure that we review every one of those cases for people with learning disabilities.

Florence Eshalomi: Good afternoon. I am one of the House of Commons members of the committee, representing Vauxhall. Minister,

you mentioned some of the practices involving DNACPR. Another thing was looking at steps the Government took to ensure that people with autism and learning disabilities who were subject to restrictive practices, such as the use of chemical and physical restraints, have appropriate access to independent reviews and community services. You may be aware of the CQC's *Out of Sight* progress report in 2022, which said that the Government failed to achieve many of their previous recommendations in this policy area. Do you know why this is, Minister?

Gillian Keegan: I cannot speak so much to what happened in the past, but I have been in the job for eight months and it is one of the things that I have taken incredibly seriously. I know that the CQC's report was welcomed. It made 17 recommendations, which were largely taken on board. There are many things that we are doing in this area and there have been some very high-profile cases, which of course concern all of us.

In the short term, we are doing a case review of people in in-patient settings, which is twofold. You will have seen some high-profile cases of those who are segregated. We have seen some of those in the paper. They have been in those situations for 10 or 20 years. Every one of those is having an independent review, and with a senior intervener who can bring together probably quite complex cases with lots of different people to try to put together a plan for those people. There are about 100 people in that situation. Everybody else is having their case reviewed to make sure that they have the appropriate medication, that there is not overmedication and that, most importantly, there is a treatment plan. We want to make sure that people are getting a treatment plan. That is the short-term action.

I chair a board called Building the Right Support. In the medium term, the most important thing is to make sure that we build the right facilities in the community. Often, people are put in these settings because there are no places for them to go that are appropriate and in the community, so we need to square that circle by making sure that we build that support. We have a plan. It will be published. I will be very happy to send that to you, because a lot of work has gone into thinking about how we can turn those words into actions, because it is really important that we end up with facilities that people can go to.

In the longer term, we have the reform of the Mental Health Act that was announced in the Queen's Speech. There are a number of quite fundamental things there. At the top-level, first, we want to separate mental health from learning disabilities. Learning disabilities are one thing. You can have an overlap—someone with a learning disability who also has mental health issues—but just because you have a learning disability does not mean that you have a mental health concern or issue. We are raising the bar so that that is much clearer.

We are giving people the right to more tribunals and the right to a nominated person of their choice. We are making sure that their treatment is much more person-centred, and that they are involved in it

and are not getting treatment done to them but are part of the answer. There will be a lot coming forward, which I am sure we will have a great deal of time to discuss in the coming months. We will do pre-legislation first, because it is very complex, so there will be a lot of time to input into that.

That is in the longer term to make sure that we have the right system in place that really takes care of people who have learning disabilities, particularly as many of them are living a lot longer and are a lot older now, and do not always stay at home or with their families. Again, they are some of the most vulnerable people in our society. As I say, I have a nephew with Down's syndrome, and the thought of him not being well treated is horrifying. We have a lot of effort and work in this area and it is something that I spend a lot of time focusing on.

Q75 Chair: The deprivation of liberty safeguards apply to individuals who need to be deprived of their liberty to enable care because they lack the mental capacity to consent to arrangements. We have heard, and everybody is aware of, the pervasive criticism of the current system where there are delays in processing. Are you confident that the new liberty protection safeguards regime, which is due to replace the deprivation of liberty safeguards scheme, will not have the same failings? When will the new system be rolled out?

Gillian Keegan: First, on the old system, my understanding is that it was seen to be too bureaucratic and complex. There was a legal case in 2014 that meant we went from something like 14,000 a year up to 243,000. It changed the bar of understanding of when you needed to seek a deprivation of liberty safeguard. That in itself caused a problem, because there was a system that was used to dealing with 14,000 or so per year and it is now 243,000. It is quite complex and bureaucratic.

To address the weakness of the current system, first, we are ensuring, again, that people are at the heart of the system and are consulted before being deprived of their liberty. It is quite a complex area, and there is also independent advocacy to ensure that somebody is there explaining it all to you, and that they are there to support the person. We will cut the number of assessments from six to three, and we will increase the number of responsible bodies that can do the assessments.

I have not gone through the complete detail to be able to answer your question and say, "Yes, I am fully confident", but at a top level the right arrangements seem to be in place to make sure that we have more people doing it, less bureaucracy, and an advocacy system. We are making some progress. We recently launched a consultation. Following the consultation, we will get a lot of inputs to make sure that I can come back and answer your question. It is our intention that this system works well. It is very important to get it right. Before any changes are introduced, we will also expect local authorities to work to understand their assessment procedures and how they can tackle the backlog that we have. That is ongoing.

Chair: Envisaging when the new system starts and the current system ends, are we talking about months or years? What sort of timeframe is it?

Michelle Dyson: We will announce that. We have this very big consultation running at the moment.

Chair: Sure, but I mean roughly.

Michelle Dyson: I cannot commit. We have to absorb the results of that consultation. It is hundreds of pages.

Chair: It could be years until we have a new system.

Michelle Dyson: It is a very big change to make in local authorities, and you have to do a lot of new training, but I hope not. Our intention is that it starts as soon as practicable, but we need to see the results of the consultation in order to understand what is practicable.

Gillian Keegan: Maybe we could come back on that, because I have not seen the responses yet. They have just come in.

Michelle Dyson: It finishes on 7 July.

Gillian Keegan: Yes, so we have not seen the full responses, but maybe when we have looked at those we could come back and let you know the kind of timeframe that we are working with.

Michelle Dyson: Can I just add another point on why I think the new system will be better? In addition to all the important things the Minister said, at the moment you go to a local authority but the local authority cannot deal with deprivation of liberty safeguards for 16 and 17 year-olds, or for people who are in the community, and those cases have to go to the Court of Protection. That is a very heavyweight system. In the new system, everything will go to the new responsible bodies, local authorities and the NHS, which will hopefully free up more space for the Court of Protection to deal with appeals if people are not happy with what those responsible bodies have found. The whole thing will hopefully be more streamlined.

Q76 **Lord Dubs:** I am a Labour Member of the Lords. Thank you for those interesting answers. My question follows on fairly clearly from the previous one. What sort of practices will be considered to constitute a deprivation of liberty for the purposes of the liberty protection safeguards? Are you able to guarantee that the safeguards will uphold the right to liberty and security, as protected by Article 5?

Michelle Dyson: Yes, absolutely. Article 5 is the foundation of all this. If we are not getting that right, we are not getting it right as a whole. We are looking at a new definition of what should constitute a deprivation of liberty. We have consulted on that and we will see what comes back from our consultation, but yes, Article 5 must be the foundation of everything that we do.

Q77 **Joanna Cherry:** Going back to the CQC and its ability to investigate

complaints, of course it can investigate complaints under the Mental Health Act, and we have heard evidence that in 2020-21 it investigated only seven out of the 2,280 mental health complaints it received. My question is directed at the Minister first. Is the CQC fulfilling its duty to adequately investigate Mental Health Act complaints? Why were only seven complaints investigated when there were over 2,000, and what data do you have to support your view?

Gillian Keegan: I do not have much data on this, so I will have to take that away. I do not have the number the CQC looked at and why it is so few. I know that you had it here. I do not know if it explained that, but I have not looked at those figures yet.

Joanna Cherry: Can you write to us about that?

Gillian Keegan: I probably need to investigate that a little myself. I have not pushed that bit of the system yet. I meet the CQC regularly, but we have not talked specifically about that.

Joanna Cherry: It is just that, at first blush, it seems an extraordinarily small percentage to be investigated, so we would like you to write to us about whether you think it is fulfilling its duty, why you think that only seven were investigated and what data you have to support your view. I wondered whether Lyn or Michelle would like to add anything.

Lyn Romeo: There are two things. Once somebody is assessed under the Mental Health Act and detained in a hospital, they have certain rights, certainly to go to a mental health tribunal. Some of those complaints may be picked up through the tribunal process or with the hospital managers. I am assuming that, if they have not been resolved at that level, they would kick up to the CQC investigating more fully, but, again, I am not sure of the detail.

Chair: It was not that they were not receiving the complaints, so it was not as if they were going to other places, because they had 2,280.

Lyn Romeo: Yes. We will have to come back to you on that.

Gillian Keegan: I will take it as an agenda item in my next meeting with the CQC to look at that and try to figure out the processes.

Chair: Either people are all complaining to the wrong place about the wrong things, in which case there is a point about the confusion of the complaints system, or else these are justified complaints but hardly any of them are being looked into. You will come back to us on that.

Gillian Keegan: Yes, I will. I will take it as an action.

Q78 **Baroness Chisholm of Owlpen:** I was surprised to see that privately funded individuals in care settings cannot rely on the provisions of the Human Rights Act. Surely care users should have their human rights protected in any care setting, no matter how they are funded. Is this true and what will happen about this? It seems very wrong, in a way.

Gillian Keegan: This is the difference between the ombudsman system and the CQC system.

Michelle Dyson: Except that the Human Rights Act was extended to cover care homes that are providing both privately funded and publicly funded provision, so I think I am right in saying that the only people to whom it would not apply are those in care homes that are exclusively private. The last time I looked, I think that was only about 7%. I would have to check if that was right, but a very small percentage of the overall numbers are exclusively private. The vast majority of care homes take both public and private, and private individuals can get judicial review of the care home and bring in the Human Rights Act as part of that, even though they themselves are privately funded. If I have any of that wrong, we will write and correct it.

Chair: That is a bit anomalous, is it not? If the Government have a responsibility for protecting human rights, including the right to family life and the right not to be subject to degrading treatment, it should not fall down just on the basis that you happen to be in a private care home. That is a gap and perhaps something that you might look at, because, looking at it from a common-sense point of view, people would think it was very odd that just your funding stream dictates the protection you are afforded of your fundamental human rights. There must be other ways to address that. You can just legislate and put those specific guarantees into legislation.

Michelle Dyson: As I said, it was extended. If we had not made specific provision in the legislation, the Human Rights Act would apply only to publicly funded people, but it was extended so that it applies to private providers that take both public and private. I accept that there is a small gap and, as things stand, your right of redress is through the ombudsman. You can complain about all the provisions of the Care Act, which are themselves based on human rights. The Care Act imbues human rights principles.

Q79 **Lord Henley:** Can we go back to training? We were told in the committee by a representative of the NHS that patient safety training makes no specific reference to human rights. I just wondered whether training on the practical application of human rights in all health and care settings ought to be mandatory.

Gillian Keegan: The care certificate is the appropriate place for training on human rights as the baseline training for all care workers. They are expected to cover this ground. I think there is scope to look at training at the higher skill levels, as well as the knowledge and skills framework and the learning and development offer that we were talking about. We are still in the process of defining what sits within that offer, but there is always scope to look at that and to make sure that it is as good as it can be, but my understanding is that the care certificate has, as a baseline, the training on basic human rights.

Lord Henley: As you say, you will look at this and there might be more.

Lyn Romeo: The professionally regulated staff—social workers, OTs and nurses—have, as part of their undergraduate training to move towards qualification, a heavy focus on human rights and the other statutory legislation. Once people join a local authority or an NHS trust in those roles, part of their core induction training and ongoing CPD will be rooted in their respect for and attention to the Human Rights Act and how that plays out in relation to all the other statutory roles and responsibilities they have, so they have a core training around that.

Lord Henley: So it is there.

Lyn Romeo: It is definitely there for professionally regulated social workers and OTs, and they have to show through the year their continuing professional development and refresher training in order to re-register, so it is how we then get them to work with care staff.

Gillian Keegan: Yes, particularly after induction.

Chair: The professionally regulated ones are a minority of those providing care in the sector. Are you saying that human rights will trickle down to the unregulated care providers through the training given to the regulated ones, or is there a proposition that all those who are going to have some training will receive it? Should it not be included in the training as you develop it?

Gillian Keegan: The care certificate that social care workers complete when they enter has the basics on human rights embedded in it. The professional strand has a lot more of a continual focus in its CPD as well. The thing for us to take away is what more we could be doing, as we continue to develop the knowledge and skills framework, to make sure that human rights are at the centre of that training, as it is in the professional CPD. That is the framework. We have not built that framework yet, but we are working to do that.

Michelle Dyson: That is absolutely right. As I was said, everything in the Care Act has human rights at its heart, so as part of the care certificate you are taught about human rights, as in all the articles, et cetera. If you are taught about well-being, nutrition and safeguarding, which are all principles under the Care Act, you are also, in that very practical way, being taught about human rights.

Lord Henley: So it is there, but there is no specific reference.

Michelle Dyson: It is there. There is no strand in the care certificate on human rights per se, but my point is that the broader training is also, in its essence, about human rights, even if it is not labelled as the European Convention on Human Rights. When you are talking about well-being, you are, in effect, talking about human rights.

Q80 **Florence Eshalomi:** You both referenced the Care Act and human rights being wedded to that. The British Institute of Human Rights criticised the lack of adequate human rights considerations in commissioning contracts for health and social care. Would you support stronger requirements for

respect of human rights in commissioning?

Gillian Keegan: This is the commissioning of the local authorities for the care. We have learned a lot of things about best practice or otherwise in commissioning. When I first arrived in the role and looked at some of the factors that were happening—we have seen some of this in the fabulous programme that Ed Balls did, for example—one of the first things was how the commissioning influences behaviours such as how long you get to see somebody, et cetera.

It is fair to say that we believe we can improve aspects of that by training. One of the big parts of the reform is, first, working with local authorities to make sure that we develop sustainable markets, but also that best practice in commissioning, which leads to the right outcomes, is input. One example might be somebody receiving domiciliary care who ended up going into hospital and the carer not getting paid. That started to trickle through into people who were looking after people not getting paid because their client had gone into hospital, so you could see aspects of poor practice. Most of that has probably gone, because they have been learning from each other.

Of course, when you have workforce shortages as well, you have to be really careful to make sure that you have a good offer for people. Some £70 million has been earmarked in the reforms to work with councils to make sure that we much better commission. Hopefully, that would also ensure that we were taking any recommendations on board as well.

The other big thing is that the CQC will also be regulating the local authorities. That is from October 2023.

Michelle Dyson: It is April.

Gillian Keegan: It is from April 2023, so there will be a regulatory role for the CQC as well as local authorities, which will be new. I do not know if you have anything to add, Michelle.

Michelle Dyson: No. That reform is really important in, for the first time, holding local government to account on how it does its commissioning, which will include human rights aspects of commissioning.

Chair: Thank you very much. At this point we will draw this evidence session to a close. I would like to thank the Civil Service team who have been here. Thank you very much for coming, and thank you very much to the Minister for coming and giving those very open answers.

You will write to us about a number of issues, including with data, but we also need clarification on the statement that the human rights application has been extended to private providers, because we take a rather different view of the impact of Section 73. Perhaps we could get a common understanding of that situation in relation to private funders. Thank you very much indeed for coming to give evidence to us. We wish you well with your review and progress on this very important issue.