Joint Committee on Human Rights

Oral evidence: Protecting human rights in care settings, HC 714

Wednesday 8 March 2022

Watch the meeting

Members present: Harriet Harman MP (The Chair); Lord Brabazon of Tara; Joanna Cherry MP; Lord Dubs; Florence Eshalomi MP; Lord Henley; Baroness Ludford; Baroness Massey of Darwen; Angela Richardson MP; David Simmonds MP; Lord Singh of Wimbledon.

Questions 37 - 44

Witnesses

II: Professor Vic Rayner OBE, CEO, National Care Forum; Nadra Ahmed OBE, Chair, National Care Association.

Examination of witnesses

Professor Vic Rayner and Nadra Ahmed.

Q37 **The Chair:** We will now hear from our second panel, who are representatives of care providers in the private and not-for-profit sectors. We have with us Vic Rayner, who is the CEO of the National Care Forum, which represents not-for-profit organisations in the care and support sector. Vic is also chair of the Government's strategic advisory forum on the social care workforce, and co-chair of the national social care advisory group on social care and technology. Welcome, Vic, and thank you for coming today.

We also have with us Nadra Ahmed, who is chair of the National Care Association. She has developed and run services since 1981, she was the registered manager of two private care homes for older people, she is chair of an organisation that represents small and medium-sized care providers and affiliated local associations, and she has generally been involved in the field of social care for 35 years. Thank you both for joining us.

The first question relates back to something that Wayne mentioned in relation to the balance of rights. We have heard concerns about care users' right to life under Article 2 of the European Convention on Human Rights being potentially violated. This is a particular problem in relation to the use of do not attempt resuscitation notices. What steps can be taken by care providers to meet their positive human rights obligations in relation to Article 2?

Nadra Ahmed: Thank you for inviting us. When this came to our attention, in the chaotic period when the primary care services had actually closed down, I would say that it was a complete shock on the part of providers that we would be facing something that actually took no consideration of those rights. When we admit people into our services, there is an assessment. When we talk to families, it is one of the most difficult questions to ask, but we do ask families about what people might want and we have that on record.

We then had really worrying information coming through to us that the primary care services were saying that these should all be do not resuscitate notices because of the situation we were in. It would be fair to say that the vast majority of providers came together and pushed back on that and upheld the rights of people as much as they could; we are there to support people to the best of our ability to live the life that they can live. It is also fair to say that we were being asked to confirm death, which our staff are not qualified to do. Primary care services were not coming in, so it was quite a challenge for us to ring someone up and say to them, "We think the person has passed away, but we can't confirm that because that's not in our remit". The pushback from the provider sector was that we did not want that to happen.

Chair: A pushback against whom?

Nadra Ahmed: Against the primary care services who were asking us to do it.

Chair: The primary care services?

Nadra Ahmed: Yes.

Chair: Okay, thank you.

Professor Vic Rayner: We were working with members, providers, who were receiving letters from local GP practices and others applying DNACPR across all residents in the home. Immediately when we got those, they were taken to the Department of Health and Social Care and to the CQC, and the CQC, the Care Provider Alliance and others issued a joint statement making it absolutely clear that that was not acceptable. It is one of a whole series of advocacy activities that providers were involved in that were very clearly not only about the right to life but about the right to healthcare, and about the right to sustain people's access to the type of community health services which the whole population should be able to access, which, pre pandemic, were often a struggle and which, post pandemic, continue to be a struggle for people in care homes to access. A big part of all care providers' roles is making sure that people continue to be able to access mental health services, primary care and community health services. That was something that we were very strongly trying to do.

It was very clear at the beginning of the pandemic that the focus on Covid was on a set of symptoms and a set of ways in which Covid manifested itself, which bore no relation to how it manifested itself in older people in particular. Because all the focus was on a set of specific symptoms, older people were not getting the right access and focus on their healthcare when they needed it. Providers were, again, able to work with organisations like the British Geriatrics Society to enable evidence to be put together. The NCF did some work with Leeds University, bringing in research and academics to show exactly the kind of symptoms that older people experienced with Covid, and therefore making sure that the right level of attention and urgency was placed on meeting those needs.

The Chair: One of the things about human rights is that they are supposed to be about the individual's rights, so it is quite hard to think of anything that flies more in the face of human rights than a blanket policy of do not resuscitate. Although this was changed, thanks to the pushback and the complaints that were raised, it does tell us something about the extent to which human rights are understood or embodied in those primary care services. Were you caught up short there and did you think, "Is that the state of belief in human rights that's going on here?"

Nadra Ahmed: Absolutely. We felt quite strongly that the rights of the people we care for were being completely compromised here. There was no rhyme nor reason for this blanket statement, and the pushback was on that. We are very clear about our role as care providers, which, as Vic has said, is about providing the very best we can for them. There was also an issue with access to a number of care services; we were told not to send people into hospital because there was nothing they could do—the hospitals were overwhelmed.

Providers really struggled with this, because our staff were being asked to deal with conditions that they were not trained to deal with in many ways. The thought was that you would have somebody with symptoms that were Covid-like, but actually they could be something else. The registered managers, in consultation with all their senior staff, were saying, "This person needs to go into hospital", and in normal circumstances that is what you would do. Then they were told, "Actually there's nothing we can do. You need to look after them in your own services". We felt that our residents were being denied the right to be treated in a hospital setting and to get the best that they could.

The Chair: Basically, because they were in a care home, their human rights were less respected than if they had not been.

Nadra Ahmed: We felt that, because there was an overwhelming situation in the nation, and we were told that the hospitals were overwhelmed, they were not a priority.

Professor Vic Rayner: It was not just about being in a care setting; it was about being in a particular age bracket, or having a learning disability or a physical disability. There were lots of challenges both in working age settings and in older people settings in relation to people's ability to access hospital services and some community services.

The Chair: Thank you very much.

Q38 **Lord Singh of Wimbledon:** Good afternoon. I am a Cross-Bench Member of the House of Lords. The European Convention on Human Rights Act states in Article 3 that, "No one shall be subjected to torture or to inhuman or degrading treatment or punishment". How do care providers meet their obligations in relation to this article, and assure that all care users have access to adequate food, fluids, medication and adequate care? Importantly, how is this monitored?

Professor Vic Rayner: The starting point is that care is a very highly regulated sector, so all the actions and activities of care providers are subject to scrutiny of the Care Quality Commission. How do organisations do this when someone gets into a care setting? Everybody who is living in a care setting will have a care plan, which will contain details of their individual care requirements and needs.

I listened to the interesting conversation with the first panel about data. There is a real opportunity on data at the moment, but, for every person with a care plan, on any given day somewhere between 200 to 300 data points are entered about their care requirements—about the food they are eating, the interactions they are having, the things they are expressing. A huge amount of data is collected on people's care plans. The challenge at the moment is that a lot of it is then locked away in a filing cabinet, and we do not access and utilise it in a way that would enable us to develop greater care more broadly across the country.

There is a real moment now where there is a Government ambition for everybody in care settings to have electronic care plans, which will enable a whole series of better data points and data collection, which will allow everybody to have greater scrutiny of that. In answer to some of the earlier questions, I am happy to explore what that might mean in practice. There is also work going on on a national minimum dataset for social care, which could pick up very clearly some of the areas that people are concerned about.

The primary focus on care provision is about ensuring that people get those personalised care plans and get the care and attention they need—that the data is being collected, assessed and reviewed through the Care Quality Commission. Electronic care planning will also give relatives the opportunity to have access to a relative's gateway into care plan to enable them to identify what kind of nutrition and hydration levels their relatives are receiving, so there are some opportunities there.

Lord Singh of Wimbledon: I was going to ask you about access for relatives, but you already answered it. Nadra, would you like to make any further comments?

Nadra Ahmed: I would just reinforce the fact that I am seeing much more. We represent small to medium sized providers. They are about 80% of the sector, so investment in telehealth and all that is slowly coming up for them as well. As I have gone around the country, I have been impressed to see people inputting information into iPads as they go around, and that goes into a central area. An enormous amount of information is being put in.

The original care plan, the assessment of care, that we receive is often not as thorough as we would want it to be, so it is built on with family interaction. We get to know the likes and dislikes of people. Nutrition is really important; if somebody does not like a particular food, providers are there to support them with other things. My father is in a care setting at the moment, and I know how hard that service is trying to make sure that they can get him eating and drinking again.

Diabetes and all other conditions are then monitored, and this is ongoing. I am always very impressed with nutrition in the services that I visit, because water and juices are available on tables, there are regular times for teas and coffees, and all those kinds of things. We have a really good package there, and the vast majority of provision makes sure that it is keeping people well, which is in our interest.

Lord Singh of Wimbledon: Thank you for that very full reply.

Q39 **Angela Richardson:** Good afternoon panel. I am the Conservative Member of Parliament for Guildford. I want to move on to the right of liberty and security, which is ensured by Article 5 of the European

Convention on Human Rights. In evidence sessions held so far, we have heard multiple concerns about delays and problems in the application of deprivation of liberty safeguards, or DoLS, which are used for people who lack capacity to make health care decisions. Do you believe that our providers also perceive this as a widespread problem for care users and, in your view, what have providers done to address this issue?

Nadra Ahmed: I am sure Vic will come in on this. It is one of the things that has been an enormous challenge through this last period. There is a huge delay from the time you make the application to when you get some responses. That period of time is often critical, and providers will be thinking about what they can do in the best interest of the person until a response is received. We have to do something about this. We have to get this right, because depriving somebody of something that we feel might hamper their mental or physical health is really difficult. Trying to get the best advice that we can through the model that is there, which I am aware is being reviewed, just feels really frustrating.

The registered managers I speak to find it extremely challenging to have to repeatedly chase, because they might make a recommendation to get somebody to come in and look at this, that recommendation is not followed up, and the time can be critical. That is all I would say. It is so time critical that it can have a detrimental effect, which is not right for a person in a care setting.

Professor Vic Rayner: I agree with Nadra that the delays are very distressing for everybody in the system. It is about the whole system and recognising the breakdowns in it.

Thinking about the liberty protection safeguard system that is coming, clearly there is a further delay in its implementation. We have not seen what the Code of Practice and the guidance will look like, which will be critical. The biggest thing we have to focus on is how we resource, support and train the whole system, so that we do not find ourselves replacing one delayed and flawed system with another that does not pick up on people's needs.

Particularly for people who are older and moving into care settings, we know that the length of time they will stay in that setting is limited to maybe 18 months or two years. With a delay of a year or more to decide something so critical we are just letting everybody down in that system. We need to think really clearly about implementation when the time comes. We need to make sure that we have clear guidance on the independence of the advocacy and who plays which role. Whatever role we are all playing, we need to ensure that we have clear training and support, and that people who need it have that additional element of protection, but that those who do not can maintain their liberty and engagement in the wider community.

Q40 **Joanna Cherry:** I want to ask about the right to private and family life, particularly in connection to visiting restrictions. But before I do that, I want to follow up with you, Vic, on what you were saying about data collection, which was really interesting. You mentioned the Government's ambition for electronic care plans, and national minimum datasets. Could you clarify what that means?

Professor Vic Rayner: There is work going on at the moment to determine what the minimum data collected from all care settings should include. Part of that is tied up with the Health and Care Bill, which has a new duty that enables central government to collect data directly from providers. There is some very active work going on to identify what will be included in that. There is a measure in there of the burden to providers—what will actually happen with the data and whether somebody will do something meaningful with it that changes practice and behaviour.

That work is happening and, as with all this work, there has to be much greater recognition of co-producing and the bits of data that will be useful. In my mind, it should be useful to everybody who has some ownership of this process. That should include some value to families, to people who are thinking about care and support services in the future, and to providers and commissioners to enhance care.

We may come on to talk about workforce, skills and competence, but one thing that we do not have right yet in care as a sector is the level of data use and data analysis that we need in order to make sure that, when we are collecting points of data and information, we are absolutely maximising the opportunity to use it to improve. Bodies like the CQC are utilising data much more effectively, but for data to really work it has to be circular and be fed back to everybody in the system.

Joanna Cherry: That is really helpful. In connection with visiting restrictions, to what extent do you feel that care providers have met their obligations to provide for the right to private and family life under Article 8 of the European Convention on Human Rights? Has the government guidance throughout the pandemic been sufficient to address concerns about visits, and has it struck the right balance between protection of the health of residents and respect for residents’ right to family and private life?

Professor Vic Rayner: We have spent huge amounts of time working with family groups, and with people who represent people who are using care and support services, through our membership and through our work with the care provider Allianz. Visiting is a critical element of people's life. We know that connection with family, with friends, with loved ones is hugely important. There has been lots of very important testimony on the experiences of families.

I want to say a bit about what providers have been engaged in doing to support visiting. It is important to note that there has been a very strong push from the provider sector to enable as much visiting as possible as early as possible, and organisations that we have been working were working back in June 2020 to actively push for greater visiting. We developed visiting protocols, we identified safe ways of visiting, and we worked with the Government to support them on the development of the guidance that came out in July that year.

Later on, in November, we spent more time on it, and the NCF brought together a coalition of over 100 organisations, which wrote to the Government demanding visiting access and access to greater testing regimes. In February 2021, it worked again with relatives' organisations to implement the essential caregivers' role, and it looks across the country and the world, working with Canada and other countries to see how they have done that. There is a very strong understanding in the care provider sector of the importance of visiting. You asked about government guidance. That has been hugely challenging, and each time the Government have put forward guidance, we have pushed for that to be much more open and to enable much more visiting.

The difficulty in the pandemic—I hope the committee will be able to recommend on this—was the level of evidence about the things that are important to people in the context of connection. The way loneliness and isolation might impact on people's mental health was strongly out of balance with the level of information that grew about the risks associated with Covid and passing on infections. That meant that the balance of risk was all about the risks of Covid to people's health, and there was no counterbalance, or nothing that the Government were able to hear, in relation to isolation and loneliness.

We have to get so much better at being clearer. Care providers were strongly saying that we could see what was happening. I worked with a provider who was developing medical frailty index tools and using them to show public health officials the impact on people's health, and the breakdown in their mental health, as a result of being kept away from family members and being refused access to visitors. There was a lot of pressure in the system on this, and decisions were being made that were counter to providers' individual risk assessments of what was right for people.

Joanna Cherry: That is really interesting, but it does not quite fit with what we have heard time and time again in this committee and in other committees. We heard it raised in Parliament today, and I believe there were families present at a briefing today in Parliament about the difficulty getting to see their loved ones. When you say that you were working with care providers, does that mean individual care homes?

Professor Vic Rayner: Yes. We are a membership body, so we work with individual care homes, but we were also working with people like Rights for Residents and the Relatives & Residents Association to produce sets of materials to enable people to look at the rights and responsibilities on visiting.

Joanna Cherry: Why do you think that has not cut through? The evidence we have heard, it seems to me, is that it has been one of the tragedies of the pandemic that old people—and, indeed, younger people with learning disabilities, mental health disabilities or autism et cetera—

have been cut off from their families and their loved ones in the most appalling way. Although nobody talks about partygate now because of the Ukraine war, we, as Members of Parliament, have seen a lot of anger from our constituents describing being unable to be at the bedside of a very loved parent dying. Many of us find it almost impossible to comprehend the suffering there must have been in that situation, but it has been widespread across the United Kingdom.

What has gone wrong here? Is it the government guidance? This committee has suggested time and time again that we need to put it on a legislative basis. You will have heard one of our witnesses on the previous panel saying that because there was human rights compliance in the Coronavirus Act in relation to easements, everybody in the sector was desperately looking for training on how they could be human rights compliant. Does that not illustrate how important it is to put guidance about care home visiting on a statutory footing? If there was a proper balance between the right to life and the protection of public health—Article 8 and autonomy issues—I do not mean to criticise the providers, but they would need to pay more than lip service to Article 8; they would have to get some pretty serious training on how to get the balance right.

Professor Vic Rayner: I am sure Nadra will want to come in. I do not think that providers were paying lip service to that. I understand that you have heard some very important testimony on that, as have we; we have been working with families to try to change that. But why did that perspective not cut through? There were more opportunities for visiting, because providers were working closely with organisations to try to enable that to happen, but there were lots of other things going on, and guidance was absolutely one of the things that were restricting the number of people who could come in, the times when people could come in, the ways in which people could enable visiting. All those things were happening. Public health decisions made nationally or locally looked at the balance of risk as infection spread rather than understanding that there was a risk to people's well-being and care as a result of that. There were very clearly counter-forces at play.

The essential caregiver role has come through as a very important element, and I share the frustrations of organisations that are saying that people are still not able to get that role. Where we can, we are doing lots of work with individual providers to reinforce that, but the message is very strong from all of us as care provider organisations that that is the position, that is what people should be doing. They should be identifying and helping people to have essential caregivers roles. They should be allowed to come in. Even though the guidance quite clearly states that they should come in during an outbreak, we are still hearing from public health teams they are preventing that happening.

Q41 **The Chair:** Can I interrupt at this point to raise the issue of the language? It seems to me that talking about enabling visiting is a problem, because that implies that the default position is no visiting and that you somehow have to enable visiting as an optional extra; that the active thing is to enable a visit. Under Article 8, on the right to family life, surely the default position should be that visits are allowed, and the active thing is stopping them. Enabling a visit sounds like you are doing everybody a favour and that you are somehow enabling things. Should we not turn it right around and have visiting as the default position? The question is whether you are going to obstruct it or not and whether you have the justification to obstruct it.

Professor Vic Rayner: I suspect that is a symptom of Covid language, in the sense that there were no restrictions on visiting prior to Covid. If you went into homes prior to Covid, they were community hubs. They were places people came to, and, for those who are digitally enabled, visitors gave biometric thumbprints to allow them to come in and out whenever they wanted, whatever time of day or night. That access was absolutely the default position. Apologies if it is a poor use of language, but it is reflective of two years of trying to fight for visitors to come in.

The Chair: Everybody talks in those terms, but it just illustrates how much in the wrong place we are on this at the moment.

Joanna Cherry: Your evidence is quite important—we will come to Nadra in a minute—because, for parliamentarians like me, our constituents' anger has been directed at individual care homes, when actually our dissatisfaction should be directed against the government guidance and some of the public health decisions. We need to learn from this that public health needs to have a correct balance between preventing people from catching Covid—or whatever the next pandemic is, God forbid—and protecting people's mental health and their human rights.

The Chair: We have heard evidence about primary care issuing its own local guidance to care providers to say, "No visits here", which has run counter to the Government saying that you should open up to more visits.

Nadra Ahmed: It has been an enormous challenge. The guidance consistently puts the responsibility on the provider: that we have to risk assess, we have to ensure. Providers were then faced with the dilemma of high infection rates, a shortage of staff and all sorts of other things going on. Insurance was an enormous issue. We just could not get insurance. The NHS's insurance was underwritten straightaway, but for care home providers it doubled—indeed, trebled in some cases—and then Covid was not included. If people were coming in, they had to make sure that they could do that. There was also a limit to the number of people who could come through the doors for visiting. Therefore, if you have a 30 to 40 bedded home and you have families wanting to come in in a week, you may not be able to do that every day, and that was a challenge. That is where the essential caregivers bit was so critical, because families with spouses or somebody who was a daily visitor could come in, and it was really important to do that.

I have lived through this recently. My father went from being in isolation for two weeks for Covid into a care service for two weeks of isolation.

That was four weeks of isolation for somebody with delirium caused by a drug that was given to him in the hospital. I lived the other side of it. If you have the right communications, the vast majority of relatives understand why that is happening, but it is very difficult. Early on in the pandemic, we asked for donations of mobile phones and iPads. We were given thousands, and we distributed them all the way out into the sector.

Providers were doing everything; they were buying them themselves to try to keep as much as they could. That goes back to the point that care homes actually operate at their very best when they are that open service, with families coming in and out, because it takes the pressure off staff as well. When you have visits going on, the staff can be getting on with something else. At this time, because the visiting was limited and the guidance was so challenging for us, the staff members who were in the building became everything—trying to keep people calm because they could not understand, especially people with dementia, why they had to look at somebody out of a window and why they could not come in. Trying to facilitate that was really challenging.

Many providers were investing in creating outside hubs, which were fine in the summer but not so good in the winter. Those were the challenges that we were facing. The vast majority of providers were doing that. Those that were not doing it were, in some cases, really concerned about staffing levels. We challenged members who said that they could not open, and it was primarily things like not being able to open in a certain week because they had four members of staff off sick with Covid and they could not cover the floor.

So there were reasons. Many of them were also worried about the risk to the relatives coming in because there was Covid in the home and how that might be covered. However, wherever possible, throughout the pandemic we worked really closely together at the CPA and pushed everything forward. We did everything possible. We made guidance understandable so that the providers could understand the guidance. Sometimes it came out on a Friday night at 8 pm, which caused us great distress, and would be implemented on the Monday. We were trying to make sure that the right was being met rather than not met.

Q42 **Florence Eshalomi:** Afternoon all. I am the Labour (Co-op) Member of Parliament for Vauxhall. Following on from my colleague’s last question about the European Convention on Human Rights, you have both outlined some of the challenges that care providers faced. The convention on human rights also protects, through Article 8, the rights of the personal development and autonomy. That is very important, and many patients would have wanted to discuss that with their family members, but those same family members were not able to visit them. How do you provide this and ensure that patients and residents can express their personal autonomy to the greatest possible extent in the decisions about their care?

Nadra Ahmed: We have regular conversations with families and friends about the people we care for, but the first and foremost point of contact for us will always be the person in our service and their wishes. It is interesting that people sometimes have the perception that somebody with dementia cannot let you know how they feel and what they like or do not like. That is not true. You can build up a picture about somebody's life from where they were before, and start to learn what they may or may not like. You can tell that as you get to know people. Therefore, they are your first port of call when you start looking at making sure that their wishes are met.

I will give you an example of a resident who came into my service who was a vegetarian and would never eat meat. She progressed in her dementia for several years, and four or five years later started to get very exercised about the fact that everybody else was having sausage, bacon and egg for their breakfast and challenged why she was not being given it. That is where you then have to refer to families, and decisions are made on that. In that case, the family member said, "Rather than get her so distressed about it, just give it to her". It was not our decision to make, but we knew that person from when they came into our service. It was very difficult for us, and the question then is how you create that.

The wishes of our residents are uppermost. There are services with 100 beds and there are services with four beds. It is about managing those systems so that you can make it very personalised as you go forward. Personalisation is nothing new. It was in social care when I started in my first care home. That was 40 years ago, which is a long time ago, and things have changed. It is part of what we do on a regular basis.

Professor Vic Rayner: I just want to add a bit about some of the advocacy work that goes on with people who do not have lots of friends and family. We know that there are a million or more people now over 65 who are ageing without children, and there is growing understanding and recognition in the care sector of the ways in which we need to support those individuals. Working with an organisation called Ageing Well Without Children, we produced toolkits and support for organisations to think about how they work with that cohort of people to ensure that their personal development and their autonomy are respected in the same way as those of others who have family and friends who can advocate and champion on their behalf are. There is an extra-special focus on people without children.

You talked about people wanting to have access to friends and family in order to make some of the critical life decisions. Although visiting was very difficult, organisations endeavoured to create lots of opportunities to enable people to have access to family and friends through technology in particular. One of the most difficult and frustrating things early on in the pandemic was families not knowing what was going on. We worked a lot with the Residents & Relatives Association to produce a protocol on communication, open transparency and engagement, and we tried to encourage its use.

Many care providers took up the very thing that we are using now—hybrid meetings and using Zoom or Teams calls and so on—to encourage family members to be able to ask those questions, whether it was as a group or for individuals. But it is incredibly hard, not just in the care system but in the health system. We have a system that is built on people having access to advocates who can help and support and be by their side. We know that is the right thing for people in care and health services, and we are keen to get back to that active position so that people can be there advocating, encouraging, supporting and enabling people to do all the things that they want to do. It is about enabling people to have the most independent and fulfilling life they can have.

Florence Eshalomi: There was still that protection for people who were able to exercise that autonomy and make those decisions about their care and personal development, and you still allowed them to do that.

Nadra Ahmed: It is their right to do it.

Q43 **Lord Dubs:** I am a Member of the House of Lords. Can I turn to the training of staff? We have received evidence about inadequate staff training in care settings and a lack of understanding of human rights protections on the part of care providers. How are human rights included in the professional qualifications available in social care, and how is continuing training and development made available?

Professor Vic Rayner: A lot of people who work in care do not have a professional qualification base. Social workers and allied health professionals and nurses who work in care have a professional regulatory environment that has a stronger ability to check people's human rights training through the qualification process. For the front-line care staff, there is the care certificate, which is the training for the people on the front line, and there are other qualifications throughout.

In relation to Sanchita’s earlier point about the explicit focus on human rights needing to be an awful lot stronger in that training programme, it is embedded in much of the training that is available on mental capacity, on safeguarding, on the way you work with people, on how to deliver person centred care, but seeing yourself explicitly as a human rights worker was a really interesting way of reflecting on that. Again, there is an opportunity, in that one of the reform agenda pieces is developing a training and competence framework for care staff and the opportunity to think more strongly about how human rights could be identified and worked on more explicitly.

Everybody in care is also adapting to and working towards a regulatory framework, via the CQC, that has human rights embedded in it, but that training could be much stronger by being specific about the human rights elements. I know the committee has heard lots of evidence about the workforce shortages in the sector and the need to bring new people into the sector and to train new people. Having something very explicit about the human rights agenda as part of care work would be a very attractive proposition for people wanting to come into work, and if we are clear that people are delivering against a human rights agenda it will stimulate and interest people to work in this sector, which is absolutely what we need.

Q44 **David Simmonds:** One of the issues that frequently arises is how matters can be resolved through a complaints process. Do all care users have access to effective complaints mechanisms where, for example, there is a guarantee of anonymity and freedom from retaliation? And if the CQC were to look into individual cases, could that improve the reach and effectiveness of complaints mechanisms?

Nadra Ahmed: I am not sure I heard the question properly.

Professor Vic Rayner: It was about complaints procedures and whether everybody using care has access to a complaints procedure.

The Chair: Also, whether they all have access to anonymity and freedom from retaliation, and whether the CQC should look into individual cases.

Nadra Ahmed: The CQC does look into individual cases. If it receives a complaint about a breach, it looks into the service where it is required to. That is what it is supposed to do. The fact that it is not visiting homes as much—. Am I missing the question here?

The Chair: You are highlighting an important ambiguity, which is the relationship with the CQC in terms of people telling it that something is a problem, and whether it sees that as an individual complaint which it does not deal with and therefore tells the complainer, "No, we do not deal with complaints", when in fact it should be a red flag for people to look into what lies behind the complaint.

Professor Vic Rayner: It is very interesting, and it is a discussion that we have had regularly with the CQC. The CQC has a very strong focus on people bringing complaints directly to it through its "Tell Us …" campaign; I cannot remember what the current Tell Us campaign is called. A big piece of work was done a number of years ago called Quality Matters, which looked at producing a unified complaints process, developed by Healthwatch in partnership with the CQC. There was a very strong focus on the complaints process going back to the provider first and then through bodies like the ombudsman and Healthwatch. Certainly, in the CQC evidence that I have read, it is clearly saying that it will not deal with individual complaints, but it is using them as part of the data awareness piece. It is going into its pool of data, which is enabling it to flag individual situations.

The Chair: Do you think that the CQC should deal with them, because we heard from Wayne and we have heard in evidence before that people wonder what the point of the CQC is if you tell it that something terrible is going wrong and it says, "Oh, we don't deal with individual complaints".

Professor Vic Rayner: In answer to the first question—does everybody have access to somewhere to make complaints?—all care providers would say that they do, in the sense that they have a complaints process because that is part of their inspection regime: to see whether they have a way in which people can make those complaints. People should always be able to access some independent complaints process. There is

Healthwatch, which is a very strong opportunity for people to do some of that, and there is also the ombudsman in relation to that. We need the regulator to be thinking about the CQC role and how it works with providers to support and develop greater improvements and practice. The question is whether it is the best body to look into people's individual complaints or whether that is a body that is set up and established as a person-centred process, such as Healthwatch.

The Chair: So the question is whether they are a watchdog or a partner. Certainly the evidence we have heard shows that there are plenty of partners in the field and that what is missing is a proper watchdog, so being able to deal with complaints might be a watchdog-ish kind of exercise.

Nadra Ahmed: I was going to say that it is quite difficult, because the role of the CQC is so beyond our comprehension sometimes.

The Chair: Ours too, Nadra.

Nadra Ahmed: At the outset of the pandemic, it was not on for us to be talking to it anyway, even if it was not about complaints, so it is very difficult to know. We get providers saying to us, "A CQC inspector rang up and vaguely asked us about something. It has obviously had a complaint, but it won't tell us anything". What it does when it receives a complaint is not mapped, and perhaps that is the strategic element that we need to understand.

Professor Vic Rayner: People need a loop back. They need to understand what has happened with their information.

Joanna Cherry: Nadra, that was a very interesting answer when you said that it was not on at the start of the pandemic. Do you mean that it was not coming into the homes, or do you mean that it just was not contactable?

Nadra Ahmed: I am on record as saying that it was not on. We did not hear much about anything from CQC that was supportive for the sector at a time when we really needed somebody to advocate for us, because providers were consistently contacting us.

The Chair: Surely the advocate is a complete opposite of a watchdog.

Nadra Ahmed: For example, we have providers that might have had an inspection two or three years ago and were not going to get any other inspections, but they may have got their act together. The importance of having a good inspection rating is that it has an impact on your insurance. If you have been told you need to improve something, you need to do that, and somebody then needs to come in and say, "Yes, you are now good". None of that was happening, because there were no visits coming into the care homes. There was a real role that we felt was a gap for us. We were being asked regulatory questions by providers that we were not able to get responses to. This is what I am saying; it was not on. It will argue—I have had the conversation with it—that it was not on. I will stop there.

The Chair: Thank you very much indeed for your evidence today, which has been illuminating, and thank you for the work that you do in the care sector, which is such a fragile and incredibly important sector. Perhaps the spotlight that has been on it, from the awfulness of Covid, can be marshalled into something that actually puts it all on a much better footing in the future. Thank you very much indeed for your evidence.