



HOUSES OF PARLIAMENT

## Joint Committee on Human Rights

Oral evidence: [Protecting human rights in care settings](#), HC 714

Wednesday 23 March 2022

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Members present: Dean Russell MP (in the Chair); Lord Brabazon of Tara; Joanna Cherry MP; Lord Dubs; Lord Henley; Baroness Massey of Darwen; Angela Richardson MP; David Simmonds MP; Lord Singh of Wimbledon.

Questions 56 – 67

### Witnesses

[II](#): Michael King, Chair of the Commission at Local Government and Social Care Ombudsman (LGSCO); Kate Terroni, Chief Inspector of Adult Social Care at Care Quality Commission (CQC); and Jemima Burnage, Deputy Chief Inspector of Hospitals - Mental Health at Care Quality Commission (CQC).

## Examination of witnesses

Michael King, Kate Terroni and Jemima Burnage.

Q56 **The Chair:** We now move on to our second session. We are taking oral evidence on protecting human rights in care settings. In this session we will look specifically at the Care Quality Commission, or CQC, and the Local Government and Social Care Ombudsman or LGSCO.

We have on this session three more excellent witnesses. First, Kate Terroni is the chief inspector of adult social care at the CQC. A registered social worker, she was previously director of adult social care at Oxfordshire County Council. She is co-chair of the ADASS workforce network. She joined the CQC as chief inspector in May 2019.

We also have Jemima Burnage, who is the deputy chief inspector of hospitals, mental health, at the CQC. She has spent most of her career working in and leading mental health services, having previously worked as head of inspection for adult social care at the CQC.

Last but not least, Michael King is the Local Government and Social Care Ombudsman. He previously served as deputy ombudsman, executive director, and chief executive officer. He has been responsible for introducing the public advice service and the jurisdiction for private sector adult care complaints at the Commission for Local Administration, which is the official body that runs the LGSCO.

I will start with the first question on areas of responsibility and then turn to colleagues. I recall us having a session with the CQC a while ago and I have seen similar sessions more recently when there were, at times, a bit of a disjoint and a disconnect between what people think the CQC does and what it actually does. Sometimes the evidence has been a bit blurred on that.

With that in mind, the CQC and the Local Government and Social Care Ombudsman have different roles in protecting human rights in care settings. For the record and especially to set the scene for future questions from our colleagues on the committee, could you each set out your areas of responsibility and explain how you work together to hold providers to account and to uphold human rights?

**Kate Terroni:** Good afternoon. I am pleased to join you today. I am chief inspector of adult social care at the CQC, which is the independent regulator of all health and social care providers in England. We hold providers to account for delivering against fundamental standards, which are about ensuring that people get high-quality, person-centred care. We use a huge amount of information we hold on providers that we hear from the public and from people who receive services to inform our regulatory approach. We go out to observe care being delivered in practice, form judgments and publish our inspection reports.

**The Chair:** Thank you. Any more to add to that, Kate?

**Kate Terroni:** No, that is it for me, thanks.

**The Chair:** Thank you. Jemima, if I may turn to you next from a CQC perspective?

**Jemima Burnage:** Thank you. I am deputy chief inspector of hospitals and I lead for the regulation of mental health services.

In addition to our regulatory role, we also have our duties, powers and responsibilities under the Mental Health Act to monitor the use of the Act for detained patients and people subject to community treatment orders and guardianship. That involves acting on complaints from people detained under the Mental Health Act and providing second-opinion doctors for patients who are refusing treatment and who are detained under the Act.

Within that, in terms of our Mental Health Act reviewers, we also have our national preventive mechanism role, which is about human rights and ensuring we monitor the service to ensure there is not a breach of human rights in terms of one of the 21 statutory bodies charged with looking at places of detention to ensure people do not suffer inhumane and degrading treatment. Those are our additional roles in the CQC as the regulator under the Health and Social Care Act and under the Mental Health Act.

**The Chair:** I do not wish to put you on the spot, Jemima, but for a lay man or someone who is perhaps watching this committee because they could not find another channel to watch on TV, if they are wondering what the CQC is, could you give a two-sentence mission statement for what you see as the CQC's role overall as an organisation?

**Jemima Burnage:** Yes. Our overall purpose is to ensure that people receive safe, effective and high-quality care. We encourage services to improve and we take action when that does not happen. Those are our key roles and responsibilities as the independent regulator of health and care in England.

**The Chair:** Brilliant. Thank you. That was excellent and clear. Michael King, could you give your perspective as the Local Government and Social Care Ombudsman perspective, please?

**Michael King:** Thank you for inviting me. We are the statutory investigation body for all complaints about local government and all complaints about social care. We have existed since 1974 doing that role. In 2010 our role expanded and so we do not look just at social care that is funded by the state. It was expanded so that we look at social care funded by local authorities and also self-funded by people.

For the whole of social care, whether in the public or private sector, whoever has arranged that care, however it is funded, people can come to us with a complaint. We look at a complaint only once the matter has

been considered by a provider body, whether it is a local authority or a social care provider, but if people are dissatisfied at the end of that process they can come to us.

We are entirely independent of the Government, the CQC and local government. People can come to us and get an objective investigation. In many ways, we function in the same sort of space as the courts and tribunals. I am appointed by the Queen so that we are independent of the Government. We operate with the powers of the High Court to carry out our investigations.

Having said that, people can come to us without any cost. It is a completely free service. They do not need a solicitor to represent them. We have a quasi-judicial role but it is accessible and simple for people to use. We look at about 20,000 complaints a year and around 2,000 of those are investigations into social care issues.

Picking up on one issue you raised, there is substantial confusion about where people can go when they have social care complaints. The law is clear: they come to the provider body first and then they can come to us. That is absolutely clear and the structure is absolutely fine, as in the legislation. There are major problems, though, with public understanding of that. We have recently presented a seven-point plan to the Department of Health for how that could be improved. That may be something to come back to in the course of this evidence. Certainly there is a problem with public understanding about our role and people's right to come to us.

**The Chair:** Within that question, I was keen to understand how the two bodies work together. Perhaps I could start with you, Michael, on how you see it working. I will come to Kate next to give her perspective.

**Michael King:** Absolutely. We have two distinct roles. The Care Quality Commission is the systems regulator. We are driven entirely by public complaints. We respond entirely to public concerns. We do not have a regulatory role. Having said that, we have two different perspectives on the same set of issues, so we try to work closely to make sure we share intelligence and that we work in a co-ordinated manner. We meet regularly to talk about that. All the decisions we make where we find fault with a social care provider or with a local authority are automatically shared with the Care Quality Commission so that they feed directly into the CQC's intelligence database. If we have an ongoing concern with a care provider, the CQC will be aware of that and can pick that up in its inspection. There is, I hope, a reciprocity of intelligence sharing there.

We are also aware that lots of people mistakenly approach the CQC with a personal complaint when they should come to us. We have worked hard with the CQC on when people have, in effect, misdirected their complaint. The CQC has a large contact centre up in Newcastle. We have done regular training for the staff there so they understand the difference in roles. We try to have a "warm transfer": if somebody is live on the phone to the CQC and it turns out they actually have an inquiry for my

organisation, we try to transfer that person in real time so that they can bring their complaint to us.

Having said that, we work hard at that relationship. There is probably more we can continue to try to do to make sure people are signposted to the right place when they have a concern. Certainly we have a positive and productive ongoing relationship.

**The Chair:** If I may come to Kate, then I will take a quick question from Lord Henley before going to Joanna Cherry.

**Kate Terroni:** Similarly to Michael's comments, we work closely with the local government ombudsman. We can warm transfer individual complaints when they come to us. We regularly signpost people.

We give advice similar to the LGSCO: we encourage people to raise issues initially with their provider to get them resolved. We also want to hear all types of feedback about the quality of care people receive, be that good, bad or mixed. We have launched a large campaign called Because We All Care with Healthwatch England to encourage more people to speak to us about the quality of their care. We do not have the powers from Parliament to investigate individual complaints, but every time an individual or a family member informs us about a quality of care that is not acceptable, it informs our understanding of quality and risk and the regulatory action we may take.

Q57 **Lord Henley:** I am a Conservative Member of the House of Lords. I have one quick question to get things absolutely straight in my mind. The CQC is the regulator and does not deal with individual complaints, but the ombudsman takes complaints but only after all avenues have been excluded. One would start with the individual complaint to the institution involved and work through in that way. If that was not satisfactory only then does one go to you, or do some complaints come through to you right at the beginning?

**Michael King:** Broadly speaking, you have outlined it exactly as it works. It is important, in our view, that local authorities and care providers take responsibility for complaints themselves and that they try to learn from them. As a matter of principle but also as a matter of law, complaints should go through those bodies first.

Having said that, we have discretion to take complaints directly from people when we feel it is appropriate to do so. For example, if somebody comes to us and says they have been complaining to a care provider for many months and have not been listened to, and the care provider simply does not have a complaints system or is not taking them seriously, we have discretion to intervene directly and deal with that complaint. We do that from time to time when we think it appropriate to do so.

**The Chair:** Thanks for that clarity. One core aspect of the role is complaints, so you will not be surprised that the next few questions by my colleagues are on the complaints process. I will hand over now to

Joanna Cherry for the first of those questions.

**Q58 Joanna Cherry:** Good afternoon. I am the SNP Member of Parliament for Edinburgh South West, but we are focusing on the English system this afternoon so my questions will be confined to that, just to be clear.

I will direct my questions in particular to Kate and Jemima because they are about the role of the CQC. At the outset I will say that we are a human rights committee, so we are interested to hear whether care users are getting their Article 13 right to an effect remedy when they have a complaint. There seems to be a bit of confusion about whether the CQC has a role in relation to individual complaints. I heard what Kate said about not having the powers from Parliament to investigate individual complaints, but I want to explore that a bit more. We have had evidence of concerns that the CQC is unduly procedurally rigid about that and its unwillingness to investigate individual complaints means that people get bounced from one organisation to another when they attempt to seek redress.

Can you be clear? In your understanding, what prevents the CQC being able to investigate individual complaints? I will start with Kate and then move on to Jemima if she has anything to add.

**Kate Terroni:** Thank you for the question. It is incredibly important that we recognise the effort and energy it takes a family member to pick up the phone and to contact us to complain. It is vital that we acknowledge that.

We do not investigate individual complaints for adult social care. Jemima can talk a little bit about people who are subject to the Mental Health Act. We signpost people to Michael's organisation to follow up on individual complaints.

We take information that we receive from the public, which might be in the form of a complaint, to inform our view of what is happening within services. A particularly poor concern raised about a provider or a number of concerns coming in may trigger us to go out to inspect a service.

In addition, when we go out and inspect a service, we have a regulation around how providers deal with complaints, so we expect care providers to have a transparent process for investigating complaints and that people experience no comeback and no fallout as a result of raising complaints. We know that the best providers out there treat those complaints and that feedback as opportunities to improve and grow.

We welcome all feedback. We want to hear from people about the quality of their care. That informs our regulatory work. Individual complaints will get followed up by the ombudsman and we look at how providers deal with complaints that come to them so that we can be assured they are doing their jobs effectively as well.

**Joanna Cherry:** Thanks, Kate. Jemima, on that point, I am aware that the CQC has a role in investigating complaints under the Mental Health Act, but I am concerned more about the care side of things. Does the

CQC need, or indeed want to have, additional statutory powers from Parliament or additional funding to take individual complaints? Are you interested in doing that?

**Jemima Burnage:** We need to know the scale of the ask. Also, I wonder whether that would add to confusion. We have an ombudsman whose role is to investigate complaints. I suspect that that would blur the boundaries if we were to take that on as well. Our two organisations have clearly distinct roles, but I absolutely hear the committee's and Michael's comments that we need to do more collectively to ensure people know the right route to get addressed.

**Joanna Cherry:** Just to play the devil's advocate here, looking at your powers overall, if somebody gets in touch with you with a specific complaint, it is within your powers to carry out a focused inspection or to require an explanation or a report, with the power then to take further steps if you were not satisfied. You have those powers. Most people would think that is what you need to do to act on a complaint.

**Kate Terroni:** Michael wants to come in as well. We look at the information we get from individuals in the round and what we know about that service: what do we know about the quality of care being delivered within that service? What do we hear from local authorities, clinical commissioning groups and our most recent inspections?

When information comes into us, it can trigger a referral to the local authority or a safeguarding alert. It can trigger my inspectors going out the following day to do a comprehensive or focused inspection and we would publish the findings. We currently do not have powers to take an individual complaint, investigate it and provide an outcome. We can take that information, look at it in the round, take regulatory action and publish our findings, but we do not currently have the powers for individual complaints.

**Joanna Cherry:** Those have to go then to the ombudsman. But you could both pass the same information on to the ombudsman as an individual complaint and trigger an investigation by you as a result of the same complaint.

**Kate Terroni:** Yes. The information can come to us. We can signpost that person directly to the ombudsman to have their complaint addressed. We could use that information and the following day go out to inspect the service and look at the issues. That intelligence would form part of a wider issue we would look at within the service. Say a complaint was raised about visiting or staff training. We would not look at the specifics in relation to that resident or that individual. We would look at how the provider addressed things like visiting or training in the round as well.

**Joanna Cherry:** Thanks. Jemima, would you like to come in? I see you have your hand up.

**Jemima Burnage:** Thank you. I wanted to help the committee in understanding the Mental Health Act. We can take up individual complaints. Those are our duties and responsibilities and powers given to us under the Mental Health Act. That means we can review and we can investigate. Similar to what Michael said, we would initially want to see what the provider has done and encourage people to make a complaint to the provider directly. In some cases that is just not possible because of the situation someone is going through detained under the Mental Health Act, but it is also a real safeguard within the Mental Health Act to be able to make those complaints about your care and treatment.

As an example, over the last year in our Mental Health Act report, we had over 2,280 complaints and concerns. We followed some of those individual complaints up but we also used that within our regulation of services, as Kate has also explained, and how we use information to formulate a review to decide what action we need to take and whether we need to look at it further. We do take a smaller number of individual complaints up, and there were over 3,000 follow-up calls to those 2,280 complaints we received last year from people detained under the Mental Health Act. We have specific duties under the Mental Health Act for detained patients.

Kate also touched on visiting. Last year we had 71 concerns raised with us around visiting and we have had 91 related to visiting this year up to February 2022. Some of those are not just related to the pandemic; for example, they relate to children visiting detained patients on wards. Lots of things can be taken up with us regarding a complaint and we will look to resolve that, take remedial action, ask for an explanation and an apology, and then maybe suggest some financial compensation. That is the range of the complaints. We also have a relationship with the Parliamentary and Health Service Ombudsman within that. I hope that is helpful.

**Joanna Cherry:** It is helpful. Basically, just to be clear about this, because of your duties under the Mental Health Act, you have one wing of the CQC that deals with individual complaints but those individual complaints come in under the Mental Health Act. When an individual complaint comes in not under the Mental Health Act but in relation to someone in care, it has to go to the ombudsman.

**Jemima Burnage:** We would encourage individual complainants to complain to the provider, but we use that intelligence and all those concerns to follow up the level, quality and safety of care. It might not mean the investigation of an individual complaint but we do use that information to inform a regulatory response around the risk to quality and safety of people using those services across health and social care. That is the same approach we would follow as a regulator.

**Joanna Cherry:** An earlier witness who gave us oral evidence last month, Professor Vic Rayner, CEO of the National Care Forum, told us about a big piece of work 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 strong focus on the complaints process going back to the provider first, as you have said, and then through bodies such as the ombudsman and Healthwatch. Can you tell us a bit about that piece of work? Have its outcomes been adopted or is it sitting on the shelf waiting to be looked at further?

**Kate Terroni:** One main outcome from that piece of work was that people had real clarity about where to take their complaints. From what we are hearing today and what you have heard in previous committees, there is more work to be done around really that.

**Joanna Cherry:** Yes. That is the issue. Even some of our witness who are experts in this field seemed a little unclear about the extent to which the CQC dealt with individual complaints. One recommendation this committee might think about is perhaps to have some statutory clarity on that, or at least some guidance-based clarity. Would that be helpful? I can see Michael nodding; I will come to him in a minute. Jemima and Kate, would that be helpful?

**Kate Terroni:** Anything that aids that clarity. I am always acutely aware that when people make the effort to get in touch and share often harrowing experiences, we want to make it as easy as possible for that to land in the right place so that action can be taken. I am receptive to any suggestions that might help that outcome.

**Joanna Cherry:** Great. Before I pass back to the Chair, Michael, did you want to come in on any of that?

**Michael King:** Yes, if I could. It is important to recognise that the distinction between complaint handling and regulation is not unique to the care sector. The same distinction exists in almost any sector with a regulator. It generally does not handle complaints. That is true in health, for example. It is true in planning. It is true in all sorts of sectors.

The reason is partly because a complaints process needs to have absolute guarantees of complete independence in reality but also in people's perceptions. It is difficult for the regulator, having made judgments about the standard of a particular provider, to then be seen by the public to be completely independent on an individual complaint. That is not a criticism of the CQC; that is just about public perception. Most sectors have a clear distinction between the role of an ombudsman investigating complaints independently and impartially and the role of a regulator with a different set of rules.

In terms of remedies we can provide which are not available to the CQC, when we investigate a complaint we can provide a remedy for the individual. That might be giving them the care that they should have been getting or it might be a financial remedy. We can also do two other things.

One is we can extend our investigations to look at other people who are affected by the same problem. When we find a problem in a care setting affecting one person, we might broaden our investigation to look at potentially hundreds of other people. We have done that recently in an investigation at Lincolnshire County Council, where about 700 have been provided with a remedy as a result of our intervention.

The other thing we do is recommend service improvements as a result of our investigation. When we find that there is a systems problem as a result of our investigation, we will recommend that the organisation should make policy or process changes that will benefit everybody. Last year in about 500 instances we recommended substantial change to the way a care body worked to improve care services. It is more than just a transactional resolution of individual complaints.

Coming back to your point about what the committee could recommend to address this public misunderstanding, we have put a number of different practical proposals on the table. One is that there should be a mandatory statutory requirement that care providers signpost to the ombudsman at the end of the complaints process. At the moment there is no requirement for them to do that. We know that the best care providers work closely with us and they signpost to our organisation, but we know that many other care providers do not signpost to us, so people are denied their right to have an independent investigation of their complaint. It would be simple to introduce a requirement for mandatory signposting and the CQC could check on that as part of its inspection regime.

We have also proposed to the Department of Health that there should be an outreach and awareness programme particularly to organisations such as Healthwatch and other intermediaries to make sure it is absolutely clear, building on the work you talked about around Quality Matters, to make sure that there is a real awareness that people can go if they have a general systems concern—to the CQC—or if they have an individual complaint that needs investigation, they can come to us.

We suggest as well that there should be a campaign of training in good complaint handling for all care providers. We already provide that training at cost price. With the backing of the Department of Health, we could provide that to every single care provider in the country.

We also propose that there should be a mandatory data return by every care provider in the country about how many complaints they deal with each year and that that should be published. It should also be considered by the board of that care provider every year.

Finally—you will be aware of this, being in Scotland—the ombudsman in Scotland is designated as a statutory complaint standards authority. The ombudsman in Scotland sets the standards for complaint handling across the sectors she is responsible for. We have proposed to the Department of Health that we should be made the statutory complaint standards authority for social care complaints so that we can set fair, consistent and

transparent standards of complaint handling across the sector. Again, that tried and tested model works effectively in Scotland. We think it would be simple to introduce that as an improvement to the system here in England, too.

**Joanna Cherry:** That was extremely helpful. Thank you to all three witnesses.

Q59 **The Chair:** Thank you very much. I have a couple of questions I want to throw in before turning to Lord Brabazon on the complaints side of things.

When we took evidence from Nadra Ahmed, who is on the board of directors for the National Care Association, she said to us, "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." I will not read the full response. It seems there is a bit of confusion with care providers as well about the role of the CQC, especially if they believe that individual cases are being looked into. I wondered what your thoughts were on that, Kate, and whether that is being looked at in terms of improving that understanding or whether that misunderstanding is true.

**Kate Terroni:** Yes, that was an incorrect assumption, as we have outlined in this discussion. We do not investigate individual complaints. The confusion might come from providers. We may receive information from the public that triggers us to go out, visit and inspect a service, and publish a rating. The providers' perception might be that that was purely triggered by feedback we received from an individual or a family.

**The Chair:** Nadra has been the chair of the National Care Association since 2001. If she is confused about it, that misunderstanding could be quite systemic. I was keen to know where you go from here if somebody who has been involved at that senior level for so long believes that the CQC looks into individual cases. Can you understand the confusion there for any lay person or anyone who has a family member they need to complain for?

**Kate Terroni:** Yes, I absolutely recognise that. We are collectively saying that more needs to be done to ensure there is real clarity about where people can go when they have a complaint to raise. But as I said, I suspect that misunderstanding is that providers may experience an inspector knocking on their door possibly as a result of information we have received from the public.

To give you a flavour of that, 52% of our risk-based inspections are triggered or partially informed by information we get from the public. We are responsive to what we hear from the public but we cannot investigate individual complaints.

We communicate regularly with the trade associations, with Nadra and Vic and Martin Green and other such colleagues. We put out bulletins weekly to the sector. Clearly there is more work that we need to do as well in clarifying that.

Q60 **The Chair:** Thank you. Jemima, before turning to Lord Brabazon on complaints, in written evidence provided to this committee, the CQC noted that in 2020-21 that it received 2,280 Mental Health Act inquiries and they were mostly from people who use services and carers, and the majority by telephone. Yet only seven of those were opened for investigation as complaints. Can you explain why there would be such a disparity between the number of those opened as complaints versus those made?

**Jemima Burnage:** Yes, I am happy to. We get a lot of complaints and concerns. We did have 2,280, as you cite from our Mental Health Act report and from the written evidence, during that year. The stepped process is we triage those to ask if they have been resolved, if we need further information and what their nature is. When that process is uncovered, as such, and we have taken some actions in following those up—I talked about the 3,000-plus follow-up calls—that is all about trying to gather information in terms of triaging those initial 2,280.

We review those and we look at the actions that have been taken. We may take some action to follow those up. Some of them may not be appropriate as complaints. We may need to pass those on to the inspection teams in terms of following that up along with other information about the service. Do we need to do a Mental Health Act visit? Do we need to attend that ward? Do we need to understand that person's care by speaking to them and their family, and the clinicians and staff on those units? When we had done that, seven complaints were fully investigated. There were quite detailed individual complaints investigations. There were seven for that year.

There is a larger number this year, which we expect to report on in our forthcoming Mental Health Act report. We think that is from close working and changing our model of response to complaints during the acute period of the pandemic early on, when we were doing more remote visits and remote Mental Health Act reviews. We used some of that resource to focus in on those complaints quickly, providing a much quicker response to triage, which reduced the number that led to investigation because we were able to follow them up proactively and quickly.

**The Chair:** Thank you. To check on that, though, there were 3,000 follow-up calls for 2,000 complaints, in broad terms, which is still only approximately 1.5 follow-up calls per complaint. Does the maths of that mean that 2,000 got a follow-up call and then the other 1,000 got one extra call each? How does that work? Surely that is not a huge amount of follow-up if people have complained.

**Jemima Burnage:** Some of those will be initial response and triage, and some will take much more detailed response. They may get passed to a Mental Health Act reviewer. Our Mental Health Act reviewers were dealing with a large number of complaints during that period because we changed that model. That may have involved going to the units, seeking information, getting records. That follow-up might be a call but then there is further work around the follow-up of the concerns raised with us.

That is not all about follow-up calls around the complaints. Activity sits beneath that in terms of finding out what happened, what concerns we have and whether it needs further resolution or investigation following that review and triage. There are different layers within that. I hope that is helpful.

**The Chair:** It is. If it is possible, could we get some further written evidence to show that tail? You have had a call, you have done a follow-up call, possible one other and then you have had the physical engagement or the visit. Is it possible to share more data on that? I am keen to understand how many of those 2,000 complaints took further investigation. Going down to seven actual investigations is quite a low number. That might be because there was a misunderstanding, perhaps, from that first complaint about what they could complain about or things could be being missed. I am keen to see that evidence if that is okay.

**Jemima Burnage:** Yes, I am happy to provide the data and follow up on the process that we follow around those complaints.

**The Chair:** Thank you very much. Building on complaints once again, we will now go to Lord Brabazon.

Q61 **Lord Brabazon of Tara:** I am a Conservative Member of the House of Lords. I would like to return to the issue of the reluctance of some care users to complain because of the fear of retaliation, which was raised with the previous panel. In response to our May 2021 report, the CQC said it would work with all parts of the social care system to offer reassurance "that feedback, concerns and complaints are welcome". What progress have you made on that?

**Kate Terroni:** If I may start on that, when we go out and inspect health and social care services, under Regulation 16 we look at how they respond to complaints, how they receive feedback and how they use that feedback to ensure that they improve the quality of care they deliver. We also look for those providers to be sensitive in how they respond to people who share information with them. They want it to be dealt with discreetly. We have a robust way of looking at how complaints are dealt with when we go out and inspect services.

We have been clear with providers that we do not expect anyone to fear or to experience poor consequences or services being terminated as a result of complaints being raised with providers. If we were to be made aware of such a circumstance, we would be interested to go out and look at the service in the round, because that would pose questions for me around the leadership and how that service was being run. We are clear that people should not experience any negative consequences as a result of raising complaints.

**Jemima Burnage:** Our regulatory response would be the same for mental health. In terms of our Mental Health Act role, we also have our second-opinion doctors, who give a second opinion on patients who refuse treatment. There is a route there.

We also have our reviewers, who are picking up infraction. They regularly speak to people. We did 682 ward reviews, many of those by remote access, but enhanced by speaking to 1,895 patients and 1,111 carers. It is built into the expectation of services providing care to people detained under the Mental Health Act that they need to make sure people are given their rights. Part of those rights is having a second opinion around treatment, being able to make a complaint and recourse to tribunals and hospital managers about their care and detention.

When I spoke about our visiting role, that is also to ensure that people's human rights are being upheld and we take issue with providers when we see that is not happening. It is proactive in the mental health space, particularly under the Mental Health Act, to ensure that there is recourse to either make a complaint or to raise issues about how the Mental Health Act has been applied to their care and treatment.

**The Chair:** We now go to David Simmonds, again on the theme of complaints.

Q62 **David Simmonds:** We have heard evidence that care users are often not familiar with your work, that investigations can sometimes take too long, and that the ombudsman sometimes lacks enforcement powers to take sufficient action afterwards. How accessible and responsive is the mechanism established by the ombudsman? Do you need stronger enforcement powers—and, if so, what—to carry out that role more effectively?

**Michael King:** As I said at the start, we have the powers of the High Court to conduct investigations. The powers to gather evidence and summon witnesses are draconian, and we get a high level of compliance, as you can imagine.

It sometimes surprises people that when we come to a conclusion on a complaint, the outcome is a recommendation. People's perception sometimes is that that feels, after a forceful investigation, like we are perhaps pulling our punches. Most of our complaints are in local government and the principle is that we would not usurp the sovereignty of local democracy. The idea is we make a recommendation but the expectation is that will be followed honourably and accepted, even when the body concerned does not particularly agree with what we have said.

That process has worked remarkably well for 50 years. We monitor compliance with our recommendations every year. I have never seen it fall below 99.5%. The 0.5% where we have not seen compliance that year normally is because a body has let it slip off its radar and, when we reopen a complaint, it is simply a case of them having delayed doing it rather than refused to. Despite us looking at thousands of complaints a year, sometimes proposing substantial remedies, it is vanishingly rare for either a local authority or a social care provider to point-blank refuse to implement our recommendations. In fact, only one social care provider in the entire history of us doing this role has twice refused to implement one of our recommendations, so the system actually works.

Having said that, there are ways it can be strengthened. I mentioned some of those earlier on, on awareness and training, but also strengthening the standards themselves.

Another area we are proposing comes back to Lord Brabazon's question. We are conscious that some people are fearful of raising complaints about social care, or sometimes they simply do not have a voice. If you lack mental capacity you simply cannot complain about your situation. One power we think we should have—the Welsh ombudsman already has this power and uses it effectively—is to look proactively at areas of care where we know there are problems but people cannot or will not be able to complain to us. We could actually take on that role of proactively looking at those areas, particularly areas like deprivation of liberty, where we know there are problems but people cannot raise their voices about it.

There are areas where our role could be strengthened but the fundamental model of the ombudsman system works remarkably well in delivering high-quality outcomes from the complaints we investigate.

**The Chair:** We will now move off complaints and on to visiting restrictions. The next question is from Lord Dubs.

Q63 **Lord Dubs:** Thank you, Chair. To what extent are care homes currently facilitating visiting in line with the Government's guidance and lifting restrictions? Does the CQC currently have access to all relevant data for monitoring restrictions, such as the number of essential caregivers appointed by care users, or the number of visits being facilitated?

**Kate Terroni:** The impact on visiting restrictions over the last two years for residents of care homes and their families has been significant, and the impact has grown as time has gone on. It is an incredibly important issue, which has had significant consequences for residents' mental well-being and so on. Throughout the pandemic, we have been clear that care providers need to follow government guidance, which has changed throughout the pandemic based on the latest scientific evidence. We have been categorically clear that we expect no providers to apply a blanket ban on visiting. Blanket bans would trigger a regulatory intervention, which would probably look like an inspection. We have been clear that we want to hear from people who use services and their families if they believe that their care provider is not falling in line with government guidelines.

The most up-to-date government guidelines on visiting were published yesterday. This says to the sector that there are no longer restrictions on visiting. Visiting should be happening across the country, although we still expect care providers to follow excellent infection prevention control measures, and possibly still have arrangements in place such as families booking to have their appointments when they arise.

The exception is that when care homes go into outbreak they are required to limit visiting to people who are receiving end-of-life care and for people to have access to their essential caregivers. Regardless of

whether a care home is in outbreak, we expect every resident to have identified an essential care group giver and for them to have indoor visits and see their loved ones. Throughout, we have been very clear. We expect care homes to follow government guidance. We will take action in response to any blanket visiting bans and we will look at concerns.

I can talk a bit about the numbers if that would be useful for the committee. Since the beginning of December, we have looked at visiting in 2,024 care home inspections. Across those 2,024 care home inspections, we were assured on 97% of occasions. In 3% of those inspections, we needed to either have a conversation with the provider to ensure that they amended their ways to follow government guidance, or in a small number of circumstances we have needed to take action. That is what we have done proactively.

Reactively, families have raised with us 226 concerns about care homes not following government guidance since 1 December. Of 226 in total, 98 were concerns about blanket visiting bans. Every single one of those cases has been looked at, often involving a phone call to the original complainant, conversations with the providers, discussions with those residents and use of our experts by experience, to hear from those people in receipt of services.

We have undertaken 43 inspections and a further 16 are in train. In 18 instances, we have found a breach of regulation in relation to visiting. So that is 226 concerns equating currently to 18 instances where we have found providers to be in breach of their regulation, and in one of those 18 instances we are in the process of closing a provider down because it has not followed visiting guidance. It is an issue we take incredibly seriously.

**Lord Dubs:** May I just follow up before I ask other members of the panel? You talk about blanket bans. How satisfied are you that you pick up enough of these blanket bans? We had some very distressing evidence some time ago about what happened in the early stages of the pandemic. I speak from memory. It was not totally clear that you were able to pick them all up. How satisfied are you that you can pick them up now?

**Kate Terroni:** I am really satisfied that we have been absolutely clear about our expectations. We have gone to additional lengths to raise awareness with the public about what they should expect when visiting a loved one in a care home. We have launched the campaign called Because We All Care to proactively ask people to tell us about the quality of their care. That translated last year to 55,000 calls received—55,000 bits of information about the care that people received.

We have been proactive in our expectations and reached out to people to ask them to tell us about any concerns they have. We have followed up in a variety of ways. Often that is just us picking up the phone to a provider and saying, "We have had concerns about how you are approaching visiting. Are you aware that the latest guidance says X?". That has been enough to see a provider fall in line and follow government guidelines.

Broadly, I would say that providers have done a really good job at that incredibly difficult balancing act of keeping people physically safe while supporting their mental well-being. In the small handful of cases where that has not happened, we have taken regulatory action.

**Jemima Burnage:** Across healthcare, but in particular mental health, we know that people often stay in hospital for longer periods. In particular, people detained under the Mental Health Act, people with a learning disability and autistic people may be in hospital for some significant time. Remaining connected to family is part of their care treatment and recovery, and a fundamental part of keeping people well and safe in hospital. People are often in acute services for shorter times, but there is still that balancing act my colleague Kate alluded to about making sure there is protection around people who are acutely unwell while ensuring they remain connected to people, particularly in end-of-life care.

I touched previously on mental health for detained patients. Last year we received 71 complaints and concerns relating to visiting, and we have received 91 this year to date. Complaints have included concerns about visiting related to Covid restrictions, but people detained under the Mental Health Act will often raise complaints and concerns with us when there is a restrictive part of their care and treatment that sometimes relates to, for example, children visiting units and whether that is safe at particular times. There is a mix of concerns around some of those restrictions.

In last year's report, we cited the case of a 16 year-old young person and talked about the impact on children and young people in hospital during the pandemic. Her mum wanted to visit her and there was a restriction in place. We did not need to take regulatory action. We worked with the provider and it was able to provide a two-hour visit. That helped the provider to think about how it could support people to visit their loved ones well.

We have also had a similar thing within mental health with a large independent health provider where it looked as though there was a blanket ban. We worked with the provider through our regulatory relationship to enable it to open the issue up, to think about people's rights and uphold them, and how important it is to be able to see loved ones.

We have been quite effective, but we ask all our inspection staff and our reviewers to be especially alert to any concerns raised with them about any blanket bans and restrictions. We want to see person-centred care and risk assessment in that way.

**Michael King:** As the committee has heard, we have investigated some very distressing complaints about people being excluded from visiting, particularly around end-of-life care, for example, care homes taking a far too rigid interpretation of what is end of life, excluding relatives from seeing a loved one in their final days and taking some irrational decisions around the interpretation of the rules.

The common theme we would draw out of some of those investigations—this goes for our investigations into complaints about care during Covid more generally—is that, although this was a very unusual set of circumstances, many of the times when we have found problems their roots have been in very common, everyday failures, such as poor communication, poor recordkeeping or a lack of understanding of guidance and legislation. Our conclusion from looking at our investigations during the Covid period is that Covid did not create new problems; it underlined and focused on underlying stresses in the social care system. Many of the problems we saw during Covid were remarkably similar to the problems we saw prior to Covid.

Even where you have these unusual circumstances during the pandemic, there has sometimes been a failure by local authorities and care providers that pre-existed before Covid to get the basics right and have robust resilient systems in place. This is at the heart of some of the problems we have seen.

- Q64 **The Chair:** I have a quick question for you, Kate—probably more of a clarification. We talked a little bit about blanket bans and people raising the issue to the CQC, and you mentioned the point that people might have raised a concern. Can you clarify what the difference is between a concern and a complaint? If somebody raises a complaint about a blanket ban they are probably complaining more broadly about something that has affected them individually, I would imagine. How do you manage that and what is the material difference between that and what the CQC is investigating a complaint?

**Kate Terroni:** Thank you for asking me to clarify that. Concerns are raised with us about care homes' approaches to visiting and it could be that they are not following government guidelines. Maybe they are not letting an essential caregiver visit. That may trigger us to take regulatory action and visit the service. That is different from a concern being raised about a blanket ban, which we think is unacceptable in any circumstances and would very likely result in us going out and crossing the threshold. Concerns have been raised with us throughout the pandemic about how visiting has been enabled in the broader term, and we have had a smaller number of concerns about blanket bans that we have also taken action against.

- Q65 **The Chair:** Thank you. Can I ask for one further detail? I recall us taking evidence from the CQC a while back and I asked how it tracks visitors to care homes. As I recall, there is no central log of how many visitors care homes have had, although if you happen to go to a care home you can perhaps see how many visitors it has had. How reliant are you on people raising that to you as a concern or a complaint individually, or do you regularly speak to them all and get data from them about how many visitors they have had?

**Kate Terroni:** Let me offer a quick sense of scale. We have approximately 15,000 care homes in the country delivering care to about 440,000 people. We are acutely aware of the regulatory burden, and we

want the workforce delivering care to people to be focusing on that rather than unnecessarily feeding information through to us. However, we have a variety of sources of information. Providers have to regularly complete provider information returns to us. They submit information on the capacity tracker. We have regular conversations with local authorities, clinical commissioning groups and health protection teams. We also have monitoring calls with providers. Since the start of the pandemic, we have done 13,000 inspections.

We set our expectations out there, we routinely reach out to ask for feedback from people, we have our programme of responsive inspections and whenever concerns are raised with us, we take regulatory action. We do not, however, ask 15,000 care homes to tell us what they are doing every day in relation to their visiting arrangements for 440,000 people.

We have to balance being agile and responding to risk and that is the approach we have taken throughout this.

**The Chair:** Thank you for clarifying that. I am now going to go to Angela Richardson, who is going to ask a question about dementia, learning disabilities and autism.

Q66 **Angela Richardson:** Mencap and the Alzheimer's Society told the committee that people with dementia, learning disabilities, and/or autism face particular challenges in care settings, for example in access to adequate treatment and personalised care. It would be very helpful for the committee to hear what your organisations are doing to ensure that care settings can provide solutions to these particular challenges.

**Kate Terroni:** We as the regulator have been talking a lot in the last few years about the outcomes that people with learning disabilities, and autistic people, experience. In October 2020, we published a report called *Out of Sight*, in which we showed that, in the absence of a comprehensive crisis service across the country, sometimes people with a learning disability or autistic people end up being placed in an in-patient unit, often a long way away from their usual place of residence in an environment that may exacerbate their distress, without regular access to therapeutic intervention and without an unrelenting focus on getting them back home. We published that report calling for significant change to ensure that people get the right care at the right place. We are about to publish a progress report on our *Out of Sight* recommendations.

It would be fair to say that there has been a huge amount of collective effort, ambition and will to do better for people with learning disabilities and autism to make sure there are really good community solutions for them, but that investment and commitment have not yet translated consistently to better outcomes for people with learning disabilities and autism.

**Angela Richardson:** We will all very much look forward to reading the progress report when it is published.

**Jemima Burnage:** It is important to touch on that report and the work we continue to do across our services concerning our regulatory response and the Mental Health Act. We need to ensure that everybody has access to personalised care, and for particular groups of people such as you have highlighted we have not seen that happening in the same way.

We know that *Out of Sight* will touch on people with a learning disability, and autistic people around restraints, inclusion and segregation, but a big aspect of our concern—you will see our key highlighted issues in the Mental Health Act report from 2021—is that much more is needed regarding access to alternatives in the community that wraps around the person in times of crisis, getting the right support at the right time.

Thinking about individual needs, if you have dementia you need services that support you. You need your community, primary care and secondary care to wrap round you. We need to support people to care well and have a good life. The same applies to people with a learning disability. Much more needs to be done for autistic people because we know autistic people will be across our services in place. We have very few specialist services for people with autism. We need to think about how communities and services—primary, secondary, acute mental health—support people who are autistic well. We need to think about people in that way.

Much greater work is needed at both system and provider levels. We need to do more to get system partners to come together to think about the needs of their population. You are right to highlight the needs of people with a learning disability, autism and also mental ill health, which is the focus of *Out of Sight*. We look forward to the panel and others looking to that joint ambition to do more to support people to live a good life and have the support they need to do that.

**The Chair:** Last but definitely not least, we are now going to talk about deprivation of liberty.

Q67 **Lord Henley:** Both of your organisations have raised concerns regarding deprivation of liberty safeguards, and you both noted that some individuals have been unlawfully deprived of their liberty, in some cases for years, in violation of their human rights. What steps have been taken to address the issue? Will the new system of liberty protection safeguards be capable of improving the situation?

**Kate Terroni:** For a number of years, in our state of care report, we have called out for more training and better understanding across health and social care professionals about deprivation of liberty safeguards, effective mental capacity assessments and best-interest decisions. Over the last 12 months, we have looked at deprivation of liberty issues in 2,310 services. On 90% of those occasions we were assured that the provider had the adequate training situation environment in place to manage that effectively. On 10% of occasions, we were not satisfied that DoLS was being dealt with appropriately. We would have taken a range of regulatory actions on the back of that. We look at DoLS as part of our regulatory work and what we have seen over the last 12 months is

reflective of what we have called for in our previous state of care reports for more training and better understanding required around DoLS.

Very briefly on liberty protection safeguards, we really welcome the expansion of these protections to people who may be restricted within their own homes, and for 16 and 17 year-olds. We note that the Government launched their consultation into liberty protection safeguards last week and we, along with a wealth of other stakeholders, will respond to that consultation.

**Lord Henley:** But 10% is still quite a large number of individual cases.

**Michael King:** This is an area we have had serious persistent and ongoing concerns about for many years. We did an investigation into a large county council a few years ago. We were looking into one complaint but, as I mentioned, we can sometimes expand our investigations to look at other issues. We realised that in the one complaint we were investigating, no proper deprivation of liberty order was in place for this person, so we looked at the authority's approach to this as a whole. We found that there were 3,000 people in that authority whose liberty was curtailed in some way. They were not in a queue. The authority had decided it was not going to look at their situation at all. We found that a further 2,000 people had previously died without a deprivation of liberty safeguard being put in place.

That authority had adopted a policy that was an extension of one that many authorities use to prioritise only the most serious cases, but it had gone beyond most authorities in saying it would not look at all at a great many of those cases. Only a very small number were going to be looked at. It had adopted that policy knowing that it was not in compliance with the law but driven by financial imperative. We have seen that over and over again in local authorities, which have said to us, "This is too expensive for us to do so we are not going to do it." That is a concern for us.

I want to give a bit of human flavour to that. A lot of people, perhaps looking from the outside of the deprivation of liberty controls, think that it is just a box-ticking exercise that it applies only to very elderly people with dementia and that the control on their liberty is probably just a locked door in the care home.

Our investigation showed that is not always the case. I saw a case of a man in his 40s who had had a stroke and was put into a residential care home for the elderly because the council could not find anywhere more appropriate. For years, he was begging to be allowed to go and live in the community. Nobody would listen to him and nobody did a proper assessment of whether he had mental capacity to decide his own future. It was only when his psychiatrist and we got involved in his case that he was allowed to choose where he lived. He was eventually freed from what was effectively detention in a completely inappropriate care home. I have also seen a case of a woman with Parkinson's disease forcibly removed from her home in the middle of the night against her wishes and without any proper checks of her mental capacity.

These kinds of cases go on and on. We have been seeing them for years and I have concerns. Obviously I cannot predict what the new provisions will do. I hope they are an improvement on the existing ones. My underlying concern is that local authorities regularly tell me that they cannot afford to implement these controls. I see that across our work as a whole. We uphold 72% of our investigations into social care. There are some serious structural problems in the social care sector. They are reflected in deprivation of liberty safeguards, but I am afraid they are reflected across the piece.

**Lord Henley:** You said earlier that 99.5% of your cases were dealt with satisfactorily and you got a proper response, and that 0.5% were not, but there is one local authority—unnamed—saying it cannot do anything

**Michael King:** It is Staffordshire County Council. As a result of our investigation, the council agreed to a programme of action to make sure it addressed that, but only because of our intervention. My concern is that Staffordshire is not an isolated example. When we were investigating Staffordshire pointed out that there are lots of other authorities in the same place.

Where we have investigated and where we have made recommendations, almost always the local authority will do as we have asked to improve. That is a good thing, but it is a reactive measure following a detailed investigation. My concern is that when we investigate social care matters as a whole—deprivation of liberty as I say, matters across the piece—over and over again we are told by directors of social services, “I know what I’m doing is not necessarily good practice and in some cases I know what I’m doing is not lawful, but I cannot afford to do it properly.” I hear that over and over again from directors of social services. I see those problems writ large in our complaints. In any system where we are year after year upholding 72% of the complaints we investigate, there is a bigger problem.

**The Chair:** I am going to bring this session to a close. Thank you to all of our committee members and especially to our witnesses, Kate Terroni, Jemima Burnage and Michael King. Thank you for a very valuable session. It was extremely insightful and hopefully cleared up some misunderstanding around the roles of the organisations. I will now formally close this meeting.