



House of Commons

House of Lords

Joint Committee on Human
Rights

Protecting Human Rights in Care Settings: Government Response to the Committee's Fourth Report

Third Special Report of Session
2022–23

*Ordered by the House of Commons
to be printed 14 December 2022*

Joint Committee on Human Rights

The Joint Committee on Human Rights is appointed by the House of Lords and the House of Commons to consider matters relating to human rights in the United Kingdom (but excluding consideration of individual cases); proposals for remedial orders, draft remedial orders and remedial orders.

The Joint Committee has a maximum of six Members appointed by each House, of whom the quorum for any formal proceedings is two from each House.

Current membership

House of Commons

[Joanna Cherry KC MP](#) (*Scottish National Party, Edinburgh South West*) (Chair)

[Harriet Harman KC MP](#) (*Labour, Camberwell and Peckham*)

[Bell Ribeiro-Addy MP](#) (*Labour, Streatham*)

[Angela Richardson MP](#) (*Conservative, Guildford*)

[Dean Russell MP](#) (*Conservative, Watford*)

[David Simmonds MP](#) (*Conservative, Ruislip, Northwood and Pinner*)

House of Lords

[Baroness Chisholm of Owlpen](#) (*Conservative*)

[Lord Dubs](#) (*Labour*)

[Lord Henley](#) (*Conservative*)

[Baroness Ludford](#) (*Liberal Democrat*)

[Baroness Massey of Darwen](#) (*Labour*)

[Lord Singh of Wimbledon](#) (*Crossbench*)

Powers

The Committee has the power to require the submission of written evidence and documents, to examine witnesses, to meet at any time (except when Parliament is prorogued or dissolved), to adjourn from place to place, to appoint specialist advisers, and to make Reports to both Houses. The Lords Committee has power to agree with the Commons in the appointment of a Chairman.

Publication

© Parliamentary Copyright House of Commons 2022. This publication may be reproduced under the terms of the Open Parliament Licence, which is published at www.parliament.uk/site-information/copyright-parliament.

Committee reports are published on the [Committee's website](#) by Order of the two Houses.

Committee staff

The current staff of the Committee are Zereena Arshad (Commons Second Clerk), Andrea Dowsett (Lords Clerk), Liam Evans (Committee Specialist), Alexander Gask (Deputy Counsel), Samantha Granger (Legal Counsel), Natalia Janiec-Janicki (Committee Operations Manager), Lucinda Maer (Commons Clerk), Aimal Nadeem (Committee Operations Officer), George Perry (Media Officer), and Thiago Simoes Froio (Committee Specialist)

Contacts

All correspondence should be addressed to the Clerk of the Joint Committee on Human Rights, Committee Office, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 4710; the Committee's email address is jchr@parliament.uk.

You can follow the Committee on Twitter using [@HumanRightsCtte](#)

Contents

Introduction	3
Provision of care	4
Conclusions 1 to 3 – CQC to monitor provider compliance	4
Conclusions 4 and 5 – preventing inappropriate use of DNACPR notices	6
Conclusion 6 – appropriate use of DNACPR notices	7
Conclusion 7 – CQC monitoring of DNACPR notices	8
Conclusion 8 – restrictive practices	9
Conclusions 9 and 10 – Deprivation of Liberty Standards	11
Conclusions 11 and 12 – non-means-tested legal aid	12
Conclusions 13 and 14 – implementation of the Liberty Protection Safeguards	13
Conclusion 15 – staff training on human rights	14
Conclusion 16 – when the provision of health and care is outsourced	15
Visiting arrangements	17
Conclusions 18 and 19 – right for one or more individuals to visit	17
Conclusion 20 – care settings to update CQC on visiting status	18
Application of the Human Rights Act	19
Conclusion 21 and 22 – extending the protections of the Human Rights Act	19
Complaints mechanisms	21
Conclusion 23 – clarified and streamlined complaints mechanisms	21
Conclusion 24 – proactive powers for Ombudsman bodies	23
Conclusion 25 – “no wrong door” policy for complaints	24
Conclusion 26 – handling of complaints	25
Conclusions 27 and 28 – raising awareness of complaints processes	27

Third Special Report

The Joint Committee on Human Rights published its Fourth Report of Session 2022–23, [Protecting human rights in care settings](#) (HC 216 / HL Paper 51) on 22 July 2022. The Government response was received on 6 December 2022 and is appended below.

Appendix 1: Government Response

This is the government's formal response to the recommendations made by the Joint Committee on Human Rights (JCHR) in its report 'Protecting human rights in care settings' published on 22 July 2022.

The government welcomes the report. Ensuring people can access quality care and support, wherever they live in the country, remains a priority for this government. Our long-term vision for delivering adult social care in England puts people and families at its heart. It is a vision that promotes independence and enables people to live well as part of a community, as well as providing more support for the workforce.

The committee's inquiry examined evidence relating to 4 main issues:

- the provision of medical and personal care
- ongoing concerns about visiting arrangements
- the complaints process for when things go wrong
- the coverage of the protections of the Human Rights Act 1998 (HRA) to all those in receipt of regulated care services

As health and care services are devolved, the inquiry focussed on care settings in England.

The government has carefully considered the evidence, findings and recommendations of the report and set out our response to its findings below. =- =

Provision of care

Conclusions 1 to 3 – CQC to monitor provider compliance

Conclusion 1 - people in care settings have the right to the highest attainable standard of health, as protected by Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). They also must have their personal needs met, in light of the protection against torture and inhuman or degrading treatment (Article 3 of the European Convention on Human Rights (ECHR)) and the principle of human dignity.

Conclusion 2 - even one instance of inadequate service that goes unnoticed is too many.

Recommendation: conclusion 3 – Care Quality Commission (CQC) must adequately monitor providers' compliance with expected standards and hold providers accountable in a timely way.

Response

The government recognises the importance of CQC's role in ensuring people in care settings receive high quality care and support which respects their human rights. As the independent regulator of health and adult social care in England, CQC monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety.

Where inadequate care is identified, CQC will take timely action. CQC uses its enforcement framework to determine which enforcement powers it should use and what action it should take. This could include publicly directing a provider to take action, restricting a provider's operation or, in cases of significant concern, taking action which would lead to the closure of a service.

Where care falls below standards, but the provider has responded appropriately to address concerns, CQC may discuss the issue with the service. This would not necessarily lead to a change in the rating of the service. CQC will take all information into account when considering if enforcement action is necessary and proportionate.

CQC is in the process of reviewing its enforcement model, which includes its enforcement policy and the way it makes enforcement decisions, in line with its changes to enable more flexible, responsive regulation.

CQC is also developing its regulatory model to make it a more dynamic assessment process where evidence is reviewed much more frequently. The goal of this is to enable the regulator to change ratings more easily and use on site visits more flexibly to gather additional evidence where needed, observe care and talk to people using the service and staff more frequently.

CQC's new regulatory model also places greater weight on the evidence from people who use services and their families. CQC is building a range of methods to gather more

evidence, including from people with communication and other access barriers. CQC is committed to ensuring that the voices of people who use services and their families are central to its regulation process.

Conclusions 4 and 5 – preventing inappropriate use of DNACPR notices

Conclusion 4 - do not attempt cardiopulmonary resuscitation (DNACPR) notices relate solely to cardiopulmonary resuscitation. Such notices must never be applied in a blanket fashion to groups of individuals, nor be conflated with decisions about other treatment escalation or admission to health and care settings

Recommendation: conclusion 5 - the government must work with providers, CQC, and other stakeholders to take steps to raise awareness and prevent inappropriate use of DNACPR notices.

Response

The government recognises the importance of preventing the inappropriate use of DNACPR decisions and ensuring guidance on DNACPR decisions is clear and properly understood by all health and social care professionals, as well as the patients involved.

The Department of Health and Social Care (DHSC) will continue to work with partners to ensure system-wide guidance on DNACPR is clear and properly understood in all settings, particularly by those patients who may not have a carer or advocate present or need reasonable adjustments to address communication barriers. This includes NHS England (NHSE), Health Education England, Skills for Care, the British Medical Association, the General Medical Council and many other partners across health, social care, local government, voluntary and community services.

A key outcome of this partnership working was the publication of the Universal Principles for Advance Care Planning in March 2022. These principles are being adopted across health and care settings to consider different groups of people, ensuring every person understands and feels involved in their advance care plans.

Further work to ensure the appropriate use and improved awareness of DNACPR notices includes:

- the publication by NHSE of patient-facing guidance on DNACPR, setting out how DNACPR decisions should be made and how individuals and their families can get support if they have concerns about a DNACPR decision
- a new requirement which came into force on 1 April 2022 and which requires GPs to record conversations about end-of-life care and DNACPRs as part of annual health checks for people with a learning disability and autistic people over the age of 14. While the end of life care section is a required part of the Annual Health Check, we would expect GPs to use their clinical judgement as to what is an appropriate discussion about end of life care with a particular child and their parents.
- the inclusion of information on DNACPR notices in the Oliver McGowan Mandatory Training on learning disabilities and autism. The Oliver McGowan Mandatory Training is the recommended training package for meeting the Government requirement for CQC registered providers to ensure their employees receive learning disability and autism training appropriate to their role, as set out in the Health and Care Act 2022 which came into force on 1 July 2022.

Conclusion 6 – appropriate use of DNACPR notices

Recommendation: conclusion 6 - there must be adequate involvement of care users and their relatives and representatives in DNACPR notices, so as to secure the care users' right to private life and their personal autonomy under Article 8 ECHR. Comprehensive records must be kept, monitored, and reviewed periodically. The Universal Principles for Advance Care Planning are welcomed, but it is crucial that the principles are observed in practice.

Response

The government recognises the importance of people being at the centre of their own care, particularly when developing and agreeing advance care plans, including DNACPR decisions.

The publication of the Universal Principles for Advance Care Planning is an important step towards ensuring patients across health and social care feel empowered to make decisions about their future care and feel confident their wishes will be considered if they are ever unable to fully participate in decision making.

To ensure the principles are observed in practice, the Universal Principles for Advance Care Planning are linked as supporting guidance to CQC's new single assessment framework. This framework sets out the evidence required to demonstrate how care users' rights are being protected in relation to DNACPR. This includes proof of the involvement of people who use services, evidence of consent and providers following the Mental Capacity Act 2005 (MCA) where appropriate in order to best deliver person-centred care and treatment.

Conclusion 7 – CQC monitoring of DNACPR notices

Recommendation: conclusion 7 - in its monitoring, assessing, and inspecting activities, CQC must continue to seek assurances that care users are placed at the centre of DNACPR notices, in a way that protects their human rights.

Response

The government accepts this recommendation and recognises the importance of the continued role of CQC in ensuring care users are placed at the centre of DNACPR notices.

The CQC review on the use of DNACPRs and associated personalised care planning during COVID-19 published its findings in March 2021. The review found widespread disproportionate use, particularly among older and disabled people during the pandemic. The report also outlined how CQC could strengthen its approach to DNACPRs through its monitoring, assessment and inspection of health and social care providers.

During, and immediately following the review, specific checks were undertaken on providers and action plans were developed. Where CQC identify that people are not placed at the centre of decision making, have concerns around their human rights, and there is evidence of a breach of the relevant requirements, CQC have the power to take enforcement action. When enforcement action is taken, the service provider must submit an action plan to CQC as part of their quality improvement plans.

CQC has also revised its inspection framework in relation to DNACPR and has built learning from the review into the development of its new regulatory model. Within the assessment framework, CQC must consider evidence and feedback from people who use services, staff and leaders to ensure that people have been involved in decision making on DNACPR.

In addition, CQC also developed a 'brief guide' to support their inspectors handling concerns relating to DNACPR and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). CQC will also link to the national good practice guidance around DNACPR for the relevant quality statements. This will effectively create a resource library to show what good practice looks like.

These changes will strengthen CQC's position to monitor and seek assurances that care users are placed at the centre of DNACPR notices in a way that protects their human rights.

Conclusion 8 – restrictive practices

Recommendation: conclusion 8 - restrictive practices should only be used where strictly necessary, as they could amount to a breach of the prohibition of torture and inhuman or degrading treatment (Article 3 ECHR) and the right to liberty and safety (Article 5 ECHR). The government must work with CQC and the Ombudsman bodies to review existing guidelines to ensure that they comply with the requirements of human rights law, and to take appropriate steps to ensure that providers only have recourse to restrictive practices as a last resort. This is of particular importance for people with dementia and people with a learning disability and/or autism, who may be more likely to be subject to restrictive practices, due to their specific health and care needs.

Response

The government is clear that the use of restrictive practices should only ever be used proportionately and as a last resort, when all attempts to de-escalate a situation have been employed. Robust guidelines are in place for the use of restrictive practices in health and care settings and are kept under review.

In hospital and care home settings, the Deprivation of Liberty Safeguards (DoLS) apply for adults who lack the mental capacity to consent to their health and care arrangements that give rise to a deprivation of liberty. This may include people living with dementia, autistic people, and people with a learning disability or an acquired brain injury.

DoLS exists to protect people's rights by ensuring that any deprivation of their liberty is in the person's best interests, is necessary and proportionate, has been assessed independently, is only authorised in accordance with the law, and can be challenged in court where necessary. Care homes and hospitals must apply to the local authority to authorise any proposed deprivation of liberty.

We know that the DoLS system is in need of reform and that an estimated 124,145 DoLS applications were not completed in 2021/22, potentially leaving thousands of people being unlawfully deprived of their liberty. We therefore want to increase the protection of some of the most vulnerable people in society and recently ran a consultation on the implementation of the Liberty Protection Safeguards (LPS), which is the replacement for the DoLS system. This consultation closed on 14 July 2022. We are evaluating responses to the consultation and will provide an update in due course.

The Mental Health Units (Use of Force) Act 2018 applies to mental health patients in NHS or NHS commissioned mental health units, potentially including people with a learning disability or autistic people. It does not apply in other care settings. The statutory guidance was published in December 2021 and the majority of the Act's powers were brought into force in March and August 2022 to better protect patients in mental health settings from inappropriate use of force. The remaining powers are expected to be brought into force in as soon as possible.

Under the Act, each mental health unit must have a responsible person accountable for ensuring that the Act is adhered to. This person must publish a policy on the use of force for staff who work in that unit, publish information for patients about the rights of patients

in relation to the use of force by staff, ensure staff are trained on the use of force, including on techniques to avoid and reduce the use of force, and keep a record of any use of force by members of staff.

Further action the government is taking to ensure that people with a learning disability and autistic people receive high quality, therapeutic care and are safe in mental health units was set out in our response to the Health and Social Care Committee's inquiry into the treatment of people with a learning disability and autistic people (published 27 July 2022), the Building the Right Support Action Plan (published 14 July 2022) and the government response to the JCHR report on the detention of young people with a learning disability and autistic young people (October 2020). Actions include working closely with CQC and NHSE to continue undertaking independent reviews for every person with a learning disability or autistic person who is in long-term segregation, seeking to support the individual to be discharged or move to a less restrictive setting where possible. In addition, NHS England have commissioned a clinical model which is being delivered through Mental Health, Learning Disability and Autism NHS-led provider collaboratives to embed good practice across inpatient services with the aim of reducing the use of long-term segregation and restrictive practices for people with a learning disability and autistic people in mental health inpatient settings. The model, developed by Mersey Care NHS Foundation Trust, follows a human-rights based framework and provides person-centred and trauma-informed approaches to working with people in long term segregation as well as specialist training to staff teams.

We are already taking steps to improve reporting, transparency and oversight around the use of restrictive practices. We publish monthly statistics from the Mental Health Services Data Set on the use of restrictive practices with people who are in contact with services for mental health and wellbeing, learning disability, autism or other neurodevelopmental conditions.

Conclusions 9 and 10 – Deprivation of Liberty Standards

Conclusion 9 - every person who is deprived of their liberty without the completion of an application within statutory timeframes is unlawfully deprived of their liberty. Where this happens, it is clearly unacceptable and constitutes a breach of the right to liberty and security (Article 5 ECHR).

Recommendation: conclusion 10 - while LPS are not fully implemented, the government must work with the regulator and all stakeholders to ensure that providers fully understand the functioning of the DoLS and comply with statutory requirements.

Response

The DoLS are an important set of safeguards for adults who lack the relevant capacity and who may need to be deprived of their liberty in order to receive their care and treatment. Local authorities have a duty to make sure that they are processing all cases under DoLS.

We know that an estimated 270,650 applications for DoLS were received in 2021 to 2022. The number of cases has increased very significantly since 2013–14 when there were only 13,500. There was a sharp increase to 137,540 in 2014–15 following the Cheshire West judgement and in subsequent years there has been average year on year increase of 12%. We also know that an estimated 124,145 cases were not completed in 2021–22, and that only 20% of standard applications were completed within the statutory timeframe of 21 days. We work with CQC and all stakeholders across the system to understand the functioning of these safeguards.

CQC has a formal responsibility for reporting annually on the operation of the DoLS and publishes this through their State of Care report.

Where issues exist, we have worked with stakeholders to ensure that the sector understands and complies with the requirements. For example, the National Mental Capacity Forum ran a series of webinars to support relevant sectors with the application of the MCA and DoLS during the pandemic, which included information on carrying out assessments remotely. We also provided written guidance during the height of the pandemic to assist the sector in complying with the requirements.

Prior to the implementation of LPS, we will continue to work with local authorities to assess the nature of delays in the system and will continue to encourage local authorities to fulfil their legal duties under these vital safeguards.

Conclusions 11 and 12 – non-means-tested legal aid

Conclusion 11 - where unlawful detention has taken place care users and their representatives must be able to challenge it.

Recommendation: conclusion 12 - non-means-tested legal aid must be available for all eligible persons subject to deprivation of liberty, regardless of whether an authorisation is in place.

Response

We recognise the importance of non-means-tested legal aid for persons subject to deprivation of liberty.

Non-means tested legal aid is currently in scope for all DoLS cases under the MCA.

Legal representation for challenging authorisations under the DoLS is non-means-tested and the Ministry of Justice (MoJ) spent £22.8 million on challenges of this nature in 2021/22.

The LPS proposals we recently consulted on will require the legal aid regulations to be amended ahead of the implementation of the new LPS and we are working closely with the MoJ to ensure that non-means-tested legal aid will be available in the most appropriate cases under the new system.

Conclusions 13 and 14 – implementation of the Liberty Protection Safeguards

Conclusion 13 - it is important that the new LPS framework does not repeat the failings of the DoLS framework, particularly regarding delays in processing, legal aid, and data gathering. We appreciate the government wishes to ensure that it gets its implementation right, but we are concerned that there is no timetable for full implementation.

Recommendation: conclusion 14 - the government must not allow any unnecessary delays to the implementation of the LPS framework, should commit to a firm timetable for its implementation, and should update us every three months on progress.

Response

We closed a 17-week consultation on changes to the MCA and implementation of LPS on 14 July 2022. We are currently analysing the consultation responses and will provide an update in due course. In line with previous commitments, we intend to give the sector sufficient time to prepare.

Conclusion 15 – staff training on human rights

Recommendation: conclusion 15 - specific training on human rights and its effects on the provision of services must be given by all registered providers to staff. CQC should work with all stakeholders to ensure this is happening in practice. It is crucial that training programmes go beyond simply stating rights or obligations, and effectively demonstrate the relevance of and use of human rights in making decisions regarding care and treatment.

Response

We recognise the importance of effective, practical training and support to ensure those working in the health and care sector are well equipped to provide high quality care.

The Care Certificate already provides specific training on human rights for unregulated roles. The Care Certificate is a package of induction training intended to be completed within the first 12 weeks of starting a new role in health or social care. Standard 4: Equality and Diversity includes the expectations for understanding legislation which applies to the role which include: the Equality Act 2010, the HRA, the MCA and the Care Act 2014. The Care Certificate also sets out an expectation that workers will explore where there might be tensions arising between an individual's rights and the duty of care. We are continuing to look at how we can improve the delivery of the Care Certificate in the sector.

Through our continued funding of Skills for Care, the Government provides a range of resources and practical toolkits for social care providers to help them attract, train and retain staff. This currently includes distributing funding annually through the Workforce Development Fund, which enables employers to claim funding towards the costs of training and development for their staff.

Conclusion 16 – when the provision of health and care is outsourced

Conclusion 16 - a public authority cannot abdicate its duty to protect the human rights of the people it serves when it outsources services to third-party providers.

Recommendation: conclusion 17 - where public bodies outsource the provision of health and care through commissioning, they have an ongoing duty to ensure that the human rights of care users are respected. There must be sufficient provision for monitoring and accountability by the contracting public authority, to allow it to identify whether human rights obligations are being discharged.

Response

We recognise the importance of ensuring that the human rights of care users are respected where the provision of health and care has been commissioned.

Section 73 of the Care Act 2014 outlines the circumstances in which the protections of the HRA apply to the provision of care and support which has been arranged or paid for by a public authority. This includes, for example, personal care for residents of registered residential care providers which is arranged or paid for, in whole or in part, by a local authority in England.

NHSE and local authorities are responsible for ensuring obligations for commissioning arrangements are discharged, including ensuring equality and human rights of care users. The NHS commissioning body is the integrated care board (ICB), which is one of the 2 statutory parts of the integrated care system (ICS).

The Health and Care Act 2022 creates new duties for CQC to review and assess the performance of ICSs and local authorities. These new duties mean CQC will have greater oversight, independently reviewing local systems on the extent to which they are meeting their care and support obligations, alongside existing regulation and inspection of individual health and care providers.

CQC's ICS assessments will provide independent assurance to the public and parliament of how well health and social care partners within an ICS area are working together to deliver high quality care. Their focus will be on the Secretary of State for Health and Social Care's objectives and priorities, including those relating to leadership, integration, quality and safety.

Where CQC identifies issues that a local authority needs to address, local authorities and their local partners will be encouraged to resolve issues autonomously. Where local authority led improvement is not possible, the Secretary of State for Health and Social Care may act to secure improvement using new powers in the Health and Care Act 2022.

This extension of CQC's powers will form part of its new regulatory approach, which seeks to ensure that the way they regulate is smarter and more relevant to the way that care is now delivered, and will complement DHSC's plans to improve the collection and use of data, and thus collectively provide greater assurance over the commissioning and provision of care and support.

The Health and Care Act 2022 also includes a new regulation making power in relation to the arrangement of healthcare services in England. This is known as the Provider Selection Regime. It is intended to give decision makers a flexible, proportionate decision-making process for selecting providers to deliver healthcare services to the public.

The Provider Selection Regime will seek to ensure that decisions about who provides healthcare services are:

- made in the best interest of patients, taxpayers, and the population
- robust and defensible, with conflicts of interests appropriately managed
- made transparently

DHSC and NHS England are working to establish the Provider Selection Regime and will provide an update on delivery in due course. The rules which will set out the Provider Selection Regime will be subject to parliamentary scrutiny through the affirmative process before they can come into force.

Visiting arrangements

Conclusions 18 and 19 – right for one or more individuals to visit

Conclusion 18 - we still do not believe that there are sufficient measures in place to ensure adequate respect for the right to private and family life (Article 8 ECHR) in relation to care users and visiting arrangements in care settings.

Recommendation: conclusion 19 - the government must introduce legislation to secure to care users the right to nominate one or more individuals to visit and to provide support or care in all circumstances, subject to the same infection prevention and control rules as care staff.

Response

Contact with relatives and friends is fundamental to care home residents' health and wellbeing and visiting should be encouraged in a safe manner. While there is a public interest to ensure visiting rights, we must take a measured approach and continue to balance the competing rights of residents and visitors against the public interest in keeping residents and staff safe.

Since 21 June 2021, guidance is clear that care home residents should always be able to have a visitor, even if they have COVID-19 or the care home is in outbreak. Current visiting guidance is available in the COVID-19 supplement to the infection prevention and control (IPC) resource for adult social care.

Data submitted by providers into the Capacity Tracker (a tool which collects data from care providers) shows that, since the guidance was published, the vast majority of care homes in England were able to accommodate residents receiving visitors.

Where we are made aware of cases in which visiting is being prevented, we are currently working with the sector and CQC to understand and address the issues. To help understand local concerns, CQC monitors issues with visiting, sharing key information with DHSC and taking appropriate regulatory action where necessary.

We are currently looking at what more can be done to strengthen the guidance around visiting.

Conclusion 20 – care settings to update CQC on visiting status

Recommendation: conclusion 20 - the government must legislate to give CQC the power to require care settings to inform them of any changes to their visiting status, and to report live data on levels of visiting and restrictions. CQC must make compliance with visiting restrictions a key consideration when undertaking its regulatory and monitoring roles.

Response

In line with guidance, CQC is clear that people in care settings should be able to welcome visitors in a safe manner.

CQC already considers visiting as part of its regulatory approach. During the COVID-19 pandemic, CQC developed an IPC tool for care home inspections to help understand how well providers were managing their IPC duties. As part of this tool, CQC added a series of wider mandatory questions, including one on visiting, which specifically asks “is the service facilitating visits to people living at the home in accordance with current guidance”. This is asked on every care home inspection CQC undertakes, and they can take regulatory action when required.

CQC also asks about visiting as part of its annual provider information return, and during contact with providers as part of its direct monitoring activity (DMA).

We are currently looking at what more can be done to strengthen the guidance around visiting.

Application of the Human Rights Act

Conclusion 21 and 22 – extending the protections of the Human Rights Act

Conclusion 21 - the HRA does not apply equally to all those in care settings. It only applies when care is local authority funded or arranged. The discrepancy between levels of legal protection for those in care settings can seem unfair – the human rights of all those receiving care should be protected equally. That the government appeared to be unclear as to the applicability of the HRA is of great concern.

Recommendation: conclusion 22 - the government should consult on whether the protections of the HRA should be extended to those receiving care and support from all regulated providers. This could be done, for example, by repealing s. 73 (3) Care Act 2014, and amending s. 73 (2) Care Act 2014 to read:

(2) The provider is to be taken for the purposes of [section 6(3)(b) of the Human Rights Act 1998 (acts of public authorities) (and the equivalent clause of the Bill of Rights Bill 2022–23, c 34(1)(b) (meaning of “public authority”)) to be exercising a function of a public nature in providing care or support.

Response

The government agrees with the committee that ensuring people receive high quality care which respects their human rights is a priority. We have established, and will continue to monitor, robust measures to ensure individuals receiving care and support are protected.

All CQC-registered providers must meet the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including person-centred care, treating people with dignity and respect, and providing safe care and treatment. CQC's human rights approach to regulation is set out on its website.

Where these are believed not to be met, individuals can bring civil claims against providers for damages on the basis that the provider has breached its duty of care or been negligent. In addition, private providers are likely to have contractual obligations to ensure the safety and wellbeing of people in their care and individuals would also be able to bring a civil claim for breach of contract.

Furthermore, the reforms announced in our adult social care white paper, *People at the Heart of Care*, will bring more people within the scope of the HRA.

S. 73 of the Care Act 2014 ensures that those for whom care is (i) funded, in full or in part, by a local authority or (ii) arranged by a local authority, are protected by the provisions of the HRA.

The announced charging reforms, namely the £86,000 lifetime cap on personal care costs and more generous means test, will make more people eligible for local authority-funded care. We expect this to increase the number of older people who benefit directly from state support in the social care system from around half to two thirds in the long term.

Once commenced, this will give all self-funding individuals with eligible care and support needs the right to have their care arranged by their local authority. This part of the Care Act is already in effect for domiciliary care.

Complaints mechanisms

Conclusion 23 – clarified and streamlined complaints mechanisms

Recommendation: conclusion 23 - complaints mechanisms that involve care settings must be clarified and streamlined. All complaints relating to care settings should be investigated either by the Local Government and Social Care Ombudsman (LGSCO) or by the Parliamentary and Health Service Ombudsman (PHSO), and not by CQC. Section 120(4) Mental Health Act 1983 (MHA) should be amended accordingly to transfer the duty to investigate complaints related to the MHA in England, along with CQC's enforcement powers for such investigations and decisions, from the regulator to the LGSCO or the PHSO. This change would help minimise some of the confusion as to which body one should direct complaints, and could better enable CQC to focus on its monitoring and regulatory role.

Response

The government agrees with the committee that the complaints process under the MHA should be streamlined and responsive. However, transferring the duty to investigate complaints made under the MHA relating to care settings from CQC to the LGSCO or the PHSO is not considered necessary to improve the process or experience for individuals who raise complaints.

Under Section 120 of the MHA, CQC would still have the duty to monitor the exercise of powers under the MHA and so have to respond to issues raised by patients or users. Therefore, transferring CQC statutory duty to investigate complaints under the MHA would likely not reduce confusion around the complaints process. Additionally, as a member of the UK's National Preventive Mechanism, CQC will need to respond to concerns received about alleged torture and ill-treatment in places of detention.

There are also clear benefits to CQC maintaining responsibility for complaints made under the MHA. CQC uses the intelligence gathered from the complaints process to uphold the rights of people subject to the MHA, and to inform its monitoring and regulatory role, including by using the intelligence to encourage services to improve.

Where the LGSCO and the PHSO, who act as the final point of recourse for administrative justice complaints, would not typically consider investigating complaints until the first local resolution stage is concluded, CQC provides added value by supporting callers to take their complaints through the local resolution stage. The regulator can forward the complaint directly to the local provider and monitor their response in accordance with local procedures and national regulations. CQC can also ensure that the provider addresses both the complaint raised as well as any other issues CQC identifies during this process. There have been instances of providers changing their local complaints policy as a result of CQC recommendations.

CQC is seeking to make information sharing around MHA complaints clearer and more robust. Current memoranda of understanding (MoU) facilitate the signposting of complaints between CQC and the LGSCO and the PHSO. CQC aims to review these MoU with the Ombudsmen to strengthen the understanding of their respective roles and

ensure that patients' complaints are handled in a timely way. CQC is also undertaking work to improve data and recording of MHA complaints, including improvements on equalities data.

Conclusion 24 – proactive powers for Ombudsman bodies

Recommendation: conclusion 24 - the government should consult on giving Ombudsman bodies the power to look proactively at areas of care in which problems are perceived, but people might not be able or willing to lodge formal complaints.

Response

The government recognises that encouraging a culture of feedback and learning is vital if we are to improve services and people's experiences of social care and ensure that anyone that has seen or experienced poor care feels empowered to provide feedback, either through a formal complaints process or otherwise.

Under current legislative arrangements, the LGSCO can consider complaints from members of the public who have suffered personal injustice arising from maladministration by local authorities and social care providers. Any expansion of this role to investigate broader issues about adult social care may overlap with the regulatory remit of CQC. As set out in the white paper, *People at the Heart of Care*, the government is already looking at new duties for CQC in relation to assessing local authorities' delivery of their adult social care duties.

PHSO is charged by Parliament with providing an independent complaint handling service for complaints that have not been resolved by the NHS in England and UK government departments. This service includes investigating CQC where an MP raises a maladministration complaint on behalf of a constituent.

The government has no immediate plans to amend the LGSCO or PHSO's remit but will keep this matter under review, as it continues to consider the appropriate level of regulation of adult social care providers on an ongoing basis.

Conclusion 25 – “no wrong door” policy for complaints

Recommendation: conclusion 25 - the LGSCO, the PHSO, and CQC must have a “no wrong door” policy for complaints. If a complaint is out of scope of one body, they must direct it to the appropriate organisations in an adequate timeframe.

Response

The government recognises the importance of complaints being handled by the appropriate body in a timely manner. The LGSCO, the PHSO and CQC all have clear processes in place to help people understand where they should make complaints to.

MoU and information sharing agreements exist between CQC, the LGSCO and the PHSO. The MoU in place between CQC and the LGSCO facilitates information sharing between the 2 organisations regarding complaints and high-risk care providers and sets out arrangements for referring cases to the appropriate organisation. The MoU in place between the PHSO and CQC highlights that ‘CQC will refer individual complaints to PHSO’.

In light of the committee’s concerns, CQC aims to revisit its MoU and information sharing agreements with the Ombudsmen to ensure they result in the simplest and most transparent process for people making a complaint.

We do not currently believe there is a strong rationale for extending legislative arrangements which allow the Ombudsmen to directly discuss a complaint or clarify questions of remit and jointly consider a complaint to CQC or any other regulatory body.

Conclusion 26 – handling of complaints

Recommendation: conclusion 26 - in its regulatory and monitoring role, CQC must take proper account of how complaints are being handled by providers, and how decisions made by the Ombudsman bodies are being implemented. CQC must also routinely look at how health and care contracts between individuals and providers are being terminated and work alongside the Ombudsman bodies and providers to ensure that individuals are not suffering retaliation after lodging complaints.

Response

The government recognises the need for robust and effective procedures for complaints being processed and handled by providers and the Ombudsman bodies.

A provider's responsibilities around complaints are linked to Regulation 16: Receiving and acting on complaints. CQC can prosecute providers in breach of this regulation if there is a failure to supply information about complaints in a timely fashion.

CQC is currently transforming how it works to ensure its regulation remains effective in a dynamic health and care landscape, and to make the process of working with CQC easier for providers and the public. As part of this, CQC's new single assessment framework focuses on what matters to people who use health and social care services and their families.

Within CQC's single assessment framework, the main quality statement for complaints is under 'Responsive: Listening to and involving people', with several other quality statements providing supporting information, such as 'Safe: Learning culture', 'Responsive: Equity in experiences and outcomes' and 'Well-led: Freedom to speak up'.

CQC values people's experiences as highly as other sources of evidence and weights them equally with other required evidence categories. CQC will review this evidence to inform its regulatory approach, and this will be considered when reviewing how providers handle complaints.

Regarding monitoring how decisions made by the Ombudsman bodies are being implemented by care providers, CQC receives data on specific cases from the LGSCO and information from the PHSO. The inspector will use this information to either liaise with the provider to ensure the Ombudsman's recommendations have been fulfilled, and/or to ensure that they are addressed in the next inspection. CQC also receives regular data on all the LGSCO's adult social care complaints and is reviewing how this data will be used to monitor services.

Each year, CQC collects information from providers via its Provider Information Return (PIR) which asks how many people have been served notice solely because of a change in their care needs, and how many for other reasons. CQC follows up with providers to gather more information, which informs their regulatory activity.

CQC is however limited in the action it can take in relation to such contractual issues as this is primarily a matter between the provider and the person using that service, which is outside of CQC's remit.

In relation to individuals suffering retaliation after lodging complaints, CQC's position is clear – it is not acceptable for people to be treated unfairly if they raise concerns and CQC will take regulatory action if they find providers failing in their responsibilities.

Conclusions 27 and 28 – raising awareness of complaints processes

Conclusion 27 - the confusion over the complaints system in care settings has an impact on the ability of care users to enforce their rights.

Recommendation: conclusion 28 - along with the recommendations above, complaint handling bodies together with the government must consider options for raising awareness of the existing complaints processes.

The government agrees with the committee that awareness and understanding of complaint processes, including the important role that complaint handling bodies such as the LGSCO and the PHSO have within this process, is a key component in ensuring that people who draw on care and support and their representatives are aware of, and able to enforce, their rights to redress.

By law, all CQC regulated health and social care providers must have a procedure for dealing efficiently with complaints, and anyone who has seen or experienced poor-quality care has the right to complain to the organisation that provided or paid for the care.

Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all care providers to have an effective and accessible system for identifying, receiving, handling, and responding to complaints from people using the service or people acting on their behalf. It is open to CQC to prosecute providers who do not respond to CQC's request for information about complaints within certain timescales.

CQC are responsible for monitoring providers' compliance with Regulation 16. CQC guidance details a range of requirements providers must meet to adhere to regulation 16, including providing information on how to complain, the process that will be followed, and information on how and when complaints should be escalated to other appropriate bodies. This information must be provided in accessible formats to meet the needs of the people using the service, and providers must provide the level of support needed to make a complaint, this may be through advocates, interpreter services and/or any other support identified or requested.

We are currently considering a range of measures to increase awareness of existing complaints processes and the important role of complaint handling bodies within these. The government will continue to discuss with the appropriate bodies the best way to achieve this.