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on the day BRIEFING

NHS Providers

Care Quality Commission final report into use of restraint, seclusion and segregation

The Care Quality Commission (CQC) has today published the final report of its review into restraint, prolonged seclusion and segregation of autistic people, and people with a learning disability and/or mental health condition. This briefing summarises key findings from today's report, but for a comprehensive overview we encourage providers to read the report in full.

Key points

- This report is the culmination of CQC's thematic review into the restraint, prolonged seclusion and segregation of autistic people, and people with a learning disability and/or mental health condition, and describes CQC's findings about the current state of the care system for these groups of individuals.
- CQC stress that the report does not give a comprehensive overview of mental health, learning disability or autism care in England, however, the fact that some of the practices the regulator saw during the review occurred has implications for the wider health and care system.
- CQC found people often ended up in hospital because they did not have the right support, early on, in the community at the time they and their families needed it. The report highlights numerous 'missed opportunities' for these groups of individuals, which includes issues around: diagnosis, waiting times, transition planning and social care support.
- Overall, CQC found the environment of hospitals wards was often not therapeutic and there was inappropriate use of restrictive practices. CQC's overall assessment of community services was that they were providing higher quality care, with fewer restrictive interventions.
- The report highlights the difficulties in finding people suitable care in the community. CQC found complex commissioning arrangements and poor communication between providers and commissioners could lead to delays in identifying suitable community care or getting the care package ready.
- CQC stress government, NHS organisations and local authorities need to work creatively to remove the barriers stopping people from getting the care they need, and put in place the funding, community placements, crisis teams and skilled staff who understand the people they care for. This action must be owned and led by government, delivered by local systems working together, and involve people and their families to ensure individuals' needs are met.

Context

In October 2018, the Secretary of State for Health and Social Care asked CQC to carry out this review as a result of ongoing concerns about the use of restraint, seclusion and segregation in care settings. CQC published an interim report in May 2019. This final report describes what CQC found about the current state of the care system for autistic people, and people with a learning disability and/or mental health condition.

CQC emphasises that this report is about the people it saw and the use of restrictive practice, and does not give a comprehensive overview of mental health, learning disability or autism care in England. The full list of services CQC visited and the scope of the review is outlined in appendix B of the report. However, CQC stresses that the fact some of the practices it saw occurred has implications for the wider health and care system. Furthermore, although the majority of people CQC saw had a learning disability or were autistic, the findings have implications and learning for settings that support people who have a mental health condition and/or who are living with dementia.

Missed opportunities to avoid hospital

CQC found people often ended up in hospital because they did not have the right support, early on, in the community at the time they and their families needed it. This was particularly the case for people CQC saw who were diagnosed as autistic. This section of the report explores the 'missed opportunities' for those people, and what support could have been put in place earlier to prevent admission to hospital. This includes issues around: diagnosis, waiting times, transition planning and social care support.

A culture of restrictive practice

CQC saw some services taking a human rights approach, but this was not the case across all services. The regulator found people's human rights were potentially being breached because:

- staff did not always have the understanding, tools or support needed to help them to provide better, safer care
- environments were not always adapted to people's sensory needs and people were not being offered support to communicate
- decisions about restrictive practices were not always reviewed regularly to make sure that there was the least restriction on people's rights possible at any given time

- people were spending too long in highly restrictive situations because of failure to plan and progress long-term goals, and the availability and quality of independent advocacy was variable.

CQC highlights NHS Accessible Information Standard which can help providers meet both their reasonable adjustment duty and their public sector equality duty. CQC stress that staff need to make difficult decisions on a day-to-day basis, balancing risks and people's rights, and a human rights-based approach can help with making these difficult decisions.

Hospital-based services

Quality of care and environment

CQC found the majority of the 43 hospital wards it visited were not therapeutic environments. In some hospitals, however, CQC found evidence of people being cared for in innovative ways with smaller units and higher staff ratios. CQC found that some people were admitted to hospital without proper assessment and did not have an assessment of their needs while in hospital. As a result, many of the people the regulator met did not have a clear care and treatment plan in place.

Where CQC found assessments were carried out and care plans were in place, the quality of these varied. Often where people did have care plans they were of poor quality, with no treatment plan to support them to leave hospital. Many of the plans CQC saw did not take account of individual needs. CQC found poor leadership and cultures were also a barrier to people receiving person-centred care. At some of the hospitals CQC visited, the regulator found that staff did not feel listened to or supported to look after the people in their care.

Quality of and access to advocacy

CQC found that access to high-quality advocacy varied across the hospitals it visited and that the role of an advocate was not consistent. There was some confusion between the provider and commissioner about who the advocate was, or which organisation provided the services, which led to some people being denied access to the service. In some cases, CQC found no evidence that advocacy had been offered to people.

CQC found examples of advocates not informed of certain people on the ward. When people did have access to advocates, there were examples of poor quality advocacy, for example where people were not engaged in decisions about their care or where advocates were not upholding people's rights. CQC found advocates were also under pressure themselves and felt they did not have enough time to support everyone that they were responsible for.

Use of restraint

Nearly all of the services CQC visited used some form of restrictive practice, which CQC was often told was used for the person's own safety or the safety of others. The use of restraint varied across the services CQC visited. In some of the hospitals the regulator found that it was rarely used, but in others it was a daily occurrence. In adult social care services, restraint was used more than seclusion or segregation.

CQC saw examples where, with the right care package and plans in place, staff could help people when they became distressed and de-escalate the situation to avoid using restrictive practices. The following examples of good practice are outlined in the report:

- Using de-escalation techniques to pre-empt early signs that someone might be distressed.
- Several providers had introduced safety pods (large bean bags that people were laid on when restrained) to reduce the risk of harm from physical restraint, while others used an impact mat or cushion.
- Care plans that included the person's views and wishes detailing when and how to use physical restraint.
- Rather than taking a hands-on approach, staff supported people to manage their own self-harm, for example by untying their own ligatures. This was appropriately risk assessed and recorded.

Long term segregation or prolonged seclusion

CQC looked in detail at 66 people who were subject to prolonged seclusion or long term segregation because the regulator was most concerned about the isolating nature of their care. The regulator only found evidence of consistently good quality care and treatment for three people.

CQC found evidence that, despite people being calm and settled, seclusion was not always ended as it should have been. In some cases, people were living under these conditions for a long time. In some care homes and supported living services CQC found that staff did not always recognise when patients were being secluded.

CQC concludes that the environment and conditions of many of the seclusion rooms in hospitals were unacceptable and did not help people to get better. Some people in seclusion were not allowed to take personal possessions in with them. While this was often for the safety of the individual, in some cases CQC found that it was due to blanket restrictions being place.

Some of the people CQC met who were in long-term segregation were living in good quality environments. In these cases, people had access to several private rooms, environments had a homely feel, and people were visible in a way that allowed staff to keep them safe at the same time as offering privacy. CQC also reviewed some people in their own flats who had access to outside space and more activities.

However, CQC found the physical environments for many people in long term segregation did not meet their needs or help them to get better. Similarly to people in seclusion, CQC found that some people did not have access to personal belongings because of blanket restrictions being in place. CQC found care plans that aim to reintegrate people on to the main ward as a step towards moving into the community were not in place for some people. Many hospitals told CQC that they struggled to reintegrate people as the unsuitable ward environment meant that it was not in the person's best interests.

The report highlights the immediate and longer-term impact of restrictive practices on people, as well as staff, and the importance of staff trained in trauma-informed care to give people opportunities to talk about the nature of their distress and to support them to move forward.

Community-based services

CQC found some examples of good practice, most of which were in the community. These services generally had a good understanding of people's needs and tailored their care and environment accordingly to meet the needs of the individuals. Staff CQC met were well trained, knew and understood the behaviour of the people they were working with, which CQC conclude meant that they could help to prevent or de-escalate situations that were causing people distress.

The following examples of good physical environments outlined in the report:

- Single occupancy environments that could be adapted to people's needs, which gave them greater control over their environment. It also reduced the need for physical intervention as people did not experience distress because of their environment.
- People being able to personalise their walls with artwork and their hobbies.
- People being able to install underfloor heating or air conditioning.
- Safe furniture, lights that could be adjusted, and sensory items.

CQC also saw good examples of care planning at the secure children's homes it visited, such as screening assessments completed on admission, including screening for autism. For each of the

children placed in a secure children's home, there was a clear aim for the time they were at the home. This was agreed at an initial planning meeting and then reviewed at each review meeting and the service measured against how they were achieving the outcomes.

CQC's overall assessment of community services was that they were providing higher quality care, with fewer restrictive interventions, than hospital services. However, CQC highlight that there being no national reporting system in restrictive practice is a limiting factor. CQC found there was more monitoring of restrictive practices at a provider level than at a commissioner level.

Commissioning

CQC found issues and disputes about funding and commissioning placements was central theme throughout the services it visited, which often prevented people from receiving the best possible care. CQC found there were often difficulties in finding people suitable care in the community. The report highlights that complex commissioning arrangements and poor communication between providers and commissioners could lead to delays in identifying suitable community care or getting the care package ready.

In some cases, CQC found that community care packages had fallen through due to issues with funding or providers feeling unable to meet the needs of the individual. These delays and failed placements could lead to a deterioration in people's behaviour. As a result, people could find themselves being moved into more secure and restrictive environments, like medium or high secure units, and could lead to them becoming 'stuck in the system'.

Conclusion and recommendations

Taking the learning from the good practice CQC has seen, the regular wants to see tangible progress in four key areas:

- Supporting people to live in their communities. This means prompt diagnosis, local support services and effective crisis intervention.
- People being cared for in hospital receiving high-quality, person-centred, specialised care in small units. This means the right staff who are trained to support their needs supporting them along a journey to leave hospital.
- Renewing attempts to reduce restrictive practice by all providers, commissioners and others. Whilst CQC know in absolute emergencies restrictions may be necessary, it should not be seen as a way to care for someone.

- Increasing oversight and accountability for these groups of individuals. There must be a single point of accountability to oversee progress in this policy area.

Full recommendations are detailed in the report, but key recommendations include:

National system change

- Single ministerial ownership to deliver the review's recommendations, with the minister working with delivery partners in health, education, social care, justice and local government to pool budgets locally and work together as soon as additional support needs for people are identified.
- NHS England should have a named specialist commissioner for complex care with oversight for: holding commissioners to account; ensuring each local area has a named individual responsible for people with complex care; developing new quality standards for commissioning specialist services.
- There must be a named budget holder for the person's care, which is likely to be a CCG or local authority. Where a new placement is required to enable discharge, the budget holder must be responsible for commissioning the identified requirements within an agreed timeframe.
- The CQC must improve its regulatory approach of services for autistic people, and people with a learning disability and/or mental health condition, including: reviewing key lines of enquiry, assessment frameworks and its approach to rating providers; increasing the number of unannounced and evening/weekend inspections; and reviewing registration processes.
- Local authorities and CCGs must report regularly on the number of autism assessments carried out in the community and the number of people admitted to hospital.
- The government and commissioners must ensure that there is enough funding for training of all staff caring for people.
- Providers must comply with the forthcoming requirement for Oliver McGowan mandatory training, train staff in de-escalation methods and alternatives to restrictive interventions using certified training providers, and ensure staff understand human rights and the Equality Act 2010.

Restrictive practices

- There must be a contractual requirement on providers to inform commissioners and the NHS England regional team when segregation or seclusion begins in hospitals.
- There must be enhanced monitoring by commissioners to ensure a plan for ending restrictions is in place and key milestones met. There must be a named person in the provider with oversight for this to report to the commissioner. Lack of progress should be escalated to NHS England.
- There must be guidance developed to ensure independent reviews required by the Mental Health Act (MHA) are of a consistently high standard and are focused on reducing the restrictions.

- Care Education and Treatment Reviews (CETRs) are made **statutory**.
- The definition of long-term segregation in the **MHA Code of Practice** must be amended to include people who are segregated for reasons other than violence and guidance on safeguarding strengthened.
- A **national reporting mechanism** must be developed for the use of restrictive interventions in children's services and adult social care services to mirror that used in hospitals.

CQC makes a number of recommendations for further work outside of the scope of this review, such as the government ensuring a wider system discussion takes place regarding the practice of people being prosecuted by providers for the injuries caused to staff, and the development of an action plan to ensure people have access to an independent advocate. CQC also commits to publishing a brief report on progress that has been made on these recommendations in Winter 2021/22.

NHS Providers view

We welcome the publication of CQC's final report of its review of restrictive practices, which focuses on the care received by some of the most vulnerable in society. As we have previously highlighted, people with a learning disability and autistic people have faced longstanding, structural inequities, which has meant too many people are not receiving the care and support they need and should expect from the health and care system.

Whilst the report is not a system-wide review of all services available and how they interact, it is clear that immediate action needs to be taken. CQC is right to emphasise government, NHS organisations and local authorities need to work creatively to remove the barriers stopping people from getting the care they need, and put in place the funding, community placements, crisis teams and skilled staff who understand the people they care for.

To do this will require sustainable levels of investment across health, social care and wider services. Investment in the health and care workforce is particularly crucial to overcome the severe shortage of specialist staff needed to deliver appropriate and personalised care in every setting. We must also see investment in facilities to improve the level and speed of access to support.

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