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# Care Quality Commission's *Out of Sight – who cares? review progress report*, March 2022

The Care Quality Commission (CQC) has reported on progress in implementing recommendations from its *Out of sight – who cares?* report and the main areas where further work is still needed. A summary of the key findings and conclusions is outlined below. If you have any questions about this briefing, please contact policy advisor Ella Fuller (ella.fuller@nhsproviders.org).

## Key points

- CQC's full report commenting on the progress made in implementing recommendations from from its *Out of sight – who cares?* report has found 13 out of 17 of the report's recommendations have not been achieved and more progress is needed.
- The following four recommendations from the report have been partly achieved:
    - the involvement of people and their families;
    - the reporting of diagnostic assessments for autism and hospital admissions for people with a learning disability and/or autistic people;
    - enhanced monitoring to ensure a plan for ending restrictions is in place; and
    - improving CQC's regulatory approach.
- CQC acknowledges efforts have been made to ensure people with mental ill health, people with a learning disability and autistic people get the right support at the right time. In particular, the report highlights many staff have been working hard to try and bring about the changes needed.
- CQC states that the full delivery of these recommendations requires further investment in order for people to feel their impact. The regulator also stresses changes must be co-produced at system, provider and individual levels, with families' views listened to and acted on.
- CQC is waiting for the 'building the right support' delivery board to publish its action plan, and wants to see delivery of this plan, alongside further investment. The report also states that a public consultation on government plans to improve the information available on the number of people in long-term segregation is expected in autumn 2022.
- CQC acknowledges it still needs to develop some of its own work to progress the *Out of sight* report recommendations, such as improving the assessment of: all community services; experiences of care for people with mental ill health and for autistic people who do not have a learning disability; and care pathways through CQC's future regulation of local authorities and integrated care systems.

# Background

The report builds on the progress report CQC published in December, which focused on actions the Department of Health and Social Care (DHSC), NHS England and NHS Improvement (NHSE/I), and CQC have made over the last year in response to the *Out of Sight* report recommendations. Our briefing summarising the December progress report can be read here, and our briefing on the *Out of Sight* report summarising its findings and recommendations can be read here.

# Summary of findings

## People's experience of person-centred care

**Recommendation 10, concerning the involvement of people and their families, has been partly achieved.**

CQC found that families still experience barriers to good co-produced care, and that it is not always easy to raise concerns with providers. The reports states that true person-centred care means ensuring that people, their families and advocates are listened to and involved in planning care, and that co-produced, person-centred care is essential for helping people to live empowered lives in the way they want to.

CQC's analysis of the latest assuring transformation data found that over half (59%) of people with a learning disability and autistic people who were in hospital in December 2021 reported that their families were involved in discussing care plans. Families were not involved for nearly 1 in 10 people and this information was not recorded for a further 23% of individuals.

CQC has seen an improvement in the quality of advocacy available. Most individuals had access to an independent advocate and more than three quarters (79%) of organisations provided advocacy which held the advocate quality performance mark. However, CQC found barriers still exist in accessing advocacy, including limited resources and skilled staff being available, a lack of advocacy when a person is in seclusion or segregation, and the need for better collaboration with family members. CQC notes that NHSE/I has allocated £4.5m towards a review of advocacy for people with a learning disability and autistic people, and that advocacy providers have been concerned about lack of funding for a long time and progress has been too slow.

**Recommendations 1 and 8, concerning people being placed in the right home with the right support and bespoke services, have not been achieved.**

The report highlights that supporting people to remain in their own community, and preventing people staying in hospital longer than necessary, requires appropriate housing and for housing, social care and health to work together with people and their families. CQC suggests that actions needed to support people back into the community and to prevent unnecessary delays to discharge include: people moving to ordinary homes with the right support, and only being in hospital when receiving treatment; support to be developed through co-production methods; and people's rights to be promoted to ensure person-centred support.

CQC found that almost a quarter (23%) of the 65 autistic people or people with a learning disability who were admitted to hospital in December 2021 were people being re-admitted after having been discharged within the last year. CQC also highlights that data from 2020/21 showed that just over half (58%) of working age adults who received care from secondary mental health services were living in settled accommodation at the time of their most recent assessment or formal review. CQC concludes that there is a lack of suitable community housing, which means that some people's needs are not being met properly.

The report states that, often, delays in individuals accessing support arise from discussions and disagreement between health and social care on which budget should be used to fund the support required. CQC recommends individual or pooled budgets that follow an individual throughout their time between services, in order to help reduce disagreements between organisations as to who is responsible for paying for and/or delivering different aspects of a person's care.

## People's experience of hospital care

Recommendation 5, concerning people receiving the right support, has not been achieved.
CQC recommends that people should only be admitted to a mental health hospital to receive planned, high quality, specialist care, and that this should be for the shortest time possible in a therapeutic environment. Discharge planning should happen as soon as people are admitted.

However, CQC concludes that too many people are still in hospital for too long, and sometimes in environments that are not therapeutic. CQC found that there were 2,065 autistic people or people with a learning disability on inpatient wards in December 2021. This represents a 6% reduction since the publication of the *Out of sight* report in 2020. Over half of people with learning disabilities or autistic people who were in a mental health hospital in December 2021 had been there for over two years, and nearly one in five (17%) had a total length of stay of more than 10 years.

CQC also found that fewer than half of autistic people or people with a learning disability in a mental health hospital had a planned date of discharge in December 2021, and one in 5 (21%) were overdue for discharge or transfer. The report states that there are many reasons for delayed discharge, but the main reason was due to waiting for either a care home or housing. NHSE/I allocated £116m during 2021/22 to support people who are ready to leave inpatient facilities to get the community support they need, however CQC has said it is too early to see a positive impact from this investment and there remains not enough appropriate community support available, which can delay discharge.

The report states that progress has been made to improve hospital environments, and to increase investment in therapies to give people a better experience in hospital. However, CQC found that understaffed wards, restrictive cultures, and a lack of hospital beds and community services were all limiting factors in achieving a good therapeutic environment for inpatients. CQC found that ward environments often focused on containment and risk management and people with autism often found hospital environments distressing. Access to psychology, occupational or speech and language therapy was not always available, and access to education for children and young people (CYP) was at times limited.

### Recommendation 16, concerning use of restrictive interventions, has not been achieved.

The report states that restrictive interventions are often used inappropriately, and there are now more people in segregation than there were in 2019. CQC found that restraint is still used too frequently, with data from October 2021 showing that there were 1,920 people in mental health inpatient settings who were subject to restrictive interventions and restrictive interventions were used 11,355 times on these people. Hospital and adult social care representatives told CQC that the numbers alone do not provide enough information and suggest more qualitative information is required to provide context about the use of restrictive practices.

CQC suggests that in order for restrictive interventions to be used only when absolutely necessary and for the shortest possible time, services should take the time to work with people, their families and advocates to understand their distress and discuss the best ways to meet their needs. The report states that independent care (education) and treatment reviews (IC(E)TRs) have had some success, but have not fully impacted people's lives by allowing them to leave segregation.

### Recommendation 14, concerning putting Care (Education) and Treatment Reviews (C(E)TR) on a statutory footing, has not been achieved.

CQC found that, even though C(E)TR are taking place, there is still no guarantee that recommendations will be carried out. CQC asks that C(E)TRs be placed on a statutory footing to

ensure that providers are accountable for implementing the recommendations and, in the meantime, providers and commissioners must ensure that C(E)TR recommendations are carried out.

The report states that key barriers to effective implementation of the C(E)TR include:

- the right people are not always involved, so decisions are not always followed through;
- the process on admission is "not tight enough". An initial C(E)TR needs to set out the reasons for admission, and then a repeat C(E)TR needs to occur within three months;
- some areas told CQC that they do not complete C(E)TRs for autistic people who do not have a learning disability, and some community mental health teams are not aware of C(E)TRs.

## People's experience of support in the community

**Recommendation 3, concerning putting Care (Education) and Treatment Reviews (C(E)TR) on statutory footing, has not been achieved.**

CQC acknowledges that, there has been significant investment in improving community support via the NHS long term plan, however, it concludes it is still too early to see the impact it has made. CQC call for action to further develop community teams to prevent hospital admission, to improve access to community support for autistic people, including crisis support, and for people to access timely diagnoses of autism in line with NICE guidelines.

The report states that, partly due to the impact of the COVID-19 pandemic, access to community services has been more difficult. Some services that keep people well in the community, like crisis cafes or respite services, had closed during the pandemic and had not fully reopened. CQC also highlights that new urgent referral rates are rising; the monthly average for referrals from January to October 2021 was 10% higher than the monthly average in 2019. Senior managers in local authorities told CQC that they needed more resources for crisis support in the community.

**Recommendation 9, concerning the reporting of diagnostic assessments for autism and hospital admissions for people with a learning disability and/or autistic people, has been partly achieved.**

CQC concluded that action is needed to improve data quality so it accurately reflects the number of referrals, assessments and waiting times for autistic children and young people. The report highlights that accurate data to monitor and improve waiting times for an autism diagnosis is key. CQC welcomes the funding committed to by the government to begin to reduce waiting times as part of the autism strategy, however the regulator states it is yet to see it have a significant impact.

## Improving people's rights

**Recommendation 4, concerning embedding human rights into commissioning and delivery of care, has not been achieved.**

CQC has highlighted the need for staff working on inpatient wards to understand principles of both the Human Rights Act and the Equalities Act 2010. Action needed to fully embed these principles include: ensuring leaders within organisations promote knowledge and understanding of human rights and rights under the Equality Act; and ensuring that individual reasonable adjustments are always in place for autistic people and people with a learning disability.

CQC had found that this is not always the case: analysis from IC(E)TRs found that 60% of reviews included evidence related to poor care and potential human rights breaches, such as restrictions on access to fresh air, activities, personal possessions and visitors. At times, CQC found steps taken to manage people did not adequately consider the implications and impact on the individual's dignity. CQC Mental Health Act reviewers also found that little progress had been made by inpatient units towards ensuring accessible information about service users' rights.

## Skilled staff to meet people's needs

**Recommendation 7, concerning having enough staff with the right skills, competencies and experience in both health and care settings, has not been achieved.**

In its original *Out of Sight* report, CQC highlighted how important it was to have the right number and skill mix of staff who had the right training. Since then, CQC acknowledges that staffing levels have been greatly affected, partly as a result of the impact of COVID-19, that services have struggled with both recruitment and retention of staff, and CQC has seen an increase in the use of bank and agency staff.

CQC found that, although significant work has taken place to implement training, the impact of training has yet to be fully realised. Furthermore, latest data shows that only 10% of social care staff had training for physical interventions. The report states that 470 staff have so far attended human rights training NHSE/I has commissioned the British Institute for Human Rights (BIHR) to deliver for 2,000 staff until the end of 2022.

The report states that there is strong support from government and stakeholders, including CQC, for mandatory learning disability and autism training for health and care staff. The report also reiterates the importance of providers ensuring staff are trained in the use of restrictive interventions, with training certified as compliant with the Restraint Reduction Network training standards.

## Ensuring people have the right local services

### Recommendation 2, concerning creating a named national specialist commissioner for complex care, has not been achieved

CQC states that quality of commissioning is essential to ensuring that people live in the place that is most appropriate to them, and the expertise of a commissioner will make the difference between people having their needs met or not. CQC initially recommended a national commissioner who would have authority over health and local authorities, however, this has not been possible to deliver without a change in legislation.

CQC found that, at times, people with learning disabilities or autistic people feel that commissioners do not understand their needs. The report highlights that new training for commissioners is now available, designed to promote understanding of people with a learning disability or autistic people, to look at good co-production and to recognise when things go wrong. So far, 81 commissioners have completed the training.

### Recommendation 12, concerning enhanced monitoring to ensure a plan for ending restrictions is in place, has been partly achieved.

The report states that restrictive interventions should be more closely monitored by commissioners, who should check that, where there are restrictions in place, there are clear steps to ensure these are ended. CQC consider that in order to achieve this recommendation, all commissioners and provider collaboratives should ensure that people are receiving the least restrictive care possible.

CQC found that evidence from senior managers in health and social care roles across eight local authority areas on the extent to which this recommendation has been acted on was mixed. Some managers said the pandemic had impacted monitoring activities, but others were more positive and described the multidisciplinary approach they were taking to review restrictive interventions. CQC concluded that the impact of improved monitoring activity has yet to be seen in hospital settings as some individuals are still experiencing restrictive interventions or long-term segregation.

## What CQC has done

### Recommendation 6, concerning improving CQC's regulatory approach, has been partly achieved.

In this section of the report, CQC highlights the work it has undertaken to improve how it identifies closed cultures and hear from people who might be experiencing them. This includes work to improve:

- its regulatory approach by reviewing and updating guidance for inspectors, spending more time speaking to people in the service and visiting services unannounced and out of hours
- training for CQC staff on learning disability and autism and looking at poor training as an indicator of a closed culture
- how CQC looks at services for people with a learning disability, autistic people and people with mental ill health by:
    - publishing an 'equality objective' (to amplify the voices of people more likely to have poor access and experiences of care);
    - embedding human rights into its draft new single assessment framework; and
    - considering the relationship between safety and human rights.
- monitoring of restrictive interventions via Mental Health Act monitoring duties
- how the regulator listens to advocates and ensures that advocacy is a key area of focus in its new assessment framework.

CQC acknowledges it still needs to develop some of the work to progress the *Out of sight* recommendations related to the regulator. This includes improving how it assesses:

- all community services
- experiences of care for people with mental ill health
- experiences of care for autistic people who do not have a learning disability
- care pathways through CQC's future regulation of local authorities and integrated care systems.

## What the government has done

**Recommendations for the government to act on (recommendations 1, 11, 13, 15 and 17) have not been achieved.**

Five recommendations were made by CQC to the government, which related to single ministerial ownership, oversight of long-term segregation, reviews of long-term segregation, definition of long-term segregation and reporting of restrictive interventions in adult social care and children's services. CQC concluded that, while the government is driving forward many recommendations made in the *Out of sight* report, including establishing the 'building the right support delivery board' to take forward the work, there is more to be done to achieve a positive impact and these recommendations have therefore not been achieved.

The CQC is waiting for the 'the 'building the right support' delivery board to publish its action plan, and want to see delivery of this plan, alongside further investment. The government is also currently

discussing regulatory changes to improve the information available on the number of people in long-term segregation, with a public consultation expected in autumn 2022.

## Conclusion

CQC concludes that, whilst significant efforts have been made to ensure that people with mental ill health, people with a learning disability and autistic people get the right support at the right time, there is still lots of progress to be made. Out of the 17 recommendations made in its *Out of Sight* report, 13 have not been achieved and four were partly achieved. CQC states that delivery of these recommendations requires further investment in order for people to feel their impact. The regulator also stresses changes must be co-produced at system, provider and individual levels, with families' views listened to and acted on.

# NHS Providers view

We welcome CQC publishing this progress report and the regulator's calls for more action to be taken to ensure people with a learning disability, autistic people and people with mental ill health can access the care and support they need. Our August 2020 report showed that there are NHS trusts who are providing high quality care for people with learning disabilities and autistic people. We welcome CQC highlighting in this progress report that many staff have been working hard to try and bring about the changes needed.

However, our report also showed systemic challenges persist and mean that progress in improving the availability of high quality care for individuals across all settings, and in all areas of the country, has been unacceptably slow. We agree that to meaningfully move the dial, the government, NHS organisations and local authorities need to work together to put in place the funding, community placements, crisis teams and skilled staff required to fully meet people's needs.

This requires sustainable levels of revenue and capital funding across health, social care and wider public services – including education, housing and employment support – to invest in high-quality services in the community. This would provide people and their families with the upstream support they need, and secure, high-quality housing provision in places where people want to live.

We also need investment in the health and care workforce to overcome the severe shortage of specialist staff needed to deliver appropriate and personalised care in every setting. We continue to call for a fully costed and funded national workforce plan, alongside increased long-term investment in workforce expansion, education and training.