CQC's thematic review of restraint, seclusion and segregation

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BILD Conference
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Our role and purpose

The Care Quality Commission is the independent regulator of health and adult social care in England

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

What is the review looking at?

Number of people subject to restrictive interventions in these settings

Pathway that the person has followed to end up in segregation and/or prolonged seclusion

Quality of care and of the **physical environment**

Safeguards in place to protect the person's rights and to protect the person from abuse

Impact of segregation and/or prolonged seclusion on **people who are subject to it and on their families**

Impact on other **patients/residents** and staff

Quality of leadership and the culture

The role of the **wider system**

We're doing the work in two phases

Phase 1	Phase 2
• Specialist NHS and independent sector wards for people of all ages with learning disabilities and/or autism. • These include assessment and treatment units and low and medium secure wards for people with learning disabilities and/or autism. • Child and adolescent mental health wards	• NHS and Independent sector mental health 'rehabilitation' and 'low secure' wards • Residential care homes for people with learning disabilities and/or autism • Children's residential services (in partnership with Ofsted) • 14 secure children's homes in England (in partnership with Ofsted).

Interim report: what does our interim report look at?

Our interim report focuses on what we have found from visiting **39 people over 35 wards**

Focused on **segregation** for people who were in a learning disability or autism ward or children and young people's mental health ward

We make **recommendations** for the health and care system, including CQC

Interim report: a system not fit for purpose for the most vulnerable people

"The 39 people we have visited who are cared for in segregation are in a very vulnerable situation. Their world is narrowed to a highly restricted existence in a single room, or small suite of rooms.

They have little or no say over decisions about their lives or their future. Many are also a long way from home - which can make it difficult for families to maintain contact"

What have we found so far?

- There have been **missed opportunities** early on - many people we visited had been communicating their distress and needs in a way that people may find challenging since childhood
- A high proportion of people in segregation had **autism**
- Some of the wards did not have a built **environment** that was suitable for people with autism
- Many staff **lacked the necessary training and skills**
- In the case of 26 of the 39 people, **staff had stopped attempting to reintegrate them back onto the main ward**
- Some people were **experiencing delayed discharge** from hospital, and so prolonged time in segregation, due to there being no suitable package of care available in a non-hospital setting

Adam's story*

Adam was admitted to his current hospital when he was 10. Since admission, Adam has been confined to a seclusion room with dimmed lighting.

The walls of the seclusion room are padded because Adam often throws himself at the walls and bangs his head on them.

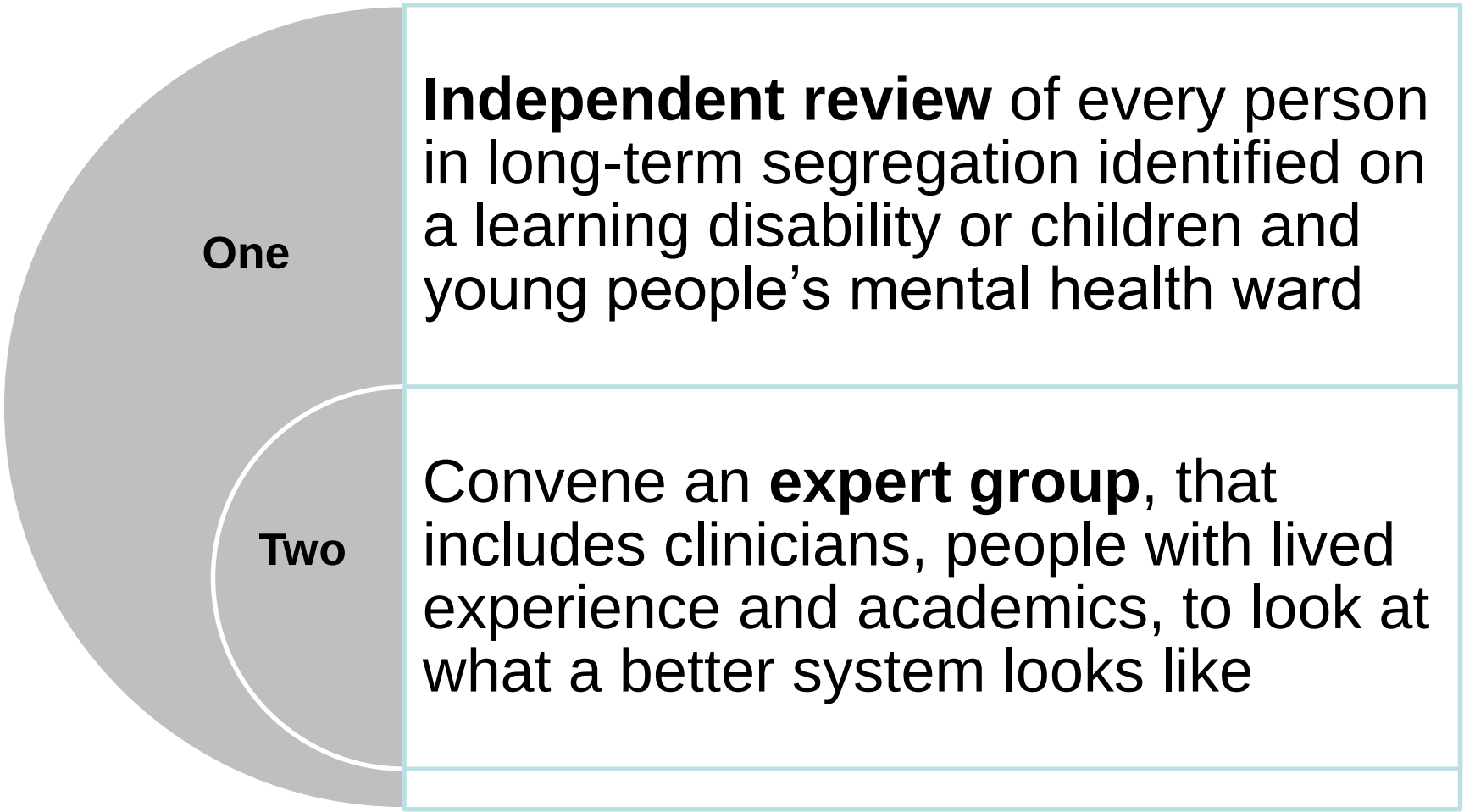
He is not permitted to use the adjoining lounge room routinely because this had not been fitted with padding.

If Adam wants to use the lounge, staff use physical restraint – for example, staff hold Adam's lower arms and guide him away from the entrance to the lounge.

He had only left the seclusion room 16 times in the 12 months before we visited him.

** Adam is not this person's real name and it is based on evidence gathered at a hospital visit

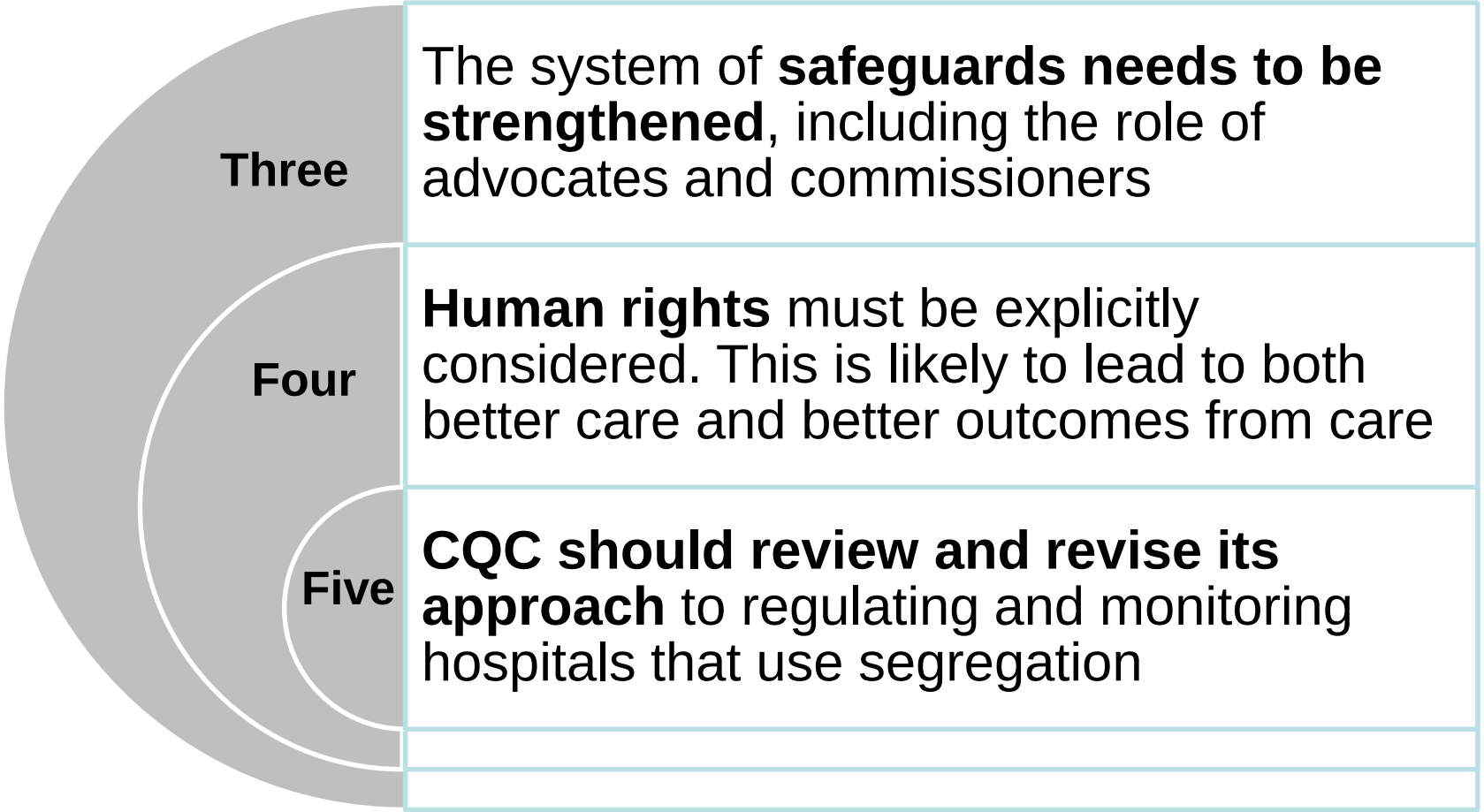
Interim recommendations 1/2



Independent review of every person in long-term segregation identified on a learning disability or children and young people's mental health ward

Convene an **expert group**, that includes clinicians, people with lived experience and academics, to look at what a better system looks like

Interim recommendations 2/2



Progress so far on reccomendations

- First meeting of expert group convened on 13 August, with representatives from voluntary sector, people who use services, families, regulators, Department of Health, NHS England and others

- We are gathering feedback on summary and proposals from that meeting from now until 13 September

- There will be a second meeting with BILD (British Institute for Learning Disabilities) in November to take forward next phase of the work

Next steps for delivering phase 2 of review

From July 2019 we are looking at the use of restrictive practices in a wider group of settings, including low secure and rehabilitation mental health wards and adult social care services

We are working with Ofsted to consider the use of restrictive intervention in children's residential services and secure children's homes

We will make further recommendations to the Department of Health and Social Care and the wider system in our March 2020 report

Differences and similarities between phase one and two

- In **phase one** we mainly focused on hospital settings – for people with a learning disability and autism, and children and young people's mental health wards

- In **phase two** we are looking more at social care services, as well as some low secure and rehabilitation mental health hospitals

- What are the differences and similarities we've found in these settings?

    - Environment
    - Staff
    - Different model of care

Phase two so far

Mental health services

- 9 complete
- 15 left to complete

Social care services

- 14 complete
- 15 left to complete
- Information gathered from over 200 via an on site questionnaire

Children's services

- We are visiting 11 children's residential settings in September and October
- We are gathering information remotely from 6 secure children's homes and visiting 3 of these

Unique oversight of care

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

22,949 adult social care services
146 NHS acute hospital trusts
234 independent mental health locations
10 NHS ambulance trusts
71 NHS or independent community health providers or locations
55 NHS mental health trusts
200 hospices
1,033 dental practices
244 independent acute hospitals
6,850 primary medical services

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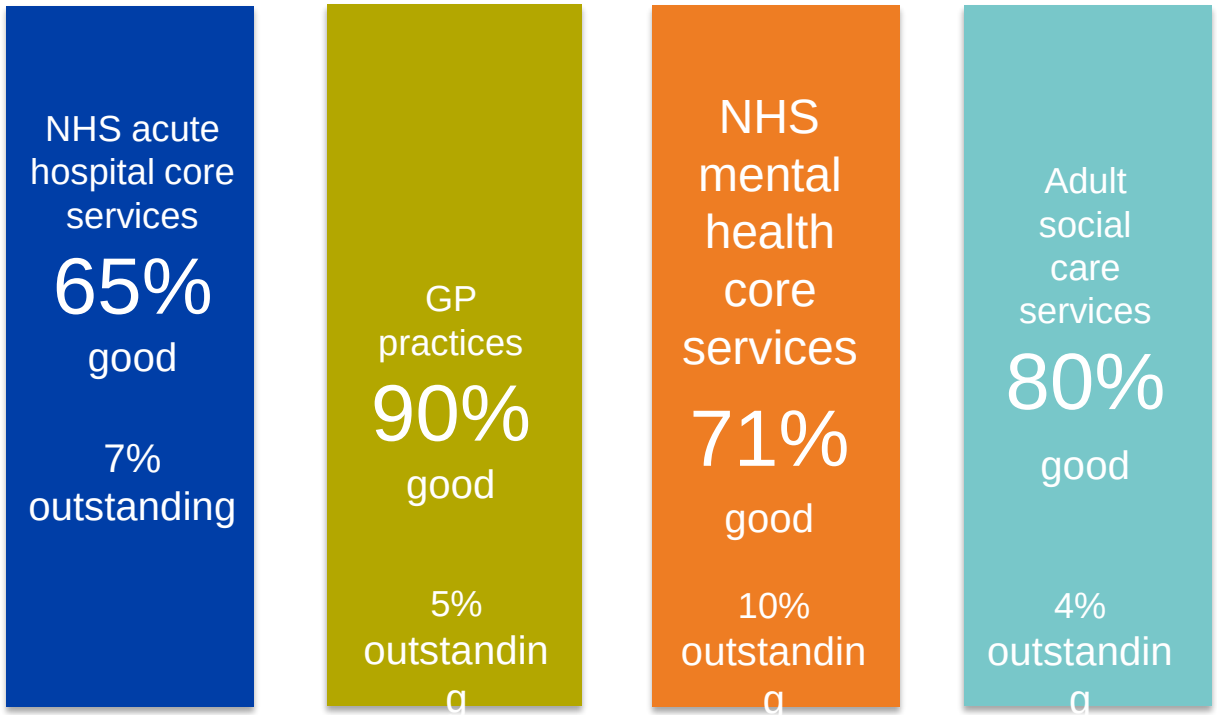
The quality of care across England is mostly good…



Ratings quality has largely been maintained

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State of Care 2018/19 - key messages

- People's experience of care is determined by whether they can access good care when needed
- Risk of being pushed into inappropriate care settings
- Increased demand and challenges around access and workforce risk creating a perfect storm

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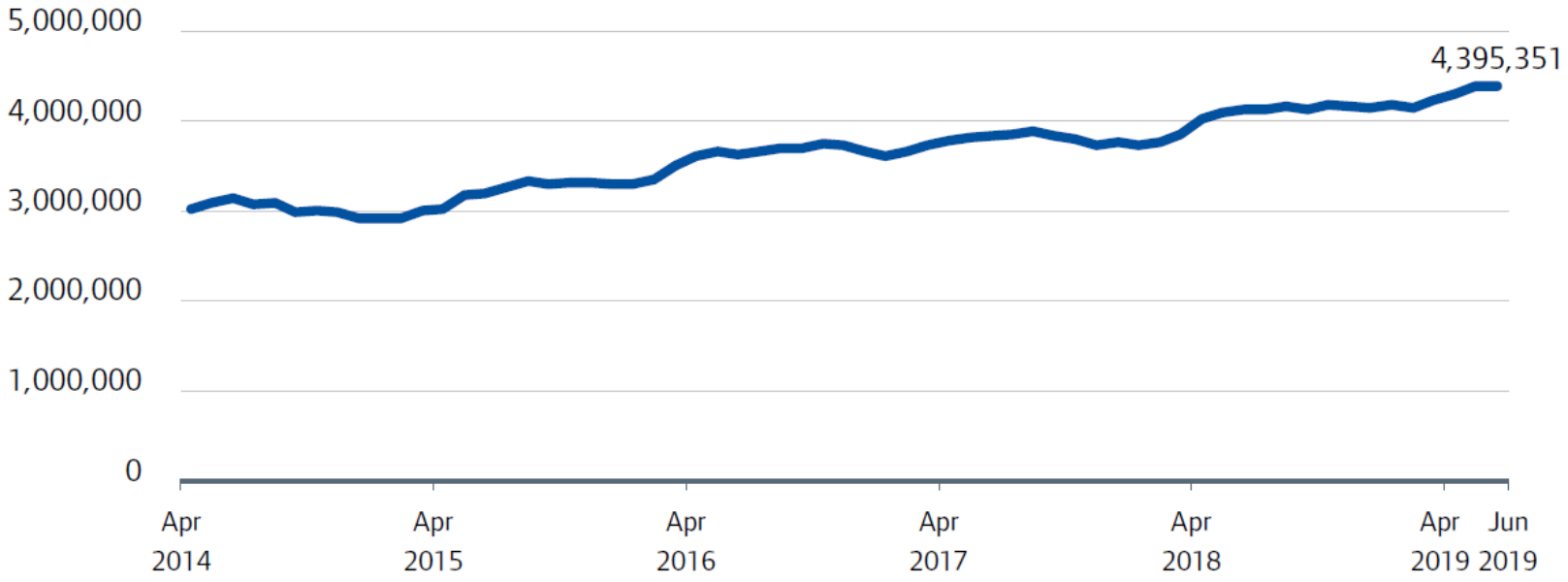
The struggle to access care

People struggling to get the right care at the right time in the right place
Risk of being pushed into inappropriate care



Total 18-week waiting list size, April 2014 to June 2019

(Source: NHS England and NHS Improvement, monthly referral to treatment times (commissioner level))

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State of Care 2018/19: A perfect storm

Access and workforce issues
Specialist nurse shortage

10%

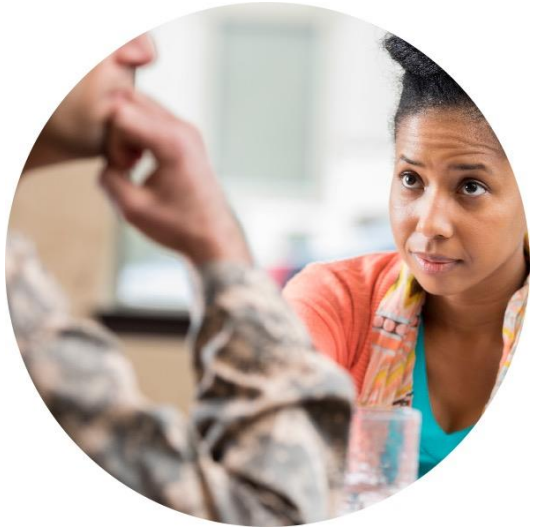
of wards for people with **learning disabilities** and/or **autism** rated **inadequate**, up from **1%** in 2018

8%

of acute wards for **adults and psychiatric intensive care** units rated **inadequate**, up from **2%** in 2018

8%

fewer **learning disability nurses** than in 2015



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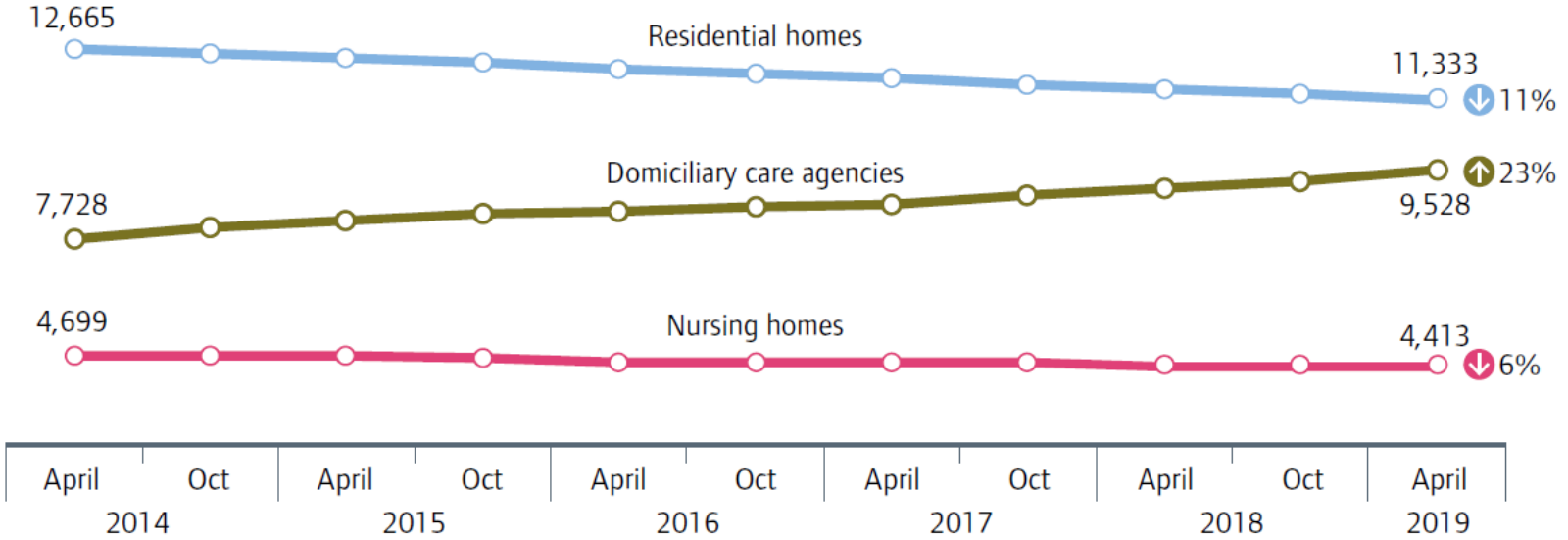
Adult social care remains fragile

Failure to agree funding solution continues to drive instability
Sustainability issues in domiciliary care
Providers continue to exit the market



Change in numbers of residential and nursing homes and domiciliary care services in England (2014 to 2019) (Source: CQC registration data, April 2019)

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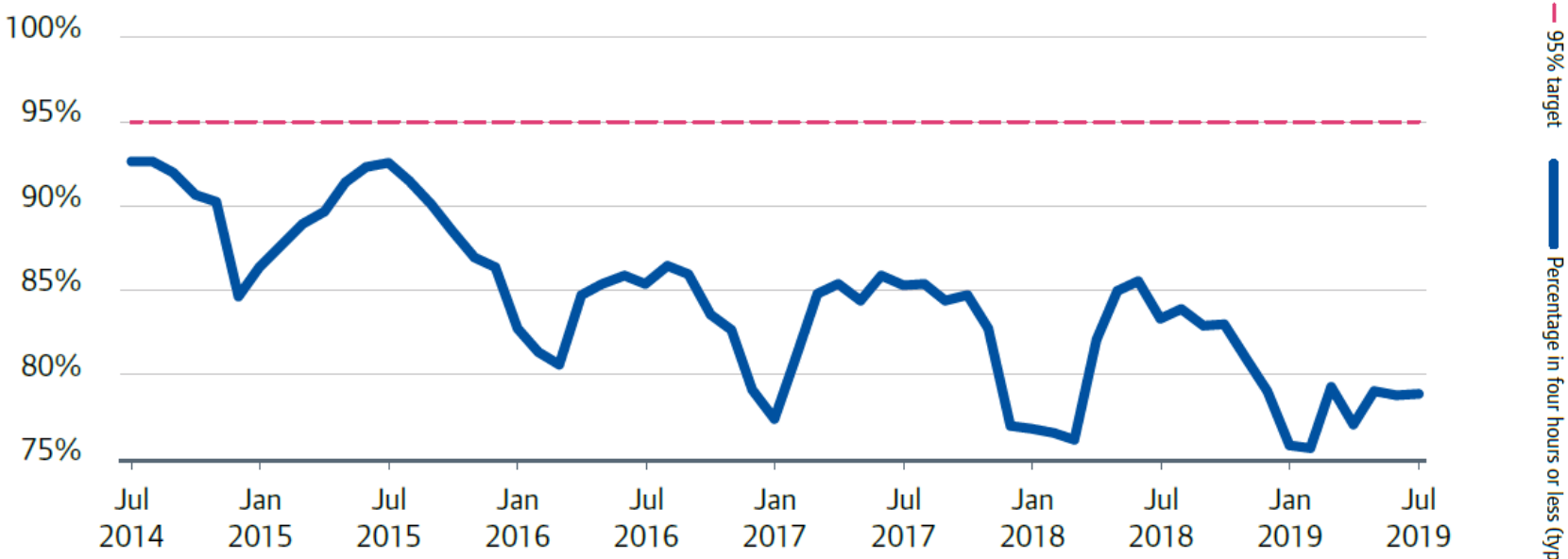
Pressure in A&E and across the system

Inspectors most likely to rate core service of emergency departments as Inadequate or RI

Collaborative working increasingly important



Monthly performance against the four-hour target in major emergency departments, July 2014 to July 2019

(Source: NHS England, A&E attendances and emergency admission statistics)

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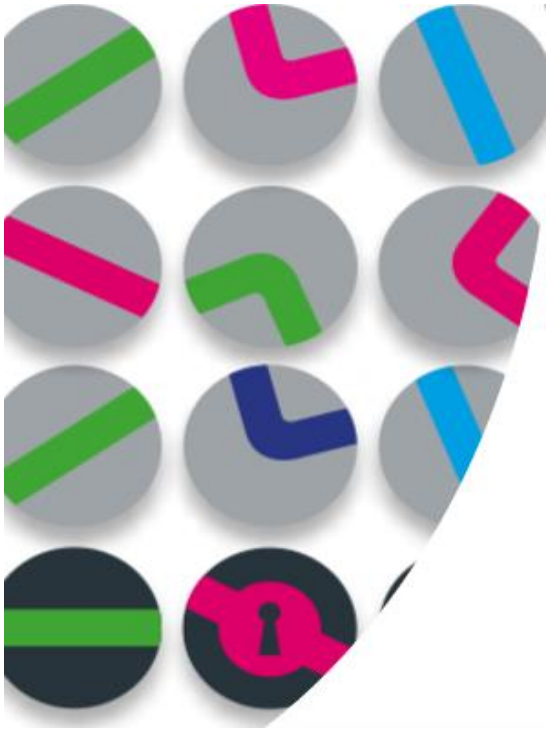
Sector findings



- Mental health care
- Adult social care

Specialist inpatient mental health care, learning disability and autism

Overall core services

69% rated good

10% outstanding

19% requires improvement

3% inadequate

- Access remains a problem
- Mixed picture of quality
- Safety is a continued concern: more than a third of NHS and independent services rated requires improvement and inadequate for safety
- Lowering quality for learning disability and autism wards

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Adult social care specific findings

Overall

80% rated good

4% outstanding

15% requires improvement

1% inadequate

- Concerns about capacity set against growing unmet need
- Staffing is under pressure with high turnover, high vacancy rates and a lack of people with the right skills
- Continued uncertainty about long-term funding

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Thank you

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