MEETING	**PUBLIC BOARD MEETING** **17 July 2019**
Agenda Item **Paper Number**	**5** **CM/07/19/05**
Agenda Title	**Update on thematic review of restraint, seclusion and segregation**
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PURPOSE OF PAPER:

To update the Board on the progress of the review and of the recommendations contained in the interim report.

IMPACT:

There continues to be considerable public concern about the use of restrictive interventions in health and care settings; including the use of segregation in hospitals for young people with mental health problems and in hospitals for people with a learning disability or autism. The Joint Committee on Human Rights is carrying out an enquiry into conditions in learning disability inpatient units and into the detention of children and young people with learning disabilities and/or autism.

1. Summary

In May 2019, CQC published an interim report on the thematic review. This focused on the use of segregation in mental health wards for children and young people and in wards for people with a learning disability and/or autism. Our principal conclusions were that this as an issue of human rights and that the 'current system of care' has failed people whose care pathway has ended with them being segregated in a hospital.

We recommended that independent reviews are undertaken of people in segregation, that an expert group is convened to propose a better system of care, that safeguards are strengthened (with a particular focus on independent advocates) and that CQC reviews and revises its approach to regulating and monitoring hospitals that use segregation.

2. Recommendation

This paper is to inform the Board of actions taken.

3. Discussion and implications

In its report on The State of Care in Mental Health Services 2014-2017, CQC commented on the frequent use of restraint on mental health wards and the wide variation in reported use. There have been longstanding concerns about hospital care for people with a learning disability and/or autism; with reports of inappropriate use of seclusion and restraint, poor ward environments, poor quality of care, excessive length of stay and damaging impact on patients and staff.

In 2018, the relative of a person who was cared for in segregation made their concerns about their care public. In response to this, the Secretary of State for Health and Social Care asked CQC to review and to make recommendations about the use of restrictive interventions in settings that provide inpatient and residential care for people with mental health problems, a learning disability and/or autism. The work was commissioned under Section 48 of the Health and Social Care Act 2008.

Phase 1 of the review (commenced January 2019) explores the use of restraint, prolonged seclusion and segregation in mental health wards for children and young people and in wards for people with a learning disability and/or autism.

Phase 2 (commenced June 2019) explores the use of prolonged seclusion and segregation in mental health rehabilitation and low secure wards. It will also review restrictive practices in social care homes for adults with a learning disability and/or autism, children's residential services and the 13 secure children's homes in England (in partnership with Ofsted).

In May 2019, CQC published an interim report that focused on the use of segregation in mental health wards for children and young people and in wards for people with a learning disability and/or autism.
https://www.cqc.org.uk/sites/default/files/20190626_rssinterimreport_full.pdf

The main source of evidence was visits to 39 people who were in segregation – 31 of these people had a diagnosis of autism (often co-existing with other conditions/problems). Our key findings were that:

- Typically, the people had had a very unsettled childhood and had been in and out of different residential settings. Moves were often triggered by a breakdown of the existing placement. The last such crisis had been the

immediate cause of admission to hospital – which was seen as the only available option.

- Some wards did not have a built environment that was suitable for people with autism.

- Many staff were unqualified and/or lacked the necessary training and skills to work with people with autism who also have complex needs and challenging behaviour.

- Some people had not received the specialist assessments and interventions that would be expected for a person with complex needs.

- Thirteen of the 39 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.

Our principal conclusions were that this is a human rights issue and that the 'current system of care', which incorporates national bodies, providers and commissioners, has failed people whose care pathway has ended with them being segregated in a hospital. We recommended that:

i. An independent and in-depth review is undertaken of each person cared for in segregation in one of these wards. The purpose is to identify and overcome obstacles to discharge. ***DHSC will shortly present options to the Secretary of State for to do this.***

ii. An expert group is convened to consider what would be the key features of a better system of care for people with a learning disability whose behaviour is so challenging that they are, or are at risk of, being cared for in segregation. ***CQC will convene a meeting of such a group in early August; with a second meeting, involving experts from other countries, to be organised by the British Institute of Learning Disabilities in early November.***

iii. Urgent consideration is given to how the system of safeguards can be strengthened, including the role of advocates and commissioners, and what additional safeguards might be needed to better identify closed and punitive cultures of care, or hospitals in which such a culture might develop. ***DHSC is leading work to consider options for how to achieve this.***

iv. All parties involved in providing, commissioning or assuring the quality of care of people in segregation, or people at risk of being segregated, should

explicitly consider the implications for the person's human rights. ***This will be a focus for phase 2 of the review.***

v. CQC should review and revise its approach to regulating and monitoring hospitals that use segregation. ***This will be taken forward through the work initiated in response to events at Whorlton Hall; including the independent review led by Glynis Murphy.***

4. Conclusion and Next Steps

The final report of the thematic review will be published in March 2020.