HOUSES OF PARLIAMENT

Oral evidence (Virtual Proceeding): The Government’s response to Covid-19: human rights implications, HC 265

Monday 18 May 2020, 2.30pm

Watch the meeting

Members present: Ms Harriet Harman (Chair); Lord Brabazon of Tara; Fiona Bruce, Ms Karen Buck; Joanna Cherry; Lord Dubs; Ms Pauline Latham; Baroness Massey of Darwen; Dean Russell; Lord Singh of Wimbledon; Lord Trimble.

Questions 31-37

Witnesses

II: Dr Kevin Cleary, Deputy Chief Inspector of Hospitals and Lead for Mental Health and Community Services, Care Quality Commission; Kate Terroni, Chief Inspector of Adult Social Care, Care Quality Commission; Ray James CBE, National Director Learning Disability, NHS England and NHS Improvement; Claire Murdoch, National Director Mental Health, NHS England and NHS Improvement.

Examination of witnesses

Dr Kevin Cleary, Kate Terroni, Ray James and Claire Murdoch.

Chair: We will move now to our second panel. From NHS England, we have Ray James and Claire Murdoch. From the Care Quality Commission, we have Dr Kevin Cleary and Kate Terroni. Thank you very much for joining us. You have heard the previous panel.

Q31 **Ms Buck:** I want to ask these questions of NHS England. The first questions flow from the report that you will be aware we published in November last year after our inquiry into people being detained in institutional settings. When we were doing the report, we looked at 2,270 people detained in institutional settings and the doubling of the number of children who had been detained. After that report, it was decided that all those cases would be reviewed over the following 12 months.

What progress was made in the months leading up to Covid, and then again since Covid, in the number of people, particularly young people, who have been released from detention or discharged?

Ray James: I am the national director for learning disability and autism at NHS England. To help with the numbers, as at the end of March 2019, 285 young people who had a learning disability or were autistic, or both, were in a specialist in-patient setting. At the end of February 2020, that figure had reduced to 235. During March, the number reduced by a further 30 to 205. That is the last available published data. The next data to be published, for the end of April, will become available on the third Thursday of the following month, which is the 21st of this month. From our oversight, I expect to see some further reduction.

For young people aged 18 to 25, the change has not been as significant. At the start of the year, in March 2019, there were 450 young people aged 18 to 25. At the end of February that was 435, and at the end of March it was 415. That data shows that there was a significant increase in the rate at which people were being discharged from hospital, from specialist in-patient settings, at the beginning of the Covid outbreak.

It is probably helpful to explain the proportions of young people who have a learning disability, have a learning disability and autism, or are autistic with no learning disability. Of the 205 young people at the end of March in an in-patient setting, 10% have a learning disability, 11% have a learning disability and are autistic, and 79% have a diagnosis of autism and no learning disability. In the 18 to 25-year-old age range, that changes slightly: 28% have a learning disability, 32% have a learning disability and autism, and 39% are autistic with no learning disability. I hope that sets out in headline terms for the Committee the overall change in the number and nature of young people in specialist in-patient care over that time.

Ms Buck: Thank you for the figures. They are very helpful. Given the indications that Ministers and others were giving to us last year, the rate of progress has been very slow and interrupted by Covid. Can you talk us through the current process and why, in the period up to March and subsequent to lockdown, there has been relatively little progress in discharging people from institutional settings?

Ray James: There has been unprecedented progress in the reduction in numbers, but it is still not as fast as we would like. The target was a 35% reduction by the end of March. A 27.5% reduction was achieved in that time. It is difficult to think of another area of specialist services where there has been that significant a reduction in the number of in-patients, but it is not as far as we wish to go. We continue to try to ensure that, wherever possible, people are supported to lead their life in a home and not a hospital, and that that important work continues across education, health and care, in every local area of the country.

Ms Buck: Would you mind being very specific about that? What are the actual steps that you take on a week-by-week basis to review that progress and make sure the mechanisms are in place to meet that target?

Ray James: Most of this is delivered at a local level. Forgive me if I explain that briefly. I will then come up to the national oversight. Out of the 48 parts of the country, 20 had reached the target reduction in in-patients at the end of March. There is still a fourfold variation between the best areas of the country and those with the highest in-patient numbers. There are many parts of the country that are proving that this can be done and others that need challenge and support.

In the work we have done, there has been significant investment at a national level. There has been continued work with local government and across the NHS to try to ensure that we are clear when each individual person should be discharged, what issues will support that discharge and that it is constantly supported and chased.

In recent weeks, probably the most common and significant challenge has been the availability of a skilled workforce to support individuals in community settings. Perhaps understandably, although very regrettably, a number of care and support providers have fewer staff available during the pandemic and have not been able to recruit and train new staff. For every young adult discharged into an independent living setting, a care and support provider is probably recruiting and training eight to 10 members of staff to ensure that they can support that person appropriately and consistently and to make a success of their discharge.

Ms Buck: Do you get regular reports on the extent to which planned discharges are being delayed because of Covid?

Ray James: Each of the seven NHS regions in the country operates something that we call a care room. That is where they oversee the detailed data at an individual level about when discharges are scheduled for and the issues that might be delaying that discharge, or, if housing supply is the issue, what is being done about that and when it is expected to be resolved.

Ms Buck: The regional variation is extremely concerning. If I understood you right, it is a fourfold variation. Can you tell us in which regions there are particular difficulties? Which are the outliers, in terms of difficulties with getting planned discharges, and why?

Ray James: In the data published at the end of March, the area of the country with the highest level of in-patient care for adults—it is split between young people aged nought to 18 and adults aged 18 plus—was Lancashire. It is probably true to say that there are a number of areas in the Midlands and the north of the country where in-patient levels are higher than they were. That said, some of those areas have made very significant progress in reducing their in-patient numbers.

Ms Buck: You said there was a fourfold variation. Is that variation coming down?

Ray James: At the start, when the data was collected, there was a fivefold variation, so there is a slight change, but there has not been a consistent pace of progress in different parts of the country. Some areas of the country started with lower in-patient numbers, so one would not have expected to see as significant a change there. To draw out another area of the country, South Yorkshire faced very significant challenge. With concerted effort by local NHS leaders and local councils, and, importantly, with meaningful involvement of people with lived experience and their families, they have delivered something like a 50% reduction in their in-patient numbers. Much more progress is being made in some areas of the country than others.

Ms Buck: You heard the evidence from Adele and Andrea. Both of them gave us a strong sense that they were receiving no information about a discharge plan and that communication seemed to have stopped. We heard very powerful and rather distressing evidence from both of them. Are the reviews and discharge plans going ahead as planned? If so, why are people such as Andrea and Adele apparently not receiving information that would reassure them as to the plans for their children?

Ray James: It was really distressing to hear the evidence that Andrea and Adele gave. I want to add my thanks for their willingness to share that, given the importance of the issues they gave testimony to. It is difficult to talk about individual cases, but of course we will be happy to follow up afterwards with each of them to make sure my team are doing anything they can to help.

During the Covid period, we have not seen an overall increase in delayed discharges of young people. We have seen a slight decrease, but there is no room for complacency. Each one of those young people needs a very personalised solution to make sure that everything possible is being done to plan for them to transition successfully to the community. In March, for example, there were 30 fewer young people in in-patient care at the end of the month than at the beginning. That is probably about four times greater than the reduction we would normally see in an average month.

Ms Buck: Finally, can you reassure us that you will review the position of anybody who was on a pathway towards being discharged, to make sure the parents and families are being communicated with, post Covid, in a way that, as we appear to have heard from today’s witnesses, has not happened in their cases?

Ray James: Yes, absolutely. At the beginning of the Covid outbreak, there was an initial reaction where a number of providers, as they tried to adjust how they provided care, treatment and support, closed to visitors. As we have gone on through the outbreak, we have heard from a number of providers that have found ways to make it possible for family members to visit and to have the ongoing contact and dialogue you described, which is so important. It was distressing to hear the two examples today where that clearly has not been the case.

I would expect the regional teams to follow up with the plans for each of the young people concerned. That is where we get the data about the number of delays and why we can say that recently there has been a slight decrease. It is important that every one of those continues to be followed up.

Q32 **Lord Singh of Wimbledon:** Thank you for coming in to brief us. What is being done to ensure that young people living with their families in the community have the support they need to prevent admissions to hospitals, which, as we have just heard, can be a very harrowing experience?

Ray James: This issue is so important. We know, and one would understand, that the ongoing, cumulative changes in people’s lives and routines as a result of this pandemic can have a growing and profound impact on young people and their families, particularly autistic young people or those with a learning disability. Changes to routine are so important to people, for example not having access to the only food they would normally choose to eat because of the difficulties. Those things can have a very significant impact on the well-being of the young people we work with and for, and their families.

We have tried to make sure that there is concerted work at a local level in every place. It is so important that schools, local councils and local health services work to support those young people with the greatest needs and potentially at greatest risk. There are things called dynamic support or risk systems that should help them identify and stay in contact with those individuals and their families. They should reach out to them to make sure they have the support they need. In some of the best examples, the local voluntary or community sector and local charities have been involved.

At a national level, we regularly reach out to our stakeholders. We hold weekly webinars to hear where we need to help with changes to government guidance, and for them to share examples of best practice and resources. Very early in the pandemic, with the restrictions on people's movement outside, that change to routine was particularly difficult for some autistic young people. Stakeholders told us about this. We worked with government and changes were made to the guidance that allowed people to exercise more than once a day, if they had particular needs, and to be supported by more than one person if necessary and appropriate.

In addition, to facilitate those national changes, lots of local charities and organisations have kindly shared easy-read resources, activities or other materials they have helped to produce, so we can ensure that practical advice and support is available for those families. It is so important in every local area that there is a collective effort across schools. For an autistic young person, the change of routine and not being in school will require careful handling. Are schools reaching out to those people to ensure they are still being supported? As we plan, in the future, for young people to return to school, many of these young people will need a very personal plan to ensure that is successful.

Claire Murdoch: I am the director for mental health services in England. For the last several months, Ray James and I have worked much more closely together to make sure that our two programmes align. Too often, one can think of learning disability, autism and mental health as separate things. We know that people need to be thought about in the round.

To go back to Karen Buck's question about how we know, Ray did not mention that he and I go out together physically to each of the regions every quarter. In addition to the daily and weekly exchanges, we go out to the regions together and look in a great deal of detail at what they are doing to prevent admissions, the service models that work, why the 20 are the best in the country and how we can help them share. We arrange national events for the sharing of best practice. There is also a degree of command and control.

We try to get the balance right between real support and sharing of best practice; being out on the stomp together, literally going to the regions and understanding what is happening there; and bringing support as well as high expectation and ambition. We do that together, both for the mental health programme and the learning disability and autism programmes. Simon Stevens, our chief exec in the NHS, has made it clear to us, and we share this ambition, that we must see the rate of progress continued and, if possible, quickened.

There should be no blanket restrictions on parents or visiting. Each case needs to be looked at individually. We have been quite clear in the guidance nationally on visiting. Although we discouraged it to some extent for obvious reasons, there were certain kinds of people with certain kinds of needs, people with learning disability, autism, dementia, women having babies, where we expected to see exceptions made. We have written out again just this week nationally. We have had the CQC on webinars with the chief execs recently reinforcing this. Thank you, Kevin Cleary. It is something we will be looking at really hard.

In terms of the community, I want to build on what Ray has said. We know that where there are community reviews—the CTRs—prior to admission, we avoid some 70% to 80% of admissions. They work. Why do they work? They work because you get education, the family, the young person, health and the local authority thinking together about what alternatives we can put in place to avoid admission. We know they work. Throughout Covid, we have still emphasised the importance of those multidisciplinary reviews prior to any admissions. It seems as though they have been successful.

We have been really insistent, throughout Covid, that our community learning disability teams continue to work. We have not stood those services down. During this time, the NHS has been open and caring for people with a learning disability in the community. We have learned a great deal at speed, in days, which would have probably taken us months and years, about how to use Zoom, like we are now, and how to therapeutically use digital means of being in touch. That is for supporting families but also youngsters.

We brought forward our plans from the long-term plan to have all-age crisis services set up across the country by 2023-24. I wrote to the system, with Ray's support, at the beginning of April, asking every part of the country to prioritise setting up 24/7 helplines for children and adults. I am pleased to say that we managed to get all those live about two weeks ago. Some of the country was already covered, but a target that was due for full nationwide covering by 2023 has been achieved in a matter of weeks. I am very grateful to colleagues for that.

We prioritised the crisis lines, and I am pleased that we have just got 100% coverage, because if parents or others do not know where to go, they need a 24/7 number. We are heavily publicising that now. We are also training staff working on those helplines on the specific needs of people with learning disability and autism, and we are making the appropriate adaptations for care. We still have an awful lot more to do, but we have very significantly pulled forward some plans.

Both our in-patient and community facilities have been targeted for staff we redeploy to keep services going throughout the period because they were such a high priority. We have seen a tail-off in some services. If other services become less busy during this period, we have taken especially therapy staff, such as speech and language therapists, occupational therapists, arts therapists, and asked providers to put them in to augment community and in-patient teams, to try to keep care as consistent as possible.

Lastly on community, we need to provide more support than we currently do to parents and carers. This has been an incredibly stressful time and we know that the next year will probably not see us returning to normal. We are all, as a society, working out what that means. Working with our local authority colleagues, we want to prioritise additional support for carers as well as our young.

Q33 **Lord Dubs:** My question is primarily directed at the CQC. While there is no blanket ban on families visiting their loved ones, as we have just heard, I think it is right to say that it is quite exceptional for such visits to be possible. Given that you are not inspecting, how can you be sure that the abuse that we know happened in the past, before lockdown, is not worse today?

Kate Terroni: I am the chief inspector of adult social care at the Care Quality Commission. Before we answer your specific question, can I say a big thank you to Adele and Andrea for sharing their experiences? For me, hearing their experience today is another reminder that we have not got it right. The system is not right for people with learning disabilities and autism. We are all clear that a hospital is not a home for people. I am a learning disability social worker by background. To hear their stories reminds me of the fighting that families have to do to get their children's care right, which is commendable, but it is sad that it has to happen. Thanks to both Adele and Andrea.

The experiences of Eddie and Danielle are interesting, because what they described was very much reflected in a piece of work we put out a year ago on restraint, seclusion and segregation. As the independent regulator, we published a report a year ago that talked about people's experiences in in-patient units. It talked about people often being moved a long way from their family home. It talked about staff not consistently having the right skills or training. It focused on the challenge of people not constantly being supported to move back into the main part of the service, let alone having that unrelenting focus on getting them back into the community.

Chair: Can I bring you back to Alf Dubs' question? We knew that abuse was taking place. It was exposed beforehand, even when there were routine parental visits and inspections. Now that parental visits are cut back and with inspections not happening on a normal basis, how are you sure that the abuse of young people who were autistic and/or with learning disabilities, which we know went on in some institutions, is not getting worse under lockdown? Are you sure it is not getting worse?

Kate Terroni: I will just explain our approach to regulation during Covid and then ask Dr Cleary to talk about these specific circumstances. Eight weeks ago, at the start of the pandemic, we decided as the regulator that with an inspector going into one person's home, inspecting that service, and then a day or two later going into another person's home, the risk of them potentially transmitting Covid-19 was greater than the benefit for lower-risk services. Throughout Covid, we have been really clear that we needed to prioritise our efforts on services that were higher risk, ones that we deemed as being closed environments or ones that historically have been of poor quality. We have focused our efforts on those services and we remain able to go into services, to cross the threshold, where we have concerns that there is risk and abuse.

Chair: You said that you remain able to. People are interested in what you are actually doing, not what you are able to do, to protect these most vulnerable young people in closed institutions from the abuse we know was meted out to some of them prior to the Covid emergency.

Dr Kevin Cleary: Since the Covid lockdown, we have continued to have visits on a risk basis. We assess the risk of an organisation on the basis of its culture, the type of patients it is looking after, complaints and whistleblowing. We have continued, in a changed form, our Mental Health Act review visits. Mental Health Act review visits are unannounced. There are normally 1,000 a year. We have developed a methodology for a virtual visit in the first instance, in which we talk to staff, patients and mental health advocates. We get a picture of what is going on in the organisation and then use that as a basis for whether we will have a further visit.

Our inspection teams have maintained contact with organisations. Based on complaints, they have contacted parents and patients to see what is happening in the organisation. For example, two weeks ago we went into a CAMHS unit, last week we physically went into a CAMHS unit, and this week we will go into another two units. While we have stopped our planned inspections, we are continuing to cross the threshold. It means that we have to get PPE equipment, but we are planning further visits over the next two to three weeks. I hope that over the next month we will get back towards a full programme of visits.

Lord Dubs: That is interesting. You have both talked about inspections happening only when they are high risk or on a risk basis. Are you satisfied that your assessment of a high risk is an adequate one? Are you getting to the truth and going in to inspect where necessary?

Dr Kevin Cleary: From a mental health perspective, we use the same risk approach we had in the past. That is on the basis of complaints, what people tell us about what is happening, whistleblowing, incidents in the unit, which we track, feedback and our knowledge of the institution. We know that 17 hospitals are in special measures at the moment, and we are keeping a very close eye on them. I am confident that we will cross the threshold when the risk indicates that we should do so.

Adele and Andrea’s stories are heartbreaking. We need to be quite clear that we are here to protect patients. If that means going to hospitals, we will do so.

Kate Terroni: There is a similar approach in adult social care. It is about looking at the suite of intelligence we have across whistleblowing, safeguarding alerts and feedback. More than ever, we have encouraged families, people who use services, where possible, and staff to give feedback on care. We have a mechanism whereby people can talk to us about their experiences of care and we use that intelligence to help inform us. We also work very closely with local authorities and clinical commissioning groups to understand where the risk is and to target our efforts accordingly.

Lord Dubs: As I understand it, based upon the risk assessment, you have done only two inspections. Is that right?

Kate Terroni: Are you asking about adult social care?

Lord Dubs: I am asking about both.

Chair: We are asking about children and young people, specifically those in assessment and treatment units.

Dr Kevin Cleary: We have done two physical inspections of CAMHS units in the last couple of weeks. We are possibly doing two visits this week, and we will go in the week after that and the week after that. The Mental Health Act reviewers are also undertaking the virtual visits.

Lord Dubs: You talked about special measures and services that have been rated as inadequate. How have you been monitoring them since the lockdown?

Dr Kevin Cleary: We continue to monitor them as we would normally. We maintain contact with them. We keep a close eye on incidents in those units and complaints. They are a priority for us to visit in the next few weeks.

Lord Trimble: What can families do if they have reason to think their sons or daughters are being mistreated? It was also suggested that we look at whether there are dedicated telephones that can be used, but I think that your colleague has just spoken about that particular matter. I wonder if you could take us through this again. To what extent are there dedicated phones and is there widespread availability?

Kate Terroni: We really encourage anyone whose loved one receives care, or who receives care themselves, where possible, to give us direct feedback on that care. You can type "feedback on care" in Google or go to the Care Quality Commission's website. We have made a much easier process for people to tell us about their experiences of care and to let them know what we will do with that information. All that intelligence is shared with the local inspector, who uses it to form a view about whether we should bring forward an inspection and go out sooner, or whether we need to signpost elsewhere.

Since January, 10,000 bits of intelligence have come to us that way. We get a large volume of information, but all information is valuable. It is also great to hear about where things are working well, so we can shine a spotlight on good practice as well as hearing where services could be doing better.

Q34 **Dean Russell:** As you will be aware, this week marks a year since the "Panorama" documentary that unveiled horrific abuse of patients at Whorlton Hall. Glynis Murphy's review of the CQC's inspection of Whorlton Hall was published in March. That concluded that the abuse could have been detected sooner if you had carried out more unannounced visits. The report made a number of recommendations for how inspections should be improved in the future. In the report produced by this Committee, prior to my time on the Committee, you had said that you will incorporate Professor Murphy's recommendations into a new strategy to improve the regulation of mental health, learning disability and/or autism services.

I know you have covered a lot of ground today, but I would like to know where you have got with this and what has been done. You talked earlier about the visits you are going to do. Are they intended to be unplanned? I want to be assured that you will carry out those particular recommendations.

Kate Terroni: In the autumn, we published some supporting information for our inspectors about how we need to tailor our approach when we go into services classified as closed environments. We have supported our inspectors to be clear in identifying when a service may have a closed environment and how they need to work differently with it. For example, they should ensure that they take an expert by experience on their visits. They should seek feedback from families and advocates before they arrive at the service, and plan their inspection differently. That information was published in the autumn. As you say, Professor Murphy's recommendations landed with us in March. A whole programme of work is under way, which I oversee, to deliver those recommendations.

We, as a regulator, are looking to our new strategy, which we will discuss with the public in the autumn. That is about how we remain a flexible regulator, as services in health and social care change at such a pace. The learning from Glynis Murphy's recommendations will go into that. How do we use intelligence and ensure that, at every point, we hear the voice of people who have lived experience in how we regulate?

Dean Russell: We heard some really heartbreaking evidence prior to you joining as witnesses. In those circumstances, when family members raise such concerns, do we make sure that those locations get unplanned visits or is it a very long process of bureaucracy and red tape? Those were very heartbreaking stories. I want to make sure we give a really clear guide to families who are giving such evidence that the reports they have made will be looked into.

Kate Terroni: Thank you for giving me the opportunity to respond to that. When those concerns come in, either through feedback on care or where people ring our contact centre, our staff are skilled at identifying when what has been shared with them might be a safeguarding risk or a risk to the quality of people’s care. That information is passed rapidly to our inspectors, who then decide whether to bring forward an inspection, make a referral to the local authority safeguarding team or, on some occasions, bring in colleagues from the police. Yes, we have the mechanism in place.

One thing that really stood out for me from the earlier panel members was when Andrea talked about raising concerns to CQC, which led to a visit, but she did not think that the visit adequately addressed her concerns. Andrea, I would really welcome the opportunity, as a personal action, to have contact with you and follow up on that specific case.

Dr Kevin Cleary: From the mental health hospitals point of view, we respond promptly to complaints. The visits we have undertaken this week are a response to intelligence we received last week. We aim to respond where necessary within four to five days. It takes a couple of days to get PPE to our inspectors, but we get it out as quickly as we can. All our visits at the moment are unannounced. I came to CQC in September 2019, from working in a provider organisation, and I strongly believe that, in high-risk environments, unannounced visits are of primary importance. You cannot tell people three months in advance that you are going to come out and see them, because it provides an opportunity to prepare. In mental health, it is my intention that, for the foreseeable future, the majority of our visits will be unannounced.

Glynis Murphy’s report was part 1. The part 2 report, which is coming out in the next few months, will look at some of the things the Joint Committee raised last time, including the issue of covert surveillance in closed institutions.

Chair: Thank you very much for that, Dr Cleary, particularly your point about unannounced visits. That is something we referred to in our report after the “Panorama” revelations. It is not just about people preparing when they know there is a planned visit; it is about covering up, is it not?

Dr Kevin Cleary: It is.

Chair: It is recognising that abusers are often very devious and make sure that they present a good front to the inspectorate in order that they should be able to carry on. That point about unannounced visits is very encouraging.

Q35 **Lord Brabazon of Tara:** My question concerns isolation and restraint. What we heard from our first two witnesses, Adele and Andrea, was quite heartbreaking. Are you actively monitoring the use of these restrictive practices? Is the incidence of forcible restraint and solitary confinement going up or down during the lockdown? Could you publish weekly figures for that?

Dr Kevin Cleary: First, in relation to patients in long-term segregation, a series of independent care reviews have been undertaken, primarily by NHS England and the Department of Health, but with support from the

CQC. We provide the Mental Health Act reviewer to do those. They are about two-thirds of the way through, so they are not all complete.

I am convening a panel at the CQC to look at what information has come through those independent reviews and to see whether we need to take further enforcement action. A couple of weeks ago, we received a fairly strong legal opinion about a possible breach of human rights and what action we can take. On that basis, we will look at what we might do, including bringing criminal charges where we think it appropriate.

We receive information on restraint and seclusion, and we have not seen a clear pattern. We know that it has gone up in some organisations, and that was a trigger for one of our unannounced visits in the next couple of weeks. I would have to talk to our intelligence and analytics to see how often we could collate that data to be published, but I am strongly of the opinion that regulation requires transparency. We must be absolutely transparent about what we know. Where possible, we will publish data. That is one of the reasons we published the data on deaths of detained patients a couple of weeks ago. If you want to improve quality, you need to shine a light on all that is happening.

Kate Terroni: There is no national reporting mechanism for restraint, seclusion and segregation in adult social care, unlike in the NHS. As we publish our final report into restraint, seclusion and segregation, there will likely be a recommendation in that area. We are still fine-tuning those recommendations with our expert advisory group of families and other organisations that would need to help deliver them.

Chair: So that I am clear, you are saying that you think there will be a requirement for these institutions to report every time forcible restraint or solitary confinement is used. That is not yet a requirement, but you might do it at some point in the future. Should you not be monitoring that now? The use of restraint and solitary confinement is an alert that things are going wrong. If you can see more solitary confinement and restraint being used, you know that things are going wrong and you need to step in.

Kate Terroni: There is such a mechanism across the in-patient units and health services that we have been talking about today. The second part to our restraint, seclusion and segregation report looked at social care settings in which people with disabilities and autism are supported in the community. In social care settings, there is no such national infrastructure. I would be very keen to see it introduced. We have it on an individual basis. When we go out and inspect providers, we look at how they support people in this area, but there is currently no requirement on social care providers as there is on health providers.

Chair: At this time, there is no requirement on assessment and treatment units to report the incidence of forcible restraint and solitary confinement. Therefore, you cannot say whether, as a result of the situation with lockdown, it is going up.

Claire Murdoch: There absolutely is. Although there are some private placements, assessment and treatment units are mainly commissioned by the NHS.

Chair: Would you be able to answer Lord Brabazon’s question? Has the incidence of forcible restraint gone up since the Covid lockdown? Is the use of solitary confinement within these units going up or remaining the same?

Claire Murdoch: We have seen no increase in the trend of long-term segregation or seclusion. The numbers are relatively low. Everyone is worrying, but we have not seen an increase. For restraint, we do not have contemporaneous enough data to tell us whether it has gone up over the last few weeks. We are working to do two things at the minute. First, providers have to report this, and we analyse trends. As Dr Cleary said, if we see a worrying change in a trend, we will intervene. We, as commissioners, or the CQC will visit. We will take action.

Through the independent task force that was established before Christmas, which will be overseen by the Children’s Commissioner, we are trying to get a more real-time dashboard, which that task force will have oversight of. We will publish that data and we are setting that up now. Based on our intelligence, we do not think there is an increase, but we are looking at that data now.

Chair: How long do they have to report the use of forcible restraint or solitary confinement? How long are they allowed before they report to you and you get that data from them?

Claire Murdoch: There is a time lag. That is why we want to move towards contemporary.

Chair: What is the time lag?

Claire Murdoch: Two weeks ago, we introduced a new situation report, which will ask for daily reporting.

Chair: What is it currently?

Claire Murdoch: At the moment, most of these reporting cycles are weekly or monthly. It goes to the NHS dataset and we analyse it, quality check and then publish. We are making that cycle quicker than it has traditionally been, but our real work is to get this information daily, and we are working on that now. What we get will go to the independent task force and be published more regularly. This is a big piece of work. We absolutely need real-time data in the open.

A rule was introduced by Parliament that all providers should publish an annual report in the public part of their board on their own seclusion and restrictive intervention rates. This is quite new, but I am wholly supportive of it. These data must be in the open. They must be real time and must be analysed over time. They must be shared with any interested party, provided it protects the rights of individuals. There is a huge piece of work going on with that right now.

Q36 **Chair:** In terms of transparency and real-time reporting, people are very concerned about the spread of the Covid infection and the incidence not only of infections but of deaths within institutions. If somebody is in an institution run by the state, the state has a higher level of responsibility for their right to life. The Minister was good enough to write to us today about greater transparency in the publication of deaths and infection rates for people in assessment and treatment units, and people with autism and/or learning difficulties. Could you explain what data has shown to date and what the reporting of that will be for the future?

Ray James: First, no deaths of children or people aged under 25 have been reported in specialist in-patient units during the Covid outbreak. There have been fewer than five deaths of people aged over 25. Forgive me; it sounds strange saying "fewer than five", but I am told that when it is fewer than five we do not reveal the precise number for fear of identifying individual cases. To say that it is fewer than five, I hope, gives the Committee a sense of the numbers we are talking about. That is for people with a learning disability or autistic people.

Data about the infection rate was initially managed at local and regional level. Providers had daily conversations about the level of infection, in which parts of their organisation and their response. In recent weeks, we have begun to stand up two different collections, first from NHS provider trusts and subsequently from mental health trusts. We will be happy to publish that data, but in one case it is a couple of weeks old and in the other it is one week's collection. It is important that we have the opportunity to validate and verify that data. They are not large numbers, but we will make that available to the Committee once it has been validated and verified. Going forward, there is an expectation that we can share this information on a weekly basis.

In relation to deaths of people with a learning disability, last week we published information about deaths in hospital settings of a range of conditions. Earlier today, we published the notifications to the University of Bristol for the review of all deaths of people with a learning disability. I hope we can put this data in the public domain and, alongside other data from the CQC or the Office for National Statistics, we can have expert-considered analysis that gives us the best possible insight into what is happening and drives important decisions about the care, support and treatment that people need.

Q37 **Chair:** Thank you for that. Finally, can I ask you a question about pace? When Claire says there will be a large piece of work done, I do not know whether to feel encouraged that it is being taken incredibly seriously, or whether it makes my heart sink because it will be months or years before it comes out at the other end. Can you reassure us about the pace of response on this? There is no doubt that we are talking about great suffering here. We are talking about solitary confinement, vulnerability to abuse and real torment for families. The situation is even more difficult because of the Covid emergency. Can you reassure us that you are working at a new pace to identify and address any problems as they arrive and deal with them as quickly as possible?

Ray James: Our commitment will be to do that. I will draw on two examples. As Claire mentioned, the children and young people's in-patient task force has an independent oversight board chaired by the Children's Commissioner. You would expect that there will be real rigour and challenge in the pace and substance of the work there. They have continued with some of their work, while naturally unable to do it all in recent weeks. Importantly, they have recruited a parent's council, which includes some parents who have given evidence to this Committee in the past. I am sure they will continue to challenge us about the pace and the difference we are making there.

Secondly, care and treatment reviews, as mentioned by Andrea earlier, are so important and they have continued. We have needed to do them virtually during the pandemic, but as Claire said earlier they have continued to ensure that, in over 80% of cases, we do not get to admission. As appears to be beginning in Danielle's case, they have introduced some challenge within the in-patient setting. I hope this is the start of some much-needed change in the future care, treatment and support that she receives.

We need to ensure that each of these individuals is followed through at pace. The independently chaired care and treatment reviews, overseen by Baroness Hollins, have also continued during this time. In each of those, we are expecting greater rigour, not just in the review taking place, but crucially in the recommendations of the review being followed through and done when it was said they would be done.

Chair: Thank you very much indeed to all four of you for coming to give evidence to this inquiry. The inquiry is still going on. If anyone wants to contact us and give further evidence, we are very keen to hear from them. Nobody can be in any doubt of the seriousness of the issue we have been considering today. Thank you very much indeed.