Dear Ms Harman,

We are writing as promised to provide the follow up information mentioned during the meeting of the Joint Committee on Human Rights earlier this week.

We welcome the committee’s keen interest in this most important of issues and want to offer our assurance that we will continue to do all we can to help more young people with a learning disability and autistic young people live their lives in homes not hospitals, central to this will be the support available in every local area, across education, health and care to those young people and their families. The cumulative effect of the changes during this pandemic will have a profound impact on many of these families, the response of government, nationally and locally, and of all public services has never been more important.

For ease of reference, the enclosed appendix provides the latest position on each of the pieces of data, information and reporting that we were asked about at the committee.

The data published on Thursday 21 May 2020 shows that at the end of April there was a further reduction in the number of people in inpatient settings, representing a 29% reduction overall and a reduction from 205 to 190 young people aged under 18 in specialist inpatient care during April. Over 80% of Care (Education) and Treatment Reviews are not leading to an admission. This is unprecedented progress but there is no room for complacency and much more to do if we are to reduce the unacceptable variation across the country.

Among the most important of changes since the committee’s previous session earlier last year is the Announcement of the Inpatient Taskforce for Children and Young People across Mental Health, Learning Disability and Autism. The Taskforce has an Independent Oversight Board chaired by the Children’s Commissioner and significant involvement of both young people and parents and carers in the detail and oversight of this important work. The work programme, which has been informed by

NHS England and NHS Improvement
recommendations made by this committee in two reports in 2019 has clear underpinnings related to the human rights of young people.

The work of the Taskforce will introduce universal training and frameworks to support personalised decision making across the sector. Whilst the workplan is broad across a range of important areas, the Committee should be aware that a specific quality improvement programme is being commissioned to offer tailored support and development to reduce the use of restrictive practices. We have established a restrictive intervention group chaired by Professor Oliver Shanley OBE, which will receive, monitor and identify themes and trends for learning, which will feed into the independent task force. The taskforce remains committed to undertaking work to improve quality and access to advocacy.

The powerful testimony provided by Andrea and Adele is a clear reminder of why this work is so important and we will ensure our Regional Teams continue to oversee progress on the discharge plans for their family members and every young person.

Thank you again for the Committee’s interest in these important issues,

Yours Sincerely

Claire Murdoch CBE
National Director Mental Health

Ray James CBE
National Director Learning Disability & Autism
Annex: Data Points

A  Inpatient Numbers

At the end of April 2020, the number of young people under 18 in a specialist inpatient setting was 190. This is a reduction of 25 from the updated figure for the end of March 2020 and a reduction of 60 since the end of February 2020.

B  People diagnosed with Covid-19 in specialist inpatient settings

Initially, this information was collected at a local and regional level. Improved collection of information on all patients diagnosed with Covid-19 in NHS mental health, learning disability and autism inpatient units started on 24 April. Since 5 May 2020, the collection has been widened to include independent sector mental health, learning disability and autism inpatient units. We are currently verifying this data, so we are not able to share it at this point.

We are not able to provide a breakdown of patients diagnosed by age.

---

1 Assuring Transformation is a live data collection system. Late reporting will always tend to increase the inpatient count when data are refreshed in subsequent months. The April inpatient count is therefore expected to rise and should be treated as provisional.
C Covid-19 related deaths of people with a learning disability and autistic people

(i) The latest data, contained within the daily death report published by NHS England and Improvement, on 21 May 2020 shows that at 19 May 2020 (reported 14 2020) 468 people with a learning disability and/or autism had died as a result of Covid-19\(^2\) in all hospital settings.

(ii) Currently, NHS England and Improvement are aware of fewer\(^3\) than 5 deaths of people with a learning disability, autism or both from Covid-19 from the beginning of March to the end of April in a mental health, learning disability and autism inpatient setting. Between 5 and 10\(^4\) people sadly died as a result of Covid-19 following transfer to an acute hospital. None of these people were aged under 25\(^5\).

(iii) NHS England and Improvement have also published the numbers of all deaths of people with a learning disability notified to the Learning Disability Mortality Review (LeDeR) Team at the University of Bristol.

D Data on restrictive practices

We have recently agreed a new timeline to give us more rapid access to data. This is still in refinement but is an important next step in giving more contemporaneous line of sight nationally, regionally and locally, in relation to restrictive practices.

Information about restrictive practices are currently collected through the Mental Health Services Data Set (MHSDS) data collection which is published monthly by NHS Digital. It is a mandated reporting requirement for all NHS funded providers of mental health, learning disability and autism inpatient care. It is a monthly publication of data relating to restrictive practices for the month which is two months before publication i.e. the most recent published data are for February 2020 published in April 2020. The link to the data is here:


---


\(^3\) ‘Fewer’ is used to preserve anonymity.

\(^4\) Range used to preserve anonymity.

\(^5\) Data supplied by NHS England Improvement regional learning disability and autism teams on 20/05/20
E Oversight of Restrictive Practices

- Local case managers and providers’ clinical executives are required to have daily and weekly oversight of restrictive practices and organisations required to input relevant data daily.
- Case managers have continued to maintain oversight of all individuals on their caseloads during this pandemic, this includes regular conversations with providers and with young people by virtual means as much as possible.
- Any use of seclusion and segregation is notified to case managers and the region responsible.
- We are rolling out a strengthened national SitRep on the use of seclusion and long-term segregation on a twice weekly basis for young people in those settings during the pandemic. Should concerns arise during analysis of this national overview, further intelligence from the regions and case managers will be followed up with additional actions where necessary.
- On a broader note for all inpatient, all age mental health and learning disability services, submission to the MHSDS for use of restrictions has remained a national reporting requirement.
- There is room for improvement in the quality and content of submissions, therefore we are working with colleagues across the system to highlight the need for accurate and timely submissions from all providers on the use of all restrictive practices in line with the national definitions and guidance.