

Supplementary evidence from the Care Quality Commission (COV0124)

Thank you for the opportunity to give oral evidence at the Joint Committee on Human Rights on our regulation of services for people with a learning disability and/or autism during COVID-19, alongside colleagues from NHS England.

We thought it would be helpful to follow up to the committee to reiterate some of the points made and to outline our actions over the coming months.

Firstly, we want to thank Andrea and Adele for their brave evidence in the panel that preceded ours. We were appalled to hear about what their children with a learning disability and/or autism are subject to when they have been receiving care. It is simply unacceptable and should not happen in a modern healthcare system. We have contacted both Andrea and Adele and our teams will speak to them further about the care being received by their children.

We have consistently raised concerns about the safety of mental health hospitals – especially the overuse of restrictive practices as well potential breaches to people’s human rights.

We are committed to holding providers to account wherever necessary in order to help keep people safe. However, for the majority of people with a learning disability and or autism, hospital is not the right place to receive care. People must be cared for close to their communities and families with the right staff to support them.

Where we are taking action during COVID-19

At the start of the pandemic, we took a decision to halt [routine inspections](#). With the information available to us, we decided that given our main concern is keeping people safe, we should not be routinely sending inspectors to services that are considered low risk. However, we want to be clear that throughout the COVID-19 pandemic we have continued to inspect where there are whistleblowing concerns or other evidence that people might be at risk of harm. We have and we will go into services during COVID-19 where we are alerted to serious concerns about people’s care and where there are human rights breaches. We plan to cross the threshold into more services in the coming days and weeks. We have committed to having a full programme of responsive inspections under way again for these types of settings, but this will not delay us from inspecting services where we are concerned about risks right now.

Our programme will include unannounced focussed inspections for these services, and we have outlined how we will meet this ambition below:

Beginning Monday 01 June 2020 - Week 1-2:

- Complete regional Management Review Meetings (MRM) over next 2 weeks to increase confidence around latest approach on human rights issues against regulation.
- Identify high risk services using the panels/risk criteria/IH risk assessments and ATUs.
- Support staff by sharing learning from the visits and inspections conducted during COVID-19 so far.

Week 3:

- Complete the Emergency Support Framework (ESF) for the services identified in independent health settings.
- Ensure PPE and other logistics are ready. For the next few weeks, we currently have enough PPE to conduct inspections.

Week 4:

- Full programme of focussed reactive inspection begins with teams (Inspectors and Mental Health Act Reviewers) from each region, supported by 'remote team members'. These include Experts by Experience where available, for interviews with staff and people that use services.
- Inspections will include evening/weekend visits where possible, however this is very challenging at present given the lack of hotels and geographical difficulties.

We are working with advocates to capture information from people who may not be able to speak up for themselves during this time, like the children of Andrea and Adele, and we are urging the public to come forward and tell us about their care through our new [Give Feedback on Your Care service](#)¹.

In addition to this, we have a bespoke approach to people detained under the Mental Health Act in [hospital](#)². This approach includes specifically reviewing individuals – either via Zoom or in person - where we are concerned there are significant human rights breaches.

Throughout the coronavirus pandemic, our core purpose to keep people safe. This role has not changed.

¹ We use what people tell us to understand the quality of care they get from services like care homes, care agencies, hospitals and GPs. It helps make care better for everybody.

<https://www.cqc.org.uk/give-feedback-on-care>

² CQC has a specific role under the Mental Health Act to check that people's human rights are maintained while they are being cared for or treated under the Mental Health Act.

<https://www.cqc.org.uk/guidance-providers/mental-health-services/mental-health-act>

Data during COVID-19

High quality data leads to good decision making and we are committed to publishing the data we have during this period in the national interest. We were clear during the session about the importance of being transparent as a regulator.

Supported by ONS we have completed a targeted [piece of analysis](#) to better understand the impact of coronavirus (COVID-19) on people with a learning disability, some of whom may also be autistic, and how the number of deaths during this period compares to the number of deaths last year.

This data shows that between 10 April and 15 May this year, 386 people with a learning disability, some of whom may also be autistic, died who were receiving care from services which provide support for people with a learning disability and/or autism. This is a 134% increase in the number of death notifications for the same period last year. This new data should be considered when decisions are being made about the prioritisation of testing at a national and local level.

We will publish further data and analysis on deaths of people with a learning disability on an ongoing basis as part of our [insight product](#).

Our concerns related to mental health hospitals

We know that there is still more work to do, with people who use services, families and others, to improve the services available to people with a learning disability and/or autism.

We need to see clear leadership at a national level in improving safety and quality of care and this needs to take an approach based on human rights. Our restraint review found that restrictive practices were being inappropriately used in some of these hospitals and some environments were incredibly poor.

Last year when our colleagues gave evidence to your committee, we said that the system was 'broken' following our Restraint Seclusion and Segregation report and that remains the case. There were several recommendations for other parts of the system which we want to see delivered:

- We recommended that an independent review is undertaken of every person placed in segregation to confirm that they are receiving good care and that no opportunities are missed to end segregation or hasten discharge.
- We recommended that an expert group, that includes clinicians, people with lived experience and academics, should be convened to consider what would be the key features of a better system of care.

- We called for a strengthening of the safeguards that protect the safety, welfare and human rights of these people whose situation has rendered them highly vulnerable.
- We recommended 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.

We also recommended that we strengthened our own approach to inspecting these services and we have begun work on this following the publication of two independent reviews ([here](#), and [here](#)).

Leadership is required to bring all national bodies in line to deliver for people. Health and social care leaders need to look beyond traditional service and commissioning barriers to deliver outcomes for people.

Commissioning and our findings in these settings

For some time, we have made it clear that people should not be in these types of settings. Poor commissioning has led to people being stuck in the system and in hospital.

In our most recent State of Care report published in October last year, we highlighted that people with a learning disability and/or autism are not getting the community or the quality hospital care they need, at the time they need it.

Updated to 1 April 2020, we found that:

- 13% of wards for people with a learning disability and/or autism across IH and NHS are rated inadequate, compared to 3% in April 2019.
- 42% of adult acute and psychiatric intensive care unit (PICU) services are either inadequate or requires improvement
- 30% of learning disability and autism wards are inadequate or requires improvement.
- This reflects a national shortage of nurses with 8% fewer learning disability nurses registered with the NMC in 2019 than 2015.

Our action in registration and inspections

Where providers try to register unsuitable models of care, we are determined to not allow their registration. We have successfully taken several providers to tribunals over our defence of our position on this and will continue to do so where

required. We are updating the guidance around this to ensure we continue to stand firm against inappropriate models of care for people.

We are also taking action against unsafe and dangerous care where we find it already in the system.

- The percentage of unannounced inspections in hospitals with wards for people with a learning disability or autism has also increased from 62% in Q1 last year to 77% in Q4, reflecting the recommendations made to us in the Murphy Review.
- 10 wards for people with learning disabilities or autism across both NHS and independent sector are currently rated inadequate and have been placed in special measures.

Good person-centred care is possible and there are good services. We know these good services are possible to deliver and there are examples where care for people is done well. We need to see faster progress in the availability of these services that put the care needs of people first.

Human rights and the voice of people

The voice of people who use services is fundamental to what we do - but we know we need to improve the way we gather this, and how we use this to inform inspections. We will continue to do this over the coming year and beyond – through our ‘closed culture’ work and our final report on the review of restrictive practices.

Our review of restrictive practices is an extremely important piece of work that we have worked closely with people who use services, families, voluntary sector organisations and national stakeholders on. We will publish final report of this when the system has the ability to act on and deliver the hard-hitting recommendations. This is likely to be Autumn and we are keeping it under constant review.

We continue to monitor human rights during COVID-19, and human rights are central to our Mental Health Act reviewer and inspection approaches.

We want to again thank you for the opportunity to provide evidence to you on this topic. We will also be submitting written evidence to the committee ahead of the July deadline, where we hope to be able to offer further information to you on these settings during COVID-19.

3 June 2020

