Analysis of information provided to the Joint Parliamentary Committee on Human Rights in support of the Inquiry into the detention of children and young people with learning disabilities and/or autism

Chris Hatton
Professor of Public Health and Disability at the Centre for Disability Research, Lancaster University, UK

26 September 2019

Analysis of independent sector and NHS inpatient services

This analysis of independent sector and NHS inpatient settings draws on information provided principally by the CQC (including information provided at the request of the Committee and publicly available inspection reports), and information provided at the request of the committee from NHS Digital.

This analysis uses detailed information on:

- 12 independent sector inpatient services selected by the Committee: Whorlton Hall; Colchester Hospital; Woodhouse Independent Hospital; St Mary's Hospital; St Andrew's Healthcare Adolescents Service; St Andrew's Healthcare Nottinghamshire; St Andrew's Healthcare Birmingham; Oaktree Manor; The Willows; Mildmay Oaks; Huntercombe Centre Birmingham; and Cedar Lodge.
- 8 NHS inpatient services selected by the committee: West Lane Hospital child and adolescent inpatient wards (Tees, Esk & Wear Valley NHS Foundation Trust); Wards for people with learning disabilities and autism (Coventry & Warwickshire Partnership NHS Foundation Trust); Forensic inpatient and secure inpatient wards (Coventry & Warwickshire Partnership NHS Foundation Trust); Wards for people with learning disabilities and autism (Nottinghamshire Healthcare NHS Foundation Trust); Forensic and secure inpatient wards (Nottinghamshire Healthcare NHS Foundation Trust); Specialist learning disability services (Mersey Care NHS Foundation Trust); Child and adolescent inpatient services (Hertfordshire Partnership University NHS Foundation Trust); and Wards for people with learning disabilities or autism (Hertfordshire Partnership University NHS Foundation Trust).

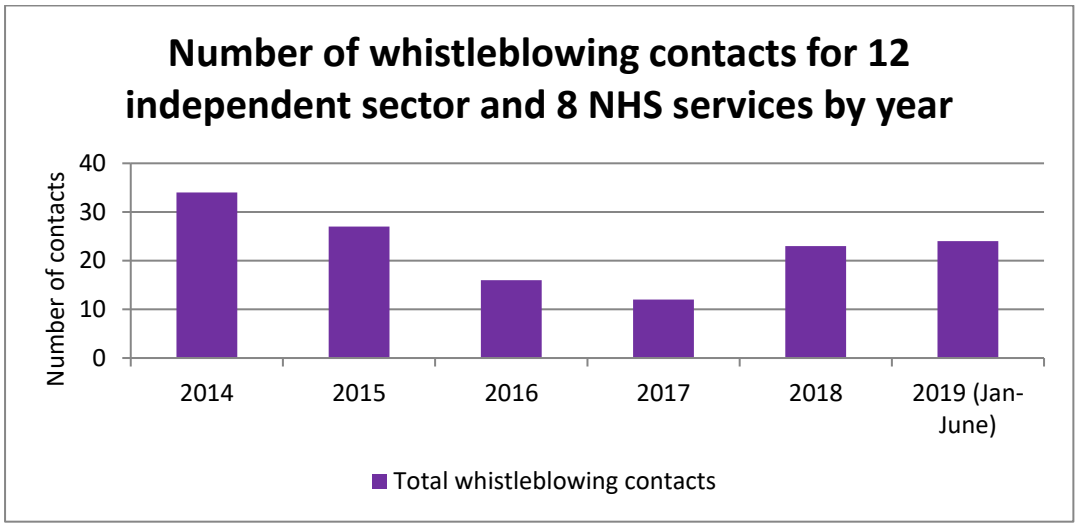
These services were purposively sampled to represent a range of provider organisations, types of inpatient service and CQC overall ratings.

Detailed information relating to each individual service is summarised in a separate document. This document presents some summary information across the 20 services.

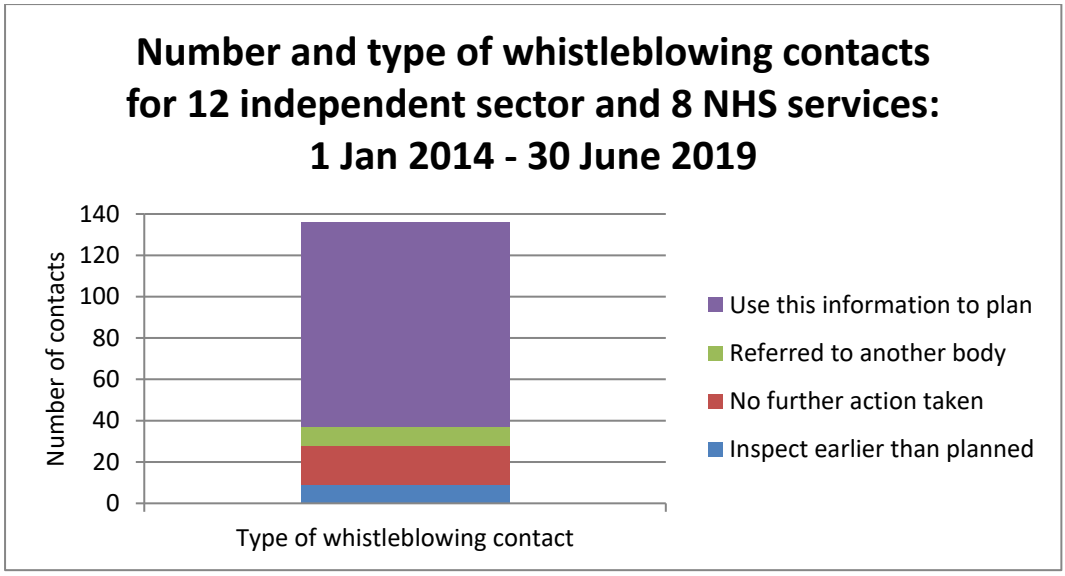
Whistleblowing

Across the 12 independent sector services there were 96 whistleblowing contacts to the CQC in total from 1 January 2014 to 30 June 2019, an average 8 whistleblowing contacts per service across the time period (range 0-19). For the 8 NHS sector services there were 40 whistleblowing contacts in the same time period, an average 5 contacts per service (range 2-14).

The graph below shows the total number of whistleblowing contacts in each calendar year across all 20 services, showing that in 2014 there were 34 whistleblowing contacts, decreasing year-on-year to 12 in 2017, then increasing again to 23 in 2018 and 24 in the first six months of 2019.



The CQC also reports their response to whistleblowing contacts in four categories: 1) Inspect earlier than planned; 2) No further action taken; 3) Referred to another body; 4) Use this information to plan. The graph below shows how the CQC responded to the 136 whistleblowing contacts from independent sector and NHS services. Of the 136 contacts: 9 were in the category 'Inspect earlier than planned' (7%, with inspections for 6 of these 9 contacts occurring in the same 6-month time period as the contact); 19 (14%) were in the category 'No further action taken'; 9 (7%) were in the category 'Referred to another body'; & 99 (73%) were in the category 'Use this information to plan'.



Safeguarding alerts and concerns

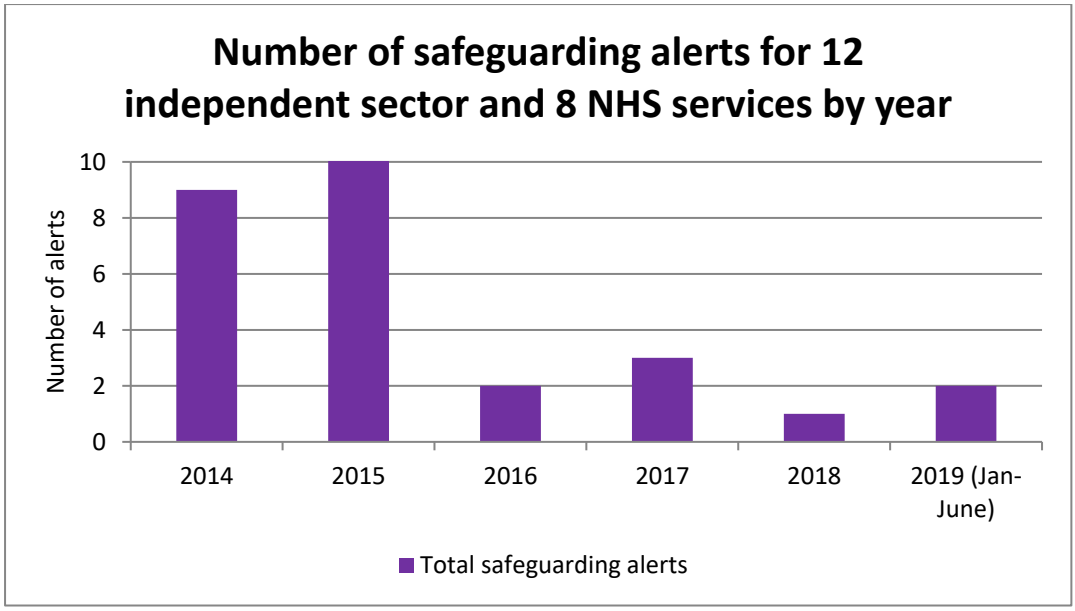
The CQC records information on safeguarding alerts (when CQC is the first statutory agency to receive the information about actual or alleged abuse or neglect; and/or CQC will or may need to take immediate regulatory action as a result of the information).

The CQC also records safeguarding concerns (when CQC is not the first statutory agency to receive the information; and there is no need for CQC to take immediate regulatory action). The CQC note that in some cases there can be several concerns logged in relation to the same incident, as follow-up calls and emails are received, and there is no way of accounting for this duplication in the data provided.

Regarding the recording of safeguarding concerns, it is important to note that up to 28 February 2018, CQC created a Safeguarding Concern record for each statutory notification of alleged abuse (18-2e Abuse or Allegation) received from providers. However, as of 1 March 2018, 18-2e Abuse or Allegation notifications received from providers stopped being dual recorded as safeguarding concerns and therefore the number of safeguarding concerns recorded drops significantly from this date. It is almost important to note that statutory notifications in the format (18-2e Abuse or Allegation) are only provided by the independent sector services in this analysis – NHS services have a different statutory reporting system, the NRLS (National Reporting and Learning System – see below). This will have the effect of NHS services reporting fewer safeguarding concerns than independent sector services until March 2018.

Safeguarding alerts. Across the 12 independent sector services there were 15 safeguarding alerts in total from 1 January 2014 to 30 June 2019, an average 1.25 safeguarding alerts per service across the time period (range 0-5). For the 8 NHS services there were 14 safeguarding alerts in total, an average 1.75 alerts per service (range 0-4).

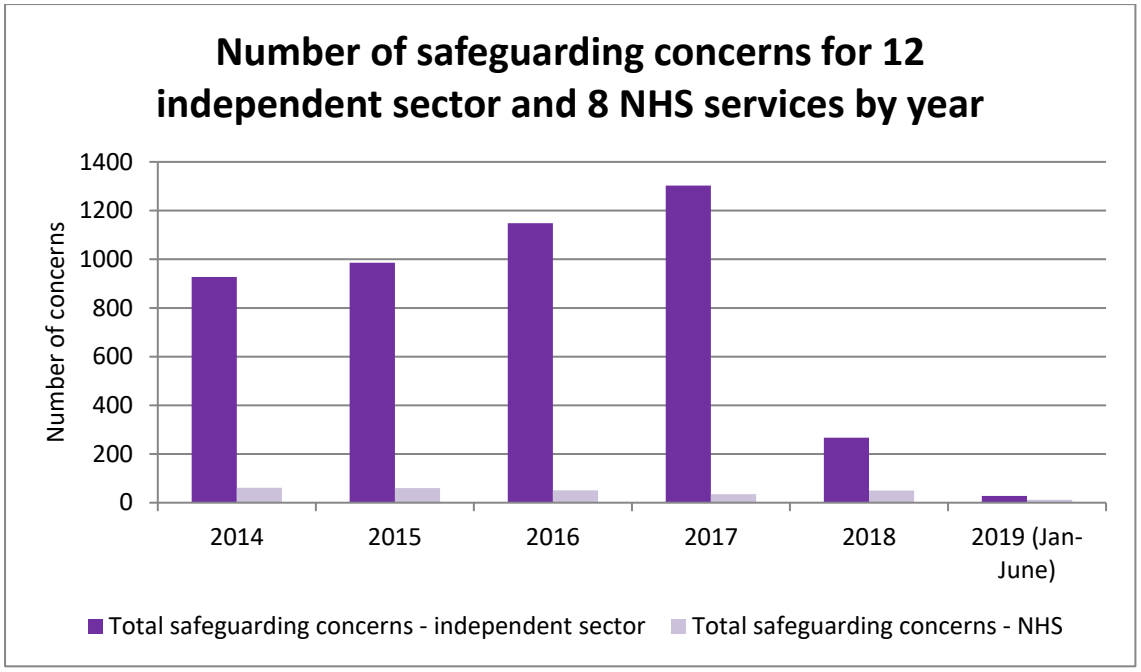
The graph below shows the total number of safeguarding alerts in each calendar year across all 20 services, showing that most of the 29 safeguarding alerts happened in 2014 (9 alerts) and 2015 (10 alerts), with relatively few safeguarding alerts from 2016 onwards.



Safeguarding concerns: Across the 12 independent sector services there were 4,659 safeguarding concerns in total from 1 January 2014 to 30 June 2019. This was an average 388 safeguarding concerns per service across the time period, with wide variation across individual services (which also vary in size and the range of needs of people within them). Three services registered 50 or fewer safeguarding concerns over the time period (3, 36 and 50 concerns respectively) and three services registered more than 600 concerns over the same time period (688, 812 and 870 concerns respectively).

Bearing in mind differences between the NHS and independent sector in how safeguarding concerns have been recorded by the CQC, across the 8 NHS services there were 269 recorded safeguarding concerns in total, an average 34 safeguarding concerns per service (range 12-137).

The graph below shows the total number of safeguarding concerns in each calendar year for the 12 independent sector and 8 NHS service separately, given the differences in recording concerns. For independent sector services there was a year-on-year increase in safeguarding concerns from 2014 to 2017, peaking at 1,303 concerns in 2017. The change in CQC recording of notifications of abuse or allegations automatically as safeguarding concerns at the end of February 2018 in independent sector services (see above) has resulted in a sharp drop in the number of safeguarding concerns recorded (to 28 in the first six months of 2019). The number of safeguarding concerns reported in the 8 NHS service fluctuates around 50-60 reported concerns per year.

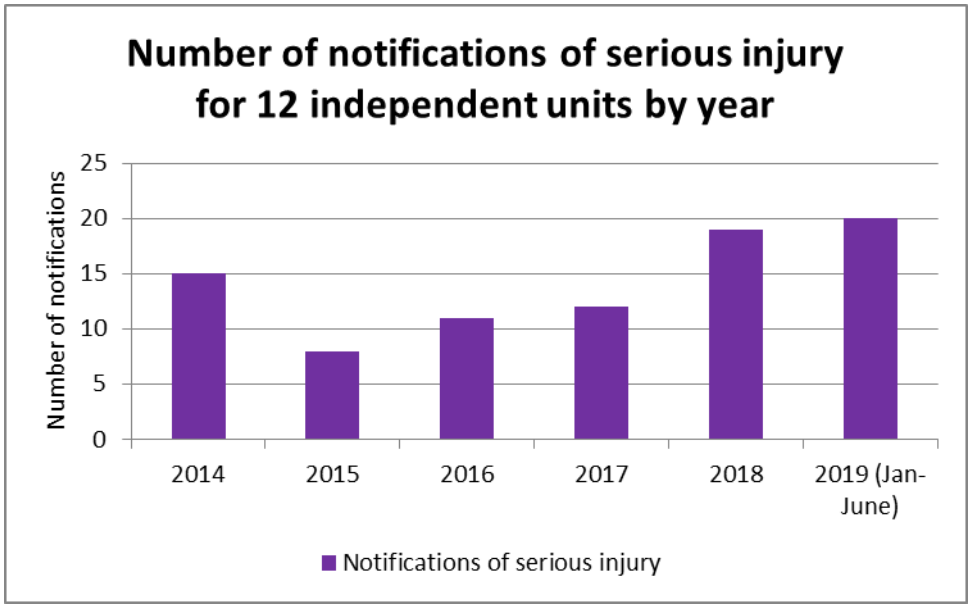


Notifications

Independent sector service providers send notifications to the CQC about a range of occurrences within the service. For this analysis, notifications about the following occurrences were investigated: serious injury (18-2a,b); abuse or allegations (18-2e); police incidents (18-2f); events that stop the service (18-2g); and deaths of people using the service (SN16). NHS services have different notification and reporting systems (the NRLS – see below).

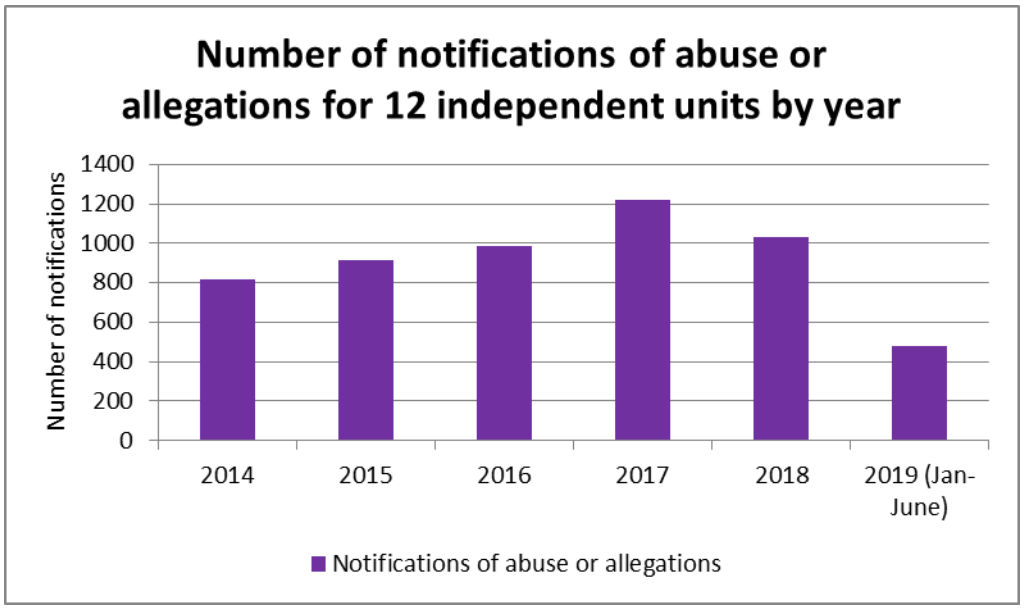
Notifications of serious injury: Across the 12 independent sector services there were 85 notifications of serious injury in total from 1 January 2014 to 30 June 2019. This was an average 7 serious injury notifications per service across the time period, varying from 1 (2 services) to 26.

The graph below shows the total number of notifications of serious injury in each calendar year. After a drop from 2014 to 2015 there has been a continuous year-on-year increase in serious injury notifications, with the figure for the first six months of 2019 slightly higher than the figure for the whole of 2018.



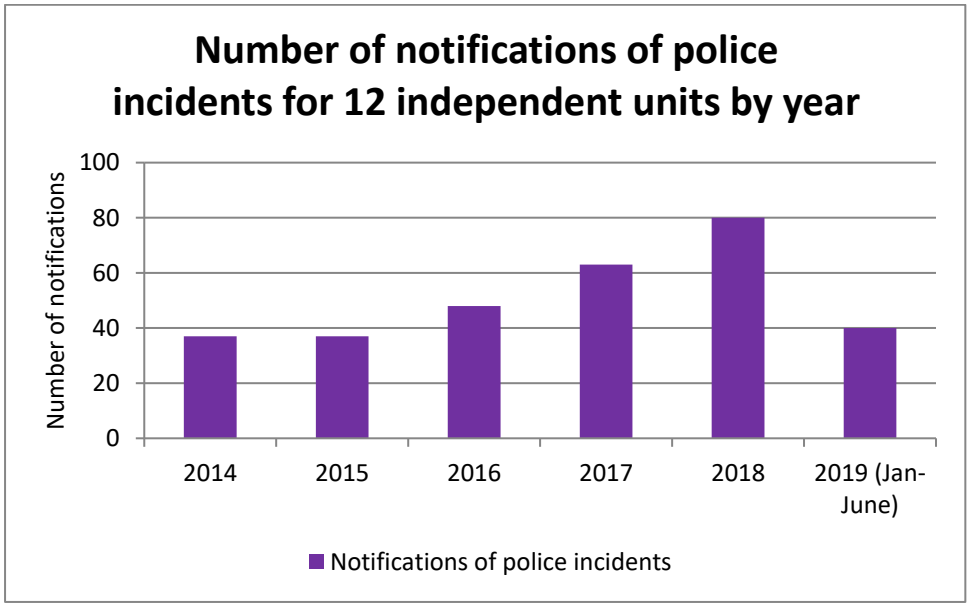
Notifications of abuse or allegations: Across the 12 independent sector services there were 5,451 notifications of abuse or allegations in total from 1 January 2014 to 30 June 2019. This was an average 454 notifications of abuse or allegations per service across the time period, with wide variation between services. Two services reported 100 or fewer abuse or allegation notifications over the time period (2 and 52 respectively) and three services reported more than 800 abuse or allegation notifications over the same time period (828, 968 and 996 respectively, or approximately one abuse or allegation notification every 2 days over a period of five and a half years).

The graph below shows the total number of notifications of abuse or allegations in each calendar year. These show a year-on-year increase from 2014 to 2017, with a fall from 2017 to 2018 and potentially again to 2019 based on figures from January to June.



Notifications of police incidents: Across the 12 independent sector services there were 305 notifications of police incidents in total from 1 January 2014 to 30 June 2019. This was an average 25 notifications of abuse or allegations per service across the time period, ranging from 1 to 94 per service.

The graph below shows the total number of notifications of police incidents in each calendar year. These show year-on-year increases from 2014 to 2018, with figures for the first six months of 2019 suggesting a similar number of police incidents to 2018.



Notifications of events that stop the service: Across the 12 independent sector services, there were three notifications to the CQC of an event that stopped the service across the time period.

Notifications of deaths of people using the service: Across the 12 independent sector services, the deaths of 14 people were notified to the CQC across the time period.

Incidents: the National Reporting & Learning System (NRLS)

NHS Trusts report incidents occurring within their services to the National Reporting & Learning System (NRLS), which are shared with the CQC via a data sharing agreement. Incidents are reported according to their type (including disruptive, aggressive behaviour, and patient abuse by staff/third party) and the degree of harm resulting from the incident (from moderate harm through severe harm to death). Independent sector services do not report incidents to the NRLS, so information from this source is only available for the 8 NHS services analysed in this report.

Data from the NRLS was made available for two groupings of services within each NHS Trust, Learning Disability Services and Mental Health Services. For some of the specific NHS services analysed as part of this report, which were sometimes relatively small components of large and diverse NHS Trusts, the NRLS service groupings were considered to be too broad to meaningfully represent notifications for the specific service. Therefore the analysis reported here concerns the 4 NHS services for people with learning disabilities and autism, using NRLS returns for learning disability services within the Trust, although this may not be an exact match (NHS Trusts may also

have community services for people with learning disabilities and autism, for example). Data were requested and made available from 1 January 2014 to 30 June 2019.

Harm. Across the 4 Trust learning disability services, a total of 183 incidents of moderate harm and 5 incidents of moderate harm were reported over the time period. A total of 21 deaths of people in learning disability services across the 4 Trusts was reported.

Disruptive, aggressive behaviour (includes patient-to-patient). Across the 4 Trust learning disability services, a total of 7,824 incidents of disruptive, aggressive behaviour were reported over the time period.

Patient abuse by staff/third party (typically used to report safeguarding concerns outside healthcare). Across the 4 Trust learning disability services, a total of 752 incidents of patient abuse by staff/third party (typically used to report safeguarding concerns outside healthcare) were reported over the time period.

Restrictive interventions, assaults and self-harm: the Mental Health Services Data Set

The Mental Health Services Data Set (MHSDS) includes information on restrictive interventions (physical restraint – prone; physical restraint – not prone; mechanical restraint; chemical restraint; segregation; seclusion; no type recorded), assaults and self-harm incidents experienced by people within inpatient mental health services, as recorded by service providers. Information from the MHSDS was made available to the Committee from 1 January 2016 to 31 December 2018. MHSDS data were provided for each organisation in three service groupings: people with learning disabilities or autism as inpatients in secondary mental health services; people with learning disabilities or autism as inpatients in child or adolescent mental health wards; and people with learning disabilities or autism as inpatients in secure wards.

By July-December 2018, 9 of the 12 independent sector services stated that they were providing information to the MHSDS (although for 1 of the 12 services MHSDS data could not be disaggregated to the level of the specific service). Three of these 12 services were not providing information to the

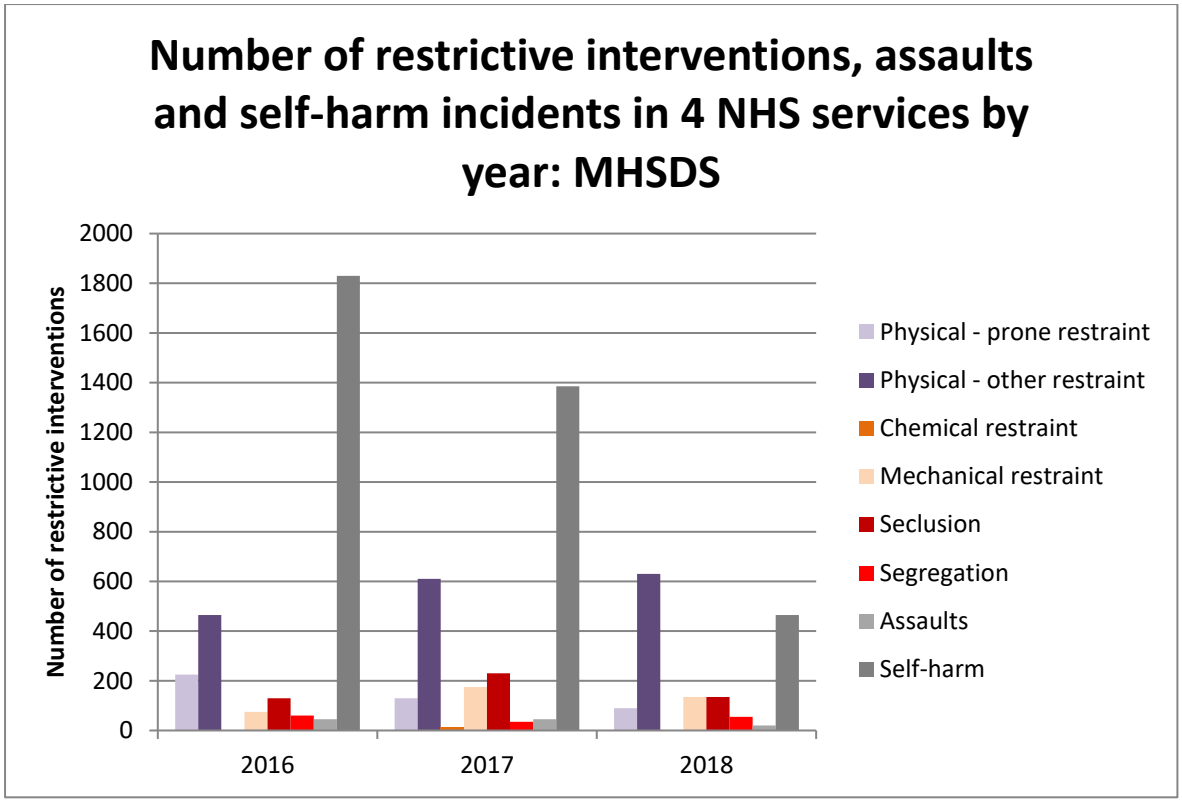
MHSDS. Amongst the 8 independent sector services where MHSDS information was available, 6 of them reported fewer than 5 restrictive interventions in total in the six-month period July-December 2018, 7 of them reported fewer than 5 assaults, and 7 of them reported fewer than 5 self-harm incidents.

All 8 NHS Trusts stated that they were providing information to the MHSDS across the whole time period reported to the committee (1 January 2016 to 31 December 2018). As with the NRLS, because the specific services analysed in this report were sometimes small components of much larger and diverse NHS Trusts, the service groupings in the MHSDS were too broad for some of the NHS services analysed in this report. For four NHS services (2 child & adolescent inpatient services, and 2 forensic and secure services) there was an approximate match to MHSDS data.

Restrictive interventions. The graph below presents information on the number and type of restrictive interventions reported in the MHSDS for the four NHS services analysed, for the years 2016 to 2018. Approximately 1,000 restrictive interventions per year were reported across these 4 NHS services; however one of these services reported fewer than five restrictive interventions in each year, compared to 650+ interventions each year reported by another service. There were also variations across services in the types of restrictive intervention reported – almost all the instances of mechanical restraint, seclusion and segregation were reported in one of the four NHS services in this analysis.

For all four services, the number of people experiencing these restrictive interventions was recorded as fewer than 5 in each six-month block, suggesting a very small number of people experience a very high number of restrictive interventions.

Assaults and self-harm. The graph below also shows the number of assaults and self-harm incidents across the four NHS services reported in the MHSDS, by year. Again there was large variation across the four services: for both assaults and self-harm incidents, the vast majority of these incidents were reported in one NHS Trust.

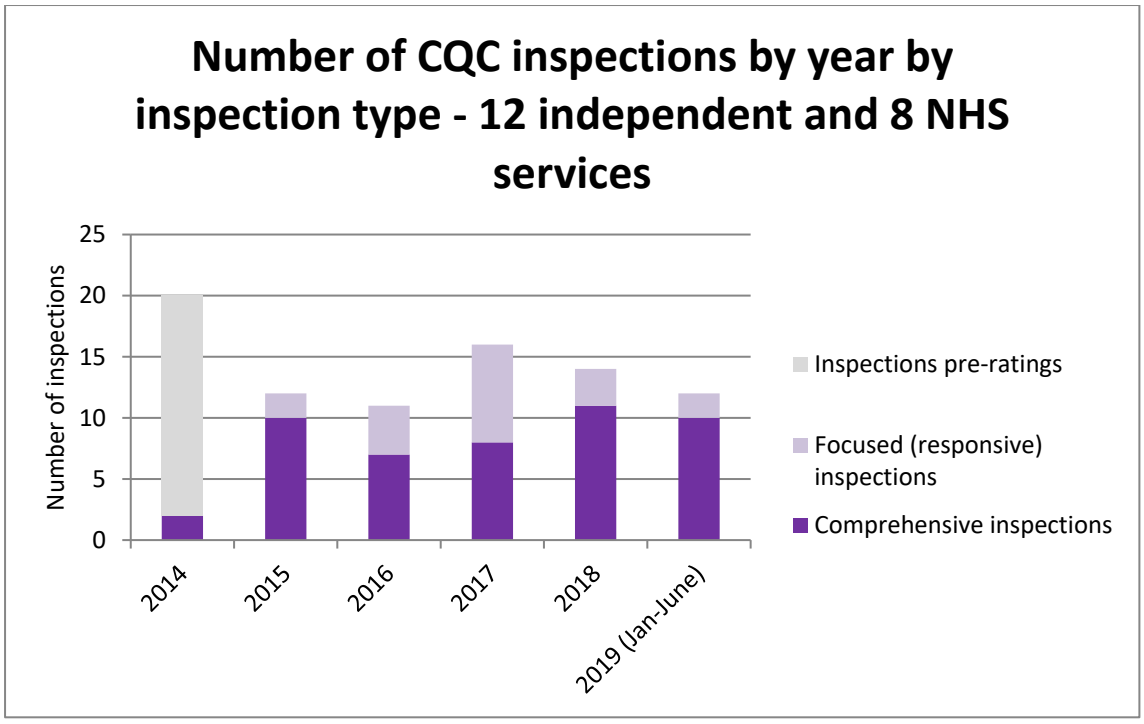

Number of restrictive interventions, assaults and self-harm incidents in 4 NHS services by year: MHSDS
Number of restrictive interventions
2000
1800
1600
1400
1200
1000
800
600
400
200
0
2016
2017
2018
Physical - prone restraint
Physical - other restraint
Chemical restraint
Mechanical restraint
Seclusion
Segregation
Assaults
Self-harm

CQC Inspections

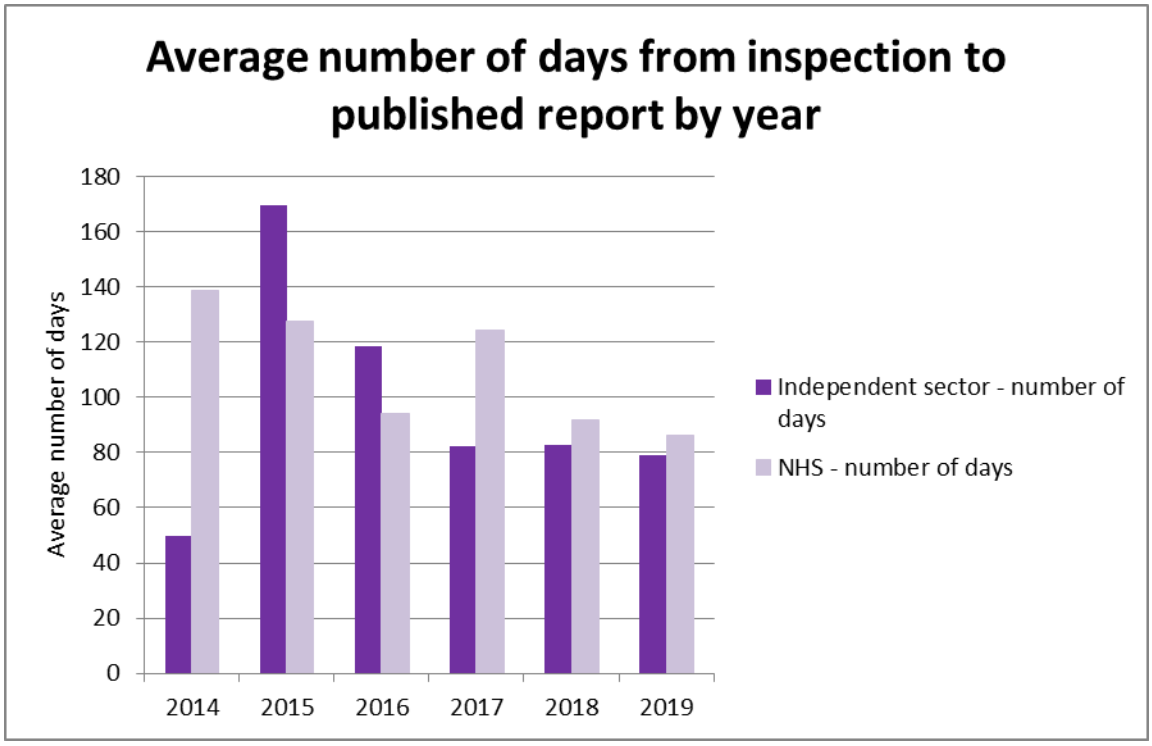
Across the 12 independent sector services from January 2014 to June 2019, there were a total of 60 CQC inspection visits (average 5 inspection visits per service). For the 8 NHS services there were 25 inspection visits in total (average 3.1 inspection visits per service).

Number and type of inspections: The graph below shows the number and type of inspection visits over the time period across the 12 independent and 8 NHS services combined. In terms of type of inspection, 18 inspections were conducted before the current rating system was introduced (all in 2014). A total of 48 comprehensive scheduled CQC inspections were carried out over the time period, with almost all services receiving either 2 of 3 of this type of inspection. All these inspections produced a full set of ratings for the specific service being inspected, although in NHS services inspections did not necessarily inspect all the parts of the service in one inspection. Finally, 19 inspections were focused and responsive, usually following up an aspect of an earlier inspection or checking on required improvements – these inspections could result in no updated ratings, updated ratings relating to specific issues, or a complete set of updated ratings.

As the graph below shows there is no clear pattern in terms of number or type of inspections over time, with some fluctuations in the number of comprehensive and focused inspections over time. The data for the first 6 months of 2019 does suggest that 2019 is likely to reach a new peak in the number of CQC inspections conducted in these 12 services.



Time from inspection to publication: The graph shows the average number of days from the first date of an inspection to the publication of the inspection report, across the time period January 2014 to June 2019. Averages are calculated separately for inspections of independent sector (overall average 94.8 days from first inspection date to report) and NHS services (overall average 113.8 days). For both independent sector and NHS services the time from inspection to report has decreased from 2015 to 2019, and currently runs at around 80-90 days.



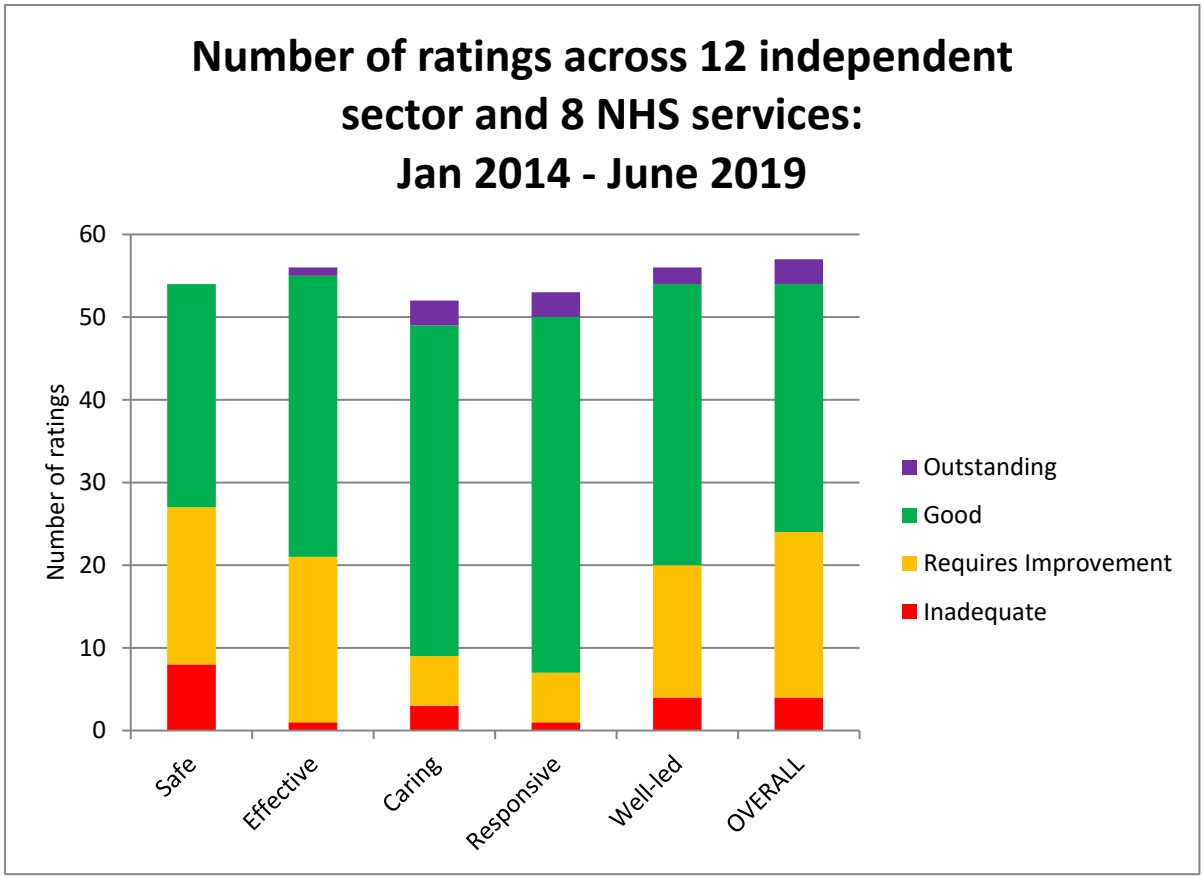
CQC ratings: CQC inspection reports (depending on whether they are comprehensive or focused) rate each service on up to five issues (Safe; Effective; Caring; Responsive; Well-led) and also provide an Overall rating. A 4-point rating scale is used: Outstanding; Good; Requires Improvement; Inadequate. Depending on the scale and range of services provided by a service, ratings of specific elements of the services (for example wards for people with learning disabilities or autism; child and adolescent mental health wards) can be inspected and rated separately, nested within ratings for the service as a whole.

The graph below shows the total number of ratings made by the CQC in all inspections for the 12 independent sector and 8 NHS services across the time period January 2014 – June 2019. The number of ratings slightly differs across different issues as focused inspections may only provide a rating on a selected issue that is the focus of the inspection.

Overall, there were 57 ratings of the overall quality of the service being inspected. In 3 of these inspections a service was rated as Outstanding; in 53% of inspections a service was rated as Good; in 35% of inspections a service was rated as Requires Improvement; and in 7% of inspections a service was rated as Inadequate.

Across the 20 services, the most recent published overall rating was Oustanding for 3 services, Good for 8 services, Requires Improvement for 6 services, and Inadequate for 3 services.

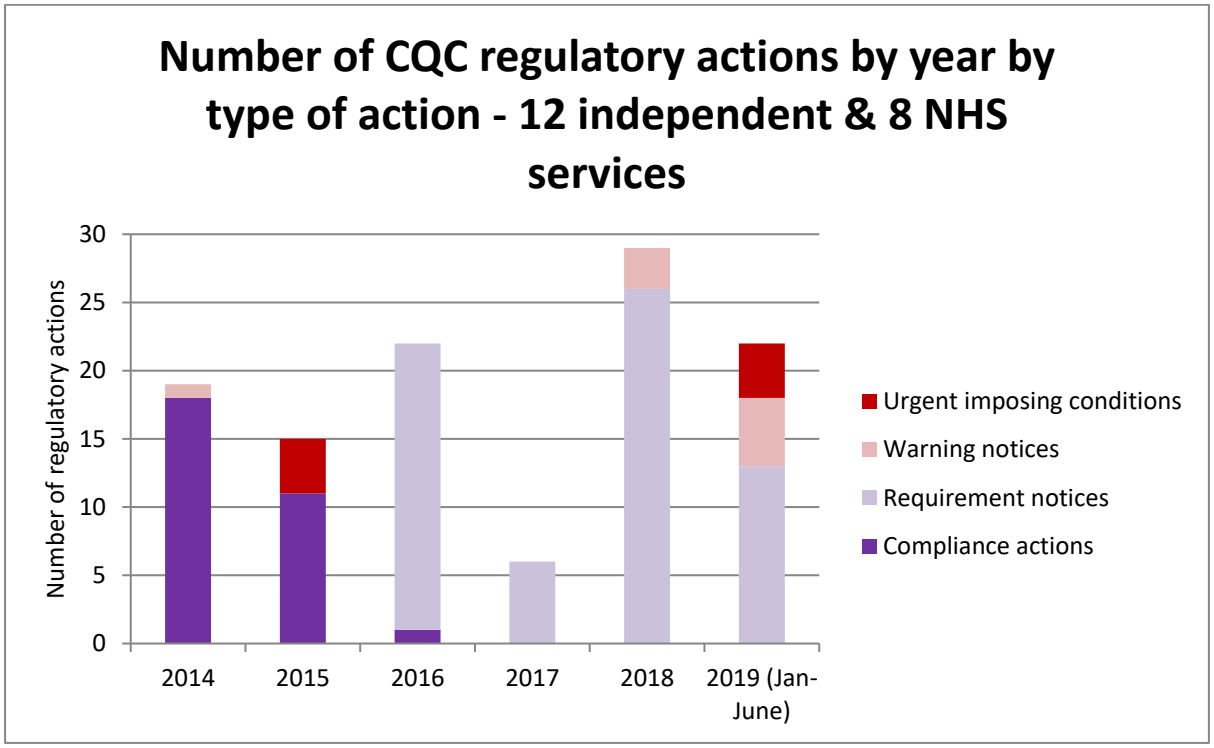
In terms of specific issues, the least positive ratings were in the Safe domain, with no ratings being Outstanding, 50% of ratings being Good, 35% of ratings being Requires Improvement, and 15% of ratings being Inadequate. The most positive specific ratings were for Responsive, with 6% of ratings being Outstanding, 81% of ratings being Good, 11% of ratings being Requires Improvement and 2% of ratings being Inadequate.


Number of ratings across 12 independent sector and 8 NHS services: Jan 2014 - June 2019
Number of ratings
60
50
40
30
20
10
0
Safe
Effective
Caring
Responsive
Well-led
OVERALL
Outstanding
Good
Requires Improvement
Inadequate

Regulatory actions

The CQC provided detailed information on the regulatory actions undertaken by the CQC, as shown by year and by type of regulatory action in the graph below for the 12 independent and 8 NHS services combined. Over the time period there were a total of 88 regulatory actions for the 12 independent sector services, an average 7.3 actions per service (ranging from a minimum of zero to a maximum of 26 regulatory actions in each specific service). For the 8 NHS services there were a total of 25 regulatory actions, an average 3.1 actions per service (range 0-7).

Across both independent sector and NHS services, he most common regulatory actions were Requirement notices (66 notices over the time period), followed by Compliance actions (30 actions), then the less common Warning notices (9 notices) and Urgent imposing conditions (8 conditions). Over time, compliance actions tended to be used in 2014 and 2015 with regulatory notices and warning notices becoming more common over time. With the exception of a sharp dip in regulatory actions in 2017 the overall trend is of year-on-year increases in the number of regulatory actions, with the data for the first 6 months of 2019 suggesting a likely peak in regulatory actions for these services in 2019.



The CQC reports that 8 of the 12 independent services have never been in special measures, 3 services are in special measures (some with conditions on admissions, but without criminal sanctions), and 1 service is closed and is being investigated concerning a potential criminal offence. Of the 8 NHS services, none have previously been in special measures although action is in the process of being taken against 1 service.