Improving Health and Lives:
Learning Disabilities Observatory

A Review of the Results of the 2011/12 Focused CQC Inspection of Services for People with Learning Disabilities

Eric Emerson

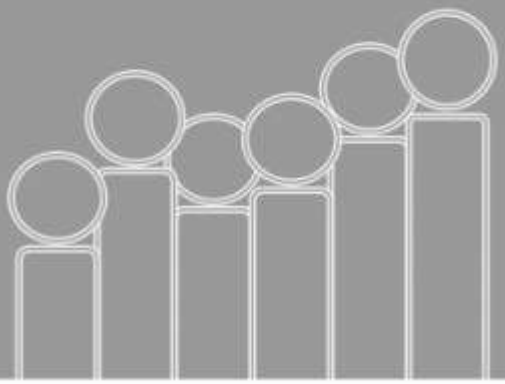

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Table of Contents

Introduction

The Learning Disabilities Public Health Observatory (LDPHO: www.ihal.org.uk) is one of a small number of specialist public health observatories for England. It was established by the Department of Health in April 2010 in response to a recommendation made by the *Michael Inquiry* into access to health care for people with learning disabilities.[1] The LDPHO is a partnership between the North East Public Health Observatory, the Centre for Disability Research at Lancaster University and the National Development Team for Inclusion.

This report summarises work undertaken by the LDPHO in support of CQC's review of services for people with learning disabilities in England. The CQC review involved the inspection of a sample of 150 services. The first five inspections were used to pilot aspects of the inspection process after which changes were made to inspection procedures. As a result, this report provides a summary of the findings and content of 145 inspection reports (excluding the five pilot inspections). Inspection reports and the CQC 'log of issues' contained in the reports were provided by CQC to the LDPHO. The LDPHO review was undertaken by Professor Eric Emerson and involved: (1) extraction and collation of basic quantitative information from the reports and 'log of issues'; (2) review of the correspondence between the content of the reports and 'log of issues'; (3) thematic analysis of the issues raised in the reports in relation to those services who were not compliant with either Outcome 4 or Outcome 7 of the inspection framework. The work contained in this report was undertaken independently, but with the agreement, of CQC. Full details of the inspection process are provided in the CQC *National Overview* report.[2]

Our report provides a simple summary of:

- Some of the characteristics of the services inspected;
- The main outcomes of the inspections;
- The relationships between service characteristics and inspection outcomes.

[1] Michael J. *Healthcare for All: Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities*. London: Independent Inquiry into Access to Healthcare for People with Learning Disabilities, 2008

[2] Care Quality Commission. *Learning disability services inspection programme: National overview*. London: Care Quality Commission, 2012.

Characteristics of the Services Inspected

Type of Service

The inspection programme was instigated following the exposure by the BBC on 31st May 2011 of abusive practices in Winterbourne View, an assessment and treatment unit for adults with learning disabilities run by Castlebeck. Initially intended to inspect 150 assessment and treatment units, or 'similar' services, the inspection programme was widened in its latter stages to include residential care homes. Of the 145 services inspected, CQC designated 72 as assessment and treatment units, 39 as secure units and 34 as residential care homes (RCH). There is, however, significant overlap between the designations of assessment and treatment units and secure units. For example, 62 of the 72 (86%) designated assessment and treatment units supported patients who were detained under the Mental Health Act. In 17 assessment and treatment units (24%) all patients were detained under the Mental Health Act.

Provider Type

Of the 145 services inspected, 68 were provided by NHS Trusts, 45 by independent healthcare providers (IHP) and 32 by adult social care providers (ASC).

Size

Size (the number of people who could be catered for on that site) was recorded in the inspection reports for 140 services (97%). Size ranged from three to 126 people, with a total capacity across the inspected services of 2,419. Half of the services catered for 11 or more people on the inspected site. If all services were operating at 100% occupancy, half of the *people supported* would be catered for in units for 25 or more people.

Occupancy

Occupancy at the time of inspection was recorded for 138 services (95%). Occupancy ranged from two to 97 people, with a total occupancy across the inspected services of 1,855 (624 patients of assessment and treatment units, 734 patients of secure units, 497 residents of residential care homes). Half of the units were currently supporting nine or more people on the inspected site. Half of the people currently supported were being catered for in units for 20 or more people.

Occupancy Rate

Both size *and* occupancy were recorded for 133 services (92%) allowing for the calculation of occupancy rate for each service and overall. At the time of inspection the overall occupancy rate for this subset of services was 79%.

Length of Stay

Length of stay was not reported in a consistent manner across the inspection reports and is less relevant to understanding the nature of residential care homes who often seek to provide a 'home for life'. A number of reports did include information on 'average' length of stay. However, it was not

clear whether these figures were based on inspection of actual data, the opinion of service managers or were based on length of stay of current patients (to the point of inspection) or length of stay of complete patient episodes (from admission to discharge). In addition, several reports explicitly mentioned that a small number of individuals who had been living in the unit for a considerable length of time had been excluded from the estimates of average length of stay. However, from the available information it was possible to determine for 88 of the assessment and treatment units and secure units (79%) whether *any* of the current occupants had been living there for more than one, two and three years. Overall:

- 89% of units were supporting someone who had been resident for more than one year;
- 75% of units were supporting someone who had been resident for more than two years;
- 64% of units were supporting someone who had been resident for more than three years.

Consideration should be given to adopting a more systematic approach to collecting information on length of stay in subsequent inspections (e.g., by using relevant questions/items from the discontinued '*Count Me In*' census).

Association between Type of Service, Provider Type and Other Service Characteristics

Average size of service (the number of people who could be supported) and occupancy (the number of people who were supported at the time of inspection) varied across type of service and provider (Figure 1). These differences were statistically significant (i.e., were unlikely to have occurred by chance alone). Pairwise comparisons indicated that secure units run by independent healthcare providers were significantly larger than assessment and treatment units (whether run by independent healthcare providers or NHS Trusts). The range of size and occupancy by type of service and provider was: NHS A&T (size 3-16, occupancy 2-16); IHP A&T (size 6-69, occupancy 3-59); NHS Secure (size 10-75, occupancy 6-43); IHP Secure (size 7-87, occupancy 7-61); ASC RCH (size 4-126, occupancy 2-97).

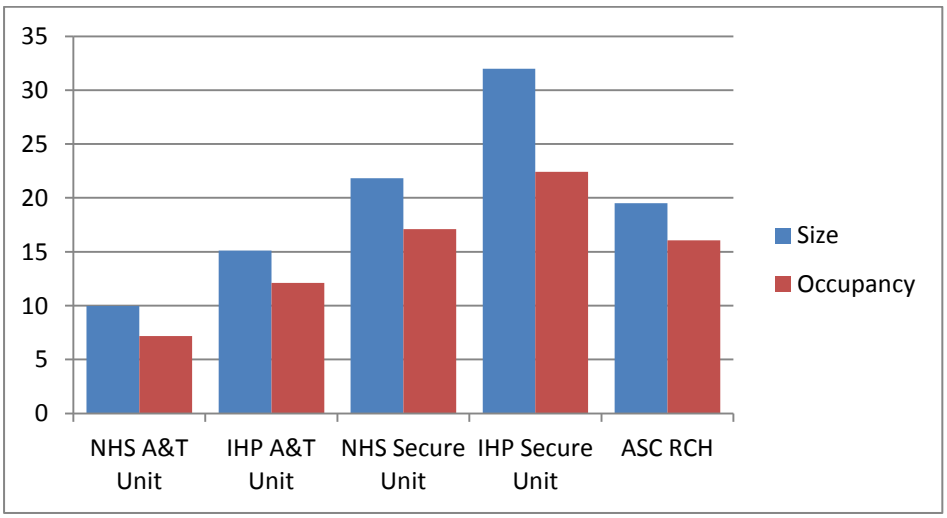

Figure 1: Average size and occupancy of services inspected

Length of stay also varied across type of service and provider (Figure 2). These differences were statistically significant for length of stay greater than two years and length of stay greater than three years.

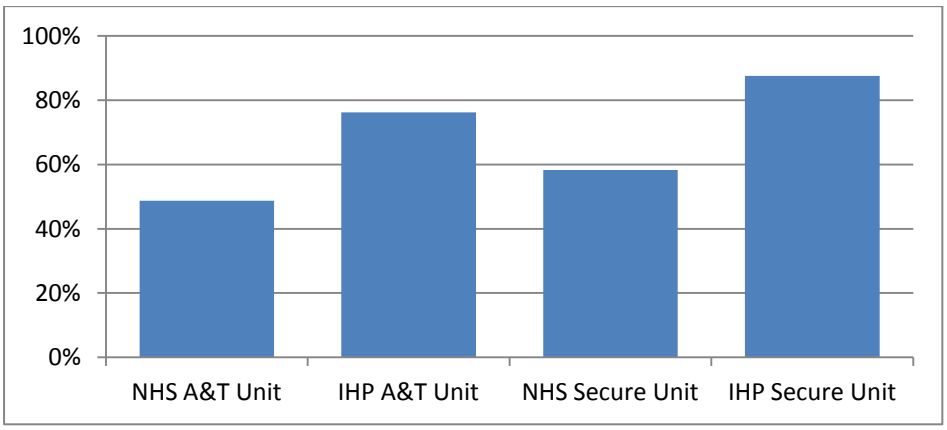

Figure 2: Percentage of Units in Which One or More Patients Has Been Resident for More than Three Years

Pairwise comparisons indicated that assessment and treatment units run by NHS Trusts were significantly less likely to have patients resident for longer than two years and longer than three years than were units run by independent healthcare providers.

There were no statistically significant differences between types of services and occupancy rates.

The Main Outcomes of the Inspections

All inspections reported on compliance with Outcome 4 (care and welfare of people who use services) and Outcome 7 (safeguarding people who use services from abuse) of the inspection framework. Possible inspection outcomes were:

- Fully compliant
- A minor concern (people who use services are safe but are not always experiencing the outcomes relating to this essential standard)
- A moderate concern (people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this)
- A major concern (people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support)

Outcome 4 was broken into the following five themes, each of which was an overall concern for CQC:

4.1 Assessing people's needs

4.2 Care planning

4.3 Meeting people's health needs

4.4 Delivering care

4.5 Managing behaviour that challenges

Similarly, Outcome 7 was broken into the following three themes, each of which was an overall concern for CQC:

7.1 Preventing abuse

7.2 Responding to allegations of abuse

7.3 Using restraint

The overall results for Outcomes 4 and 7 are summarised by type of service in Figures 3-5. Figure 3 shows the overall outcome attained on Outcome 4. Figure 4 shows the overall outcome attained on Outcome 7. Figure 5 shows the highest level of concern identified across Outcomes 4 and 7. In each chart two sets of data are presented:

- The percentage of services that attained a particular outcome;
- The percentage of *current* residents living in units that have attained a particular outcome.[3]

[3] It should be kept in mind that data from only 138 services is available for this measure.

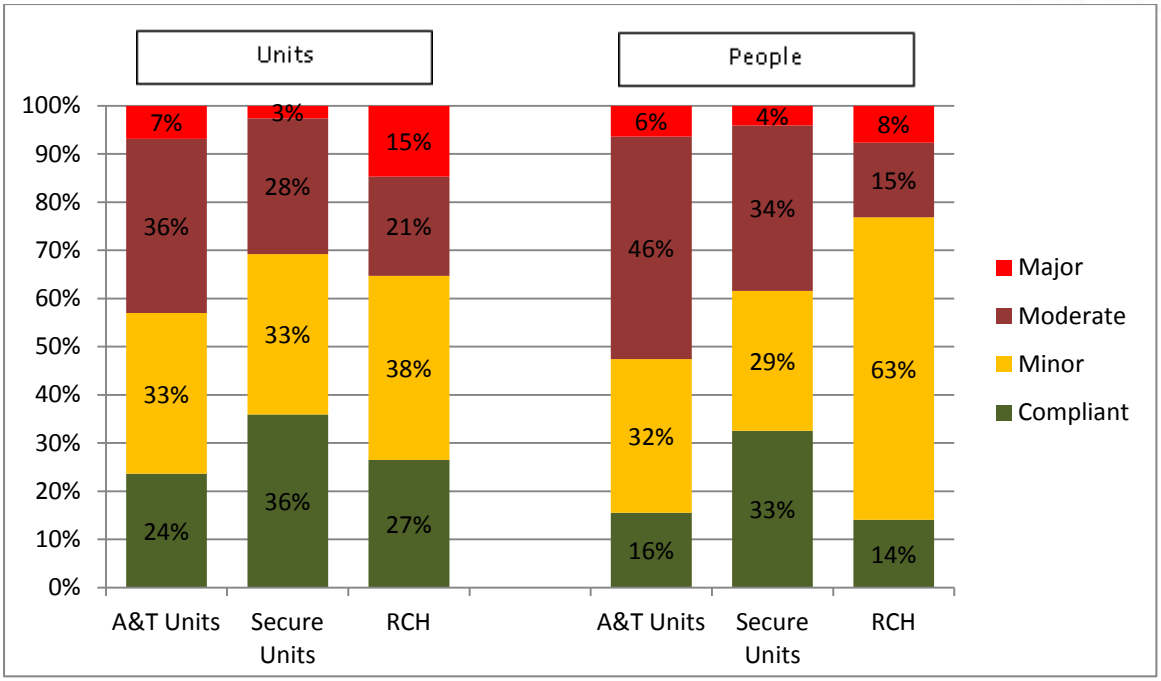

Figure 3: Percentage of Services and Percentage of Current Residents Living in Services by Level of Concern and Type of Service for Outcome 4 (Care & Welfare)

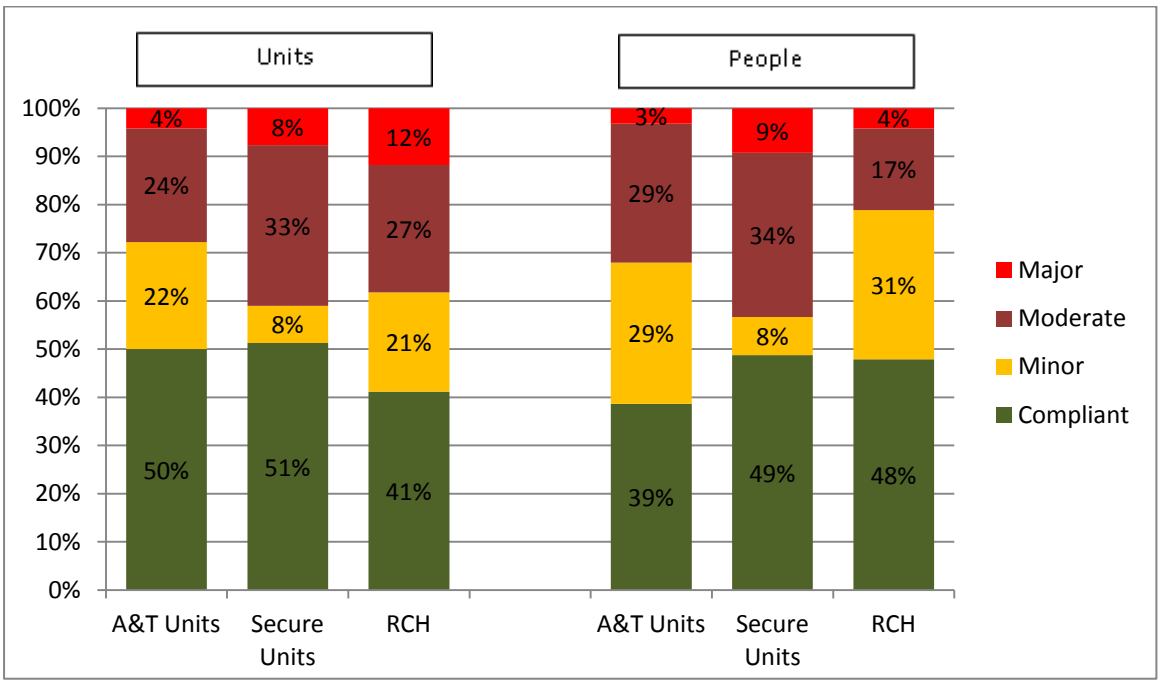

Figure 4: Percentage of Services and Percentage of Current Residents Living in Services by Level of Concern and Type of Service for Outcome 7 (Safeguarding)

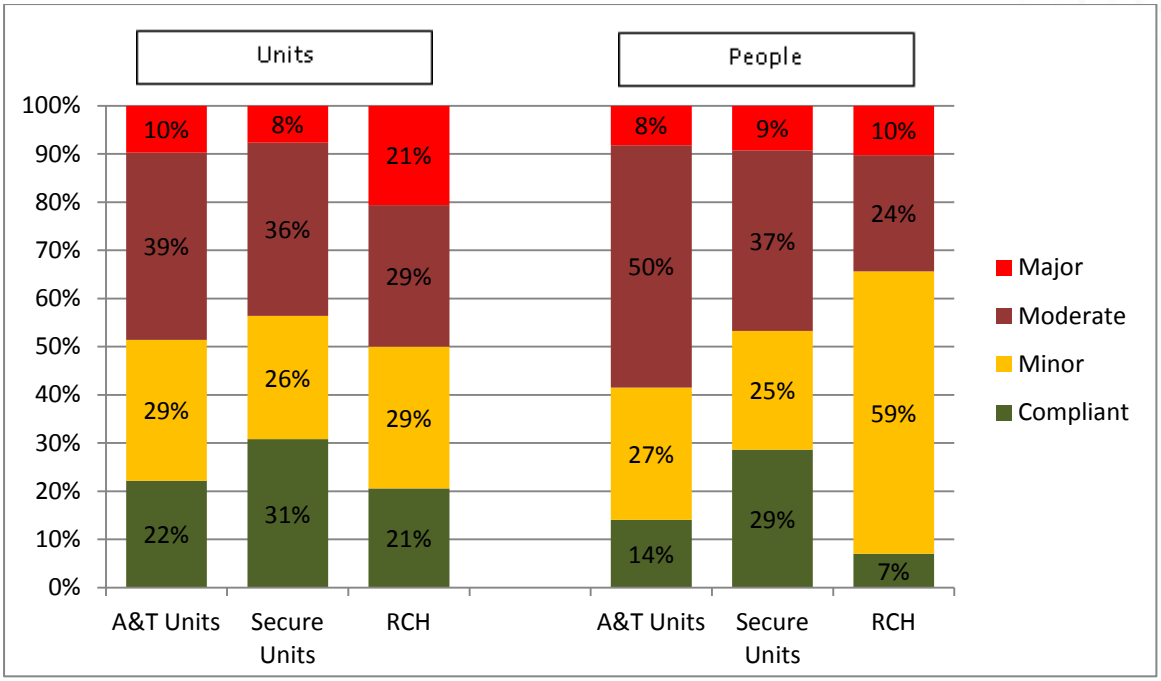

Figure 5: Percentage of Services and Percentage of Current Residents Living in Services by Highest Level of Concern and Type of Service for Outcomes 4 (Care & Welfare) and 7 (Safeguarding)

As can be seen, viewing these results in terms of the number of *people* potentially affected (rather than *units*) presents a less positive picture. Thus, while 22% of units were compliant with both Outcome 4 and Outcome 7, only 14% of residents in the units sampled were living in units that were compliant with both of these outcomes. These differences are due to a tendency for smaller units to perform marginally better on the assessed outcomes than larger units.

Table 1 summarises outcomes for the eight themes of Outcomes 4 and 7. Due to the small percentage of 'major concerns', these have been combined with the category of 'moderate concerns' to create the category of 'moderate or major concerns'.

Table 1: Judgement by Outcome Themes by Type of Service

	Assessment & Treatment Units			Secure Units			Residential Care Homes		
Outcome & Theme	Comp	Min	Mod/ Major	Comp	Min	Mod/ Major	Comp	Min	Mod/ Major
Outcome 4: Care and Welfare									
4.1 Assessing people's needs	74%	17%	10%	87%	8%	5%	77%	9%	15%
4.2 Care planning	32%	32%	36%	51%	26%	23%	35%	29%	35%
4.3 Meeting people's health needs	61%	29%	10%	74%	18%	8%	62%	18%	21%
4.4 Delivering care	51%	26%	22%	62%	23%	15%	56%	21%	24%
4.5 Managing behaviour that challenges	75%	7%	18%	72%	21%	8%	65%	12%	24%
Outcome 7: Safeguarding									
7.1 Preventing abuse	72%	13%	15%	77%	8%	15%	53%	18%	29%
7.2 Responding to allegations of abuse	78%	6%	17%	74%	5%	21%	71%	6%	24%
7.3 Using restraint	61%	15%	24%	54%	13%	33%	71%	12%	18%

As can be seen, for assessment and treatment units moderate or major concerns were most likely to be raised with regard to care planning. For secure units moderate or major concerns were most likely to be raised with regard to the use of restraint. For residential care homes moderate or major concerns were most likely to be raised with regard to care planning.

It should be noted that compliance with the Regulations against which services are inspected[4] does not necessarily indicate the presence of high quality. Of the 14 *assessment and treatment units* that were compliant with both Outcomes 4 and 7 and for whom length of stay information was available, the majority (9; 64%) supported patients who had been there for three years or more. It was noted that in one of these services (which was deemed fully compliant with these two key outcomes)

> *'the length of stay for patients receiving assessment and treatment does not reflect good practice and guidance, resulting in patients being detained for lengthy periods. Admission records showed that five patients have been at the*

[4] As specified in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009

service for over seven years, with a further four patients who have lived there for an average of four years, with no future plans for discharge in place.'

In another it was noted that

'When we inspected there were three patients resident on the six bed unit, one of these had been there just over five years. When we visited there were four patients living at [name], where the average length of stay was eight years.'

The disjunction between compliance and broader notions of quality in this, and other, instances may call into question the extent to which the current Regulations are fit for purpose for the inspection of Assessment and Treatment Units for people with learning disabilities.

The Association between Characteristics of Services and Outcomes

Provider Type

The association between provider type and inspection outcomes was evaluated separately for assessment and treatment units and secure units across Outcome 4, Outcome 7 and the eight individual outcome themes. Two aspects of compliance were investigated: (1) whether the service was fully compliant; (2) whether the service was either fully compliant or compliant with only minor issues identified. Tables 2 and 3 present the results of these analyses in terms of an indicator (the odds ratio) of the 'effect size' or strength of the relationship between provider type and outcomes and also whether these differences are 'statistically' significant.

In these comparisons the compliance outcomes of units operated by independent healthcare providers are taken as the reference point. The odds ratio estimates the extent to which the odds of compliance in units operated by NHS Trusts are greater or smaller than those attained in units operated by independent healthcare providers. An odds ratio of 1.0 indicates that there is no difference between the two types of providers. An odds ratio of greater than 1 indicates that the odds of compliance are greater in NHS units. An odds ratio of 2.0, for example, indicates that the odds of compliance are twice as great in NHS units when compared with units operated by independent healthcare providers. An odds ratio of less than 1 indicates that the odds of compliance are lower in NHS units. The 'statistical' significance of the association is an estimate of the probability that the observed difference between providers is likely to have occurred by chance alone.

Table 2: Odds of Compliance in Assessment & Treatment Units Run by NHS Trusts in Comparison with Units Operated by Independent Healthcare Providers				
	Fully Compliant		Compliant or Only Minor Issues	
	OR/p	95%CI	OR/p	95%CI
Outcome 4: Care & Welfare	3.35	0.86-13.03	3.31*	1.21-9.01
4.1 Assessing people's needs	1.91	0.65-5.55	2.61	0.54-12.69
4.2 Care planning	2.70	0.86-8.45	2.54	0.93-6.91
4.3 Meeting people's health needs	1.25	0.47-3.40	13.50**	1.52-119.61
4.4 Delivering care	1.39	0.53-3.65	2.11	0.68-6.53
4.5 Managing behaviour that challenges	1.60	0.54-4.75	2.47	0.73-8.32
Outcome 7: Safeguarding	3.30*	1.26-9.72	3.02*	1.04-8.75
7.1 Preventing abuse	3.02*	1.04-8.75	1.59	0.43-5.82
7.2 Responding to allegations of abuse	6.01**	1.79-20.19	7.59**	1.83-31.46
7.3 Using restraint	3.46*	1.26-9.49	2.52	0.83-7.64
* p<0.05 **; p<0.01; OR = odds ratio; OR = odds ratio, p = alpha probability, CI = Confidence interval for the odds ratio				

Table 3: Odds of Compliance in Secure Units Run by NHS Trusts in Comparison with Units Operated by Independent Healthcare Providers				
	Fully Compliant		Compliant or Minor	
	OR/p	95%CI	OR/p	95%CI
Outcome 4: Care & Welfare	3.75	0.92-15.34	1.75	0.44-6.93
4.1 Assessing people's needs	1.67	0.25-11.42	1.06	0.06-18.17
4.2 Care planning	3.18	0.86-11.79	1.43	0.32-6.39
4.3 Meeting people's health needs	6.55*	1.17-36.61	2.24	0.19-26.91
4.4 Delivering care	3.33	0.86-12.92	1.06	0.19-6.05
4.5 Managing behaviour that challenges	2.33	0.55-9.83	2.24	0.19-26.91
Outcome 7: Safeguarding	3.18	0.86-11.79	4.13*	1.06-16.10
7.1 Preventing abuse	2.62	0.55-12.48	2.40	0.39-14.97
7.2 Responding to allegations of abuse	1.85	0.43-7.96	2.02	0.41-9.99
7.3 Using restraint	4.00*	1.05-15.21	3.60	0.87-14.87
* p<0.05 ** p<0.01 OR = odds ratio, p = alpha probability, CI = Confidence interval for the odds ratio				

For all 40 comparisons, units operated by NHS Trusts were more likely to be compliant than services operated by independent healthcare providers. For 29 comparisons (73%) odds of compliance were at least twice as great in units operated by NHS Trusts. For 11 comparisons (28%) these differences were statistically significant. The overall pattern of results is highly statistically significant. Taking the eight themes as independent judgements, the probability that these would all favour one type of provider by chance alone is less than 1 in 250.

In an alternative approach to analysis we pooled the results across assessment and treatment and secure units and used multivariate analyses (logistic regression with multiple imputation of missing data) to estimate the independent association between provider type on outcomes when controlling for unit size and type (assessment and treatment or secure). The results of these analyses are presented in Table 4.

As in the previous analyses, for all 20 comparisons units operated by NHS Trusts were more likely to be compliant than services operated by independent healthcare providers. For 13 comparisons (65%) odds of compliance were at least twice as great in units operated by NHS Trusts. For 11 comparisons (55%) these differences were statistically significant.

Table 4: Estimate Independent Association between Provider Type and Compliance when Controlling for Unit Size and Type (Assessment and Treatment or Secure)

	Fully Compliant		Compliant or Minor	
	OR/p	95%CI	OR/p	95%CI
Outcome 4: Care & Welfare	3.40*	1.24-9.28	2.31*	1.00-5.33
4.1 Assessing people's needs	1.81	0.69-4.75	1.90	0.45-8.05
4.2 Care planning	2.76*	1.14-6.68	2.16	0.91-5.10
4.3 Meeting people's health needs	1.76	0.75-4.09	7.48*	1.48-37.84
4.4 Delivering care	1.95	0.87-4.37	1.59	0.59-4.26
4.5 Managing behaviour that challenges	1.73	0.71-4.22	2.13	0.68-6.63
Outcome 7: Safeguarding	3.22**	1.41-7.34	3.38**	1.43-8.00
7.1 Preventing abuse	2.51*	1.01-6.23	1.74	0.59-5.12
7.2 Responding to allegations of abuse	3.49*	1.34-9.09	4.69**	1.59-13.82
7.3 Using restraint	3.43**	1.50-7.83	3.00*	1.22-7.34

*** p<0.05 ** p<0.01**

OR = odds ratio, p = alpha probability, CI = Confidence interval for the odds ratio

Size & Occupancy

There were no systematic relationships between unit size or occupancy levels and outcomes for assessment and treatment units and secure units. There some evidence that higher occupancy rates were associated with higher levels of compliance in residential care homes overall and for themes 4.1, 4.3, 4.4 and 7.2.

Length of Stay

There were no systematic relationships between indicators of length of stay and outcomes for assessment and treatment units and secure units.

Specific Issues Identified

The following section is based on a thematic review of the text of those inspection reports of assessment and treatment units and secure units which registered moderate or major concerns with either Care and Welfare or Safeguarding. Relevant text was read and used to generate a list of themes/issues (e.g., lack of detail in the care planning process). All relevant text was then reread and coded to identify the presence/absence of these themes. Only themes that were reported in five or more inspection reports are discussed below.

Care & Welfare

The most commonly noted failings in delivering effective Care and Welfare related to deficiencies in **care planning** (including discharge planning) and the **provision of appropriate activities**.

Key failures in **care planning** included a **lack of personalisation and of patient involvement and ownership**. A common concern was that care plans were 'not person centred'. Rather, they were described as having a primary focus on tasks associated with clinical co-ordination with little evidence that they reflected patients' preferences or aspirations. Lack of personalisation and patient ownership was also reflected in concerns repeatedly being raised about the **lack of easy read or more 'accessible' formats** of care plans and patients **not having access to copies of their plans**.

A range of problems were also noted with regard to the **poor implementation** of care planning. These included:

- Plans not being completed
- Lack of detail
- Failure of care plans to include any goals
- Goals not having target dates for review
- Lack of timely review/updating
- Lack of monitoring/evaluation
- Poor linkage between different care planning/monitoring systems
- Disorganised & inaccessible storage of plans (e.g., paper copies in locked filing cabinets, electronic files with restricted access)
- Plans not being read/followed by staff
- Actions not implemented (including failure to administer prescribed medication)
- Lack of involvement or carers and support workers.
- Poor attention to patients' health needs in care planning.

Perhaps most worrying was that specific mention was made in five reports (including four reports of assessment and treatment units) of the **complete absence of discharge or rehabilitation planning**.

The second most commonly raised concern related to the **range, nature and extent of activities and support available** within the setting, particularly in the evening or weekend. Difficulties in accessing *preferred or planned* activities were reported on several occasions, an issue that has obvious links to the lack of personalisation in care planning. However, it was also clear that concerns with access to activities reflected constraints imposed by general policies and procedures and lack of (or inefficient use of) resources. Thus, for example, meals being provided by a local hospital and the absence of

budgets to enable patients to buy and cook their own food place obvious limitations on access to a range of domestic activities and the development or maintenance of independence. On a number of occasions concern was raised that planned activities (including patient leave) were cancelled at short notice or simply not considered due to staff shortages.

> *'We found patients to be sat bored on the ward just watching TV or in their rooms. Staff told us they felt the ward needed an activities co-ordinator as they did not have the time to provide stimulating activities. ... Staff and patients told us that social skills such as cooking, doing laundry and shopping was not maintained as it was against hospital policy.'*

Concern was also raised about the timely and appropriate access to professional support such as Speech and Language Therapists. Finally, concern was raised on five occasions about lack of reasonable access to food and water, including staff inflexibility around set meal times and access to drinks.

The relative frequency of these concerns (occurrence as a percentage of units in which moderate or major concerns were identified) is presented in Figure 6.

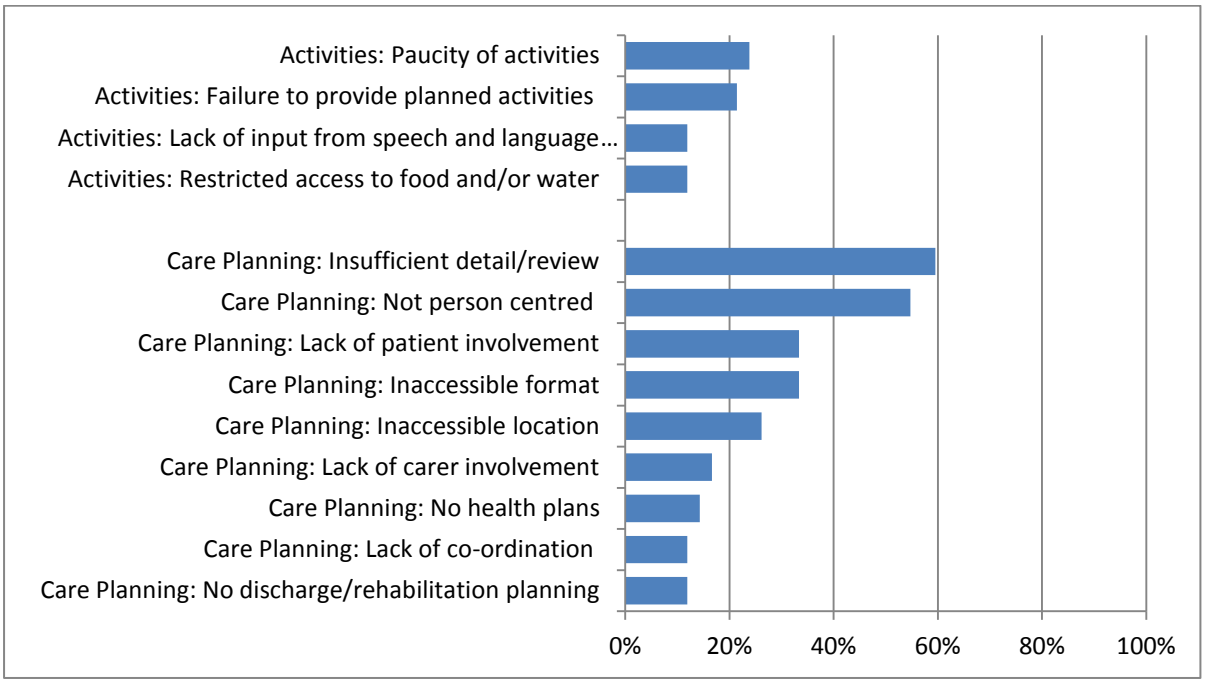

Figure 6: Occurrence of specific concerns regarding care and welfare as a percentage of units in which moderate or major concerns were identified

There were few notable differences between assessment and treatment and secure units or between units operated by NHS Trusts and independent healthcare providers in the frequency of the reporting of particular concerns. The one exception was that the absence of any discharge/rehabilitation planning was three and a half times more likely to be reported in units operated by independent healthcare providers.

Safeguarding

The concerns that were raised regarding safeguarding procedures fell into three broad categories.

First, comments were made regarding the competence of care staff (and occasionally unit managers) with regard to their understanding of safeguarding policies and practices.

Second, concerns were raised regarding the consistency of the implementation of local safeguarding procedures and the effectiveness of local arrangements for patients and carers to raise issues of concern or make complaints. Specific concerns were raised with regard to failure to raise (or delays in raising) safeguarding alerts.

Third, concerns were raised regarding the use of restrictive behaviour management practices such as physical restraint and seclusion. Specific concerns were raised with regard to:

- Inadequate recording of incidents of physical restraint and seclusion
- The lack of clear and personalised guidelines on the appropriate method of restriction
- Failure to learn from incidents that have occurred (either through 'reflective learning' or quantitative audit to identify underlying patterns).

The relative frequency of these concerns (occurrence as a percentage of units in which moderate or major concerns were identified) is presented in Figure 7.

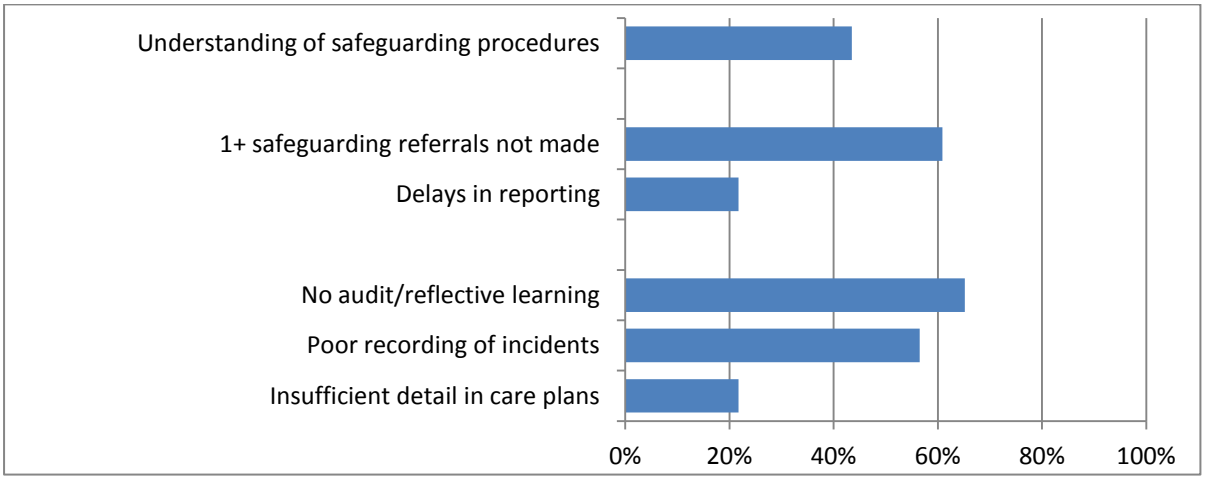

Figure 7: Occurrence of specific concerns safeguarding as a percentage of units in which moderate or major concerns were identified

Again, there were few notable differences between assessment and treatment and secure units or between units operated by NHS Trusts and independent healthcare providers in the frequency of the reporting of particular concerns. The one exception was that failure to raise safeguarding alerts was three and a half times more likely to be reported in units operated by independent healthcare providers.

Summary

Overall, less than one in four of the 145 units inspected were fully compliant (with no minor concerns raised) with both Outcomes 4 (Care and Welfare) and 7 (Safeguarding) of the inspection framework.[5] Only one in seven of the current residents of the 145 units for which information was available were being supported in units that were compliant with both Outcomes 4 and 7.

Concerns raised regarding Care and Welfare fell into two broad categories:

- Deficiencies in care planning (including discharge planning);
- The range, nature and extent of activities and support available within the setting.

Concerns raised regarding Safeguarding fell into three broad categories:

- The competence of staff regarding their understanding of safeguarding procedures;
- The consistency of the implementation of local safeguarding procedures;
- The use of restrictive behaviour management practices such as physical restraint and seclusion.

There were marked differences in compliance between units operated by NHS Trusts and independent healthcare providers. For every comparison made, units operated by NHS Trusts were more likely to be compliant than services operated by independent healthcare providers. For many of these comparisons odds of compliance were at least twice as great in units operated by NHS Trusts. These differences in probability of compliance are highly unlikely to be accounted for by random error or chance fluctuation.

There is a notable similarity between the concerns expressed in these reports and the findings of the national audit of specialist inpatient healthcare services for people with learning difficulties in England undertaken by the Healthcare Commission in 2006.[6]

It should be noted that compliance with the Regulations against which services are inspected does not necessarily indicate the presence of high quality care. Of the 14 *assessment and treatment units* that were compliant with both Outcomes 4 and 7 and for whom length of stay information was available, the majority (9; 64%) supported patients who had been there for three years or more. Indeed, it was reported in one of these services that

> '*the length of stay for patients receiving assessment and treatment does not reflect good practice and guidance, resulting in patients being detained for lengthy periods. Admission records showed that five patients have been at the service for over seven*

[5] It is important to note that we have adopted a different approach to categorising compliance than CQC, for whom 'compliance' includes compliant with minor concerns (see Care Quality Commission. *Learning disability services inspection programme: National overview*. London: Care Quality Commission, 2012)

[6] Healthcare Commission (2007). *A Life Like No Other: A national audit of specialist inpatient healthcare services for people with learning difficulties in England*. London: Commission for Healthcare Audit and Inspection

years, with a further four patients who have lived there for an average of four years, with no future plans for discharge in place.'

The disjunction between compliance and broader notions of quality in this, and other, instances may call into question the extent to which the current Regulations are fit for purpose for the inspection of Assessment and Treatment Units for people with learning disabilities.