

# Closed cultures and reducing restrictive practices

Friday 15 December 2023, 10:30am – 12:30pm

Partners in Care and Health

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# Welcome and Housekeeping

**Welcome** - Hilary Paxton, Senior Adviser, People with a learning disability and autistic people, Partners in Care & Health

- Please remain muted with camera turned off.
- We are recording the webinar plan to publish the recording and the slides, but please note that the presentation from Alexis Quinn will not be included in the published versions.
- There is a separate question and answer time after all the presentations.
- Please put questions in the chat
- Please contact us at [pch@local.gov.uk](mailto:pch@local.gov.uk) if you wish your email to be removed from this list



# Running order

- **Restraint reduction and the interface with closed cultures – CQC perspective** – Stefan Kalee and Hayley Moore
- **Experience of restrictive practice - Why should it be reduced in social care?** – Alexis Quinn, Restraint Reduction Network – Please note, that this lived experience presentation contains sensitive personal information and will not be published
- **Importance of Independent Advocacy in preventing and challenging closed cultures** – Gail Petty, NDTI
- **Responding to closed cultures and restrictive practice work undertaken following the Hesley Review** – Leemya McKeown, Kent County Council
- **Q & A**



# Reducing restrictive practices and Closed Cultures

**Hayley Moore**

Deputy Director - Safeguarding and Closed Cultures

**Stefan Kallee**

Interim Deputy Director - People with a Learning Disability and Autistic People

*LGA Webinar 15 December 2023 – Closed Cultures and Restraint Reduction in social care*



# Why do we need a new policy position?

- **Out of Sight**, and progress report March 2022: A journey through the system to seek to understand the experiences of autistic people and/or people with a learning disability
- We know, all of us, that the use of restrictive practice can have a devastating impact on people and cause them trauma
- We put together an EAG to talk to partners of care and people with lived experience
- This policy position is a direct outcome of those conversations; we needed more clarity.



# Our new position

- We've repeatedly called for providers to act immediately to reduce the use of restrictive practice and to ensure they provide person-centred, trauma informed care, always
- We needed to address this issue head on and develop a clearer, stronger position on the use of restrictive practice
- This new position builds on our new responsibilities to assess local authorities and healthcare providers together
- We'll apply this cross-sector position to all areas of our regulation
- As a result, we expect all providers to know what restrictive practice looks like and to actively work to reduce its use in their settings

# What does our policy say?

- Restrictive practices often harm people. Use them by exception, as the last resort and in accordance with the least restrictive principles.
- CQC expects care to be person-centred. We expect providers and system partners to promote positive cultures, relational support and trust between people and staff.
- They must listen to and seek to understand people, including how people communicate their needs, emotions, or distress.
- Focus needs to shift to one which respects all people's rights, provides skilled, trauma-informed practice support and promotes recovery.
- Where restrictive practices are used, providers and system partners must analyse why they were used, what their root causes were, and seek to reduce their use.



# Our expectations: CQC, providers, people and partners

I want to highlight **five** key areas of our expectations for ourselves, providers, partners and people;

1. People's experience
2. Importance of leadership and learning culture
3. Engagement and conversations
4. Workforce
5. Environment

# 1. People's experience

- People's views and experience matters – it's at the heart of what we do
- [Give Feedback on Care](#)
- Conversations with us or through Experts by Experience on Inspection
- Coproducing publications and even our new single assessment framework
- We cannot get the right place without people sharing their experiences and concerns with us, that includes the good stuff too
- Experiences of good practice help us to share better ways of caring for people through our independent voice
- Our strategy makes a commitment to deliver regulation driven by people's needs and experiences of care.

## 2. Importance of leadership and learning culture

- We expect leaders to lead and maintain a culture of learning within their organisation.
- We expect leaders to promote person centred care and support to promote quality of life and future wellbeing.
- **Are you fostering reflection and learning in your organisations?**



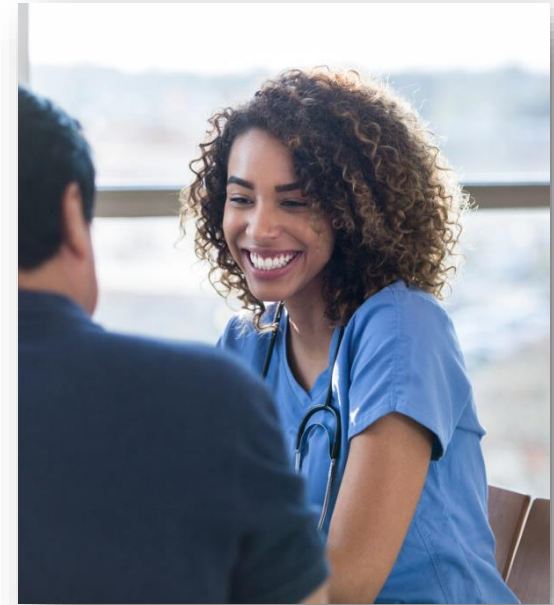
### 3. Engagement and conversations

- We want meaningful engagement with the right people at the right time to make a difference.
- We will seek and listen to views and experiences of leaders and help to guide and support leaders to engage with us.
- We want to promote better oversight of restrictive practice and ensure Boards understand the data coupled with the impact on people and their families.



## 4. Workforce

- **What support is there for the workforce?**
- Pay and benefits offer, training and development (like trauma informed practice) or staff satisfaction
- But giving staff the opportunity to reflect on their practice can contribute to staff physical and mental wellbeing
- Supporting staff to seek support when they are not feeling their best can only be a good thing for both staff and for people in your service.
- Supporting staff to build relationships and trust is important to the wellbeing of people in your service.



# 5. Environment

- Where we live impacts on how we live, how we recover and influences our mental wellbeing
- Therefore, it's important that we focus on enabling environments that support better outcomes for people
- But it's not just the place.....



## 5. Environment continued

- Most people know restraint in its extreme forms, there are subtle forms of restrictive practice such as;
  - Keeping a walking frame out of reach
  - Keeping people in specific areas
  - Making people use bibs or feeding cups
  - Denying people access to visitors or food due to lack of staff/time
- Many of these examples make it quicker and easier for staff to manage people, but it is not the person-centred trauma-informed care that we expect to see.

## 5. Environment continued

- Let's talk about blanket policies, which are another form of restrictive practice and are applied to everyone regardless of their individual needs. Some of these could look like;
  - Stopping people from using the kitchen
  - Setting bedtimes
  - Bedrooms being locked at certain times of the day
  - Remote CCTV monitoring
- We encourage providers to challenge the use of blanket restrictions to ensure that they are not unintentionally restricting people's liberty and human rights.





# Our position is clear – We need to work together

- We'll continue to raise awareness through sharing examples of good practice we see and the important role leadership and culture play.
- Across CQC we are rolling out training co-produced with BILD/RRN to help us improve our regulation.
- Our new policy and inspector guidance will be incorporated into our new single assessment framework later this year.
- We will keep talking to leaders, providers and providing guidance and support through our 'always on' approach through events and communications.
- We have our senior specialists to support teams across the organisation to get this right.

Reducing restrictive practices is one of our priority areas – but it is everyone's responsibility.



We all can and must do better to eliminate the inappropriate use of restrictive practice in health and social care.

# Closed cultures



# What brought us here?

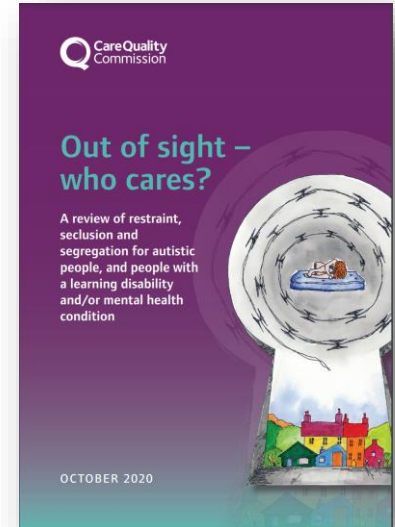
We've seen too many times over the past few years that people aren't getting access to the right care.

[Prof. Glynis Murphy report](#) - Independent reports after Whorlton hall

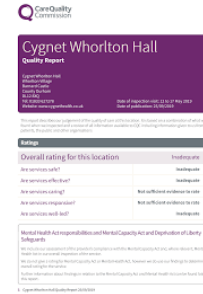
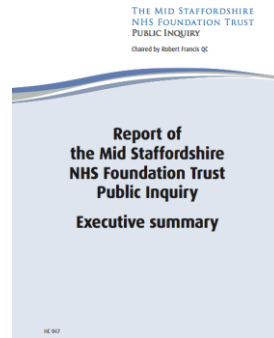
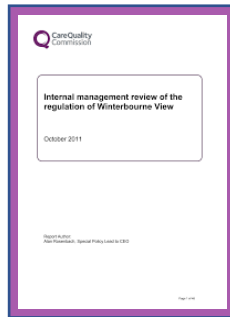
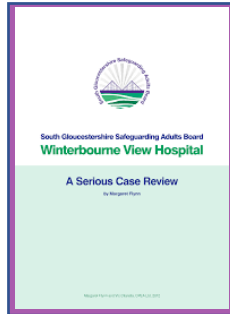
[Closed Cultures](#) - These reports led to our closed cultures work

[Out of sight who cares? review](#) – focused on the use of restrictive practices such as: restraint, seclusion and segregation for autistic people and people with a learning disability and / or mental health condition

The work to **transform** services is about making changes, for the benefit of all the people using them.



# Why does speaking up matter within regulation?



# Key features of a good safety culture\*

*“[a good patient safety culture is] one where the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care”.* **NHS England**

- Behaviours and relationships of staff
- Open communication
- Psychological safety
- Organisational practices
- Involvement of those who use services

\* [Rapid Literature Review: The characteristics of safety cultures - Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk/resources/publications/rapid-literature-review-the-characteristics-of-safety-cultures)

# Identifying closed cultures

*A poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm.*

Certain features increase the risk of a closed culture:

- Services where people are unable to leave of their own accord
- Live-in services such as shared lives, supported living services
- Any service where one-to-one care is provided
- A provider changing the type of service it offers in response to market or other influences

# Early warning signs

## **People may experience poor care, including unlawful restrictions**

- Restrictions, including restraint, long-term segregation and prolonged seclusion, being imposed on people without an assessment of need, legal authority/legitimate aim or that have been imposed legitimately but are not subject to review and or do not ease over time.
- Poor or absent communication plans for people who have communication needs and or communication plans not being followed.

## **Weak leadership and management**

- Staff are not supported or encouraged to raise concerns and or staff are discouraged or afraid to 'speak up'

## **Poor skills, training and supervision of staff providing care**

- A high use of poorly inducted agency staff or locums who do not know people's needs.
- Staff work excessively long hours or overtime.

## **Lack of external oversight**

- There is limited interaction with outside agencies due to failings on the part of the service to submit mandatory information such as notifications or safeguarding referrals.



# Learning from Whorlton Hall – Next steps

## NEED FOR CLOSER WORKING BETWEEN CARE QUALITY COMMISSION AND LOCAL AUTHORITIES TO IMPROVE OUTCOMES FROM ORGANISATIONAL SAFEGUARDING ENQUIRIES IN SPECIALIST HOSPITALS

Current guidance does not articulate with adequate clarity the necessary collaboration between CQC and host local authorities where there are quality issues that become organisational safeguarding concerns about specialist hospitals. This means that local authorities with a safeguarding role for people living in settings in their area undertake repetitive cycles of organisational safeguarding enquiries which result in them telling providers to do what they should already be doing, and which have little sustained effect on improving the experiences of patients. This risks perverting the purpose of safeguarding and incurs significant cost in terms of resource and time for the host authorities but has little impact on the providers or benefit to the people living in the specialist hospitals.

## Hayley Moore

Deputy Director – Safeguarding and Closed Cultures

## Stefan Kallee

Interim Deputy Director – People with a learning disability and autistic people

[www.cqc.org.uk](http://www.cqc.org.uk)

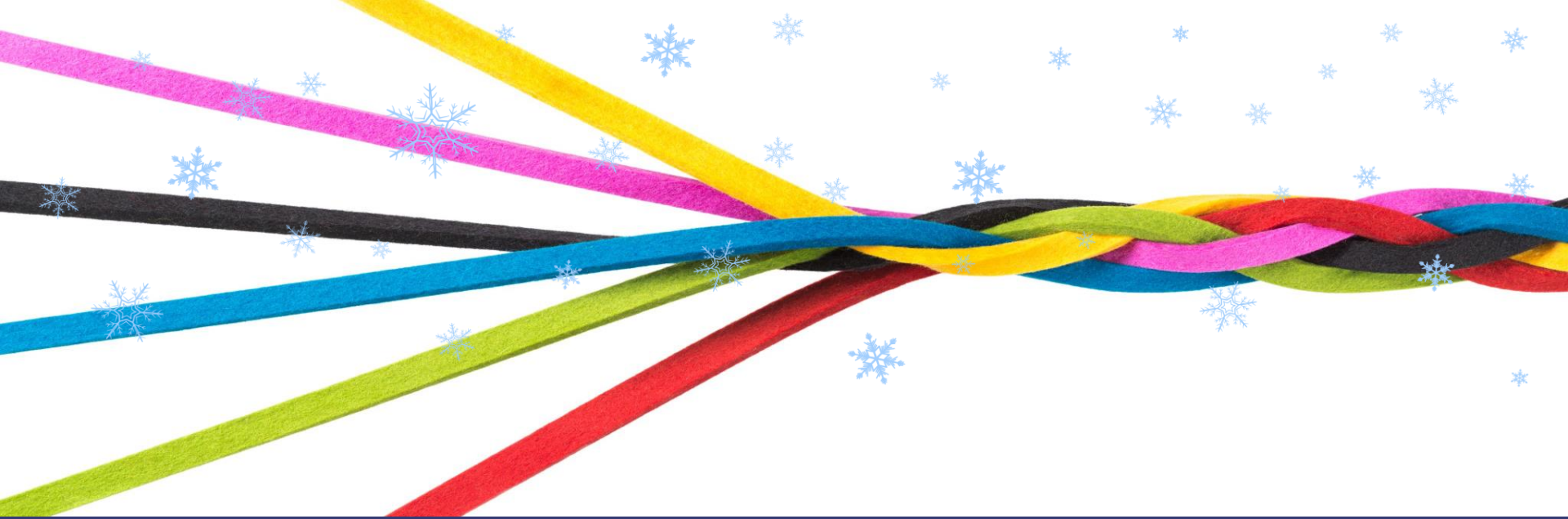
[enquiries@cqc.org.uk](mailto:enquiries@cqc.org.uk)

 [@CQCProf](https://twitter.com/CQCProf)

 [youtube.com/user/cqcdigitalcomms](https://youtube.com/user/cqcdigitalcomms)

 [facebook.com/CareQualityCommission](https://facebook.com/CareQualityCommission)

*“There is still much to be done to ensure that people with mental ill health, those with a learning disability and autistic people, get the right support at the right time”*



# Advocacy in Closed Cultures

Gail Petty – Advocacy and Rights Programme Lead, NDTi

# Strengthening the role of advocacy in Making Safeguarding Personal



## A review of advocacy

for people with a learning disability  
and autistic people who are inpatients  
in mental health, learning disability or  
autism specialist hospitals

**Summary report**



Kate Mercer and Gail Petty

October 2023

in partnership with:



# Advocacy in closed cultures....



# Advocacy has always been a safeguard

People's voices

People's needs

People's preferences

People's rights

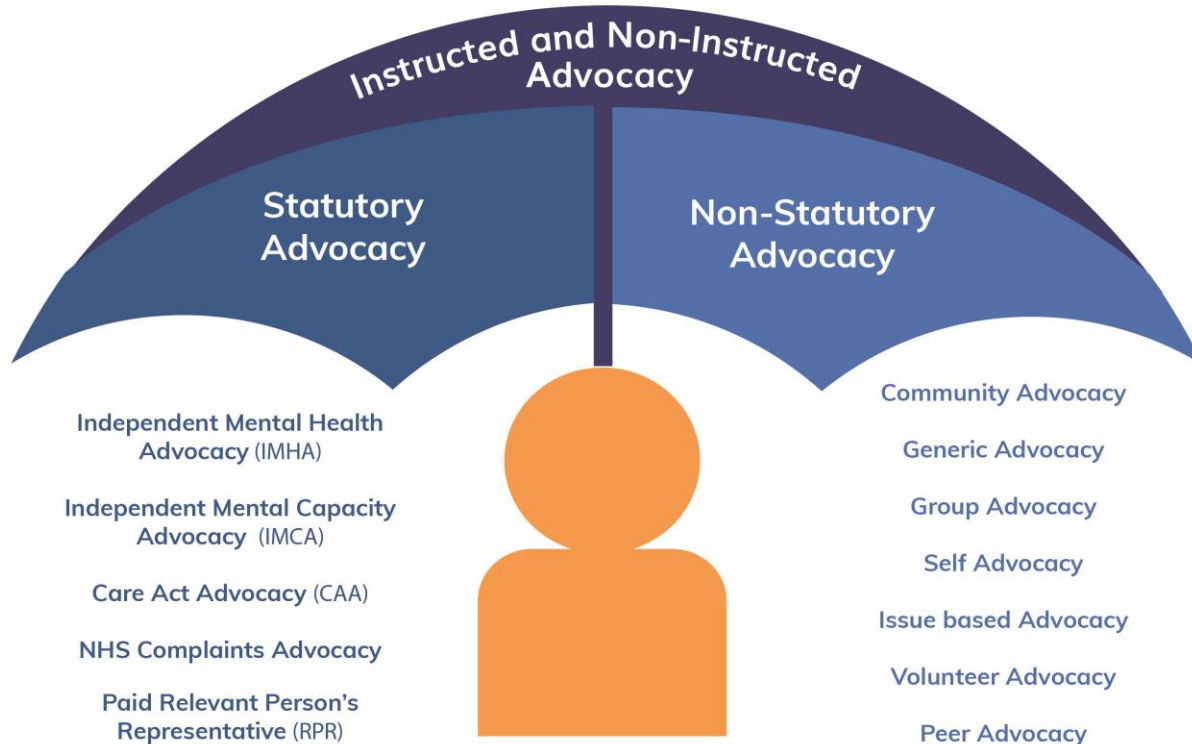
People's uniqueness

People's safety



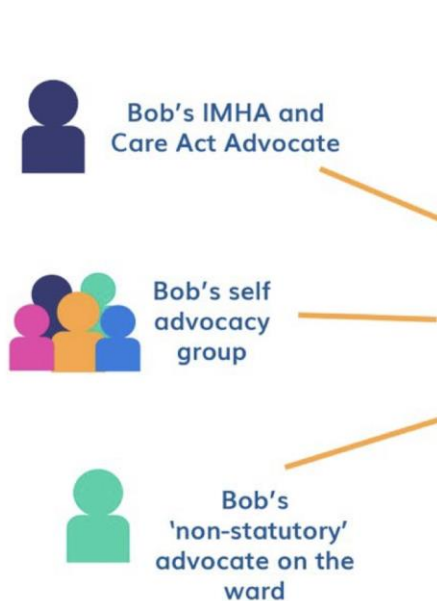
# Different types of Advocacy

## (Commissioned) Independent Advocacy

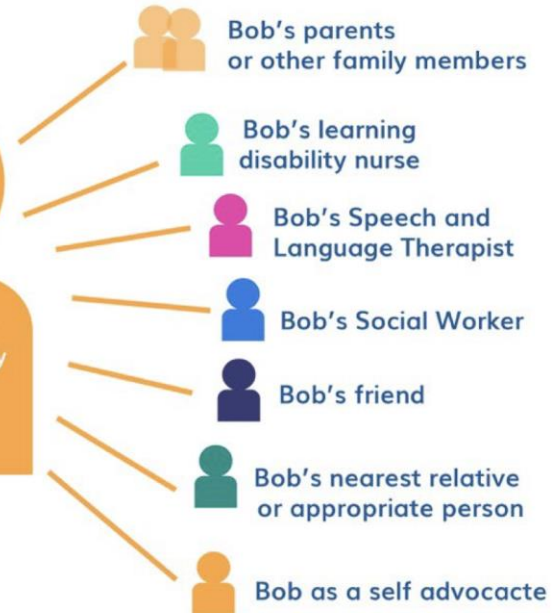


# Different types of Advocacy


## (Commissioned) Independent Advocacy




## Natural Advocacy







But, recently  
reports and  
our review  
found.....



...that at the moment, advocacy isn't  
always the effective component of  
safeguarding people in closed  
cultures that it should be. There are  
many interconnected reasons for  
this....



# Effective advocacy in closed cultures – findings from the review



- People need to be able to access a range of different types of advocacy, especially peer and self-advocacy group (broader offer)
- People need access to more holistic, longer term, person led advocacy. People need to be able to build a relationship with their advocate. One advocate for as long as they want and need.
- Advocacy needs to be more easily available and easier to access (no national helplines, one provider, strong relationships between advocacy organisations and providers)
- Advocates need to be present and be able to be wherever people are
- People need their advocates to work alongside their family members and other key people in their life
- Advocates need to be supported in their practice to ensure they are providing effective, person led, independent support.
- Advocates need to exercise professional curiosity and have a good understanding of human rights and safeguarding in order to ensure they are providing effective support

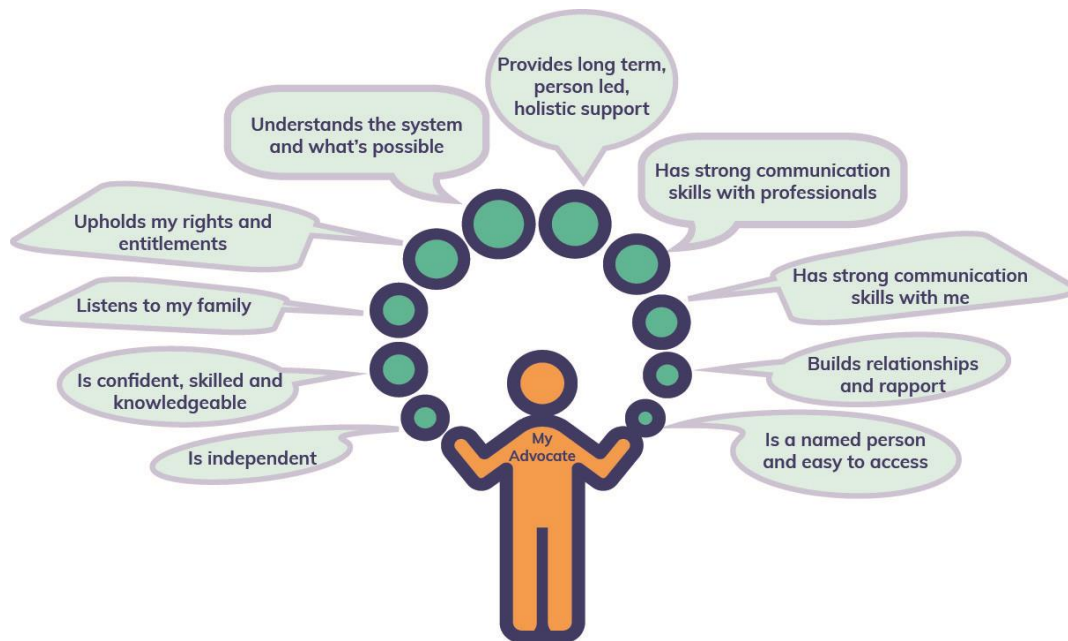


## All of the above means advocacy needs to be resourced appropriately

- Advocacy needs to be commissioned independently and for the advocacy offer to be more consistent across areas and regions.
- People need the people around them (staff, friends and families) to support their access to advocacy
- Increased oversight of commissioning and delivery of advocacy. Advocacy should be monitored to ensure adequate availability and quality in each region.



What people  
and families  
want



Gail Petty

[gail.petty@ndti.org.uk](mailto:gail.petty@ndti.org.uk)

[www.ndti.org.uk](http://www.ndti.org.uk)



# Being present

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- Spend time with people, build relationships, get to know how people respond. Know how to communicate with people with different needs - Notice changes
- Talk to other people who know the person well (with permission or if non-instructed)
- Question if you're unable to see people
- Drop in and move freely
- Cover gaps in service
- Get to know people and the environment, deeply. What's the culture? How are people spoken about? Are people involved in their care? What does it look like, smell like feel like? Notice changes
- Identify if anything is hidden
- Build relationships with staff – be known to them
- Ask questions
- Facilitate feedback – challenge and good practice
- Systemic advocacy
- What else?



# Taken from the NHSE review – people’s experiences

*“One person had been in seclusion for weeks and was required to pass their poo out through a hatch, as well as be subject to other indignities. A strong advocate would have been “all over this” but the advocate appeared to have accepted it as the norm, justified by the pressures on the staff team and other issues”. Professional stakeholder*

*“If you have a problem and you’d like to speak to advocacy, I want to speak to them. They say sorry, call tomorrow. It goes to the advocacy control centre - it’s their policy” Person who accesses advocacy*

*“I asked for an IMHA to visit my son, but they [advocacy provider] told me they would only visit if he asked them to. He doesn’t have much speech and certainly wouldn’t be able to do this. They told me I had misunderstood IMHA” Family member*

*“They aren’t very independent. The advocate has an NHS pass and keys to the ward” person using advocacy*



# Taken from the NHSE review – people’s experiences

*“We went to an IC(E)TR for an autistic man who also had a learning disability. The IC(E)TR was so concerned the care was so poor that the person’s human rights were being breached. The advocate had endorsed the hospital’s position. The advocate had bought into the hospital’s perspective, everything was about risk and managing risk, which justified the person’s segregation”. Professional stakeholder*

*“The advocate goes to my daughter’s ward rounds and CTRs. I have no idea why as she knows nothing about my daughter, and she never sees her from one week to the next. I find it so wrong”  
Family member*

*“Advocates won’t think twice about speaking to professionals about what is important to a person, or what’s going on in their life, or how they communicate. They don’t seem as willing to do this with family members. I don’t know why. Families know their loved one a lot more – yet advocates aren’t asking them” Professional stakeholder*



# Taken from NHSE review – from advocates

## None of this is okay, but it's become normal

*“I’m not allowed on the ward – I have to make an appointment to see a specific person”*

*“We get a phone call and go over; we don't have a presence at all. There is a generic advocacy service on site, but they aren't IMHA. This is ridiculous for the patients and confusing”*

*“In two of the private wards, when we have raised safeguarding concerns, say because of lack of staff and the risks, they have now decided we are not allowed onto the wards. We have to meet patients in the family room”.*

*“We have huge waiting lists for IMHA support due to not enough funding for advocates so sadly we can't support everyone who need the support”*





# Taken from NHSE review – from advocates

*“Due to funding issues and the demand, I don't feel we have enough staff. Most of us have to work unpaid hours in addition to keep up with the demand”*

*“We do not provide ongoing advocacy – its issue based and then we close the case. People can re-refer but have to wait on a short waiting list again”*

*“Most of our advocacy is short term, rights based - like telling people what their rights are and Tribunals. We don't really get involved in the broader care and treatment plans or longer decisions”*

*“The whole sector has become so far removed from peer advocacy It feels like I'm working for McDonalds, we are just providing a service.”*



# CQC Out of Sight 2020

- Access to high-quality advocacy varied across the hospitals we visited and that the role of an advocate was not consistent.
- There was some confusion between the provider and commissioner about who the advocate was, or which organisation provided the services. This led to people being denied access to the service. In some cases, there was no evidence that advocacy had been offered to people. Even where people were allocated an advocate, they were not always engaged in decisions about the person's care.
- There were examples of where the advocate was not informed of certain people on wards.
- When people did have access to advocates, there were examples where advocacy was of a poor quality, where advocates were not upholding people's rights.
- Advocates were also under pressure themselves and felt they did not have enough time to support everyone that they were responsible for.



# Thematic Review of the Independent Care (Education) and Treatment Reviews (Baroness Hollins) 2021

Advocates were involved in some, but not all IC(E)TRs. There was concern about the quality and/or independence of advocacy for some people and particular concerns for people who do not have families and the lack of independent specialist advocacy.

Overall, where advocacy was in place the quality was felt to be 'poor to alright'.



# Safe and wellbeing reviews: thematic review and lessons learned 2023

The reviews indicated that not enough was being done to support people to maintain links with friends and family, or to access support from an independent advocate

Concerns were raised about timely access to advocacy and the quality of advocacy services. It often fell to family members to be advocates in place of professional advocacy

One of the main points was that the availability and quality of advocacy for people in hospital is generally inconsistent.



# Safeguarding Adults Review on Whorlton Hall Executive Summary 2023

**An illusion of advocacy provision for people with learning disabilities and/or who are autistic, and who are inpatients or at risk of being admitted to specialist hospital**

Current arrangements for the commissioning and oversight of advocacy services and the skill requirements of independent advocates, are inadequate for people with learning disabilities and/or who are autistic, who are in-patients in specialist mental health hospitals or who are at risk of becoming in-patients. This leaves people in the most high-risk settings, the least well served and creates a false security that advocacy is in place.

# Children services' response to closed cultures

Leemya McKeown, Assistant Director of Safeguarding Professional Standards & Quality Assurance, KCC

Within children services the conversation about closed cultures on an explicit level has been triggered by the  
**National Panel Review**

# Overview of the Panel – Phase 1

108 children & young adults suffering serious abuse & neglect in 3 **Doncaster** independent residential settings. Abused in 'plain sight' of many public agencies. They had 'Forgotten Status'.

The first phase of review is an examination of what went wrong & why?



# Overview of the Panel – Findings from Phase 1

Quality assurance processes in the local authorities placing children at the settings were inconsistent & did not enable them to have a full picture of the children's progress, welfare & safety.

Local authorities & partner agencies placing children at the settings put great reliance on the reports provided by the settings & did not sufficiently challenge them.

There was a lack of triangulation with other independent sources of information about the children.

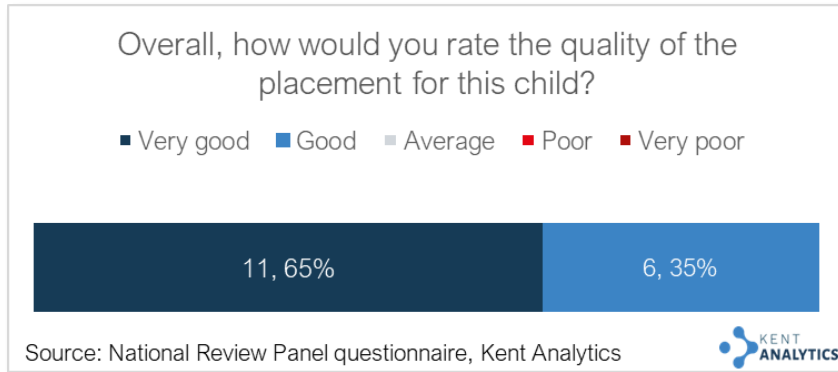
The degree of proactivity from local authorities in undertaking statutory visits to the children had a significant impact on their safeguarding.

# Overview of the Panel – Phase 1 Actions

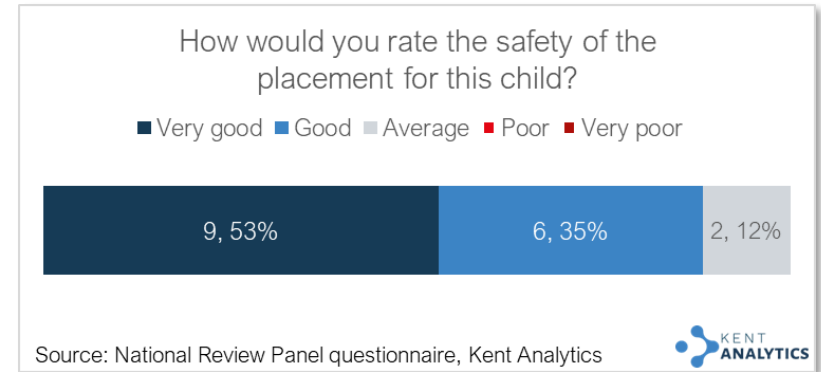
All DCSs & Ofsted to initiate urgent assurance action to undertake a quality & safeguarding review for all children placed in similar types of provision & provide an Overview Report. This also included review of LADO responses to referrals

# Overall opinion of quality & safety of placements

The **quality** of two-thirds of placements has been rated as 'very good' with the remaining third rated as 'good'



In relation to the **safety** of a placement just over half are rated as 'very good', a third as 'good', with the remaining two placements rated as 'Average'



## Notes on how to read these charts:

The figures in the charts show the number of respondents & the proportion of the cohort that these represent. So in the case of those who responded 'very good' to the quality of the placement (dark blue in the chart to the left), this was 11 responses, representing 65% of the cohort.

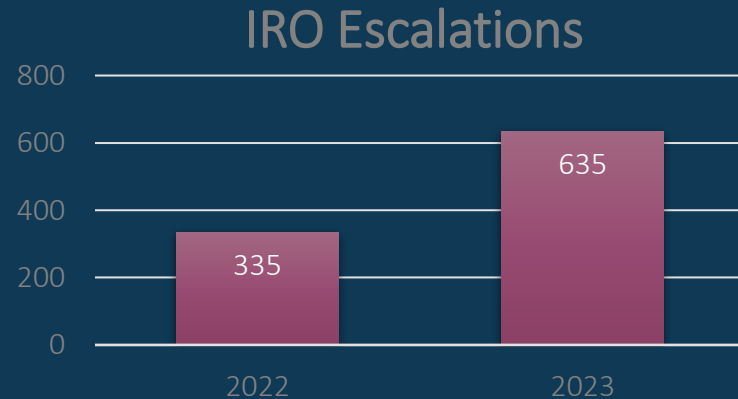
# Lived Experience vs Living Experience





# It's not all about the social worker

- Launch of IRO's external escalations
- Relaunch of purposeful visiting form & scoping meetings
- Developing diversity & inclusion plans across ICS



## PRACTICE FRAMEWORK

### Children's rights based approach added to the practice framework

#### QA Unit Guidance & Voice of the Child

- Set out expectations of the important of statutory face-to-face visits & what a framework of advocacy for children & their families could look like.
- VSK participation – Hearing children's stories.

#### Staff Training & Development

- Enabling staff to have the skills to communicate with children with disabilities, complex needs & behaviour that challenges.
- Helping staff understand DOLS, use of restraints legal frameworks & language, & integrating rights thinking into service offer.
- Understanding what closed cultures are & the warning signs & what they can do.

#### Leadership

- Reflective practice leadership with a clear line of sight from senior management.
- Commissioning arrangements to YJ to align with CSW so where children are placed in secure rem& settings senior management focus on the quality of provision, bench marking the child's needs.



# Closed Culture Actions so far & next steps

National Review following Phase 2 - explore the changes needed to the wider system launch Spring 2023

Relaunch of the Purposeful Visiting form enabling social workers, IRO's & commissioning to have a full picture of the children's progress, welfare & safety in residential / commissioned services.

Mandatory training provided for all staff January 2023

Updated Scoping Meeting procedures to support the need of systemic action to safeguard & promote standards of care for children

Launch multi-agency IRO escalation process September 2022. Targeted action for all professional network to be active corporate parent & be responsible for progressing children's individual care plans

Updated flowchart & guidance on KPON

Continue training in conjunction with children participation scheme & residential managers to create a series of videos.

Developing an advocacy framework

Developing diversity & inclusion plans across ICS

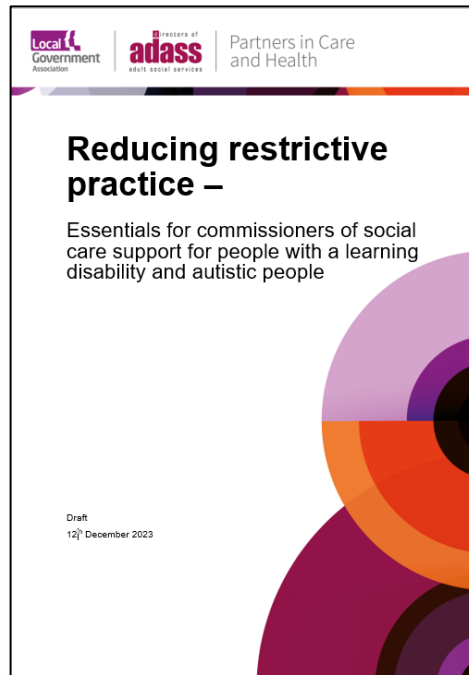
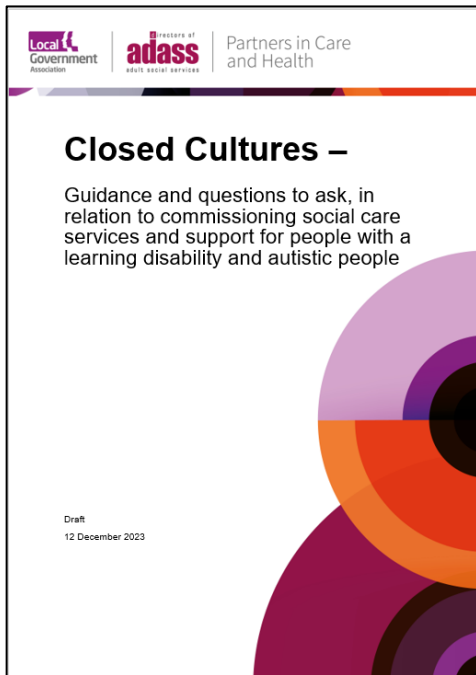
# Questions

- **Stefan Kalee and Hayley Moore from CQC**
- **Alexis Quinn from the Restraint Reduction Network**
- **Gail Petty from NDTi**
- **Leemya McKeown from Kent County Council**





# Two resources coming soon



# Thank you

