# Annex A: DHSC response to individual recommendations

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Responses from the Department of Health and Social Care (DHSC) to the Baroness Hollins’ recommendations regarding independent reviews for people with a learning disability and autistic people in long-term segregation in a mental health hospital setting.

## Recommendations 1 and 2

Recommendation 1: all staff working with people with a learning disability and/or autistic people should be delivering therapeutic and human rights-based care. This should be supported with development opportunities for staff in the community to increase positive risk-taking to help people develop and grow. All staff that use any restrictive practice need to be trained in:

* law and policy including human rights, and the [United Nations Convention on the Rights of Persons with Disabilities](https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html) and the [United Nations Convention on the Rights of the Child](https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child)
* de-escalation and preventative approaches in accordance with the Restraint Reduction Network [training standards](https://restraintreductionnetwork.org/know-the-standard/) as legislated in the [Mental Health Units (Use of Force) Act 2018](https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018)
* tier 2 of the Oliver McGowan Mandatory Training or equivalent training on tier 2 capabilities from the [Core Capabilities Frameworks](https://www.skillsforhealth.org.uk/info-hub/learning-disability-and-autism-frameworks-2019/)
* the [HOPE(S) model](https://www.merseycare.nhs.uk/hopes-model)

Recommendation 2: practice leadership should be improved by commissioners of services for people with a learning disability and/or autistic people undertaking the following training:

* tier 2 of the Oliver McGowan Mandatory Training or equivalent training on tier 2 capabilities from the Core Capabilities Frameworks
* the HOPE(S) model

DHSC and NHS England should also consider how best to equip commissioners with relevant skills and knowledge to ensure cost effective and humane commissioning, including understanding the legal and policy frameworks relevant to the assessment, planning and delivery of community-based services and support.

### DHSC’s response to recommendations 1 and 2

We agree that staff should be suitably trained to ensure they can properly support people with a learning disability and autistic people. There are a number of ongoing pieces of work, as highlighted in recommendations 1 and 2, which will achieve this ambition.

The Health and Care Act 2022 requires registered providers to ensure their staff receive specific training on learning disability and autism appropriate to their role. We are rolling out the Oliver McGowan Mandatory Training, which touches on the Human Rights Act 1998, and other relevant legislation to support this. Part one of this training - an e-learning package - is now live and has already been completed by over 400,000 people. We expect service commissioners to undertake the Oliver McGowan Mandatory Training regardless of whether they are regulated by the Care Quality Commission (CQC). On 27 June 2023, we launched the public consultation on the Oliver McGowan draft code of practice, which will guide providers on how to meet the new legislative training requirement. The non-easy read consultation closed on 19 September 2023 and the easy read consultation closed on 16 October 2023. We are considering all responses to the consultation to inform any changes needed to the draft code of practice.

It is also a requirement under the Mental Health Units (Use of Force) Act 2018 that the responsible person for each mental health inpatient unit should provide training for staff on the use of force. This training needs to comply with the Restraint Reduction Network Training Standards 2019. This act includes measures to both reduce the inappropriate use of force and to ensure accountability and transparency about the use of force in mental health units. The majority of the provisions included within the act were brought into force on 31 March 2022 and 18 August 2022. Remaining provisions, including in respect of accountability and transparency arrangements, are expected to be brought into force in due course. Statutory guidance (see the section [Requirements of the act](https://www.gov.uk/government/publications/mental-health-units-use-of-force-act-2018/mental-health-units-use-of-force-act-2018-statutory-guidance-for-nhs-organisations-in-england-and-police-forces-in-england-and-wales)) was published in 2021 to support mental health inpatient units to understand how they should meet legal obligations placed on them by the act.

The HOPE(S) training model aims to embed good practice across inpatient services and reduce the use of long-term segregation and restrictive practices for people with a learning disability and autistic people. HOPE(S) is commissioned by NHS England until December 2024 and will be evaluated by an independent research body to assess its impact.

Skills for Care has developed and deliver a learning disability and autism version of the Commissioning for Wellbeing Qualification, Level 5. NHS England is providing funding from April 2022 to March 2025 for health commissioners to access the training.

## Recommendation 3

Professional bodies should issue good practice guidelines on the assessment and treatment of people with a learning disability and/or autistic people in solitary confinement. To help develop those guidelines this should include identifying relevant capabilities from the Core Capabilities Frameworks and training opportunities. These are nationally recognised frameworks that have been developed to capture the skills, knowledge and behaviours needed for staff working across health and social care to support people with a learning disability and/or autistic people.

Clinicians should be held accountable when they fail to follow these good practice guidelines. Examples of failings may include:

* failing to assess someone in a timely manner
* failing to report to commissioners and hospital managers if staff do not have the required skills to deliver recommended treatment
* failing to attend C(E)TRs
* being found to have used punitive measures such as the withholding of section 17 Mental Health Act 1983 leave
* failing to develop a clinical environment that does not rely on enforced isolation in solitary confinement

If someone is admitted to hospital, the referring team in the community should be clear about the goals of admission, and remain involved, seeking to support the person’s return home as soon as possible. Their role is firstly relational, building trust, sharing their professional skills, and helping the person to share their story so that their distress can be better understood and seamless, and ongoing care and support provided. Commissioning approaches which favour episodes of care, where services are commissioned for discrete blocks of time, instead of being outcomes based, are not effective for people with a learning disability and/or autistic people and should be discontinued.

### DHSC’s response to recommendation 3

This recommendation is for consideration by professional bodies, who are independent of government. We are supportive of professional bodies issuing guidelines on the assessment and treatment of people with a learning disability and autistic people who are in long-term segregation in a hospital setting.

In July 2023, NHS England published the guidance [Acute inpatient mental health care for adults and older adults](https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/) to support the commissioning and delivery of timely access to high quality therapeutic inpatient care, close to home and in the least restrictive setting possible. The guidance sets out key principles for commissioning the right inpatient care. It has clear expectations for the care of people with a learning disability and autistic people when they are admitted to a mental health hospital, including that:

* they will have had a community/pre-admission C(E)TR
* staff will work with the person and carers to understand their needs and wishes
* reasonable adjustments to care will be identified and put in place

## Recommendation 4

Everyone in solitary confinement must have access to independent specialist trained advocacy, specialist free legal advice and a redress scheme must be made available to them.

### DHSC’s response to recommendation 4

Access to an independent mental health advocate is a statutory right for people detained under most sections of the Mental Health Act, including people in long-term segregation. It is important that advocacy is of a high quality. This is why DHSC requested that NHS England co-produce a review of advocacy aimed at understanding the experience of advocacy for people with a learning disability and autistic people who are inpatients in mental health, learning disability or autism hospitals. Findings from the advocacy review have been used by NHS England to enhance the guidance on advocacy within the dynamic support register and Care (Education) and Treatment Review policy and host commissioner guidance.

The existing [NHS compensation scheme](https://resolution.nhs.uk/services/claims-management/advice-for-claimants/) can be used where individuals have suffered harm as a result of treatment which falls below the minimum standard of competence.

We would encourage patients and their families to make use of these existing mechanisms. We also expect staff to make patients and their families aware of their rights and the resources available to them and we will consider further how to promote these.

Legal aid is currently available for all matters under the Mental Health Act, including to challenge detention before a mental health tribunal. Legal aid in relation to applications challenging detention before the mental health tribunal are exempt from the means test.

## Recommendation 5

Solitary confinement for people with a learning disability and/or autistic people should become ‘never events’ in the following instances (and see [annex C of Baroness Hollins’ final report](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023)):

* for children and young people under 18 years of age
* where it does not meet minimum standards for adults (see proposed [Solitary confinement code of practice framework](https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023), developed by the Oversight Panel)
* where it lasts for longer than 15 days

If solitary confinement is used as a ‘never event’ it must trigger:

* a serious investigation as stipulated in [NHS England’s never event policy](https://www.england.nhs.uk/publication/never-events/)
* private company directors and senior trust management must be held to account for failing to provide a safe and therapeutic environment

The use of other restrictive interventions should be closely monitored to ensure that there is not an increase in their use because of the reduction in solitary confinement.

### DHSC’s response to recommendation 5

We are committed to reducing the use of long-term segregation for people with a learning disability and autistic people.

It is imperative that where long-term segregation is used, it meets the standard set out in the existing Mental Health Act 1983: Code of Practice, which includes that the environment should be no more restrictive than is necessary and should be as homely and personalised as risk considerations allow. Action should be taken where this does not happen, including safeguarding concerns being raised through formal channels and [any quality concerns to be addressed in line with NHS England commissioner oversight guidance.](https://www.england.nhs.uk/publication/monitoring-the-quality-of-care-and-safety-for-people-with-a-learning-disability-and-or-people-who-are-autistic-in-inpatient-care/)

There are a number of practical implications of including long-term segregation as part of NHS England’s never events policy. NHS England’s never event policy applies across all NHS commissioned services. They are only used ‘when an action can be considered as being wholly preventable with clear mechanisms in place to prevent their occurrence’. Using this definition, long-term segregation could not currently be classed as a ‘never event’ while long-term segregation remains permissible under the Mental Health Act. When the Mental Health Act 1983: Code of Practice is revisited, if changes are made to the minimum standards to be followed when long-term segregation is used, we will consider whether there are further actions we can take to include scenarios where long-term segregation is used that falls below the minimum standards as ‘never events’.

Therefore, we do not feel this would be the best way of achieving a reduction in the use of long-term segregation in the short term under the current legislative framework. However, we remain committed to supporting the culture change, sharing and reinforcement of good practice and quality oversight that supports staff working in a mental health inpatient setting to use the alternatives to restrictive practices.

## Recommendation 6

Solitary confinement should become a notifiable event to CQC as well as to the integrated care board (ICB) executive lead for learning disability and autism and the provider board. The notification should be made within 72 hours of a person entering solitary confinement.

### DHSC’s response to recommendation 6

We recognise the importance of reporting the use of long-term segregation to improve accountability and enhance safety of patients. We are considering changes to CQC regulations (which would be subject to Parliamentary approval) to improve reporting and notifications by providers to CQC on use of specified restrictive practices. Once in place, the intention is that this will provide a better flow of information, supporting CQC to convene an IC(E)TR as soon as possible where someone is moved into long-term segregation. The IC(E)TR will make recommendations to support safe care and treatment in the least restrictive setting.

## Recommendation 7

Before admission, clinical contracts must be agreed between commissioners and hospital managers regarding the services for people with a learning disability and/or autistic people being commissioned. These clinical contracts should be outcomes based and include the responsibility of local services, including community clinicians, as well as hospital clinicians, to collaborate to achieve timely discharge.

Key points:

* clear complaints procedures must be in place to ensure that concerns that an ICB has failed to undertake its commissioning responsibilities appropriately can be investigated thoroughly and in a timely manner. Commissioning should be overseen by the ICB’s executive lead for learning disabilities and autism. CQC and NHS England’s roles in monitoring effective commissioning should be clarified
* commissioners should benchmark their own outcomes and cost effectiveness against best practice in the UK and internationally
* boards of private hospital groups and senior management in NHS trusts where crimes are found to have been committed by staff in their hospitals must retain financial and legal accountability
* when a person has been detained in solitary confinement, for any length of time, the ICB must ensure the person is offered trauma-informed therapy for as long required and that financial compensation is available and accessible

### DHSC’s response to recommendation 7

We agree that there should be clear agreement between clinical teams, commissioners and providers about the purpose of admission to hospital and the care and treatment plan for the individual.

In 2022 NHS England commissioned a clinical contracts pilot across inpatient mental health settings to help identify whether the introduction of a formal agreement between patients, their families, providers and commissioners could help focus the purpose of a hospital admission and ultimately reduce the need for inpatient care of long lengths of stay.

Learning from this pilot informed the recent refresh of the [Care (Education) and Treatment Review: key lines of enquiry](https://www.england.nhs.uk/publication/care-and-treatment-review-key-lines-of-enquiry/). The key lines of enquiry now include prompts for panel members that help identify the key aims of a hospital admission. The clinical contracts pilot emphasised the importance of strengthening existing processes to improve shared responsibility for treatment aims between commissioners, clinicians, people and their families. NHS England will continue to consider the outcomes of the pilot as part of their ongoing work.

## Recommendation 8

To protect those in solitary confinement, safeguarding processes must be strengthened by:

* ensuring that peoples’, relatives’, and staff voices are acted on immediately when a complaint or concern is raised
* [CQC’s guidance on closed cultures](https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures) should be reviewed to see if the guidance remains fit for purpose
* family members and advocates should be able to visit those in solitary confinement at any time of day or night if they consider it necessary, in the environment in which they are living
* family members need to be provided with information about how to raise a safeguarding or other concern, including having contact details of the responsible commissioner for the hospital placement
* current protections for whistle-blowers should be reviewed to ensure protections are adequate and fit for purpose
* a safeguarding register should be maintained and shared on an agreed frequency with CQC documenting indicators of poor care and treatment

CQC should make greater use of covert surveillance, in a way that does not add to the power imbalance between the staff and patients that already exists. Blanket use of technological surveillance must be regularly reviewed to ensure it continues to meet the principle of least restrictive and remains rights-respecting.

### DHSC’s response to recommendation 8

CQC has formed a safeguarding and closed cultures team, who are committed to addressing closed cultures, including raising awareness that closed cultures can occur across all health and social care settings.

CQC is focusing on reducing restrictive practices as a priority. In August 2023, [CQC published a policy position](https://carequalitycomm.medium.com/restrictive-practice-a-failure-of-person-centred-care-planning-b9ab188296cf), setting out their expectations for the health and social care sector. It emphasises that services should have a positive culture, be person centred and focused on prevention and therapy, and aim to reduce restrictive practices.

The policy position expectations and focus will be reflected in CQC’s single assessment framework, which is followed when inspecting services. CQC is developing training for their inspectors with support from the British Institute of Learning Disabilities to help improve reporting where CQC identifies the use of restrictive practices during inspections.

CQC has also conducted a [Listening, learning, responding to concerns](https://www.cqc.org.uk/publications/listening-learning-responding-concerns) review. This reviewed staff and public whistleblowing and reporting mechanisms and whether CQC is a listening organisation - for example, how well CQC listen to whistleblowing concerns and how well CQC work with people who raise concerns about care with them.

Work is underway to explore how best to prioritise, resource and co-ordinate extensive improvement activity around these and related areas.

DHSC is committed to ensuring all patients, including people with a learning disability and autistic people, receive safe and high-quality care. That is why a rapid review into data on mental health inpatient settings was commissioned by DHSC ministers to produce recommendations to improve the way data and information is used in relation to patient safety in mental health inpatient care settings and pathways. People with lived experience were consulted to inform the review. The review was published in June 2023 and included recommendations around tackling closed cultures and ensuring safe, therapeutic and compassionate care. The government will be issuing a response in due course.

In addition, the new Health Services Safety Investigations Body (HSSIB) is launching a series of national investigations into mental health inpatient settings as one of its first priorities. The investigations will identify risks to the safety of patients and the HSSIB will seek to address those risks by making recommendations to facilitate the improvements of systems and practices in the provision of mental health care in England.

One way we have strengthened safeguarding processes since Baroness Hollins’ interim report was published in July 2021, is that in January 2022 the Chief Social Worker for Adults published an independent joint briefing, [Revisiting safeguarding practice](https://www.gov.uk/government/publications/revisiting-safeguarding-practice), to support social workers and other adult safeguarding practitioners to carry out their duties under the Care Act 2014 effectively.

## Recommendation 9

Both long-term segregation and seclusion of people with a learning disability and/or autistic people are renamed solitary confinement.

### DHSC’s response to recommendation 9

We appreciate that this recommendation is designed to introduce terminology which reflects the severity of long-term segregation.

However, a change in terminology would impact existing legal and regulatory frameworks which distinguish between seclusion and long-term segregation. Introducing new terminology at this time could lead to unintended consequences and cause confusion, due to the term ‘long-term segregation’ being used in the Mental Health Act 1983: Code of Practice and being clearly distinguished from ‘seclusion’. Any changes to the language used would need to be fully explored to help avoid negative unintended consequences before a change in terminology can be considered. We will use this recommendation and the rest of Baroness Hollins’ report to consider whether a terminology change should be made upon updating the Mental Health Act 1983: Code of Practice when it is next reviewed.

## Recommendation 10

The government must publish an annual report on the progress towards ending the use of solitary confinement for people with a learning disability and/or autistic people. This should outline any learning, with both examples of best practice and areas for improvement. A commissioner to oversee this work should be considered.

### DHSC’s response to recommendation 10

As CQC is taking over implementation of IC(E)TRs, they will be considering how to report on progress both to DHSC and nationally.  As part of their delivery of IC(E)TRs, CQC will evaluate and identify learning from the programme.

## Recommendation 11

To prevent admission or readmission into hospital at times of acute distress where the community support services do not meet a person’s immediate needs, we recommend:

* alternative accommodation to hospital should be available within each integrated care system (ICS) area in times of acute distress, or emotional and behavioural crisis, and to facilitate earlier discharge
* commissioners should undertake pilots and evaluate the effectiveness of ‘intensive recovery pods’ (homely places of safety in the community) which are autism friendly, trauma informed and where the person and those supporting them feel safe
* alternative crisis responses and intensive support teams in learning disability and autism services are being developed in some places but are not universally available. Consistent, more reliable, robust and familiar multi-disciplinary community mental health support involving teamwork between the person themselves, their family and/or advocate is required. Integrated support from specialist practitioners in occupational therapy, speech and language therapy, specialist nurses, psychology, psychiatry and psychotherapy is essential.

### DHSC’s response to recommendation 11

We recognise and agree with the importance of ensuring that people have the appropriate support in the community when they need it. The government is committed to supporting people to live in the community and avoid unnecessary mental health hospital admissions.

In January 2023, we set out detail on how £150 million of capital investment, first announced at the 2021 Spending Review, will be used to build mental health urgent and emergency care infrastructure. This includes £7 million for up to 100 specialised mental health ambulances across the country to provide better care and support for people experiencing a mental health crisis.

We are also funding 160 wider capital schemes - including to provide and improve crisis cafes, crisis houses, mental health urgent care centres, health-based places of safety and broader improvements to crisis lines and emergency departments. This will mean care can be provided in more appropriate spaces for those in need.

Specifically for people with a learning disability and autistic people, the [Building the Right Support Action Plan](https://www.gov.uk/government/publications/building-the-right-support-for-people-with-a-learning-disability-and-autistic-people) sets out the actions we are taking to support this group of people to live ordinary lives in the community. In 2023 to 2034 we are investing £125 million of health funding as part of the NHS Long Term Plan for services for people with a learning disability and autistic people. This includes funding for community support, children and young people’s keyworkers, and specific support for young people with autism.

The [NHS Long Term Workforce Plan](https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/), published in June 2023, considers the challenges facing the NHS workforce over the next 15 years and sets out the steps needed to address them. The ambition is to increasingly shift mental healthcare towards early intervention and prevention, with treatment primarily delivered in the community.

The Long Term Workforce Plan seeks to optimise the use of multi-disciplinary teams, setting out an expansion of new and extended roles to increase the breadth of skills within such teams, to better meet the needs of patients, their families and unpaid carers, and enable more care to be delivered in primary and community settings.

## Recommendation 12

DHSC, NHS England and CQC should commit to funding and delivering interventions to reduce the use of solitary confinement and move people to the least restrictive setting and out of hospital as soon as possible. These interventions include IC(E)TRs, senior intervenors, the HOPE(S) programme, and ensuring each person in solitary confinement has an independent advocate. There should also be the introduction of a discharge co-ordinator who should be allocated to people with a learning disability and/or autistic people who enter solitary confinement to help monitor the implementation of their therapeutic plan and manage both their discharge out of hospital and their rehabilitation in the community.

### DHSC’s response to recommendation 12

We are committed to reducing the use of long-term segregation for people with a learning disability and autistic people. This ambition was the driver behind IC(E)TRs, the HOPE(S) model and the Senior Intervenors’ pilot.

As set out above, CQC will be taking over responsibility for delivering IC(E)TRs for an additional 2-year period, with support from NHS England. This will preserve the positive impacts of the programme, adopt learning from the programme to date including improvements to the approach and ensure that the care of people with a learning disability and/or autistic people in long-term segregation will continue to be scrutinised. CQC will report on the programme and gather feedback from people who receive an IC(E)TR and their families.

The HOPE(S) pilot is funded until 2024 and will be independently evaluated.

The Senior Intervenor pilot has been evaluated and we are considering the findings as part of our ongoing work.

Keyworkers for children and young people aged up to 25 continue to support with discharge planning.

The department is working with NHS England and other system partners to develop guidance for discharge from mental health, learning disability and autism inpatient settings. This will set out how NHS bodies and local authorities can work together to support the discharge process for people and ensure the right support in the community, including for people with a learning disability and autistic people.

Learning from all of these workstreams will be considered as part of future work to support people out of long-term segregation and towards discharge.

## Recommendation 13

Anyone who has been in solitary confinement should be monitored for 2 years following discharge from hospital to ensure changes are sustainable and they are receiving good community support. It is important they are receiving the correct therapeutic support to address the difficulties that may have arisen as a result of the trauma associated with solitary confinement.

To assist with this, the keyworker scheme for children and young people should be expanded in each ICS so that a named keyworker is provided for adults on the dynamic support register, or where there are similar identified needs. This role has a broader remit than the discharge co-ordinator role in recommendation 12 and is responsible for working with people to avert distress and family breakdown.

### DHSC’s response to recommendation 13

We recognise the importance of monitoring people at risk in the community to avoid unnecessary hospital admissions for people with a learning disability and autistic people provided such monitoring respects people’s privacy and complies with data protection legislation.

This is why NHS England has published guidance on the implementation of dynamic support registers and updates to the Care (Education) and Treatment Review (C(E)TR) policy which came into effect in May 2023.

Community C(E)TRs can be triggered ahead of someone being admitted to hospital to identify alternatives to inpatient treatment.

Dynamic support registers, which should include both people at risk of mental health hospital admission and people in hospital, are an important tool for understanding the care and support needs of individuals. This allows the proper support to be offered to individuals, supporting them to live well in the community and to avoid a hospital admission.

Being added to a dynamic support register should enable people to access additional support as appropriate, for example:

* enabling community multi agency co-ordination to ensure the right support is in place in the community
* a Care (Education) Treatment Review at the appropriate time
* referral to keyworker service (for children and young people)

NHS England’s mental health acute inpatient guidance also sets out expectations that care must be joined up across the health and care system, so inpatient services should work in a cohesive way with partner organisations, at admission, during a person’s inpatient stay and to support an effective discharge, so that people are supported to stay well when they leave hospital.

The responsibility to monitor the wellbeing of individuals in this way, where they have provided consent to do so, sits with local ICBs, however we encourage ICBs to share themes and learning more broadly to enable NHS England to help support change on a wider scale.

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