



Care and Treatment Review: Policy and Guidance

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Document Status

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Care and Treatment Review

Policy and Guidance

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

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Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

1	Policy statement.....	5
2	Policy Aims	6
3	Scope of Policy	8
4	Policy Context	9
5	Care and Treatment Reviews - the process.....	11
6	Care and Treatment Reviews – Standards of a good review.....	15
7	Care and Treatment Review Process	19
8	People at risk of admission ('At risk of admission' registers).....	22
8.1	Context.....	22
8.2	Scope of the Register.....	22
8.3	Role of CCG commissioners.....	22
8.4	Consent and Information Governance	23
8.5	Identification of people who are 'At Risk of Admission'	24
8.6	What information should be held on the register?	26
9	Care and Treatment Review – Community (Pre-admission)	27
10	Care and Treatment Review – 'Blue Light' meeting- where a Community CTR is not possible.	28
11	Care and Treatment Review – Post-Admission.....	29
12	Care and Treatment Review – Inpatient (Mandatory 12-monthly review or 'right to request')	31
13	Right to Request a Care and Treatment Review	32
14	Roles and Responsibilities	33
15	Interface with Other frameworks: Access Assessment for Specialised services; CPA, EHCP; Capacity to Consent.....	35
16	Governance.....	39
17	Clinical Disagreements & Escalation of Concerns.....	41
	Appendices	43
	Appendix 1– Available letters, templates, guidance and easy read documents to support the Care and Treatment Reviews.....	43
	Appendix 2– Data to support the monitoring of CTR pathway implementation & effectiveness of outcome.....	44
	Appendix 3– Checklist for Care & Treatment Review steps pre-review, review and post-review.....	45
	Appendix 4– Guidance for Ministry of Justice restricted patients following a CTR where outcome is ready for discharge.....	48

1 Policy statement

The following policy sets out the expectations for implementation of Care and Treatment Reviews (CTRs) for people with learning disabilities in England.

CTRs have been developed as part of NHS England's commitment to improving the care of people with learning disabilities with the aim of reducing admissions and unnecessarily lengthy stays in hospitals and reducing health inequalities.

In writing this policy NHS England considered the potential effect of it on people with characteristics that have been given protection under the Equality Act 2010, with particular attention paid to their health outcomes and the experiences of patients, communities and the workforce. We have complied with the requirements of this process, as the policy is reviewed over the coming months we will continue to review this process, and undertake Key Lines of Enquiry as they emerge as areas which require further consideration.

CTRs bring together those responsible for commissioning and procuring services for individuals who are at risk of admission or who are inpatients in specialist mental health or learning disability hospitals, with independent clinical opinion and the lived experience of people from diverse communities with learning disabilities and their families.

The aim of the CTR is to bring a person-centred and individualised approach to ensuring that the treatment and differing support needs of the person with learning disabilities and their families are met and that barriers to progress are challenged and overcome.

CTRS are being driven by the NHS but involvement of local authorities in the CTR process and its outcomes are necessary for improving care and treatment for people with learning disabilities and their families.

The 'spirit' in which CTRs are carried out is paramount and is rooted in principles of human rights, person-centeredness and co-production.

2 Policy Aims

This policy and guidance has been produced by building on the experience of the Improving Lives Team and the learning from the implementation of CTRs between October 2014 and the end of March 2015 for over 1400 people, as part of the Transforming Care programme. This has included extensive engagement with, and the support of, people with learning disabilities, their representatives and their families.

This work has led to the recommendation that CTRs are 'business as usual' for Clinical Commissioning Groups and NHS England commissioners.

The implementation of CTRs across the patient care pathway aims to:

- support people with learning disabilities and their families to be listened to and equal partners in their own care and treatment pathway
- prevent people with learning disabilities being admitted unnecessarily into inpatient Learning Disability and Mental Health hospital beds
- ensure any admission is supported by a clear rationale of planned assessment and treatment together with defined and measurable outcomes
- ensure all parties work together with the person and their family to support discharge into the community (or if the only option, to a less restrictive setting) at the earliest opportunity. Local authority involvement in all CTRs is best practice, ensuring that relevant issues can be fully addressed and all solutions explored for the safe discharge of individuals into community based settings.
- support a constructive and person-centred process of challenge to current care and treatment plans where necessary
- identify barriers to progress and to make clear and constructive recommendations for how these could be overcome

This policy/guidance and associated standards and tools will be used for the following reasons:

The timescales, tools and standards enable people with learning disabilities and their families to understand the process and have an opportunity to be 'properly' engaged. (Note: the tools are not exhaustive or tailored for each individual and therefore will need to be supported with individualised, person-centred approaches for each person).

Safeguards are inherent to the process together with documentation that supports expert advisers.

Safeguards are similarly placed to ensure appropriate professional engagement (Professional registration and DBS requirements, advice on Conflicts of Interest).

Role descriptions, responsibilities and specifications are clear before, during and after review to deliver robust governance.

The CTR must be carried out to the highest standard in order to be effective and to assure the person and their family that the expertise and capability of the NHS and its partners is being used to the full in planning to meet their needs and maximise their quality of life.

Integrity and credibility will be lost if people and their families, or others involved in this process, feel that a CTR has been carried out in a sub-optimal manner.

The CTR process is triggered at the point when a person is identified as 'at risk' of being admitted to a specialist learning disability or mental health inpatient setting. The CTR facilitates a process of seeking alternatives to admission if possible and, if not, follows them through any subsequent admission, period of assessment/treatment and towards discharge. This process needs to be supported by the development locally of an 'At Risk of Admission' register, which enables commissioners to ensure that the appropriate support is being provided for people in the Community (see section 8 for further definition and guidance of the 'At Risk of Admission Register').

The CTR process is underpinned by a distinct pathway (see figure 1.0) that initiates reviews at key points. The reviews are facilitated by a suite of tools to ensure a comprehensive, person centred approach and a degree of independence avoiding unnecessary admissions are avoided and lengthy inpatient stays.

3 Scope of Policy

The policy relates to people of all ages with learning disabilities who are at risk of admission or currently in receipt of specialist learning disability or mental health inpatient services and are the commissioning responsibility of NHS England or the Clinical Commissioning Groups.

This policy does not apply to people with learning disabilities admitted to general hospital for assessment and treatment of physical illness.

Care and treatment reviews have been designed in response to concerns about the care and treatment of people with learning disabilities and in particular the poor experiences, abuse and poor quality services exposed in a number of recent scandals. These, together with national audit, also highlighted unnecessarily lengthy stays in hospital. The policy is based on the principle that 'Hospitals are not Homes' and that people should be supported to live in community settings.

The policy includes those subject to Ministry of Justice (MoJ) restrictions, other than for the pre-admission part of the pathway where the route into hospital is through the courts or from prison. There is recognition that some people transfer to hospital via the criminal justice system and these individuals can be subject to a MoJ restriction Order that means they have to serve a minimum sentence, (e.g. sections 47/49, 48/49) In these circumstances even though CTRs cannot speed up the discharge process they can check that the individual is safe, getting the appropriate and effective current care and treatment based on their reason for admission to hospital (rather than prison) and that there is planning taking place for discharge (however far ahead that may be).

Where a transfer is taking place between inpatient settings as part of the planned care and treatment pathway, for example a move from High to Medium Secure services, this is to be treated as a continuous inpatient stay and therefore would count as continuous treatment for the purposes of the one year CTR.

Where there is an intention to transfer a person to a setting of higher security then this should trigger a CTR using the 'community' template.

Potential reciprocal agreements are currently being discussed with the other UK jurisdictions for individuals who are placed away from their country of origin.

4 Policy Context

The Winterbourne View Concordat and Transforming Care policies published in 2012 set a national target for all people with learning disabilities currently inappropriately residing in specialist learning disability or mental health inpatient settings to be discharged to locally based community provision by the 1st of June 2014.

In April 2014 data collected on behalf of NHS England identified that 2024 people with learning disabilities were staying in hospital without an agreed date of discharge. The majority of these people were not considered to be ready for discharge to the community on the basis of 'clinical decision'.

The National Audit Office report published in January 2015 found that in September 2014 there were 920 people in mental health hospitals who still had no date for transfer to the community and in 691 cases this was because a clinician had 'decided they were not ready'.

Since the 1980s government policy has focussed on the closure of long-stay hospitals, reduction of the use of inpatient beds and the provision of mental health and learning disability health services in the community.

Emerson et al (2007) found that in England there was a reduction (24%) in the overall number of in-patients from 4,435 in 2006 to 3,376 in 2010. Within that, the proportion of patients in independent sector provision rose from 21% to 32% and the number of independent sector providers increased (from 48 to 61).

Learning disability strategies specifically have sought to promote a social model of disability, to move away from the history of institutional care and its inherent infringement of human rights. Repeated revelations of emotional, physical and sexual abuse of people with learning disabilities in hospital care have prompted reactive responses and changes to, or strengthening of, strategies and policies for health and social care. Monitoring and regulation and attempts to empower the voice and rights of people with learning disabilities and their families is a central tenet of the CTRs

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¹ 'Learning Difficulties', the Social Model of Disability and Impairment: Challenging epistemologies
Dan Goodley Disability & Society Vol. 16, Iss. 2, 2001

Including All of Our Lives: Renewing the social model of disability
Liz Crow In Morris, J (Ed) (1996)
Encounters with Strangers: Feminism and Disability, Women's
Press, London

Invisible victims: crime and abuse against people with learning disabilities
C Williams 1995 London: Jessica Kingsley

Preventing abuse in accommodation services: From procedural response to protective cultures. S
Robinson and L Chenoweth
Journal of Intellectual Disabilities March 1, 2011 15: 63-74

Research and practice show that people with learning disabilities are admitted to hospitals due to challenging behaviour, exacerbations of mental illness, offending behaviour and/or breakdown of community residential support.

Some 10-15 % of people with learning disabilities present behavioural challenges with 'more demanding' behaviour being shown in 64% of this group, 50% of whom live with their families. (Emerson et al 2007)

The Mansell reports (1993 & 2007) and Challenging Behaviour – a Unified Approach (RCPsych, BPS, RCSLT 2007) addressed the understanding of and response to behavioural challenges presented by people with learning disabilities. Mansell emphasised the need for capable environments to be able to support people effectively in their own home or community, non-hospital settings. 'A unified approach' laid out an integrated framework for the assessment and support of people presenting behavioural challenges and provided good practice and standards for clinicians, commissioners and other stakeholders.

As a result of the limited progress since the Winterbourne View Concordat and continued protracted lengths of stay within these inpatient settings, NHS England developed a model and process for reviewing people's care and treatment.

CTRs were introduced in October 2014 initially for people with learning disabilities who had no discharge plan in place and were inpatients in low secure or non-secure hospitals. Following a period of consolidation of the learning from implementation, extensive testing of the draft policy and templates and engagement across the four NHS England regions, alongside testing whether using CTRs when someone is at risk of admission helps to prevent unnecessary admissions, the Care and Treatment pathway is to be implemented as business as usual from November 2015 with a review planned over the coming 12 months.

5 Care and Treatment Reviews - the process

CTRs were initiated with a target of supporting the discharge of 50% of the people who were inpatients on the 1st April 2014 by the end of March 2015. The process introduced a level of external scrutiny to existing processes, in effect offering those people in hospital a degree of 'second opinion'.

The CTRs were designed to bring an additional challenge and an alternative perspective which, in part, is achieved by the inclusion of an 'Expert by Experience' (a person with learning disabilities or family carer of someone with a learning disability, who has relevant experience) and the additional input of an independent clinical reviewer.

The person responsible for ensuring the CTR takes place is the responsible commissioner for the person in hospital (or the CCG commissioner if the individual is at risk of admission) and each review follows a given process and framework for the organisation and conduct of the review; there is a requirement to complete and distribute provided and standardised documentation at certain stages of the process.

If the individual is in a hospital bed commissioned by Specialist Commissioning Teams in NHS England, it is vital that the originating CCG commissioner or their delegated representatives are involved in the review along with the relevant local authority. This involvement is imperative in order to carry out future planning, which should occur from day one of admission, even where this is related to a restricted section under the Mental Health Act. Although an individual may have a minimum custodial sentence attached to their pathway, CTRs have highlighted that people can become very distant from, and even lost to, their communities with no discharge planning or thought being given that they will be discharged in some circumstances. It may also be that because of an offence committed by the individual they cannot return to their original community, and this will need to form part of the future planning discussions at reviews.

The CTR process has at its core the imperative of listening to the individual and their family, understanding the current rationale for providing care in hospital and where required, providing a sufficient level of challenge where progress or outcomes are felt to be limited or unsubstantiated.

The initial findings of CTRs carried out during 2014/15 added more weight to a body of evidence and shows that:

- People with learning disabilities are often admitted to hospital when it is not necessary or there could be viable alternatives. They often remain in hospital longer than is appropriate for their presenting problems.
- Unnecessary hospital admissions for people with learning disabilities place the individual at risk of potential or actual physical, emotional, and psychological harm in both the short and longer term.
- A significant proportion of people who are in hospital have no clearly defined outcome-based treatment or discharge plans.

- People with learning disabilities in long term institutional settings are more likely to be prescribed medication and to be subject to restrictive physical interventions
- Flexible, multi-disciplinary community-based services through a dedicated, responsible CCG/Local Authority commissioner provide the most appropriate, and effective approaches to meeting need.

The evaluation of CTRs and the findings of the ‘preventing unnecessary admissions’ pilot support the case for strengthening the approach and embedding this across the regions as part of ‘business as usual’ in order to address the following objectives:

- Preventing unnecessary admissions to hospital.
- Promptly reviewing the proposed care and treatment and discharge plans of people who have been urgently admitted to hospital.
- Ensuring that where admission to hospital is appropriate there are clearly defined expected outcomes and a discharge plan.
- Reviewing care and treatment and discharge plans of people who have been inpatients for 6 months or more (or sooner by request where there is dissatisfaction with progress).
- Improve health outcomes through early access to the most appropriate services and the provision of integrated and holistic care

There are key points along the patient care pathway where CTRs may be held (see Fig 1 below) and there are templates and tools to support each of these (Appendices 1 & 2). The only exception to this is where an urgent admission is being considered where there is no time to safely hold a Community CTR, and at this stage the introduction of a ‘Blue Light’ meeting (see Section 10) has been included.

Care and Treatment Review pathway standards

Standards have been developed in order to ensure consistency of quality of application of the CTR pathway, to support effective implementation of the pathway in the community and in hospital.

These standards are in line with existing best practice and relevant legal frameworks

1	The CCG Commissioner will maintain and keep safe a register of people assessed to be at risk of admission in their local area. This will include all people at risk, regardless of current funding responsibilities and including those in local authority commissioned placements. ²
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² An entry onto a register will need to be in line with exemplar standard 11 below and have the consent of the individual, or, if the individual lacks capacity, a best interests decision.

2	An agreement will be in place across all stakeholders to ensure the lawful and secure sharing of information about people with a learning disability who are 'at risk' of being admitted.
3	The CCG Responsible Commissioner will use the 'at risk of admission register' to ensure there are appropriate and timely reviews, care planning & risk assessment in place and that care coordination is in place as required under the CPA framework
4	There will be an identified lead in all agencies (health, education and social care) who will ensure that when someone is identified as being 'at risk' or when a request is made for admission, appropriate packages of support are in place to try and prevent an unnecessary admission. This will include but not be limited to personal budgets, personal health budgets, and integrated personal budgets.
5	Everyone at risk of admission or admitted to inpatient services will have a named care coordinator (ordinarily this will be under CPA) who will retain responsibility for the person regardless of their geographical residence, and whether they are in the community or hospital.
6	<p>No planned admission will take place without a Community CTR (excludes those via a criminal justice route such as court disposal or prison transfer)</p> <p>Note: where admission is being sought in an urgent and unplanned way, the 'Blue Light' protocol provides support & prompts for the commissioner in aiming to avoid unnecessary admissions</p>
7	Where an admission takes place there will be a clear rationale for this with clear expected outcomes, anticipated length of stay and a preliminary discharge plan that will be in place from the point of admission and agreed by the commissioner.
8	When an admission takes place without a pre-admission review, there will be a post admission review within 10 working days of admission.

<p>9</p>	<p>A CTR will be offered following a period of 6 months as an inpatient. This includes individuals with a clear treatment plan and/ or a planned discharge date.</p>
<p>10</p>	<p>A CTR can be requested by the individual or their representative, the family, or by any member of the clinical or commissioning team where there is dissatisfaction with progress, quality of care or concerns regarding a discharge plan</p>
<p>11</p>	<p>CTRs and any related recording or disclosure of personal information will be with the explicit consent of the individual (or when appropriate someone with parental responsibility for them), or if they lack capacity, assessed to be in their best interests applying the Mental Capacity Act 2005 and its Code of Practice. However, confidential information can be recorded and shared to help a child or young person who is or may be at risk of harm, or an adult who is or may be at risk of offending or of suffering harm or loss from offending. The information recorded or shared should be in proportion to the risk in each case and a record made of the basis of the judgement. Patients will be provided with details of who will have access to their data and purposes it will be used for, with appropriate support offered to address any questions.</p>

6 Care and Treatment Reviews – Standards of a good review.

The following standards serve to ensure that all reviews adhere to a prescribed level of quality and outputs that cover the process from the point at which a person is being considered for potential admission to hospital. These indicators will ensure that the review delivers the best outcomes for people and that the review is a positive and inclusive experience.

Prior to a review

- The responsible (local) commissioner will ensure the CTR is set up (CCG commissioner for Community review and 'Blue Light')
- If an individual is identified as potentially requiring a hospital admission their consent will be sought for a planned Community CTR being convened and given the information they need to help them decide
- If the individual lacks the capacity to consent to CTRs as part of their overall care and treatment then a best interest decision-making process should be initiated unless they have a representative who has lasting power of attorney for health and well-being who can make this decision on their behalf
- The individual's family, wherever appropriate (see paragraph 4.55 of the Mental Capacity Act Code of Practice) will be given information on the care and treatment review process.
- All parties involved in the review will be sent information explaining the process (template in toolkit)
- A diverse range of expert advisers (both clinical experts and experts by experience) who meet the 'Expert Adviser' specification will be recruited.
- In identifying both experts and professionals to form part of a review team, the responsible commissioner or their delegated co-ordinator should ensure that the knowledge, skills and experience of the expert advisers are commensurate with the presenting needs of the person to be reviewed and/or any particular issues which warrant enhanced expertise e.g. a Psychiatrist's input for contentious issues with medication, or a Clinical Psychologist where there are issues concerning behaviour management or the need for psychological therapies
- Where there may be issues of a sensitive/emotive nature to be discussed and explored within the review the responsible commissioner should be aware of this when selecting potential reviewers and ensure appropriate support is provided during and following the review.
- CTR panel members will complete Care & Treatment Review Induction Training

- The review panel will receive information about who is in the review team they will be working with and will be sent the appropriate review tools in advance of the review.
- It is recognised that not all admissions will be planned and in such cases when an individual is identified as being in need of an urgent hospital admission and there has not been adequate time to set up a CTR the responsible commissioner must be made aware as soon as possible and a 'Blue Light' meeting should take place. Although 'Blue Light' meetings are convened at short notice any disclosures of personal information must still be in accordance with exemplar standard 11 above.
- This 'Blue Light' meeting will take place either face-to-face or via teleconference and must ideally include all professionals involved in supporting the individual. It would also be good practice to involve the individual (and when appropriate their family members or suitable independent advocates).
- Should an admission take place following a 'Blue Light' meeting the individual must have a full post-admission Care and Treatment Review within 10 working days.

As part of a review

- The review panel will be made up of the responsible commissioner and two independent expert advisers; one expert by experience and one clinical expert. If the commissioner is unable to attend then they must ensure that they send a representative who carries delegated authority.
- The commissioner responsible for the person's care following discharge, which should include local authority colleagues or joint commissioners, should be involved in the review process. This is vital for planning for the future and understanding and resolving any barriers.
- It is expected that each Care and Treatment Review will take about a day. (There may be exceptions where it takes more or less than one day but the norm is expected to be one day based on the experience of CTRs conducted to date).
- Reviewers will meet the individual whose care and treatment is being reviewed as part of the day (unless they lack capacity and do not wish to be part of the process which has been assessed to be in their best interests under the MCA) and this should be in an environment where the person feels comfortable and supported by someone of their choice.
- Reviewers will meet family unless the family do not wish to participate or the individual has not consented to their involvement. As families often need to travel long distances to attend such reviews this meeting can be face-to-face on the day, by secure internet-based video communication, via email or on a different day dependent upon what is most convenient for the family members. Language and communication needs of participants should be considered.

- Records will be reviewed (including care plans, person centred plans, positive behaviour support plans, medication cards, communication passports, care programme approach review notes, health action plan, Mental Health Tribunal reports). The service provider must ensure that all relevant information is provided at the beginning of the day and where possible in a format that is clear to all the team.
- The reviewers will meet the current clinical team, including staff who provide direct face-to-face support for the individual as well as the responsible clinician. This usually takes place through a number of interviews. It is important to meet with staff who provide direct support separately to senior staff
- Members of the 'aftercare' team should be interviewed e.g. community psychiatrist, community nurse, social worker.
- The review panel will have time together to reflect, consolidate their findings and complete the review template.
- The review panel will meet with everyone at the end of the review to present their findings and recommendations and engage in a discussion about these and suggested next steps.
- The commissioner is responsible for writing the findings and recommendations in accessible language. The individual, their family (if appropriate) and those directly involved in their care should be given a copy. The report will make clear who is responsible for each action and by when.
- Recommendations should be clear, time-limited, embedded in local systems such as CPA and any responsibility for action/escalation should be documented at time of CTR. The aim is for people to leave CTRs with an understanding of what will be implemented, when and by whom and how this will be followed up.
- The commissioner is responsible for raising and escalating quality or safeguarding concerns with relevant agencies. However this should only be done with the informed consent of the individual unless he or she lacks capacity.

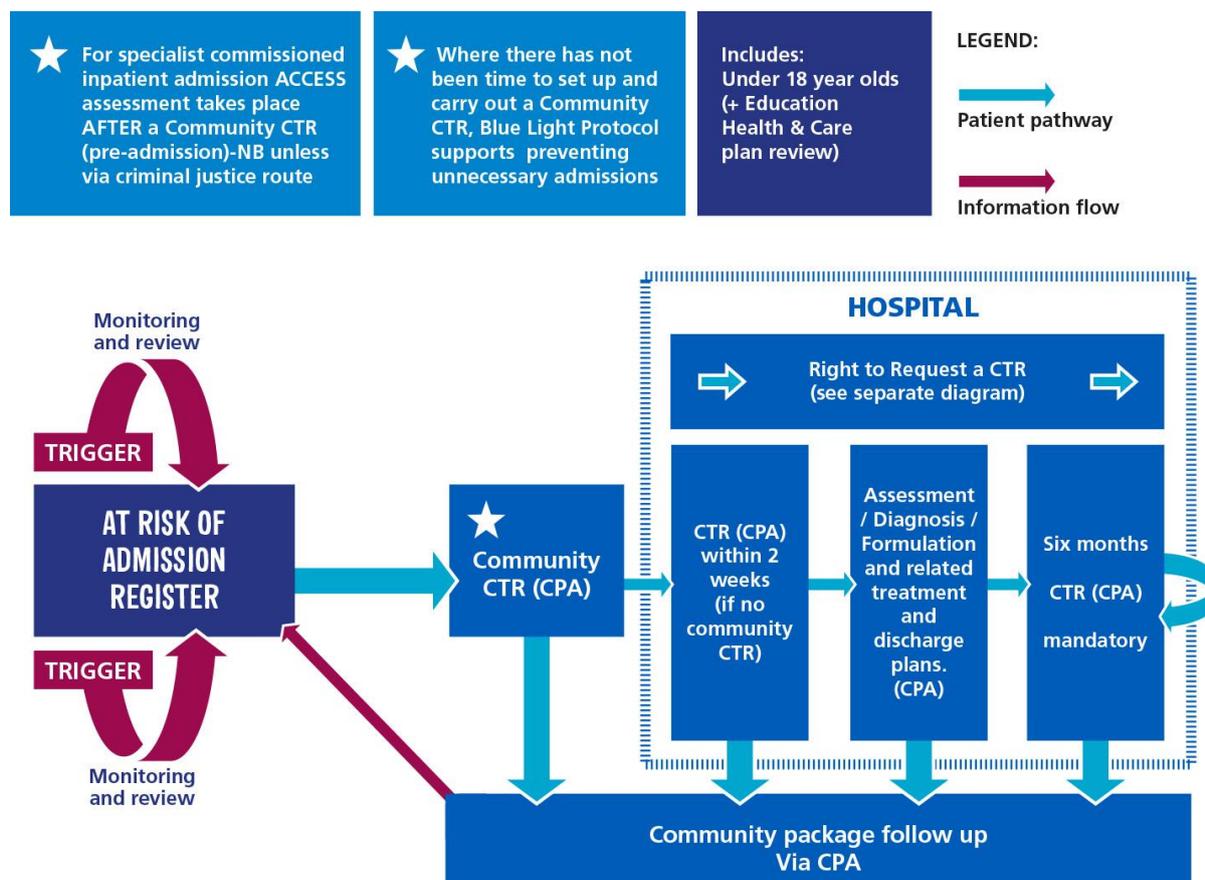
Following a review

- The commissioner is responsible for following up the recommendations of the review panel, having agreed on a reasonable timescale for this at the review. This may be delegated (e.g. to the community care coordinator) but overall responsibility remains with the commissioner. Where the commissioner has concerns that such recommendations are not being achieved they will escalate in accordance with local CTR policy.
- The commissioner will follow up on any specific quality or safeguarding concerns raised by the review process and ensure that these are raised as appropriate through local reporting procedures and governance pathways.

- The individual, professionals and family members will be sent a letter thanking them for their involvement in the review process.
- The Excel review template will be submitted as defined in the local CTR Policy and stored securely as part of the individual's medical record as agreed locally (by the commissioner)
- The review team members will be offered debriefing/support; for the expert by experience this may be through an Expert Hub. The experience of carrying out CTRs can be a difficult or traumatic one and it is vital that debriefing/support is available to all team members and that they can have access to this beyond the review day when needed.
- Following either a planned or unplanned pre/post-admission CTRs where the outcome is admission to hospital the individual must have a full CTR within 6 months and every 6 months thereafter [or by request if progress is not on track]

7 Care and Treatment Review Process

Figure 1.0 describes the CTR pathway



The commissioner (CCG or NHS England) will be responsible for overseeing implementation and co-ordination of Care and Treatment Reviews, the recruitment and support of independent Expert Advisers who are Experts by Experience (which may be through a locally developed expert hub) and Clinical Experts.

The commissioner will initiate the review by writing to the person being reviewed, to family members and others involved in their care and treatment.

The commissioner or their delegate will liaise with the inpatient or local community service regarding a venue for the review that is appropriate and enables the person and their family to take part in the review. It may be that the family cannot be at the review in person, in which case, secure internet-based video communication or phone facilities should be made available to ensure the family can participate.

The commissioner is responsible for gaining consent from the individual who is going to be reviewed. This consent will cover both the process and the required information sharing that enables it. The person's capacity to give consent will need to be assessed and it is vital that he or she is supported in this process by using accessible information (materials in the toolkit) and by getting the help of people who know the individual well and understand their communication needs. This discussion needs to outline what and how information will be shared about the individual and their care as well as why. An accessible letter will be sent to the individual explaining

the review and should be used to support the discussion and assessment about their capacity to give consent for the Care and Treatment Review.

If the individual is unable to consent then due process under the Mental Capacity Act would need to be followed to decide if this review is in their best interests. An accurate record of this process and judgement must be made. Copies of this documentation should be made available to the commissioner to ensure they are aware that consent has been obtained within the requirements of the Mental Capacity Act.

The review team will meet at the start of the review to discuss the plan for the day, how this will be managed and to establish an initial 'pen portrait' of the person being reviewed.

The commissioner will chair the review and be responsible for logging key findings and recommendations onto the assessment/report template.

The review will be carried out in a consultative and discursive manner, with the aim of supporting people to find solutions and unblock barriers to discharge together with the individual and their family, clinical team and commissioners.

At a minimum the Responsible Clinician and senior nurse should be present and should have gathered views and input from other clinicians with every effort being made during the review to gain the views of staff who are directly involved with supporting the individual on a day to day basis. Information will be sought on specific formulations and diagnoses including physical health care needs.

The review team will be able to review the individual's notes, including easy read material. It will be useful to view the most recent care plans, communication plans, annual health check, any mental health tribunal outcome reports, medication sheets, risk assessment and risk management plans and activity and person-centred plans. It is essential to find out what a typical day is like for the individual from their perspective and from that of their care staff.

The CTR is not an inspection of the provider so whilst learning about the ward environment and seeing the therapeutic interventions may be of interest this may not address the central question of whether the patient has to be in a hospital bed in order to have their health and care needs met. Similarly absence of a credible community-based service to meet somebody's health and care needs does not mean they are clinically unfit for discharge, it means that the right services have yet to be commissioned.

The review team will make a decision on whether they feel that there are more appropriate, effective and safe alternatives to hospital admission or whether the individual could be discharged from inpatient hospital care. The review team will feed back to all involved in the process at the end of the day and discuss their findings and recommendations. These recommendations will have a timescale assigned with clear indication of who is responsible for delivery and how this will be followed up. These recommendations could be for the individual, their family, the clinicians, or the commissioners. This should take the form of a discussion with all parties involved to reach consensus on actions and timescales. Follow up will usually be through the regular statutory Care Programme Approach meetings. The CTR outcome should lead to a revision in the individual's CPA Care Plan, which should be discussed in the

final part of the review. The CPA Care-coordinator will be responsible for updating the care plan and ensuring all the necessary areas are covered within this discussion.

The Commissioner will feed back required data to their local/regional team on the outcome.

The CTR team are empowered on behalf of the person with learning disabilities to ask questions based on a human rights and least restrictive framework. The team has a role in constructively but robustly challenging inappropriate or ineffective practice, supporting cultural change and a shifting model of care from inpatient to community care.

8 People at risk of admission ('At risk of admission' registers)

8.1 Context

Local health and social care services are broadly aware of those people with learning disabilities living in the community who may be at risk of inpatient admission. Usually they are known to local intensive support teams, social care/local authority services and community learning disability teams or have often previously had periods of inpatient care.

The range of local intelligence that the CCG Commissioner holds in relation to these individuals varies considerably and therefore strengthening this knowledge should lead to improved awareness of need and more responsive commissioning. This is important to ensure that people with learning disabilities are supported to stay well, and have appropriate support to remain in the community and avoid unnecessary admissions. These are costly not only financially but, more importantly, can potentially be damaging to them and their family, often leading to prolonged admissions and a loss of connection with the local community.

Throughout the testing periods for the latest CTR policy it was noted that areas who were the most successful at creating a working 'At Risk of Admission Register' were those where partnership working was seen as a priority, where there were clear communication channels between agencies and teams and where a flexible and immediate response could be put in place at times of crisis in the community.

8.2 Scope of the Register

The initial focus of the 'At Risk of Admission Register' will be on adults, and children with learning disabilities who are of transition age (usually aged 14 plus) and must include children of transition age who are in 52-week residential school placements who through their Education Health and Care Planning (EHCP) processes are identified as being at risk of admission.

The 'At Risk of Admission Register' will identify those people who are likely to require a 'Community CTR' to prevent their unnecessary admission, or to ensure that if admission is required it is for the shortest possible time and has clear outcomes.

This 'At Risk of Admission Register' is seen to be a first step in a broader piece of work on 'risk stratification.' This work, which will follow publication of the 'New Service Model' will focus on prevention and early intervention.

Further work will be undertaken to develop guidance to support local area approaches to risk stratification, covering information management and governance issues at a later stage.

8.3 Role of CCG commissioners

The CCG commissioner through their work with partners who are involved in supporting people in the community will identify those individuals who are at risk of admission. The 'DH Winterbourne View Review Concordat: Programme of Action' December 2012 asked that 'all primary care trusts develop registers of all people

with learning disabilities who have mental health conditions or behaviour that challenges in NHS-funded care as soon as possible and certainly no later than April 2013' and that CCGS should 'maintain the local register from 1st April 2013' Commissioners now provide input to the Assuring Transformation Data collection as part of the Health and Social Care Information Centre data collection. This data collection is vital as it highlights the population in hospital.

The 'At Risk of Admission Register' is to be held locally and in accordance with the local CTR Policy.

All CCGs are expected to hold an up-to-date risk register. Risk registers will be subject to review in CCGs where it is recognised that inpatient admission rates are high.

In order to build the register there will need to be closer working relationships developed with other statutory services and third sector community providers who may be aware of those people not known to existing learning disability services but who are at risk of admission, e.g. Police, Accident and Emergency department. Through this the CCG commissioner will ensure that there is the highest possible level of awareness of people in their community with a diagnosis of learning disability.

The 'At Risk of Admission Register' requires:

- close, collaborative working across health and social care that will enable an improved understanding of the local population.
- assist commissioners to track individuals, identify existing gaps in current service provision and design
- partnership working with relevant stakeholders, to better consider the types of resource required to provide more robust community-based alternatives.

8.4 Consent and Information Governance

CTRs and any related recording or disclosure of personal information, such as on the At Risk of Admission Register will be with the express consent of the individual or, if he or she lacks capacity, assessed to be in their best interests applying the Mental Capacity Act 2005 and its Code of Practice. Commissioners must remember and fulfil their obligations to inform the patient about the use of their data (who, what, how and why) as part of this process of seeking consent.

The Department of Health are working on a Transforming Care 'Guidance on Obtaining Consent' and associated 'Consent Form' This is currently being tested and is designed to support information sharing for this cohort, which is seen as particularly valuable to ensure that people are receiving the right support in the right place, and that unnecessary admissions to hospital are avoided.

The CTR toolkit includes a consent form for inclusion on an 'At Risk of Admission Register' that is to be used to explain its purpose and gain consent from individuals for their inclusion (or if they lack capacity, assessed to be in their best interests applying the Mental Capacity Act 2005 and its Code of Practice)

It is proposed that each Clinical Commissioning Group (or an organisation on behalf of the CCG, for example a CSU) will be required to develop a register of those 'at risk' of admission. They will be data controllers of the information and should

designate information asset owners with direct responsibility for it. The data controller will make sure that the data is stored securely with necessary access controls.

Data sharing agreements will need to be in place between parties who are going to have access to this information (given the express consent of the individual to use their personal data in this way as set out in Exemplar Standard 11) in line with each organisation's data sharing policies.

Once someone has been identified at risk, a process for gaining their consent to be held on a register is carried out at this point to enable them to be added to the register and followed up, possibly with a community CTR. Additionally where people are discharged from hospital, who are at higher risk of re-admission, consent can be sought for holding their details on a register at time of discharge.

The 'At Risk of Admission Register' will include information to enable monitoring whether the individual is effectively supported and reviewed in order that contingency plans can be put in place as necessary, including support for family/carers. Where the criteria for the Care Programme Approach (CPA) are met this should be the framework used to follow up on the agreed package of support and provide a named person (the care coordinator) for the individual and their family.

These Registers will be subject to regular discussion and updating with input from the multi-disciplinary teams across health, education and social care and representation from other key providers of services.

8.5 Identification of people who are 'At Risk of Admission'

Factors that may place someone at risk of admission are likely to include:

- Significant life events and/ or change such as bereavement or abuse.
- Unstable / untreated mental illness
- Previous history of admission(s).
- Presenting significant behavioural challenges.
- Being supported in an unstable environment or by a changing staff team.
- Not being previously known to learning disability services.
- Having no fixed address.
- Being in contact with the Criminal Justice System.
- Presenting 'in crisis' at Accident & Emergency Departments.
- Having no family carers/advocates.
- Having drug and alcohol addiction problems.
- Having no effectively planned transition from Child to Adult learning disability services.
- Being placed in specialist '52-week' residential schools.
- Having recently been discharged from long stay hospital beds.

Indicators of being 'at risk of admission' and eligible for inclusion on the register will depend on a number of factors including local community services available, robustness of existing support packages and local risk thresholds.

N.B. Please note this list is not exhaustive.

The determination of the level of risk is likely to be locally agreed through existing regular partnership meetings but should reasonably include all people with learning disability who have had an unplanned hospital admission or who have been managed by a crisis team or similar to avoid a hospital admission in the past year.

A decision about inclusion in the register will be made locally based on cross-agency discussion and in line with Exemplar Standard 11 in relation to consent. (the toolkit includes an information leaflet and consent form about the 'At Risk of Admission Register')

It is likely that inclusion on the 'At Risk of Admission Register' will take account of the following:

- a) where someone is placing themselves or others at serious and/or significant risk of harm
- b) where the individual's community placement or tenancy is at risk of irretrievable breakdown and where this would pose a significant risk to the safety of the person and/or others
- c) where hospital admission is being considered as an option
Inclusion on the 'At Risk of Admission Register' will indicate the possible need for a Community CTR, application of CPA Policy and allocation of a CPA care coordinator.

8.6 What information should be held on the register?

The minimum information maintained in an 'at risk of admission register' should include:

Identifiable information (Name or NHS patient number)
Name of allocated CPA Care Co-Ordinator
Name of current service provider or support in place through a personal budget
Whether or not there is a current care plan that includes contingency planning with current risk assessment in place
Date of last review of care plans and risk assessment
Whether or not the provider is signed up to the 'Blue Light' protocol
Whether or not the person is at immediate risk of placement breakdown and / or admission
Date of Community CTR(s) held
Reason why this person is at risk of placement breakdown and/or admission
If the individual has been offered a personal budget, personal health budget or integrated personal budget where this is appropriate.
Date consent gained for inclusion on 'At Risk of Admission Register'

Please note that it is anticipated that this minimum data set will be developed further to meet the needs of local commissioning and the local population.

This will be reflected in the organisations' local CTR Policy.

9 Care and Treatment Review – Community (Pre-admission)

The following is subject to exemplar standard 11 above.

The preliminary stage of the Care and Treatment Review pathway promotes initiation of a Community CTR where hospital admission is being actively considered or sought. This review seeks to establish whether or not the person actually needs to be admitted to hospital and whether their care and treatment needs could be met effectively and safely in the community. This should include checking whether a personal budget, personal health budget or integrated budget has been offered

When a person is identified as being at risk of admission the professional who holds lead responsibility for their case and has an understanding of the increasing risk will notify the responsible commissioner (or their delegated representative) if there are escalating risks and/ or unmet needs which make an admission more likely.

The decision will be made with the responsible commissioner (or delegated representative) as to whether the situation can be resolved promptly and safely with the use of existing resources or if a Community CTR needs to be held.

A Community CTR should ensure that all alternatives to hospital admission are explored and resources are used flexibly to meet people's needs. These resources may include specialist health teams, local authority respite provision (supported by specialist health teams), voluntary agencies, short breaks, and self-advocate and carer organisations to provide peer support. Where costs are being considered as a determinant of appropriate intervention, it is essential that the personal and long-term costs on quality of life and impact on individual human rights are given a high priority alongside financial considerations.

Admissions for assessment and treatment should be based on a clear, detailed and outcome-focussed care and treatment plan. The plan should specify what issues require further assessment, what this would add to what is already known about the individual, why this assessment can only take place in a hospital setting and what added value this would be expected to bring to their overall pathway of care.

Adverse and confounding effects on assessment related to the hospital environment and the potential trauma of the process to the individual and their family must be taken into account. Planning for discharge and robust commitments to continuing support in a community setting should be firmly established and documented prior to admission. Admissions for assessment and treatment should not be used as 'step-down' or intermediate placement while planning longer-term community support.

Hospitals should only be used when not to do so would place the individual or others at risk of significant physical, emotional or psychological harm. This should be based on a comprehensive risk assessment by a multidisciplinary team, adhering to locally agreed protocols, within the context of all appropriate legal and procedural frameworks. The risk assessment process should reflect levels of evidenced risk, and must seek to balance the safety needs of local communities against the rights and freedoms of the individual.

The Community review tool is to be used for the Community CTR.

10 Care and Treatment Review – ‘Blue Light’ meeting- where a Community CTR is not possible.

Requests for admission can occur where the person’s presentation is changing rapidly or they are previously unknown to services. Where such a situation is at the point of ‘crisis’ and as a consequence there is no time for setting up a CTR, an assertive, fast and measured response will be required if those responsible are to safeguard against admitting the person unnecessarily into an inpatient service.

A ‘Blue Light’ meeting offers the commissioner advice, steps and prompts to help avoid unnecessary admissions. It recognises that where an admission request is at very short notice it is not always practical to set up a full CTR, obtain consent and involve expert advisers. A meeting, possibly by teleconference, should be set up to engage the person their family and all those around the individual to think creatively about what alternative supports and interventions could be put in place.

Should the individual be admitted to hospital then a post-admission CTR will be held within ten working days to ensure that a clear care pathway is identified and a proposed discharge date is in place with further review dates agreed and logged on the register.

There is a stand-alone protocol for the ‘Blue Light’ meeting that will support commissioners in the steps to take to avoid unnecessary admissions. This protocol is based on existing good practice guidance (e.g. MHA Code of practice 2015) and seeks to support people by the least restrictive option and ensure that the individual and, where appropriate their family, are involved in the decision making process and their views fully incorporated.

This process is subject to exemplar standard 11 above.

11 Care and Treatment Review – Post-Admission

The following is subject to exemplar standard 11 above.

The Post-Admission review will take place where no Community CTR has taken place, and will use the relevant CTR tool for children and young people, adults in secure settings or generic tool and follow the quality standards for CTRs.

The post admission CTR will take place within 10 working days of admission.

The purpose of the post-admission CTR is to:

- review the circumstances and process of admission to establish if hospital admission is the most appropriate solution and whether care and treatment can in fact be provided in the Community rather than hospital.
- to establish a clear idea of the purpose of admission, the expected outcomes, timescales and to ensure that planning is already underway for discharge.

A key finding of early CTRs carried out for people who are in hospital has been an absence of planning for leaving hospital, which has often led to significant delays in discharge. Clarity regarding purpose of admission and anticipated outcomes from admission, where this has not been possible through a Community CTR, should be sought within two weeks of admission. (If an individual has been detained under Section 2 of the Mental Health Act it is expected that a decision will have been made about diagnosis and treatment within 28 days). If there are exceptions where the CTR cannot be implemented in line with the policy, then these will need to be reported together with the reasons for this.

The relevant templates and tools are listed in Appendix 1. Where hospital care and treatment is felt to be appropriate the review will ensure that there is a clear plan for assessment, treatment and discharge and a proposed discharge date will be set.

It is viewed as best practice to use Root Cause analysis at this point in the pathway, in order to learn from unplanned admissions and to understand why the person was admitted and how this could have been prevented, is viewed as best practice. As this is a best practice approach NHS England would advocate that this approach is used in all such circumstances, below is a link to resources available on the NHS England website which details Root Cause analysis, the theory which underpins this approach, and the tools to be used when implementing such an approach.

<https://www.england.nhs.uk/patientsafety/root-cause/>

The National Team, in continued collaboration with regional colleagues will scope and plan for the necessary enhancements required reducing reliance on inpatient services. The policy will be reviewed within 12 months of issue as 'Business as usual'.

During this time there will be a need for continued data collection which will show not only the numbers of CTRs carried out but also outcomes of these CTRs, as well as

actions taken to ensure the achievement of these outcomes. This will reinforce the policy aims of CTRs as outlined in section 2.

12 Care and Treatment Review – Inpatient (Mandatory 6-monthly review or ‘right to request’)

The following is subject to exemplar standard 11 above.

The 6 monthly CTR will be conducted using the relevant support tool. These reviews will focus on the safety, care and future planning for those people who remain in specialist inpatient assessment and or treatment services. The emphasis will also be on establishing the reasons for extended hospital stay, barriers to progression and discharge and a review of whether the correct or most effective treatments are being provided. The review will be solution-focused to find ways to overcome barriers to discharge, agree actions, responsibilities and timelines.

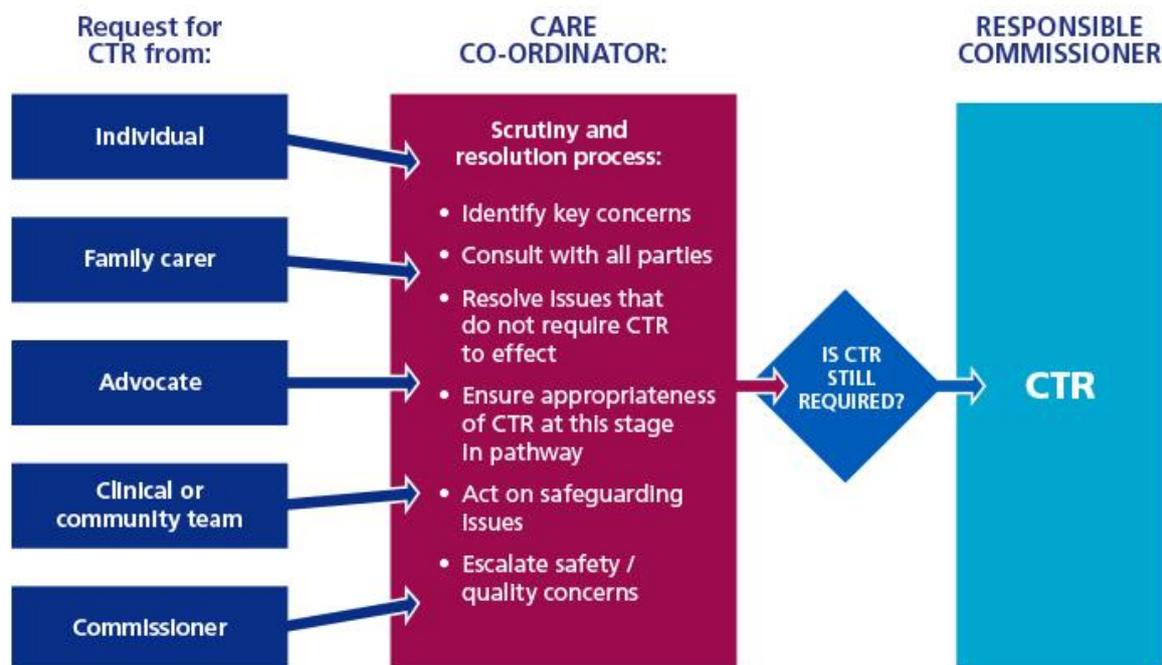
The appropriate tool will also be used for a CTR that has been requested.

Following a CTR for people who are subject to Ministry of Justice requirements, the protocol in Appendix 4 supports the steps to be taken to liaise with the MOJ effectively. This has been devised based on learning from MOJ related barriers to discharge or transfer. The MOJ will ensure that the cases flagged with them are fast-tracked.

13 Right to Request a Care and Treatment Review

Figure 2.0

PATHWAY FOR CARE AND TREATMENT REVIEW ON REQUEST



The request for a CTR can be made by the following people (subject to necessary consent);

- The individual in receipt of services.
- The individual's family or carer
- The Responsible Commissioner
- The advocate for the individual in receipt of services.
- The team who are supporting the individual, either from the inpatient services, or within the community.

The CTR can be requested at any point along the inpatient pathway where there are concerns regarding suitability of the service, the treatment plan, the individual's safety and wellbeing and/or if there is no clear discharge or transfer date and plan.

Requests for CTRs should be directed to the CPA care coordinator whose first response should be to address the concerns that have led to the request as promptly and thoroughly as possible, potentially mediating any concerns or dissatisfactions without the need for a review. Should the applicant continue to feel that a CTR is necessary then the care coordinator will contact the commissioner who will process this request according to locally established protocols and respond to the request for a CTR.

NB: The CTR request should not be regarded in itself as a form of complaint and should not be handled through usual complaints channels.

14 Roles and Responsibilities

NHS England National	<ul style="list-style-type: none"> • Setting standards • Issuing policy & guidance • Support to regions from central team, in place until March 2016 • Support to regions on quality assurance processes • Providing assurance to NHS England Board based on regional/area assurance processes
NHS England Regional	<ul style="list-style-type: none"> • Ensuring adherence with agreed guidance and standards • Assuring engagement and follow up from CCGs • Gaining assurance from CCGs using the Commissioning Assurance Framework • Providing Assurance to Regional/Area Responsible Officer/Regional Director
Clinical Commissioning Groups	<ul style="list-style-type: none"> • Ensuring engagement of CCG commissioners • Ensuring any immediate actions resulting from reviews are followed up • Working in partnership with Local Authorities to deliver discharge/transfer plans • Tracking delivery of discharge/transfer plans recommended by CTR • Develop positive working relationships with inpatient and community providers to ensure effective delivery. • Proving assurance to CCG Board • Providing assurance to Regional/Area Team
Providers and clinicians	<ul style="list-style-type: none"> • Ensure that the CTR process is implemented as set out in the pathway. • Work in partnership with Commissioners to facilitate CTRS • To support people with learning disabilities and their families in the CTR process including with understanding the review process, at risk of admission register and with consent. • Work in partnership with people with learning disabilities and family carers and partners co-productively in the CTR. • Ensure agreed recommendations are implemented from the CTR

It is the role of the Transforming Care regional leads and their nominated directors to ensure the implementation of this policy. During the period up to end of March 2016 additional support and resource will be available to the regions from the central team. This offer is made with the express intention of enabling regions to interpret

the revised policy and CTR process in order to embed this within service models and procedures in their area and to support the development of quality assurance frameworks and gathering of any learning from implementation of the policy.

It will be the role of the central team to work with those regional colleagues to help scope and plan for the necessary enhancements required to fulfil the ambition of reducing reliance on inpatient services and thereby, in the longer term, enable CTRs to become 'business as usual'.

The National Team, in continued collaboration with regional colleagues will scope and plan for the necessary enhancements required reducing reliance on inpatient services. The policy will be reviewed within 12 months of issue as 'Business as usual'.

15 Interface with Other frameworks: Access Assessment for Specialised Services; Care Programme Approach, Education Health & Care Plans; Capacity to Consent

An important objective within the development of CTRs is to ensure the overall approach interfaces with existing processes and frameworks.

This includes those operated via Specialist Commissioning Teams in NHS England, the legal frameworks of the Care Programme Approach, Education Health and Care Plans for children and young adults, and the provisions of the Mental Health Act, incorporating the Mental Capacity Act and its Code of Practice.

Access to specialised services (including CAMHS & Secure Services)

Any individual who is at risk of admission due to the nature of their mental health needs should first have had a planned Community CTR.

If the outcome is that referral to specialist commissioning for access to a secure or CAMHS bed is the appropriate option the CTR will also aid in establishing a foundation for the Access Assessment which should take place as described in the NHS standard contract and service specification as used by NHS England specialised commissioners for Children and Young People and Adults.

Access assessments are undertaken to determine the most appropriate placement for the person in terms of mental health need and level of relational security required. They are, by definition, about managing an abnormal presentation of mental health need and by their nature are complex and robust processes.

The current referral routes for Access Assessments are categorised within three different response times:

- Emergency – initial response and assessment within 24 hours.
- Urgent – on receipt of referral a verbal response is given within 24 hours and an assessment within 4 weeks.
- Routine – initial response within 14 working days and assessment within 1 month.

By integrating the provisions of both the CTR process and the Access Assessment it is intended that this will ensure that consideration is given to the whole care pathway and will help to strengthen the range of treatment modalities available. It will also ensure that all other alternatives have been considered before secure provision is agreed as the appropriate placement option.

It should be noted that an admission into secure care is onerous and should be carefully and robustly justified since this has a significant and enduring limitation on the individual's liberty with a profound lifelong impact on their future care.

It is also important to note that where NHS England is the responsible commissioner for an individual it is vital that there is good communication with the responsible commissioner and local authority to ensure that a future plan can be put in place for the individual. The Local authority and/or CCG have to be represented at the review

in order to achieve effective joint working with NHS England who remains the responsible commissioner. This representation may be delegated to a community care coordinator to attend on their behalf, especially where the individual is at the start of their treatment and subject to Ministry of Justice restrictions that mean a minimum custodial sentence applies.

However, in all circumstances it is vital that there is representation from the services in the community to which the person intends to return in order to maintain those links and enable planning to take place from day one of admission.

Care Programme Approach (CPA)

The Care Programme Approach (CPA), implemented consistently and effectively with high quality care management should be the baseline process of regular review for people with learning disabilities who fulfil the criteria for CPA; those who require: multi-agency support, active engagement, intense intervention, support with dual diagnoses and who are at higher risk (Refocusing the Care Programme Approach, DH 2008)

The Revised Mental Health Act 1983 Code of Practice issued in January 2015 sets out the latest guidance on the key features of CPA, when to use it, who should be involved and on care planning. There is a section on CPA which should be read in conjunction with this policy/guidance.

<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

CTRs are not the same as CPA though they will cover the same core areas and will be able to provide supporting information for a local CPA process. CTRs will differ in emphasis and process from CPA in:

- Providing a degree of independent scrutiny
- Challenging elements of the care and treatment plans where appropriate
- Involving independent experts by experience
- Involving independent clinical experts
- Being chaired by and directly involving commissioners
- Routinely involving local authorities in the reviews

The CTR process has been designed to complement existing arrangements for CPA. Community and Post Admission review meetings should fulfil the necessary requirements of CPA ensuring that people with learning disabilities and their families/carers are not expected to attend several similar meetings and will also reduce the duplication of effort across services.

The CTR will lead to the outcome of a revised CPA plan that will be the responsibility of the care coordinator to complete and share with all, including the individual and their family as appropriate, and ensuring that any outstanding areas not covered within the CTR are completed as per local CPA Policy.

Education, Health and Care Plans (EHCPs)

Education, Health and Care Plans are the statutory process for children and young people with learning disabilities aged 0-25 and in full-time education. This process is not replaced by the CTRs but they provide an opportunity to review or initiate the EHCP and ensure there is a plan in place to complete this and an identified lead person. The CTR will add the benefits listed above including independent scrutiny.

The CTR process has been designed to complement existing arrangements for Education, Health and Care Plans. To avoid duplication CTRs should involve Education representatives from the individual's local authority responsible for their statement of educational needs. This will also ensure that children and young people with learning disabilities and their families are not expected to attend several similar meetings.

Capacity to Consent

The responsible commissioner or their representative is responsible for ensuring that individual capacity to consent is assessed and that the relevant legal frameworks are followed. Where an individual lacks capacity to consent, a process of best interest's decision-making should be initiated as set out in the Mental Capacity Act Code of Practice. It must be remembered that individuals may have fluctuating capacity, and when this is the case decisions should await the individual's return to capacity unless delay would not be in his or her best interests. Individuals who lack capacity should still be as fully involved as they can be in any decisions about their care. The national toolkit includes accessible information to help the individual understand the nature and purpose of the review & for the consent to have personal information held on the At Risk of Admission Register.

It must also be remembered that any assessment of capacity is decision specific, and in this case will only relate to the CTR itself, it does not extend beyond this meeting. Any decisions regarding future information sharing post CTR will require a separate assessment of capacity and agreement

Best practice should be followed in obtaining consent from a child, young person or from an adult who has parental responsibility. Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own treatment, unless there is significant evidence to suggest otherwise.

Children under the age of 16 are presumed to lack capacity, but can consent to their own treatment if it is thought that they have enough competence and understanding to fully appreciate what is involved in their treatment. Otherwise, someone with parental responsibility can consent for them. However, parents and others with parental responsibility should be fully involved in decisions unless that would prejudice the child's well-being (the Fraser Guidelines). Whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required (Gillick competence).

<http://www.nhs.uk/Conditions/Consent-to-treatment/Pages/Children-under-16.aspx>

Note: A review cannot take place without the consent of individuals with capacity or if they lack capacity a best interests decision being taken on their behalf and formally documented to that effect.

Mental Health Tribunals

For people who are detained in hospital under the Mental Health Act or remain under supervision, extended leave, guardianship or restriction in the community, Tribunals are an important provision for review of the legal framework by which care and treatment is delivered. Tribunals cannot determine the nature of the treatment but they have the power to discharge people, recommend leave, recommend supervised community treatment, and decide on delayed or conditional discharge.

The effectiveness of a Tribunal depends very much on the information that is available or presented to Tribunal members and to the patient's legal representative. The views and wishes of nearest relatives will also need to be taken into account. CTRs therefore may have an important role to play in improving the quality and quantity of information and the quality of care and treatment plans that will come before a Tribunal. The National Team are continuing to pursue work with the Tribunal service and the Ministry of Justice to ensure that there is mutual benefit to the embedding of CTRs in the patient pathway.

16 Governance

The governance of the on-going delivery, monitoring and evaluation of CTRs will be held by each of the NHS England regions and their respective teams and Clinical Commissioning Groups (CCGs). This will be supported by existing governance frameworks.

It is anticipated that health and wellbeing and safeguarding boards will take an interest in the implementation and outcomes of CTRs for people with learning disabilities who are at risk of admission or who are in hospital, and CCGs may be requested to provide reports on delivery of the CTR pathway, as well as on admissions, and discharges from specialist mental health or learning disabilities hospitals.

Local CTR Policy

Each CCG will be expected to develop a local CTR Policy. This will include the following:

- Local population based data, including how many CTRs are anticipated for the locality
- Local risk criteria used to define the 'At Risk of Admission' population.
- Governance arrangements locally including who is responsible for the register, the process for managing the register, any information sharing agreements in place between parties, where the risk register is held, who is responsible for updating the register and how it gets reviewed, and updated.

Quality assurance reporting requirements

Methods and frequency of reporting will be determined by regional teams/area teams and CCGs in accordance with their agreed quality assurance mechanisms. However, Directors of Nursing or Chief Clinical Officer will be held accountable for quality assurance of CTRs implementation and outcomes. The evidence and feedback referred to below should be anonymised and not have patient identifiable information

Responsible officers/regional directors are expected to base their assurances on;

- Evidence that standards set out in the guidance are being met (Note 2), with particular focus on legal issues such as consent, Registration/DBS checks etc.
- Evidence that immediate actions following CTRs (e.g. safeguarding referrals) are followed up
- Evidence that discharge/transfer plans are being 'tracked'
- Feedback from external expert advisers that they are well supported and able to engage well with the CTR process (Note 1)
- Feedback from people with learning disabilities and their families on the quality of the review and the subsequent outcomes (Note 1)

Note:

- 1) The CTR toolkit includes an accessible questionnaire to support the gathering of feedback on experience and outcome from people involved in the review and from panel members.

- 2) The CTR template incorporates a checklist with key quality indicators to support quality assurance activity.

It is anticipated that the quality assurance framework will be tested and developed over the period up to end March 2016.

17 Clinical disagreements, disagreements between parties on future plans & escalation of concerns

Clinical Disagreements

It is not anticipated that there will be many occasions of disagreement between parties at an outcome of the CTR, based on experience so far.

Where clinical disagreements occur that specifically affect decisions on an individual's pathway, it is imperative that these issues are resolved before future planning decisions are made. Local reconciliation panels should be used or set up if not already in existence involving the individual's Responsible Clinician the clinical reviewer on the CTR panel and an independent clinical expert. This panel should be chaired by a Clinical Director (medical or nursing) from within the respective local or NHS England team. This process will be set out in the local CCG policy.

Additionally the national team can be contacted for advice in these circumstances and support includes a desk top review, or additional challenge.

Disagreements between parties on future plans

Where there are disagreements that relate to responsibility for future packages of care between parties, this should be escalated to the relevant NHS England and/or CCG Director of Nursing or Chief Clinical Officer to resolve. This is required to prevent the disagreement leading to a lengthy inpatient stay where an individual is ready for discharge (leading to a delayed transfer of care).

A formal more detailed escalation process will be developed over the coming months to support implementation of Transforming Care.

Escalation of Concerns relating to Quality and Safety

Concerns raised may include:

- Concerns about staff members and their conduct, lack of competency in relation to person centred care, poor quality documentation and the use of restraint either physical or chemical.
- Concerns about infection prevention, poor environmental conditions such as lack of personalised accommodation, lack of appropriate stimuli in the environment.
- Concerns about lack of resource to meet person's needs, inability to be able to access social environment due to lack of resource, inability to be able to meet physical health needs through attendance at primary and secondary care.

The review team, through the Responsible Commissioner, which is either NHS England Specialist Commissioning or the CCG, should escalate any concerns through the relevant route that depend on the concerns identified including:

- Care Quality Commission
- Local Authority Safeguarding team

- CCG Contracting team
- Local Quality Surveillance Groups (QSGs)
- NHS England contracting team

Responsibility for escalating concerns

If there are concerns in relation to the quality or safety of a service and/ or provider, the responsible commissioner is to be responsible for following these up. The responsible commissioner should:

- Note the outcomes, key findings and recommendations of the review panel.
- Feed these back to the review attendees, including family and reviewers.
- Ensure relevant data is appropriately captured and reported.
- Raise any concerns through the appropriate channels, e.g. to the provider, CQC, local authority lead commissioner for establishment, ensuring relevant paperwork is completed and actions are followed up. As well as local forums where such issues regarding care provision can be raised to ensure high quality care is maintained, and any issues and concerns addressed.
- Ensure that concerns are shared through the relevant NHS England or CCG internal reporting mechanisms such as Quality surveillance groups (QSGs) to ensure that where an area is commissioned by several commissioners' relevant concerns are shared appropriately.

NHS England through the regional transforming care leads will hold the CCG and Specialist Commissioners to account to ensure that the recommendations of reviews are implemented. Escalation to Delivery Directors and to Accountable Officers will be used where actions are not appropriately taken forward.

Complaints relating to the CTR process

Where complaints are made by the individual, the family or providers this will be dealt with as outlined in the local CTR policy. It is likely that this will be in-line with the complaints procedure of the responsible commissioner organisation.

Appendices

Appendix 1– Available letters, templates, guidance and easy read documents to support the Care and Treatment Reviews

Please note that specific tailored templates have been developed where it is felt that they are necessary, for example, the letters arranging reviews for children, CTR templates for secure, and for children and young people. However any of the templates can be tailored and adapted to make them more personalised.

- Letters/Email Template for arranging review
- Letters to the individual about a review (easy read)
- Letter to family/carers
- Review Feedback Form for those attending a review
- Consent information to support individuals to decide about CTRS & being included in the At Risk of Admission Register
- CTR General Information leaflet (Including right to request a CTR)
- CTR Review templates & report format
- Top Tips for responsible commissioner
- Example of one day review schedule
- Example Introductory Meeting Agenda
- Comments and Discussion sheet to support review process.
- Expert adviser Specifications & the role of the chair of a CTR
- Accessible questions for Experts by Experience
- Post Review Thank You template letter to the individual
- Post Review Thank You template letter to carers
- Blue Light Protocol tool to support commissioners

Appendix 2– Data to support the monitoring of CTR pathway implementation & effectiveness of outcome

The impact of the Care and Treatment Pathway will be measured using local, regional and national anonymised data sets alongside tools such as feedback questionnaires and local audit (the toolkit provides some of these instruments).

The majority of the data required will be accessed via existing routes including the Assuring Transformation dataset, and as an interim the NHS England Regional trackers will be used (to capture Community CTRS and their outcome). However, commissioners should also take into account the duties placed on them under the Equality Act 2010 and with regard to reducing health inequalities, duties under the Health and Social Care Act 2012. Service design and communications should be appropriate and accessible to meet the needs of diverse communities.

Ref: Guidance for NHS Commissioners on Equality and Health Inequalities Legal Duties

<http://www.england.nhs.uk/ourwork/gov/equality-hub/legal-duties/>

The national team are exploring whether any additional anonymous information collection from the CTR templates will be useful nationally to support the programme's delivery, and this will be discussed and developed through the next six months.

The range of information gathered described above will seek to determine:

- If each area has an At Risk of Admission Register and a way to find out whether or not these are effective in ensuring additional support and/or predicting admissions
- If the prescribed service standards are being met at each stage of the pathway.
- If quality standards are met for CTRs across the Pathway
- Whether or not people are admitted following a Community CTR or Blue Light Meeting.
- If there is a reduction in length of stay, following CTRs
- If we can judge rates of readmission following the prevention of an admission or following discharge from an inpatient setting.
- If the experience of the care and treatment review is a positive one for individual and their family
- Whether or not the individual and their family have an improved experience of care and support following a care and treatment review

Appendix 3– Checklist for Care & Treatment Review steps pre-review, review and post- review

This checklist is intended to be a useful guide for the commissioner responsible for the care and treatment review. It provides the steps that need to be taken in planning and setting up a review and the relevant material within the toolkit to assist with this.

The checklist also provides a level of quality assurance, and reflects the quality indicators of a care and treatment review.

Local detailed processes will need to be established to enable this to work smoothly and ensure that steps are all completed, which will lead to a productive review. Additionally local detailed processes will need to be set up to ensure the infrastructure is in place to deliver CTRs (examples of this are processes to ensure that the pool of expert advisers are trained, supervised, DBS checked and supported as set out in the expert adviser specification; that there are mechanisms in place to recompense expert advisers that meet the procedural and policy requirements of the CCG/NHS England).

NB steps can be delegated – the accountable person for each step shown below is the responsible commissioner for the individual - the individual tasks can be delegated to others however.

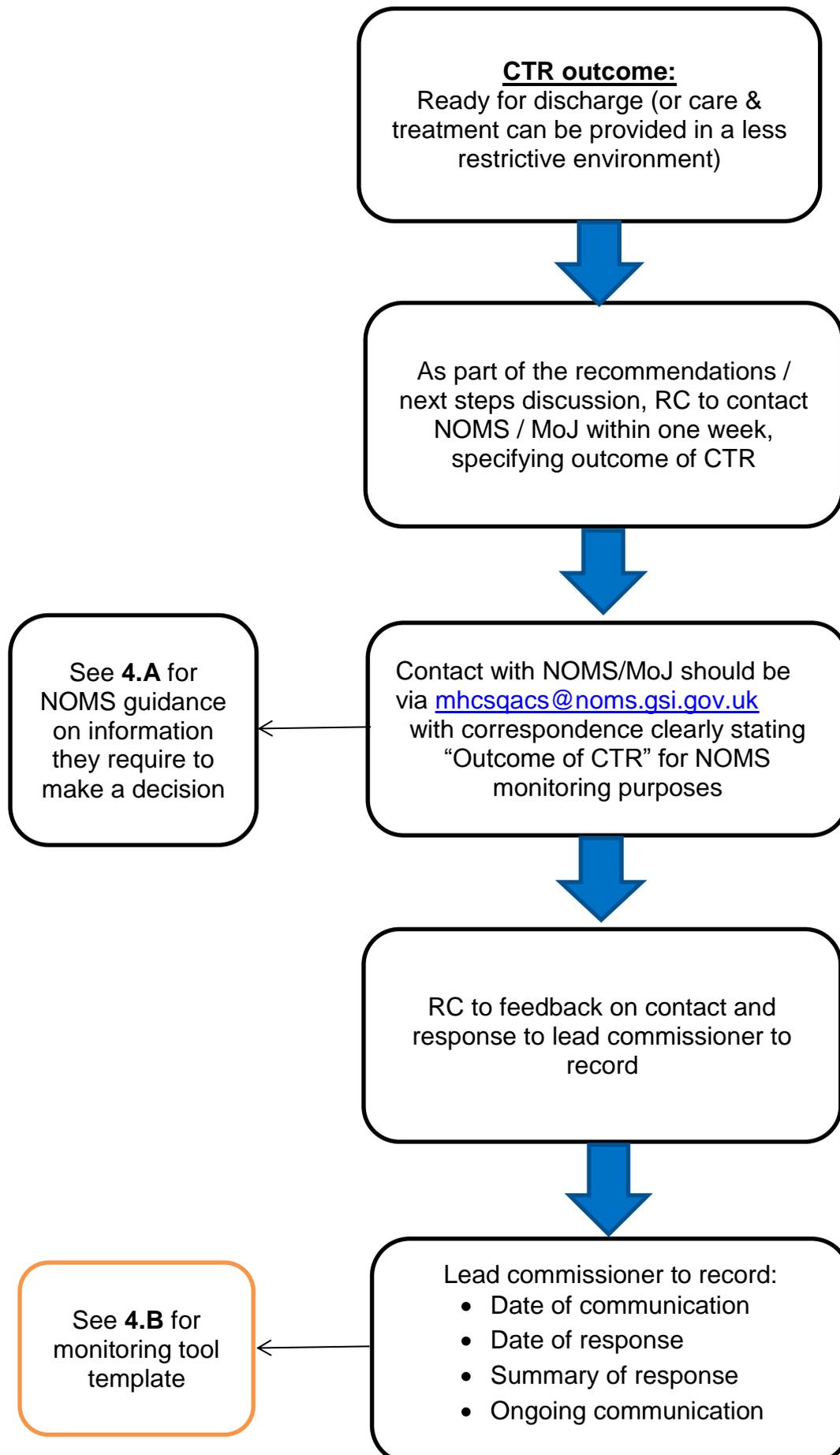
When	Stage	Activity	Who specify if delegated	Toolkit title to support	Tick when complete
Ongoing	Recruit CTR team members, checks and payments	- Set up infrastructure to deliver CTRs (e.g. processes to recruit Experts by Experience and other expert advisers, training, supervision, DBS checks and support as set out in the expert adviser specification. - Set up payment methods for expert advisers which meet procedural and policy requirements of the CCG/NHS England).		Section 1 General information Expert adviser specifications	
One-off action as soon as possible	Preparing template letters for individual and family carers.	There are new pre CTR and follow-up thank you letters in the CTR toolkit. These will need your local NHS logo to be inserted on p.1 top right, also contact information,		Section 2: Tools to support CTR before the day - CTR set up letter easy read letter, family carer letter, and letters in the children’s section. Section 4:	

		and saved as your local letter templates.		- Thank you letters for individual and family carers	
Ongoing	Blue Light protocol	Support for commissioners re urgent admissions (Where there is no time to carry out a community CTR).		Section 1 General Leaflets: - Blue Light Protocol	
Ongoing	At Risk of Admission register	See relevant section in this document			
Pre-admission CTR 1+ week		Pre-review - setting up a planned CTR – allow 2+ weeks Pre-admission CTRS – shorter timescale of 1+week may be needed to enable rapid response.			
2+ weeks before a planned CTR To give time for consent & choice to include family carers, so carers have time to plan.	Consent	Seek the person's consent. Also seek the person's wishes about whether/which family carers to invite to take part. If the individual lacks capacity, carry out process to decide whether a CTR is in his or her best interests (MCA Code of Practice for best interest decisions). If the person is under 16, seek carer/guardian consent.(NB if inpatient and under 18 years old use the letter template for Directors of Children's services for local authority that have responsibility for SEN, to ensure relevant education rep is at the meeting)		Section 1 General Information: - (For inpatients) Having a CTR includes consent information - Or At risk of hospital admission information and about consent. - All - General information leaflet for all ages. - All - What to expect from my CTR checklist (The above to be used with your local easy read consent form to ensure written consent is obtained. The person/carer will need a copy of the completed consent form)	
2+ week before	Set up CTR	Agree date, set up of day, venue, invitees Prepare provider for CTR		Section 2: Tools to support CTR before the day - Top tips for commissioner/chair of CTR - Set up Letter or	

		If under 18, letter to Director of Children's Services		Email for Six Monthly and 'By Request' Care and Treatment Review Process - CTR letter Director of Children's services.	
2 + weeks before	Confirm date and invitations to take part	If the person wants family carers to take part, prepare and send the family carer letter as soon as date/venue are agreed. Also write to the individual. Alternative letters for children/parents Ensure letters are personalised to include date of sending, name, date of review, sender etc.		Section 2: Tools to support CTR before the day Either the core letters for adults - CTR invite letter family and - CTR set up letter easy read Or letters for children/young people - CTR children's review letter and - CTR Letter parent or representative	
2+ week before	Organising expert advisers	Identification of expert advisers matched to the individual in terms of skills/ experience. Expert advisers will need minimum information on the individual in advance in order to select if they feel unable to carry out role		Section 1 GENERAL LEAFLETS Expert adviser specifications	
1+ week before	Materials needed	Send securely all relevant resources to panel members including where they are meeting and at what time		CTR template relevant to individual and circumstances	
		ON THE REVIEW DAY		MATERIALS NEEDED	
	Management of the day	Carry out review. If family carers are taking part by telephone, ensure they are called. Ensure any concerns raised are dealt with appropriately (see policy). Ensure there is feedback at the end of the day, and all attenders are clear		Section 3 – on the review day CTR Agenda CTRs example review schedule CTR Tool - comments/discussion CTR templates for CTR team CTR info sheets for Experts by Experience Policy/guidance Section 2: Tools to	

		of next steps and any outstanding actions or follow up required.		support CTR before the day - What to expect from my care and treatment review -Top tips for commissioner/chair	
Immediately after review	Report	Report to be written in accessible language (no jargon). Submit report to central point as per local CTR Policy Ensure all who attended the review receive a secure copy of the report (redacted if appropriate).		CTR templates include an easy read report section Excel template (will have submit button)	
		POST REVIEW			
Within 2 weeks	DATA	Update relevant information system with required information from review		HSCIC template	
Within 2 weeks	Thank you letters	Letter to the individual, professionals and family involved thanking them for their input.		Section 4 – Following review day - Thankyou letter easy read individual - CTR Thankyou letter Family	
Within 2 weeks	Quality assurance & review outcomes	Anonymised questionnaires on experience of the review for Expert advisers the individual, family and providers as agreed locally for Quality Assurance(QA) purposes ensure QA checklist completed on CTR template		Section 4 – Following review day - CTR Feedback Form - CTR template QA checklist	

Appendix 4 – Guidance for Ministry of Justice restricted patients following a CTR where outcome is ready for discharge



4.A - Guidance on conditional discharge provided by Ministry of Justice (NOMS), Mental Health Casework Section (MHCS)

Legal Provision

The Secretary of State has the power to conditionally discharge a restricted patient under section 42(2) of the Mental Health Act 1983 (The Act).

(The independent First Tier Tribunal (Mental Health) may also discharge under section 73 of the Act.)

The MHCS section of the Ministry of Justice will consider discharge (transfer and leave) on behalf of the Secretary of State

Criteria

The Secretary of State may discharge a restricted patient by means of a warrant if he considers that the mental disorder is no longer of a nature or degree to warrant continued detention in hospital.

It is usual for discharge to be subject to carefully considered conditions. These normally relate to where the discharged patient should live; compliance with supervision by a clinician and social supervisor; and to any other reasonable conditions considered appropriate for each case. For example, it might be thought necessary for an individual to not being able to live near a school due to previous offences against children, or having to comply with regular therapeutic interventions such as medication, or psycho social interventions.

Sometimes it might be thought appropriate to apply more stringent conditions, such as a 'no contact' condition with a victim, or an exclusion zone. Such conditions will only be applied after very careful consideration of individual circumstances, case law and of the patient's human rights.

MHCS may take any of the following into account when considering discharge:-

The below issues should be addressed by the responsible clinician in any request for discharge, or when MHCS and the clinician are working together with leave requests, with a view to future discharge.

- The diagnosis/es
- Details of the index offence and other offending
- The patient's mental state at the time of the index offence
- The patient's mental state now
- The background, family history and formative development of the patient
- The symptoms of the mental disorder past and present and whether/how these were linked to the index offence
- Historic risk factors
- Progress in hospital, including the completion of any therapy designed to reduce risk

- Future possible triggers or relapse indicators referring to mental health and associate or referring to offending
- How the risks have been removed/reduced/managed over time
- What risks remain
- How these residual risks will be mitigated and managed safely in the community
- Progress on leave from the inpatient facility
- Appropriateness of the proposed care plan – the responsible clinician should propose conditions
- Victim issues – we will liaise with the Victim Contact Service where appropriate
- If the patient has been discharged before then recalled to hospital, we would look for how this might be avoided in the future
- Appropriate conditions to ensure, as far possible, that the patient presents no undue risk to others (or themselves)
- Adequate and suitable accommodation, taking into account the potential level of risk presented by the patient

Note: This list is not exhaustive and other factors may be taken into account depending on the circumstances of the particular patient. MHCS is not prescriptive with regard to specific interventions being undertaken but how the patient has engaged with treatment available to reduce/manage his/her risks.

MHCS will rarely get involved in the preparation of a care plan; but for complex and/or high profile cases, we might be able to attend care plan (or MAPPA) meeting.

4.B- Monitoring tool template (MOJ restricted patients)

This is to be used by the responsible commissioner to track outcomes and follow up for restricted patients

Patient Reference Number	CTR date	CTR outcome	Provider name	RC name	RC referral date to MOJ	Type of referral (request for leave, discharge)	Date of response from MOJ	Narrative response	Any escalation