



Care and Treatment Review

Code and Toolkit

**A guide for commissioners, panel members
and people who provide support**

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Introduction

The purpose of the Care and Treatment Review (CTR) Code & Toolkit

The main purpose of the CTR Code and Toolkit is to provide a solid framework for CTRs in order for them to be delivered to a consistently high standard across England.

The CTR Code and Toolkit is primarily designed for people who attend CTRs in a professional capacity but is of use to anybody who needs to understand the 'rules' of a CTR. There are two easy read booklets, **"My Care and Treatment Review"** and **"My CTR Planner"** booklets which are specifically designed for the person whose care is being reviewed. The booklets can be found here: www.england.nhs.uk/ctr

The toolkit is intended to offer practical support to people who are planning CTRs, with a checklist for commissioners and providers to use.

The CTR policy includes a set of Discharge Standards and Steps to help commissioners and all involved navigate through the discharge process, to provide tips, helpful links and a stepped guide, as well as to enable a better experience of involvement for children, young people and adults and their families. The discharge standards and steps are at the back of this document.

Care and Treatment Reviews

Throughout this Code when the term "people" is used, it is referring to adults, who have learning disabilities, autism or both. There is a version of this Code that applies to Children and Young People.

CTRs are focused on those people who either have been, or may be about to be admitted to a specialist mental health / learning disability hospital either in the NHS or in the independent sector.

CTRs bring together those responsible for commissioning and providing services (this will include nurses, social workers, education commissioners and other health, education and social care professionals alongside strategic commissioners where appropriate) with independent clinical opinion and the lived experience of people and families from diverse communities with learning disabilities, autism or both.

CTRs are driven by the NHS but the involvement of local authorities and education services in the CTR process and its outcomes is integral to improving care and treatment for people with learning disabilities, autism or both 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. To this end, the principles and standards were produced in response to the CTR Policy Engagement exercise undertaken during Autumn 2016.

The principles and standards are designed to ensure that all people who have a CTR have a consistent quality CTR experience leading to an effective review of their care and treatment.

These standards support the implementation of the CTR Policy, in the community and in hospital, with criteria that details best practice. Panel members need to familiarise themselves with the principles and standards, and hold each other to account for delivery against them. The standards will form the basis for quality assurance activity.

Key Lines of Enquiry

In common with the approach taken by the Care Quality Commission, the CTR policy will use Key Lines of Enquiry (KLOE) to guide and structure the review process.

Each KLOE consists of a key question followed by examples of probe questions that reviewers can use to explore and gather information on the issue under discussion. Each KLOE will also suggest sources of evidence that the review team might look for or ask to be provided to substantiate their findings.

The Key Lines of Enquiry will provide information and evidence to enable a summary and feedback for the person that says:

Am I safe?

What is my current care like?

Is there a plan in place for my future?

Do I need to be in hospital for my care and treatment?

The 10 KLOEs that a CTR seeks to address are:

1. Does the person need to be in hospital?
2. Is the person receiving the right care and treatment?
3. Is the person involved in their care and treatment?
4. Are the person's health needs known and met?
5. Is the use of any medicine appropriate and safe?
6. Is there a clear, safe and proportionate approach to the way risk is assessed or managed?
7. Are any autism needs known and met?
8. Is there active planning for the future?
9. Are family and carers being listened to and involved?
10. Are the person's rights and freedoms being protected and upheld?

Section 1

The PERSONAL Principles of Care and Treatment Reviews

At its core, the CTR has a set of principles based around the word PERSONAL which the CTR panel should always uphold. Panel members each have an equal role in making sure these principles are followed:

1. **P**erson centred and family centred
2. **E**vidence based
3. **R**ights led
4. **S**eeing the whole person
5. **O**pen, independent and challenging
6. **N**othing about us without us
7. **A**ction focused
8. **L**iving life in the Community

1. Person centred and family centred

The person and their family should be at the centre of the CTR. The CTR checks that the people who provide the person's care are working in a person and family centred way and that people get all the information and support they need to have an active part in the CTR before, during and after in the way that works best for the people involved.

2. Evidence based

The CTR Panel should all be able to see and hear information to help them understand what is working or not working about the person's care. The panel will check that care is carried out to a high standard. This is so they can decide with the person and others if anything needs to change or get better.

3. Rights led

The person has the right to be treated as an equal partner in their CTR and to have all the support they need to take part. The CTR should uphold the person's rights. Rights that ought to be considered are choice, contact with family, independent advocacy and being able to say what one thinks. Other rights are being treated well, having a good quality of life and being respected for one's personal life and beliefs.

4. Seeing the whole person

A CTR is not just about a person's mental health or how they behave. A CTR is holistic and sees the whole person. Their quality of life, likes, dislikes, choices, hopes and fears. The CTR will ensure that the care is delivered in a way that is culturally sensitive to the person.

5. Open, independent and challenging

Each person on the CTR panel can say if something does not seem right about the person's care. They can ask questions and say if something needs to change. The CTR panel will make recommendations to improve the care the person receives – doing this is called an action. Actions will go in to the CTR report that is agreed by the panel at the end of the CTR.

6. Nothing about us without us

The person, and their family carers if taking part, should be fully involved in the CTR. From giving consent, to getting ready, taking part, getting a copy of the CTR report and knowing what is happening afterwards. The CTR report should also be written in words the person will understand.

7. Action focused

After the meeting, the CTR report should have clear actions. Actions are things that need to be done. The actions should be easy to understand. The report will say who needs to do each action and when it should happen by. The actions should improve the care the person receives now and in the future. The commissioner will check these things are happening and that the person knows the reason if any action cannot be carried out on time.

8. Living life in the community

CTRs are about what is needed to help people live well in their communities. When someone is in hospital, a CTR will ask if they need to be there, or if their care can be provided safely in the community. It will also look at how people are supported to access the community while they are in hospital. The CTR will check there are good plans in place to keep the person safe in the community. The CTR will also check that the plans give the person the chance to lead as full and independent a life as possible.

Section 2

The Standards

Principle 1. Person centred and family centred

Standard 1.1 The person and their family will be given information about the Care and Treatment Review in advance.

Standard 1.2 Before a CTR, the responsible commissioner will ensure that the person has given consent or if the person lacks capacity, that a Best Interests decision has been made.¹

Standard 1.3 The person will be supported to get ready for the CTR using the “My Care and Treatment Review” and “My CTR Planner” booklets.

Standard 1.4 Reasonable adjustments should be made to the CTR process as required to ensure that the person is fully involved, present and able to participate as they wish.

Standard 1.5 The panel will make time available to meet separately with the person and their family carer. This could be meeting them all together or separately according to the person’s wishes.

Standard 1.6 Following a CTR the person and their family are supported to understand what will happen next.

Standard 1.7 The commissioner will ensure that the person’s needs are understood and that an appropriately skilled and experienced clinical expert is present on the CTR panel.

Principle 2. Evidence based

Standard 2.1 CTRs use a standardised, structured approach to the review of a person’s care by using specifically designed Key Lines of Enquiry (KLOE).

Standard 2.2 The CTR will look for evidence to support its findings and note these on the KLOE template.

Standard 2.3 Specifically the CTR will look for evidence that clinical and best practice guidance has been followed; this will be recorded on the KLOE template.

Standard 2.4 Information to help answer the KLOEs will be gathered together before the CTR takes place.

Principle 3. Rights led

Standard 3.1 Where there is concern that the person’s human rights may not be being upheld appropriately this will be identified on the KLOE template and relevant action taken.

Standard 3.2 The CTR will ask about the provision of independent advocacy for the person.

Standard 3.3 The CTR will ask about legal representation for the person (e.g. at tribunals).

¹ Mental Capacity Act, 2005

Principle 4. Seeing the whole person

Standard 4.1 Each CTR should take around a day to complete.

Standard 4.2 The CTR will include the people who are important to the person being reviewed.

Standard 4.3 People who are, or who will be, supporting the person should be part of the CTR – including local authority representation.

Standard 4.4 The review will ask about physical health, mental health and general wellbeing.

Principle 5. Open, independent and challenging

Standard 5.1 The review panel is made up of three people and will include: Chair – the person's commissioner; and two independent advisers – an expert by experience and a clinical expert.

Standard 5.2 The chair should be able to demonstrate that they have worked in partnership with the panel members including agreement on the content of the report.

Standard 5.3 The CTR panel will ensure that they have provided basic information about themselves to the person (for example name and photograph) and introduced themselves fully when they meet the person.

Standard 5.4 Where a CTR panel does not reach agreement, the differing opinions will be noted in the KLOE template.

Standard 5.5 The chair will ensure at the beginning that everybody who takes part knows what a CTR is about.

Standard 5.6 The review team will have completed Care and Treatment Review Training.

Standard 5.7 The panel members will all declare if they have any conflicts of interest.

Standard 5.8 The CTR will ensure that the reasons for, and the expected outcomes of, an admission/ continued admission are clearly recorded.

Standard 5.9 The CTR will question aspects of care and treatment that are not consistent with good practice or evidence based guidelines.

Standard 5.10 The CTR will keep asking whether the person's care and treatment could be delivered in a non-hospital setting.

Standard 5.11 A follow-up CTR will always check why any actions previously agreed have not been carried out.

Principle 6. Nothing about us without us

Standard 6.1 Every person will be supported to fully engage in their own CTR wherever possible considering how the person is supported to use their preferred method and/or tools of communication.

Standard 6.2 At the CTR a person will be identified who will communicate the progress on actions to the person and their family/carers following the CTR.

Standard 6.3 Following the CTR, the commissioner will write a report about the review in words that all involved can understand. The commissioner will make sure the person, their family/carers and others who need a copy get the report within two weeks.

Principle 7. Action focused

Standard 7.1 CTRs check that people are safe. When a CTR finds that people may not be safe, the chair will discuss this with the person, record on the KLOE template and raise concerns to the relevant authority or agency.

Standard 7.2 The CTR will identify gaps in the person's care and treatment. The panel will make SMART² recommendations to address these gaps in order to ensure appropriate treatment and discharge plans are in place.

Standard 7.3 The person's CPA care coordinator will make sure that the outcome of the CTR is reflected in the CPA care plan and will be followed through within the CPA process.

Standard 7.4 The outcomes of the CTR will identify the named individuals in the person's care team who will make sure the CTR recommendations are embedded in other relevant assessment and planning processes along with clear timescales, for example Education Health & Care Plan; Child in Need plans, risk assessments, etc.

Standard 7.5 CTRs will identify whether long term planning to support discharge (e.g. housing or where bespoke care packages may be required) is being considered and planned for at the earliest opportunity including the engagement of competent service providers.

Standard 7.6 The commissioner is accountable for follow up after a CTR and ensuring recommended actions are being carried out on time. Where actions are not carried out, the commissioner will explain to the person and their family why this is.

Principle 8. Living life in the community

Standard 8.1 A record of the reasons why the person's care and treatment cannot be carried out in the community will be made on the KLOE, where this is the outcome of a CTR.

Standard 8.2 The CTR will look for evidence of up to date, positive and proactive risk assessment and risk management plans that address the safety of the person and of others now and in the future.

Standard 8.3 The CTR will ask about the person's circle of support and how the person is being enabled to be part of their local community.

² SMART Recommendations mean that the recommendations should be:

Specific	What exactly should happen and the name of the person responsible for ensuring that it is carried out.
Measurable	How will people know if the recommendation has been implemented satisfactorily?
Action-focused	Recommendations should be in the form of clear tasks to be carried out by named persons.
Realistic	Recommendations have to be possible to achieve not merely aspirational or outside the remit or capabilities of the individuals named.
Time-framed	There should be a specific stated date by which the recommendation is to have been implemented or reviewed.

Section 3

The Standards in Practice

Principle 1. Person centred and family centred

Standard 1.1 The person and their family will be given information about the Care and Treatment Review in advance.

Criteria

- 1.1.1 The person, their advocate and their family will receive adequate notice of the CTR.
- 1.1.2 This will be done in writing and adjusted to the needs of the person, with telephone contact to back this up if needed.
- 1.1.3 The person will have the opportunity to change the date of the CTR if the proposed date is not convenient for them.
- 1.1.4 The person is able to withhold their consent from their family being involved in their CTR.

Standard 1.2 Before a CTR, the responsible commissioner will ensure that the person has given consent or if the person lacks capacity, that a Best Interests decision has been made.

Criteria

- 1.2.1 The commissioner is responsible for ensuring that the person's capacity to consent is assessed, this can be delegated to a hospital or community provider. Consent should be documented on the NHS England CTR consent form.
- 1.2.2 Where the person does not have capacity to consent and there is no-one who has the authority to decide who has lasting power of attorney,³ then a Best Interests decision must be made about the CTR taking place in line with the Mental Capacity Act.
- 1.2.3 It must be made clear to the person that if they do not give consent to a CTR, it will not have any adverse effect on their day to day care.

³ This has to be documented and registered at the Office of The Public Guardian.

Standard 1.3 The person will be supported to get ready for the CTR using the “My Care and Treatment Review” and “My CTR Planner” booklets.

Criteria

- 1.3.1 The person should be supported to access and understand the **My Care and Treatment Review** and the **My CTR Planner** booklets which support the person with preparing for their CTR. The Planner includes an accessible consent form, CTR planning document, feedback form and a template for recording actions in the way the person finds helpful.
- 1.3.2 The commissioner or provider will spend time supporting the person to prepare with these documents for their CTR.
- 1.3.3 The person will be supported to go through their last CTR and CPA to help them understand what progress has or hasn't been made with their care and treatment.

Standard 1.4 Reasonable adjustments should be made to the CTR process as required to ensure that the person is fully involved, present and able to participate as they wish.

Criteria

- 1.4.1 Before the CTR, the chair will ensure that the panel has a full understanding of what reasonable adjustments need to be made to ensure that the person can be fully engaged with the CTR process.
- 1.4.2 Where a person wishes to have a CTR but does not want to be present, they should be supported to let the panel know what their views are and what they want to happen. This could be in a written document they are supported to write (see 1.3.1) or they could be supported to make a video of themselves to share with the panel.
- 1.4.3 Reasonable adjustments made to the CTR process should be documented and could include:
 - Ensuring that all communications are in line with the person's wishes and communication passport
 - That regular breaks are planned in
 - Ensuring that the room is free from noise
 - That a supporter attends to support an expert by experience panel member where required
 - That the CTR is divided in to shorter periods to take place over more than one day
 - That interpreters will be made available to support the person.

Standard 1.5 The panel will make time available to meet separately with the person and their family carer. This could be meeting them all together or separately according to the person's wishes.

Criteria

- 1.5.1 The chair should ensure that there is a mutually convenient time planned for meeting with the person and/or their family carer. If the family carer was invited and wishes to participate but cannot attend the CTR, a mutually convenient time will be arranged to telephone them.
- 1.5.2 A person centred approach should be taken with regard to how many of the panel meet with the person, where and for how long.
- 1.5.3 All panel members should be willing to share basic, non-sensitive information about themselves when they first meet the person. This is to reduce any sense that the person is there to be questioned by people who are unknown and to act as an 'ice breaker'.

Standard 1.6 Following a CTR the person and their family are supported to understand what will happen next.

Criteria

- 1.6.1 The person and their family should be offered verbal feedback at the end of the CTR. This could be through attending the closing meeting of the CTR.
- 1.6.2 The person and their family should be given a copy of the CTR document once it is completed.
- 1.6.3 The commissioner and the provider will work together to ensure that the actions from the CTR are embedded within the person's CPA plan and followed through.
- 1.6.4 The commissioner may request the provider to give the person, family carer and/or advocate as appropriate, regular updates on progress against action points.

Standard 1.7 The commissioner will ensure that the person's needs are understood and that an appropriately skilled and experienced clinical expert is present on the CTR panel.

Criteria

- 1.7.1 The commissioner will ensure that they understand the person's presentation, and any key issues or barriers for example;
- The person has a learning disability and presents with behaviour that services find challenging
 - The person has autism in the absence of a learning disability
 - The person has a learning disability and has autism, or there are concerns that autism may be present but undiagnosed
 - The person's main purpose of admission is to treat a major mental health disorder
 - The person has a history of offending and is currently detained under section 37, 38, 47 or 48 of the mental health act (with or without a restriction order)
 - The person is under 18 and in a CAMHS unit or at risk of admission to one
 - Where there are particular barriers or concerns, eg over-medication, to allocate a clinical expert who has this expertise.
- 1.7.2 The commissioner should consider whether it is appropriate to find a clinical expert who meets the Clinical Expert (Enhanced) criteria, see page 34. This may be necessary when there are particularly complex issues around Mental Health Act law or prescribing.
- 1.7.3 Where an expert hub is used to find panel members, they should recruit clinical experts against the skill sets identified at 1.7.1 to ensure the hub is supplying appropriately skilled clinical experts.

Principle 2. Evidence based

Standard 2.1 CTRs use a standardised, structured approach to the review of a person's care by using specifically designed Key Lines of Enquiry (KLOE).

Criteria

- 2.1.1 The commissioner will use the NHS England CTR KLOE template.
- 2.1.2 The commissioner will support the panel members to use the prompt questions to seek the evidence they need to establish whether each KLOE is being achieved.

Standard 2.2 The CTR will look for evidence to support its findings and note these on the KLOE template.

Criteria

- 2.2.1 The commissioner will ensure that the CTR findings are based in evidence and assurance rather than reassurance.
- 2.2.2 The panel will have access to contemporaneous documentary evidence of the assessments, the care planned and the care delivered.
- 2.2.3 The panel will cross reference those documents. For example; if an activity planner shows a therapy session occurring on a Wednesday afternoon then the panel will review the progress notes to ensure that the session took place as planned and how the session went.

Standards 2.3 Specifically the CTR will look for evidence that clinical and best practice guidance has been followed; this will be recorded on the KLOE template.

Criteria

- 2.3.1 As appropriate, the panel will review whether the appropriate NICE guidance below is being followed.

NICE Guidance related to people with a learning disability can be found here

<https://www.nice.org.uk/guidance/population-groups/people-with-learning-disabilities>

NICE Guidance related to people with autism can be found here

<https://www.nice.org.uk/guidance/qs51>

NICE Guidance on Autism Spectrum Disorders in under 19s can be found here

<https://www.nice.org.uk/guidance/cg170/chapter/1-recommendations>

- 2.3.2 The clinical expert will support the panel to understand whether best practice and NICE guidance is being followed and that NICE guidance is adhered to in the clinical records.
- 2.3.3 The provider should ensure there is a paper copy of the relevant NICE guidance available if the CTR is taking place where there is no internet access.

Standard 2.4 Information to help answer the KLOEs will be gathered together before the CTR takes place.

Criteria

- 2.4.1 The commissioner (for a community CTR) or the provider (for an inpatient CTR) will ensure that all the necessary information is collated and ready for the panel's arrival. A checklist of necessary documents is at Section 5.

Principle 3. Rights led

Standard 3.1 Where there is concern that the person's human rights may not be being upheld appropriately this will be identified on the KLOE template and relevant action taken.

Criteria

- 3.1.1 The panel will discuss whether there is insufficient evidence that a person is having their human rights upheld.
- 3.1.2 Panel members should then document their concerns that a person may not be having their human rights upheld and will make appropriate recommendations.
- 3.1.3 Panel members should assure themselves that the care team respect the whole person including their cultural identity as defined by the person and not by others.

A human rights based approach

Taking a human rights based approach is about integrating the principles of human rights into policy and decision making.

The PANEL principles underlying a human rights based approach are:

- Participation – people take part in decision making and have a voice.
- Accountability – organisations and people need to be more accountable for realising human rights.
- Non-discrimination – everyone has the same rights (regardless of their ethnicity, gender, income, religion for example).
- Empowerment – to give the power to the people to know and claim their right in order to make a difference.
- Legality – to make sure all decisions answer to human rights legal standards.

(UNESCO 2006)

The British Institute of Human Rights has lots more useful information that can be found here

<https://www.bihar.org.uk>

Standard 3.2 The CTR will ask about the provision of independent advocacy for the person.

Criteria

- 3.2.1 The panel will document whether the person has an independent advocate to support them.
- 3.2.2 If the person does not have an advocate, the panel will consider whether there is evidence to support that the person could benefit from having an advocate and if so, make an appropriate recommendation.
- 3.2.3 The commissioner should seek to understand from the service provider how effective the advocacy service is and when a person lacks consent, assure themselves that the advocates available to the person have a good understanding of non-instructed advocacy.

Standard 3.3 The CTR will ask about legal representation for the person (for example at tribunals).

Criteria

- 3.3.1 The panel will document whether the person has a Mental Health Act Solicitor.
- 3.3.2 The panel will document whether the person has an Independent Mental Health Act and/or Mental Capacity Advocate.
- 3.3.3 Where there is an absence of any of these three roles, the panel should consider from the person's viewpoint whether any of these roles could benefit the individual's care and treatment. If there could be benefit then appropriate recommendations should be made.

Principle 4. Seeing the whole person

Standard 4.1 Each CTR should take around a day to complete.

Criteria

- 4.1.1 The CTR should be planned for a whole day.
- 4.1.2 Where the person feels that a whole day CTR would be too long for them, the commissioner should divide the process and arrange it over shorter sessions (over 2 half days for example).
- 4.1.3 When the CPA is being held on the same day, the chair of the panel with the consent of the person, should delegate attending the CPA to one of the panel members so the CTR can still be progressed.

Standard 4.2 The CTR will include the people who are important to the person being reviewed.

Criteria

- 4.2.1 The person should be able to invite people to attend the CTR who are important to them. This could include for example, their girlfriend, their best friend or their spiritual leader.
- 4.2.2 The person has the right to attend the CTR with their legal representative.

Standard 4.3 People who are, or who will be, supporting the person should be part of the CTR – including local authority representation.

Criteria

- 4.3.1 A representative from each of the agencies supporting the person now or in the future should be invited to attend.
- 4.3.2 The invited representative should attend the CTR. If the person is unavailable then they should provide a written report to the CTR including their view on each KLOE.
- 4.3.3 Representatives who attend from any agency must be the lead worker for the person.

Standard 4.4 The review will ask about physical health, mental health and general wellbeing.

Criteria

- 4.4.1 The panel will see documented evidence of a thorough approach to physical health care. This will include an Annual Health Check undertaken by the GP with whom the person is registered.
- 4.4.2 The panel will see documented evidence that mental health diagnoses are supported by clear assessment processes. It is expected that people who move between Responsible Clinicians have their diagnoses robustly reviewed to ensure that they are appropriate. A diagnosis of a major mental health disorder should not be solely based on historical indicators.
- 4.4.3 The panel should review the individual's general wellbeing. They should consider for example:
 - does the person look well?
 - do they have the opportunity to undertake activities that are of interest to them?
 - are they able to get outside regularly for fresh air?
 - are they able to have a healthy diet and/or one which they follow, for example halal or a vegan diet?
- 4.4.4 The panel will ensure that the care delivered is sensitive to the person's cultural identity, including race, sexual orientation, religion or belief.

Principle 5. Open, independent and challenging

Standard 5.1 The review panel is made up of three people and will include: Chair – the person’s commissioner; and two independent advisers – an expert by experience and a clinical expert.

Criteria

- 5.1.1 The review panel consists of three people. The chair may bring relevant colleagues, for example a case manager or an administrator to document the CTR. The expert by experience may attend with a supporter. But none of these other people form part of the formal CTR panel.
- 5.1.2 The independent panel members will have had appropriate Disclosure and Barring Service (DBS) checks.

Standard 5.2 The chair should be able to demonstrate that they have worked in partnership with the panel members including agreement on the content of the report.

Criteria

- 5.2.1 The chair should ensure that both the expert by experience and the clinical expert have opportunities to give their views within each KLOE, finding and recommendation.
- 5.2.2 The chair should record the key points of view from each panel member.

Standard 5.3 The CTR panel will ensure that they have provided information about themselves to the person (for example name and photograph) and introduced themselves fully when they meet the person.

Criteria

- 5.3.1 Once the panel have been allocated to the CTR, the chair should forward basic information about the panel members to the person.
- 5.3.2 When the panel meet the person, they should fully introduce themselves with their names and backgrounds.

Standard 5.4 Where a CTR panel does not reach agreement, the differing opinions will be noted in the KLOE template.

Criteria

- 5.4.1 The chair will have documented the dissenting views of panel members either within each of the KLOEs or if more appropriate in the concerns box of the KLOE template.

Standard 5.5 The chair will ensure at the beginning that everybody who takes part knows what a CTR is about.

Criteria

- 5.5.1 The chair should ensure that each person attending knows the background of why CTRs were introduced and the purpose of the CTR.

Standard 5.6 The review team will have completed Care and Treatment Review Training.

Criteria

- 5.6.1 The chair will ensure that themselves and the other panel members have had an induction to being a CTR panel member and access to ongoing CTR training and supervision.

Standard 5.7 The panel members will all declare if they have any conflicts of interest.

Criteria

- 5.7.1 The chair will ask the other panel members whether there are any conflict of interests that should be declared. If the conflict of interests would impede the CTR then it should be deferred.

Standard 5.8 The CTR will ensure that the reasons for, and the expected outcomes of, an admission/continued admission are clearly recorded.

Criteria

- 5.8.1 The panel will record the rationale for the admission/continued admission of the person and the expected outcomes.
- 5.8.2 The panel will record the expected length of stay of the person.
- 5.8.3 The panel will examine progress against the expected outcomes and the length of stay.
- 5.8.4 Where there is lack of progress, this will be identified in the KLOE template and actions recommended.
- 5.8.5 Where the panel believes that there is little prospect of the person achieving the expected outcomes within the existing service then they should recommend discharge or a transfer.

Standard 5.9 The CTR will question aspects of care and treatment that are not consistent with good practice or evidence based guidelines.

Criteria

- 5.9.1 Where care is not in line with good practice or evidence based guidelines, this should be documented on the KLOE template and appropriate recommendations made.
- 5.9.2 If the person's care and treatment has suffered a detriment and their discharge has potentially been delayed as a result then the panel should consider raising a safeguarding concern and/or a Care Quality Commission (CQC) alert.

Standard 5.10 The CTR will keep asking whether the person's care and treatment could be delivered in a non-hospital setting.

Criteria

- 5.10.1 The panel will consider whether there are reasonable grounds for a continued admission.
- 5.10.2 The panel will use their knowledge, expertise and experience to understand whether a person could reasonably be cared for in a community setting.
- 5.10.3 The panel will review the person's community service specification.
- 5.10.4 The panel will make recommendations as to whether the community service specification will meet the person's needs and whether a discharge should be recommended.

Standard 5.11 A follow-up CTR will always check why any actions previously agreed have not been carried out.

Criteria

- 5.11.1 The panel will read the findings and recommendations from at least the last CTR.
- 5.11.2 If recommendations have not been followed through the panel should question the responsible person to ascertain why.
- 5.11.3 If there is no good reason why a recommendation has not been followed through then this should be documented, raised as a concern and the chair should raise it at a higher level within the organisation and with the regional lead at NHS England.

Principle 6. Nothing about us without us

Standard 6.1 Every person will be supported to fully engage in their own CTR wherever possible considering how the person is supported to use their preferred method and/or tools of communication.

Criteria

- 6.1.1 The chair will ensure that everybody who attends the CTR is treated with respect and allowed sufficient time and space to be able to meaningfully contribute to the CTR.
- 6.1.2 The person will be able to sit in for as much or as little of the CTR as they wish.
- 6.1.3 Where the person or their family/carers hold different views to the professionals and/or the panel the chair will document these views and what the points of disagreement were and why.

Standard 6.2 At the CTR a person will be identified who will communicate the progress on actions to the person and their family/carers following the CTR.

Criteria

- 6.2.1 The chair of the CTR will receive an outline of the person's communication needs before the CTR takes place.
- 6.2.2 The provider will ensure that all documents are accessible to the person using their preferred method and/or tools of communication.
- 6.2.3 The person is entitled to have supplied for them a professional who can support them to fully engage whether this is an advocate, an interpreter if English is not their first language or a sign language professional who is independent of the service and NHS.
- 6.2.4 The Chair will record on the KLOE template who is responsible for communicating the progress on actions to the person and their family/carers. The responsible person should ensure that the progress on actions is communicated in line with the person's needs.

Standard 6.3 Following the CTR, the commissioner will write a report about the review in words that all involved can understand. The commissioner will make sure the person, their family/carers and others who need a copy get the report within two weeks.

Criteria

- 6.3.1 The commissioner will summarise the completed KLOE template in to an accessible report.
- 6.3.2 The commissioner will ensure that a copy of the report is sent to the person, their family carers and others who need a copy so that it arrives within two weeks of the CTR date, in line with NHS Information security requirements..
- 6.3.3 The report should always be made available to the person's Mental Health Act Solicitor, Independent Mental Health Act Advocate and Independent Mental Capacity Act Advocate.
- 6.3.4 The CTR report will always inform the professional's report to the person's next Mental Health Act Tribunal hearing or Hospital Manager's meeting.
- 6.3.5 When a person has had a community CTR, that report will always be provided to doctors making a decision about any admission and/or detention to hospital and the Approved Mental Health Practitioner in the case of a detention.

Principle 7. Action focused

Standard 7.1 CTRs check to see that people are safe. When a CTR finds that people may not be safe, the chair will discuss with the person, record on the KLOE template and raise concerns to the relevant authority or agency.

Criteria

- 7.1.1 The chair will ask for all attendees' views on whether the person is safe.
- 7.1.2 The chair will record the person's own view on whether they are safe.
- 7.1.3 The panel will be able to have access to the living environment of the person. With the person's permission they will be able to see the person's own room.
- 7.1.4 The panel will have access to all incident and safeguarding reports relating to that person since the last CTR including where named as perpetrator or victim.
- 7.1.5 The panel will have access to all the person's risk assessments, both current and historic.
- 7.1.6 The chair will document the panel's views on the person's safety and make appropriate recommendations.
- 7.1.7 The chair will raise safeguarding or CQC alerts where necessary.

Standard 7.2 The CTR will identify gaps in the person's care and treatment. The panel will make SMART* recommendations to address these gaps in order to ensure appropriate treatment and discharge plans are in place.

Criteria

- 7.2.1 All professionals who attend the CTR should show candour when discussing the person's care and treatment. They will be open about any shortfalls in the care and treatment and suggest what needs to happen to achieve the best outcomes for the person. If a professional believes that a person is ready for discharge then this should be disclosed.
- 7.2.2 The person will have an existing documented care and treatment programme with an expected date of discharge.
- 7.2.3 The person will have a community service specification.
- 7.2.4 The chair will record all gaps in the care and treatment in the KLOE template and make appropriate SMART recommendations.
- 7.2.5 If any panel member believes that gaps in service provision has delayed discharge or caused the need for admission then the chair should document this in the KLOE template.

*SMART Recommendations mean that the recommendations should be:

- S**pecific
- M**easurable
- A**ction focused
- R**ealistic
- T**ime-framed

Standard 7.3 The person's CPA Care Coordinator will make sure that the outcome of the CTR is reflected in the CPA care plan and will be followed through within the CPA process.

Criteria

- 7.3.1 The CPA Care Coordinator will ensure that the recommendations are embedded within the CPA process. The recommendations are to be discussed at the person's next CPA meeting with progress against the recommendations being reviewed and documented.

Standard 7.4 The outcomes of the CTR will identify the named individuals in the person's care team who will make sure the CTR recommendations are embedded in other relevant assessment and planning processes along with clear timescales, for example Education Health & Care Plan; Child in Need Plans, risk assessments, etc.

Criteria

- 7.4.1 The chair will document all the recommendations in the KLOE template.
- 7.4.2 The chair will name the individual who is responsible for ensuring the recommendation is carried out and by when.
- 7.4.3 The service provider should review the recommendations and progress toward them in ward rounds. If there are delays in achieving goals, the CPA coordinator and the commissioner will be made aware in writing. These conversations will be clearly documented.
- 7.4.4 The person and their family/carer should always be provided with a written explanation when a recommendation has not been actioned within the timeframe.
- 7.4.5 The chair is responsible for ensuring that the report and recommendations reflect the holistic nature of a CTR.

Standard 7.5 CTRs will identify whether long term planning to support discharge (e.g. housing or where bespoke care packages may be required) is being considered and planned for at the earliest opportunity including the engagement of competent service providers.

Criteria

- 7.5.1 A person will have an expected date of discharge recorded.
- 7.5.2 The commissioner should always seek evidence of hospital service providers and community team members working together to understand the person's community service specification.
- 7.5.3 Where necessary the commissioner should consider bringing in a community service specification expert to draw the plans together.
- 7.5.4 At the earliest opportunity competent service providers should be brought in to review the person and their service specification to see how deliverable it is ahead of the specification being put out to tender.
- 7.5.5 Where the panel members believe there is a lack of progress toward discharge they should make appropriate recommendations to expedite the process.

Standard 7.6 The commissioner is accountable for follow up after a CTR and ensuring recommended actions are being carried out on time. Where actions are not carried out, the commissioner will explain to the person and their family why this is.

Criteria

- 7.6.1 The commissioner should ensure that the delegated actions are reported upon regularly and give the timeframe to the accountable professional.
- 7.6.2 Where the professional is not making adequate progress, the commissioner should escalate that with the appropriate organisation and where necessary through contract management.
- 7.6.3 When after trying, the professional and the commissioner agree that a CTR recommendation is not achievable then they should agree a course of action and ensure that the person, their family/carers are advised of the situation. This decision should also be a minuted agenda item in the person's next CPA meeting.

Principle 8. Living life in the community

Standard 8.1 A record of the reasons why the person's care and treatment cannot be carried out in the community will be made on the KLOE, where this is the outcome of a CTR.

Criteria

- 8.1.1 The panel will review the community service specification to ensure that it reflects the person's hopes and dreams.
- 8.1.2 The panel will seek evidence that the person was fully involved in writing the community service specification. The person should have a choice as to where they live, whether they live in their own home or in shared accommodation and where there are amenities close by that they can access to live the life that they would choose.
- 8.1.3 The panel will take a view on whether the community service specification will meet the holistic needs of the person and provide enough support to minimise any risk of admission or re-admission.
- 8.1.4 If there are reasons why the person's care and treatment cannot be carried out in the community the reasons will be recorded on the KLOE template and a date set for review.

Standard 8.2 The CTR will look for evidence of up to date, positive and proactive risk assessment and risk management plans that address the safety of the person and of others now and in the future.

Criteria

- 8.2.1 The panel will have access to the person's full range of risk assessments.
- 8.2.2 The panel will ensure that the risk management plans address the safety of the person and others both now and in the future.
- 8.2.3 The panel will seek evidence that positive risk taking is within the plans.
- 8.2.4 The panel will make recommendations where the person's risk is not being proactively managed.

Standard 8.3 The CTR will ask about the person's circle of support and how the person is being enabled to be part of their local community.

Criteria

- 8.3.1 The panel will ensure the views of those who know the person best, for example family, friends, direct care staff and advocates are taken into account.
- 8.3.2 The panel will always consider and make recommendations in relation to how the person will stay in touch with families, siblings and their local communities.
- 8.3.3 The panel will look for community contact where the person is currently staying.

Section 4

CTR Experts by Experience and Clinical Experts: Role Descriptors

An Expert by Experience booklet is available from the NHS England [CTR website](#) which describes the role in more accessible language. This booklet also includes information about the PERSONAL principles and KLOEs.

Introduction

Care and Treatment Reviews take place in order to provide a person centred, independent process to look in depth at the needs of people with learning disabilities, autism or both, who are staying too long in hospital settings or are likely to be admitted to mental health / learning disability wards in hospitals.

CTRs provide an assessment of somebody's care and treatment in an inpatient setting or in the community, to identify the factors that are preventing their timely discharge or preventing adequate and safe support being provided where they live.

Care and Treatment Reviews use the PERSONAL principles:

1. **P**erson centred and family centred
2. **E**vidence based
3. **R**ights led
4. **S**eeing the whole person
5. **O**pen, independent and challenging
6. **N**othing about us without us
7. **A**ction focused
8. **L**iving life in the Community

Recruitment and support of Experts by Experience and Clinical Experts:

NHS England and CCGs have a responsibility to set up a support network that will be responsible for recruiting and supporting Expert Advisers that includes Experts by Experience (people with learning disability, autism or both and family carers) and Clinical Experts (psychiatrists, psychologists, nurses).

It is sometimes the case that an Expert by Experience will need to be accompanied by a supporter. Supporters play an important role in helping the expert to carry out their responsibilities effectively and each individual will have developed different working styles with their chosen supporters. This needs to be understood and facilitated by the review panel as a whole.

It is important that the supporter maintains their role in enabling the Expert by Experience and not as a member of the panel. The supporter should ensure that the process of the day, the form of information and communication and the discussion with individuals or groups are carried out in such a way that the Expert by Experience can make the optimum contribution. Supporters should be enabled to challenge any parts of the process that are impeding the Expert by Experience's ability to make a full and equal contribution.

Supporters, just as other members of the review team, are expected to comply with the policy and procedures of NHS England or CCG, as well as the NHS England or CCG code of conduct & confidentiality agreement.

Transmission of the CTR Report will be made available to you in line with NHS Information Security requirements. In line with NHS policies, you will be provided with information regarding the formal method for destruction of any information made available to you and this method will be discussed and agreed at the end of the review process. On the day this means that you are never to remove any patient information from the CTR and that any notes you make during the CTR must be given to the chair for shredding.

Conflicts of interest:

It is essential that Experts by Experience and Clinical Experts are able to act in as independent a role as possible in a care and treatment review.

Expert advisers must declare to the convenor of the review in advance if they have any conflicts of interest that would interfere with this independent role:

Conflicts may arise if the adviser, their family members, close relatives or personal friends are:

- working for a private / independent hospital service provider
- own or have a financial interest in a private service provider
- related to or have a non-professional relationship (e.g. friendship) with the service user and/or their family
- Having worked for the service previously (where the CTR is taking place).

(It is also possible that those working for an NHS provider that had a financial interest in the outcome of the CTR could be seen, on external review or challenge of the process, as not having made decisions that are independent of financial consideration for the organisation. Advisers should consider their role and practice carefully in light of this and if there is any doubt then the expert should discuss this with the lead commissioner at the point at which they are requested to take part).

The following role descriptions lay out the criteria for these different expert advisers.

EXPERTS BY EXPERIENCE

About the Expert by Experience role

Role Summary

- To work alongside clinicians & commissioners carrying out the review of a person's care and treatment.
- To bring another viewpoint that comes from your own experience. This experience may have been as someone with a learning disability, autism or both, who uses or is supported by services. The expert may have had experience of admission to a specialist learning disability hospital or have had extra support in order to avoid admission.
- Alternatively they may have experience of being a family member for someone with learning disability, autism or both.
- They will assist the team in helping to get better communication with service users and families. They will also help people to better understand their views and experience.
- They will support Equality, Diversity and Human Rights at all times.
- The role of the Expert by Experience is confined to the day of the review, it is not expected that experts will have on-going involvement with the person beyond this.
- This role is not one that should ever be undertaken by someone who has had solely professional experience of working with people who have a learning disability, autism or both. For example as a health care support worker or an advocate.

Main responsibilities

- To be willing to share introductory information about themselves with the person being reviewed.
- To be involved as a member of the review team. A review for one person lasts a day.
- To follow the guidance for Expert Advisers.
- To use the Care & Treatment Review KLOEs as the tool for reviews.
- To attend induction training and other specific training identified.
- To follow the policy and procedures of NHS England or CCG, as well as the NHS England or CCG code of conduct & confidentiality agreement.
- To help complete a report highlighting key findings and recommendations on the day of the review with the commissioner who is lead for the review.

Section 2 – How the Expert by Experience role works in practice

Experts involved in reviews need to:

- Talk to the review lead before the visit if necessary (usually on the phone).
- Tell the review lead if there are issues that they would find too upsetting to listen to (e.g. histories of abuse).
- Attend on time and be present for the whole review.

Experts take part in the review by:

- Being part of the introductory meeting and getting a brief "pen-picture" of the person being reviewed.
- Speaking with the person and their family – alone or with other review team members.
- Speaking with staff who work directly with the person and who know them well.
- Being supportive to family members who may attend the review.
- Being part of the feedback session at the end of the day.
- Making notes or writing parts of the report (with assistance when needed) which is handed to the Chair of the review (Commissioner) at the end of the day.
- Completing feedback forms on being part of a review.
- Discussing & commenting on the report before it is completed.

The preparation and visit is expected to take a maximum of 8 hours.

Section 3 – The skills or experience an Expert by Experience needs

What	What people will need to be able to do
Knowledge and experience	<ul style="list-style-type: none"> • Bring personal experience of either being a person with a learning disability, autism or both who may have used hospital services, community services or both <i>or</i> being a family carer for someone who is a user of services for people who present significant behavioural challenges or mental health problems either as an inpatient or supported in the community. • Bring personal experience of working with services, commissioners or providers to enable discharge from hospital and support people to live in the community. • Understand and be committed to equal opportunities and diversity. • Have an understanding and experience of person centred approaches and how this should shape people’s care and support. • Have an understanding about what good support looks like in the community. • Have a broad understanding of Positive Behavioural Support.
Skills	<ul style="list-style-type: none"> • Be able to communicate directly with people who use services and their families in a range of ways. • Be able to contribute to compiling a report (with or without support). • Be able to keep information confidential. • Be able to ask questions to ask about the person’s care and treatment and to challenge poor practice. • Be able to recognise what good practice and services look like.
Personal attributes	<ul style="list-style-type: none"> • To be reliable and punctual. • To be flexible in approach and solution focussed. • To be able to reflect on findings and thoughts as part of a team. • To be prepared to accept support in carrying out a thorough and focussed review and in reaching a shared outcome. • To have experience as described above.
Other important things	<ul style="list-style-type: none"> • Be able to travel to reviews (with or without support). • Be able to use email & phone to communicate (with or without support). • To have a DBS check if not already in place. • To be aware of any conflicts of interest and to make these known to the review co-ordinators before any reviews take place (see notes above). • To understand and accept that conflicts of interest may make it inappropriate to take part in a particular review. • To have signed a confidentiality agreement.

Section 4 – What payment or other support is available from NHS England

We want to make sure that all team members feel supported, equally valued and are able to make a full contribution. We want to make sure that experts taking part in reviews get whatever support they need.

It is important that expert advisers are provided with the right training and support before, during and after the care and treatment reviews.

This will include:

- Training to carry out the role.
- Preparation and information on the review in advance (where to meet, what type of environment the review is taking place in).
- Accessible materials to support them to carry out their role within the review.
- Support & guidance from the chair of the review.
- Debriefing and support following a review.

We have based rates of pay on the CQC Acting Together Programme rates.

The suggested rate of pay for an Expert taking part in a review work is £20 per hour (or £150 per day)

Travel or accommodation expenses will be paid in addition if the Expert is travelling outside their immediate area. This needs to be in line with the relevant organisations' policy for payment of expenses (for example in NHS England this would be the Public and Patient Voice on Covering Expenses).

This policy includes payment for support hours.

CLINICAL EXPERT

About the Clinical Expert role

Role Summary

- To work alongside Experts by Experience & responsible commissioners carrying out review of a person's care and treatment.
- The Clinical Expert will be somebody with a professional health qualification, such as Doctor (Psychiatrist), Psychologist, Nurse, Occupational Therapist, Speech and Language Therapist.
- The Clinical Expert will be able to offer a different perspective to the existing clinical team and will engage the person, their family and their local team in discussion to identify if there are barriers to discharge or to identify what support would enable the person to live their life in the community.
- The Clinical Expert, where required, will advise the other members of the team on matters such as the Mental Health and Capacity Acts, diagnosis, mental and physical health issues, treatment options and their evidence base.
- Clinical Experts are expected to promote Equality, Diversity and Human Rights throughout their role.

Main responsibilities

- To be willing to share introductory information about themselves with the person being reviewed.
- To be involved in the whole of the review day.
- To use the Care & Treatment Review KLOEs as the tool for reviews.
- To ensure that Best Practice and NICE guidelines are followed, and to ensure that NICE guidelines are adhered to in the person's clinical notes.
- To provide an independent clinical opinion free from commercial or other organisational interest.
- To attend induction training and other specific training identified as necessary.
- To follow the policy and procedure of NHS England, as well as the NHS England code of conduct & confidentiality agreement.
- To support the CTR Chair (responsible commissioner) to complete a review report highlighting key findings and recommendations on the day of the review.

Section 2 – How the Clinical Expert role works in practice

Experts involved in reviews need to:

- Talk to the review lead before the visit (usually on the phone).
- Attend the review punctually and to remain throughout the whole review.
- Receive and read the review materials and accompanying guidance and protocols.

Experts take part in the review by:

- Enabling a brief pen picture of the patient to be obtained in the introductory meeting.
- Meeting the person whose care and treatment is under review, staff & families – alone or with other review team members.
- Being part of the feedback session at end of day and facilitating the process of discussion, challenging current practice and opinions where necessary and forming conclusions and recommendations for future care.
- Writing own notes or part of the report, all of which is handed to the CTR Chair at the end of the day.
- Discussing & commenting on the report before it is completed.
- Completing feedback forms on being part of a review.

Section 3 – The skills or experience a Clinical Expert needs

What	What people will need to be able to do
Knowledge and experience	<ul style="list-style-type: none"> • Have current, substantial and demonstrable experience of community models of support for people with learning disabilities, autism or both who have mental health diagnoses and/or can present behaviours seen as challenging. • Understand and operate within a person centred framework, and show that they have worked with people with learning disabilities and family carers as equal partners. • To have an understanding of, and commitment to, equal opportunities, diversity and human rights. • Understand what “good” looks like in services for people with learning disabilities, autism or both. • To understand when hospital admissions may be counter-productive in an individual’s care. • Have an understanding about what good support looks like in the community. • Have experience of setting up packages of community support for people with learning disabilities, autism or both seen as challenging, in partnership with the individual their family and other key partners. • Have experience of avoiding admission to inpatient services for people with learning disabilities, autism or both who are seen as challenging. • Have experience of risk assessment and constructive, positive approaches to risk management.
Skills	<ul style="list-style-type: none"> • Be able to communicate directly and effectively with people who have a learning disability, autism or both and their families. • Be able to challenge existing practice. • Be able to make holistic assessments of individuals as well as their family, social and physical environment and how these relate to emotional and behavioural aspects of the person. • Be able to work in an open and respectful partnership with others in multidisciplinary teams and with service users and families. • Have an understanding of the application of Information Governance policy.

Personal attributes	<ul style="list-style-type: none"> • To be reliable, punctual and flexible. • To believe that people with a learning disability, autism or both have the right to live an ordinary life in the community and not live in a hospital or other segregated setting. • To be open to joint learning & participating in training and reflection. • Be able and willing to take responsibility for own physical & mental health or seek support if needed. • Be able to reflect on own experience and practice and ask for support where necessary.
Other important things	<ul style="list-style-type: none"> • To be registered with the relevant regulating professional body and in good standing with their specialist professional organisation (e.g. NMC, BPS, RCPsych). • Be able to travel to reviews (with or without support). • Be able to use email, & phone to communicate (with or without support). • To have a DBS check if not already in place. • To be aware of any conflicts of interest and to make these known to the review co-ordinator in advance of the review. (See notes above). • To understand and accept that conflicts of interest may make it inappropriate to take part in a particular review. • To have a signed a confidentiality agreement.

Section 4 – What payment or other support is available from NHS England

Rates of pay for Clinical Experts are negotiated locally. A comparable rate of pay for Clinical Advisers for the CQC is £300 per day is based on the CQC "Associate Inspector's General Expenses, Travel and Subsistence Policy and Procedures".

Travel or accommodation expenses will be paid in addition if the Clinical Expert is travelling outside their immediate area, in line with the local contracting organisational policy.

Where agreements are reached with local organisations to provide clinical reviewers this will be locally negotiated to include any arrangements for reimbursement.

CLINICAL EXPERT (ENHANCED)

About the Clinical Expert (enhanced) role

Role Summary

- To work alongside Experts by Experience & responsible commissioners carrying out review of a person's care and treatment
- To be involved in reviews of people who have been in hospital settings for a long time and/or where there are on-going difficulties in facilitating their discharge
- The Clinical Expert will be somebody with a professional health qualification who is an Approved Clinician (Mental Health Act) and has acted as Responsible Clinician for individuals under the Act. This will primarily be Psychiatrists but may included Clinical Psychologists or Consultant Nurses
- The Clinical Expert will be able to offer a different perspective to the existing clinical team and will engage the person, their family and their local team in discussion to identify what barriers to discharge or to identify what support would enable the person to live their life in the community.
- The Clinical Expert, where required, will advise the other members of the team on matters such as the Mental Health and Capacity Acts, diagnosis, mental and physical health issues, treatment options and their evidence base.
- Clinical Experts are expected to promote Equality, Diversity and Human Rights throughout their role.

Main responsibilities

- To be willing to share introductory information about themselves with the person being reviewed.
- To be involved in the whole of the review day.
- To use the Care & Treatment Review KLOEs as the tool for reviews.
- To ensure that Best Practice and NICE guidelines are followed, and to ensure that NICE guidelines are adhered to in the person's clinical notes.
- To provide an independent clinical opinion free from commercial or other organisational interest.
- To be prepared to challenge existing care and treatment plans and plans for discharge where appropriate.
- To attend induction training and other specific training identified as necessary.
- To follow the policy and procedure of NHS England, as well as the NHS England code of conduct & confidentiality agreement.
- To support the CTR Chair (responsible commissioner) to complete a review report highlighting key findings and recommendations on the day of the review.

Section 2 – How the Clinical Expert role works in practice

Experts involved in reviews need to:

- Talk to the review lead before the visit (usually on the phone).
- Attend the review punctually and to remain throughout the whole review.
- Receive and read the review materials and accompanying guidance and protocols.

Experts take part in the review by:

- Enabling a brief pen picture of the patient to be obtained in the introductory meeting.
- Meeting the person whose care and treatment is under review, staff & families –alone or with other review team members.
- Being part of the feedback session at end of day and facilitating the process of discussion, challenging current practice and opinions where necessary and forming conclusions and recommendations for future care.
- Writing own notes or part of the report, all of which is handed to the CTR Chair at the end of the day.
- Discussing & commenting on the report before it is completed.
- Completing feedback forms on being part of a review.

Section 3 – The skills or experience a Clinical Expert needs

What	What people will need to be able to do
Knowledge and experience	<ul style="list-style-type: none"> • Have current, substantial and demonstrable experience of community models of support for people with learning disabilities, autism or both who have mental health diagnoses and/or can present behaviours seen as challenging. • To have experience of working with inpatients as a Responsible Clinician. • To have experience of being RC for people subject to Part3 of the Mental Health Act and of working with the Ministry of Justice in the management of those on restriction orders / supervised discharge. • Understand and operate within a person centred framework, and show that they have worked with people with learning disabilities and family carers as equal partners. • To have demonstrable experience of working with individuals who are sexual offenders and with those who have been subject to abuse. • To have a knowledge of autism, its diagnosis, accompanying psychological and behavioural difficulties and how to effectively work with these. • To have an understanding of, and commitment to, equal opportunities, diversity and human rights. • Understand what “good” looks like in services for people with learning disabilities, autism or both and what additional skills and resources are required to support those who are subject to restrictions and/or who present behavioural challenges and a risk to themselves and/or others. • To understand when hospital admission and on-going detention in hospital may be counter-productive in an individual’s care. • Have experience of setting up robust and creative packages of community support for people with learning disabilities, autism or both seen as challenging and presenting significant risk, in partnership with the individual their family and other key partners. • Have experience of using alternatives to admission to inpatient services for people with learning disabilities, autism or both who are seen as challenging. • Have experience of risk assessment and constructive, positive approaches to risk management.
Skills	<ul style="list-style-type: none"> • Be able to communicate directly and effectively with people who have a learning disability, autism or both and their families. • Be able to robustly and constructively challenge existing practice. • To be able to bring to the review theoretical and practical knowledge of working with complexities of mental health, autism, challenging behaviour, trauma and sexual offending. • Be able to make holistic assessments of individuals as well as their family, social and physical environment and how these relate to emotional and behavioural aspects of the person. • Be able to work in an open and respectful partnership with others in multidisciplinary teams and with service users and families. • Being able to work constructively and creatively within the constraints of legal provisions. • To support others in taking managed risk where appropriate. • Have an understanding of the application of Information Governance policy.

Section 5

CTR Document Checklist

These are the documents that should be prepared ahead of the day for the CTR panel and put in to a pack. The CTR panel will not take any of these documents away with them nor make copies of them to take away. The CTR chair will be responsible for ensuring that all written and verbal information provided will be kept private and confidential within the CTR.

For a CTR in a hospital the responsibility for producing the pack is with the provider.

For a community CTR, the commissioner is responsible.

- Risk assessments.
- Mental Health Act papers.
- The most recent Mental Health Act Tribunal report.
- Social circumstances report.
- The community service specification and/or discharge plan.
- The last four weeks of progress notes.
- Safeguarding reports from the last year.
- Incident forms where restraint was used, either since admission or last CTR.
- Health Action Plan.
- Person Centred Care Plan.
- Positive Behaviour Support Plan and other care plans.
- Education, Health and Care Plan.
- Communication Passport.
- Hospital Passport.
- Medication Chart.
- Mental Capacity Assessments.
- Ministry of Justice documents, where appropriate.
- Activity Planner.
- Care Programme Approach plans and meeting minutes.

Section 6

Organising a CTR: Commissioner Checklist

Before the day

- Identify person needing a CTR.
- Identify if there are any reasonable adjustments to be made for the CTR.
- Identify if there are any requirements for particular experts, e.g. Females, experts in autism etc.
- Set date, ensure convenient for the person and their family.
- Book a meeting room.
- Arrange for the person to receive the **My Care and Treatment Review** and the **My CTR Planner booklets**.
- Ensure that enough time (ideally 2 weeks or more) is allowed for the person to give their consent (see Planner booklet), to decide who they would like to invite to their CTR, and for those people to be invited to attend by you or the provider as agreed.
- Ensure that yourself or the lead community/service provider team member have time booked in with the person to prepare for the CTR.
- Arrange for the Expert by Experience and Clinical Expert to be booked and ensure that they have invites and agendas sent to them, and have all the necessary support to attend eg. Travel, proof of identity document/badge if needed, health or support needs planned for the day.
- Ensure that yourself or the service provider have got all the necessary documents together for the CTR panel.

On the day

- Take the CTR KLOE template to the review and ensure the experts are broadly aware of this and how they can contribute to it during the CTR.
- Follow the agenda.
- Ensure that reasonable adjustments are made, if necessary, for the person, family and panel members and that non-technical language is used where possible.
- Complete the KLOE template and agree the findings and recommendations with the panel members.
- Feedback to the person, their family and to the service provider or community team in non-technical language. Agree with provider and all present who will carry out actions, timescales and who will be responsible for ensuring that actions are carried out.

After the day

- Send a copy of the KLOE template to all the necessary people within 2 weeks of the CTR.
- Raise any safeguarding concerns with the local authority and any alerts with the CQC.
- Ensure that the recommendations and actions are carried out and embedded in the CPA.
- Ensure that experts are supported to discuss their feelings about the CTR.
- Ensure that experts have handed back all the person's records, their own notes made during the CTR and that they clearly understand about transmission and destruction of secure information in line with NHS Policy.

Section 7

Model Agenda for CTR



Care & Treatment Reviews – Model Agenda

England

TIME	PANEL MEETING
<p>9.30am – 10.00am</p>	<p>The panel members meet and prepare for the day ahead; they should introduce themselves, advise of any potential conflicts of interest and understand what reasonable adjustments will need to be made to support the person, panel members or other people attending the CTR.</p>
<p>10.00am – 10.30am</p>	<p>An initial meeting takes place with all involved parties around the table.</p> <p>The Chair leads the meeting, giving the context for Care & Treatment Reviews, the aim of the review and the CTR principles.</p> <p>The panel should then be given a written or oral ‘Pen Picture’ of the person from someone who knows them well and discuss briefly ‘what’s working or not working’ about the person’s care.</p> <p>The plan needs to be agreed for the day including best time and place to meet with the individual and any family members involved and how others will be met (either in groups or individually).</p>
<p>10.30am – 3.00pm</p>	<p>The panel throughout this time need to fit in the following:</p> <ul style="list-style-type: none"> • meet with the person whom they are reviewing and their family. • gain an understanding of the environment in which the person is currently living. • it may be that the ‘Expert by Experience’ reviewer meets with the family/carer wherever they are comfortable to be met with. • the review team meet with members of the multi-disciplinary team in order to determine: their current level of input, the treatment they are providing, community support/future planning. Depending upon treatment being provided, this would ordinarily include the person’s Responsible Clinician or doctor, psychologist, named nurse, other lead therapists. The reviewers should encourage interviewees to explain their role, their input with the person, and their role/ thoughts in relation to discharge planning and outcomes. • the review team should meet with the person’s advocate and also members of direct care staff working with the person in order to identify both their knowledge and their understanding of the individual. • lunch.

TIME	PANEL MEETING
	<ul style="list-style-type: none"> • For the purpose of cross checking, the reviewers should determine if the care and treatments prescribed by the multi-disciplinary team translate directly to the delivery of day to day care for the individual. • The reviewers should explore staff resource, staff training, risk management, incidents/recording/reporting and debrief, use of restrictive practices, and discharge planning. • The review team should review clinical documentation. This is carried out to assure the accuracy of written records/plans against the actual delivery of such in practice. Due attention should be afforded to reviewing a sample of the following documentation; including behavioural strategies, functional analysis, risk assessment, health action plans, CPA minutes, incident reports, any person centred documentation. <p>NB – the meetings with the person, their family/carers, the professionals and the reviewing of records can be done concurrently by the panel splitting as agreed is appropriate.</p>
<p>3.00pm – 4.30pm</p>	<p>The review team should complete the KLOE template, reflect on the findings and then write their recommendations.</p> <p>During the final part of the review the review team look at answering the big questions and the supporting range of questions on the checklist.</p> <p>This will inform the feedback and the panel need to prepare key findings and prepare clear recommendations, timescales and those responsible.</p>
<p>4.30pm – 5.30pm</p>	<p>Feedback/discussion – this session will be led by the Chair and provide feedback on key findings, and recommendations.</p> <p>The feedback session will be structured around the four key headings:</p> <ul style="list-style-type: none"> • Am I safe? • What is my current care like? • Is there a plan in place for my future? • Do I need to be in hospital for my care and treatment? <p>The final session should encourage all to contribute and be solution focussed. Ensure the responsibility of the CPA care coordinator in updating the care plan is clear.</p> <p>Time should be allowed for ensuring the panel has a chance to debrief, and if not arrangements are made to do this outside of the day.</p> <p>NB – If concerns are picked up relating to quality and safety during the review process, the escalation process is to be followed in the CTR policy/guidance to ensure swift action is taken via relevant existing frameworks e.g. CQC; safeguarding and internal NHS quality surveillance groups. The responsibility for escalation sits with the responsible commissioner. These actions should be recorded on the KLOE template (there are tick boxes to record this).</p>

Section 8

Care and Treatment Review – Provider Checklist

Getting ready for a Care and Treatment Review

Your ref: _____

Checklist for _____ Date of CTR _____

How long since the last CTR (if there was one)? _____

The care co-ordinator is _____

Contact details _____

The CTR chair (or commissioner?) is _____

Contact details _____

Other key contacts: _____

	ACTION	BY	DATE
	ONGOING		
	<p>The person understands what their CTR is about and how it can help them. You should support the person to use the two booklets about Care and Treatment Reviews. They are available with and without symbols. One provides information, the other is a CTR Planner which provides forms for consent, preparation, on the day and afterwards. They can be downloaded from www.england.nhs.uk/ctr</p> <p>The person should be offered staff, advocacy and/or family support if appropriate to help them plan for and monitor their CTR progress.</p> <p>Staff are aware of the CTR Principles and Standards (same web address) and understand rights based approaches eg.</p> <p>www.humanrightsinhealthcare.nhs.uk</p> <p>DH Easy Read Mental Health Act – www.nhs.uk/easy-mentalhealthact</p>		

	ACTION	BY	DATE
	<p>If the person is in hospital, the provider and staff are using Discharge Steps and Standards (see Section 10) to ensure that discharge is progressing well.</p> <p>The person is supported to produce an accessible discharge plan. http://www.changepeople.org/Change/media/Change-Media-Library/Free%20Resources/Discharge-Toolkit-TABS-new-buttons.pdf</p>		
	AT LEAST TWO WEEKS BEFORE THE CTR		
	<p>Consent to a CTR and to family/advocacy involvement if appropriate is gained – to give people, families and advocates time to make arrangements. Raise any issues with the CTR chair promptly. The signed CTR Consent Form is copied and sent to the CTR chair and care co-ordinator. If the person lacks capacity and does not have a legal appointee, a Best Interests Process is followed and documented.</p>		
	<p>Practical arrangements for the day have been made and sent to the CTR chair and others eg. a suitable room or two rooms to enable the CTR panel to meet with more than one person at a time, food and drink arrangements made and confirmed, along with any regulations the panel needs to know about getting into the building and travel information.</p>		
	THE WEEK BEFORE THE CTR		
	<p>Get the documents ready which the CTR panel may ask to see – it is best to do this before the day of the CTR. The document checklist is at Section 5 of the CTR Code and Toolkit.</p>		
	<p>If the person has had a CTR before, you should review what happened last time with the person and what progress has been made since. Support the person to prepare what they would like to say and any questions they have for the panel.</p>		
	<p>Support the person to prepare for their CTR. There is a document for this in the person’s CTR Planning booklet, which should be completed in the person’s own words where possible. If the person has communication difficulties, other methods should be used to ensure their views are captured. If the person wishes, involve family carers and/or advocacy in helping to complete the profile. The person should bring this document to their CTR meeting if they are happy to do so.</p>		

	ACTION	BY	DATE
	Reflect on what you think is working or not working for the person and possible solutions, in case your views are sought on the day. This is about what you think, not a team opinion. You can ask to speak to a panel member if not directly invited. Your views will be treated confidentially.		
	ON THE DAY OF THE CTR:		
	Support the person to take part in the way they feel most comfortable eg. meeting members of the panel privately, choosing to have a family carer, staff member or advocate present, or choosing to meet panel members on their own. The person should be given time to meet the panel on their own terms, and have time to decide on the day. The person might feel more comfortable meeting panel members on the ward or in a different room from where the CTR is taking place – you should support this to happen if so. The CTR is a person-centred process – it is vital that the person’s wishes are respected and the person is happy with the way it is carried out.		
	Support the person to present and discuss their CTR planning document in the way they wish and check what support they would like in this, if any.		
	The CTR respects how the person chooses to take part. The person and family if appropriate are given the right amount of time to take part, the CTR is not too onerous for the person, people the person has chosen to attend to support them are there.		
	Staff feel able to share their views in confidence and respect is shown for their views.		
	WITHIN A WEEK OF THE CTR:		
	Staff reflect on the CTR with the person and with other staff as needed. Any queries or concerns are recorded and flagged up with the CTR chair.		
	The person is supported to fill in the feedback form in their CTR Planner booklet by someone they choose, if they wish. Copies are sent to the CTR Chair and Care Co-ordinator. A copy of this form can also be used by other people who were involved in the CTR.		
	Immediate actions needed are:		
	The CTR report should be received within 2 weeks by post. If not, ask the CTR chair for a copy which can be circulated to everyone who took part, including family carer/advocate if relevant.		

	ACTION	BY	DATE
	Support the person to understand the report and write the CTR actions in their own words in their CTR Planner booklet.		
	<p>A staff meeting is held to decide who will carry out CTR actions by when. This should be discussed with the CPA Coordinator who is responsible for embedding the CTR recommendations within the CPA Plan.</p> <p>These are:</p>		
	These actions are carried forward into CPA and/or other care meetings for regular review.		
	WITHIN 3 MONTHS OF THE CTR:		
	<p>A staff meeting is held to record progress of CTR actions and any further action needed to complete by the due date. Key things to do eg:</p> <ol style="list-style-type: none"> 1. Discuss progress since the CTR with the person, their advocate and family carer if involved; 2. Follow up with relevant people if key actions have not yet begun to take place; 3. Identify who is responsible in the staff team for making sure follow-up is carried out and reported back to the CTR Chair. 		
	<p>The recommendations and any concerns raised from CTRs should be collated by the provider organisation so that any themes can be reviewed and learning can be understood to improve the care and treatment for all people using their services.</p> <p>Ensure that the Clinical Governance team are made aware of CTR outcomes in order for organisational learning to occur.</p>		

Section 9

The Role of the Chair in Care and Treatment Reviews

The core review panel in a Care and Treatment Review (CTR) is comprised of:

1. The Chair (responsible commissioner)
2. An Expert by Experience
3. A Clinical Expert

It is expected that the responsible commissioner, in addition to having set up and coordinated the CTR, will chair the review.

The role of the chair is to make sure that the CTR is carried out in a manner that:

- Is based on the principles and standards laid out in the CTR policy.
- Is independent, fair and constructive.
- Ensures that all relevant views are heard and discussed.
- Ensures that the views and wishes of the person whose care and treatment is being reviewed, and their family members if involved, are clearly established and are at the centre of the reviews discussions.
- Ensures that both experts are fully involved and treated as equal members of the team. They bring important skills to the CTR and to the drafting of the report, which should be a collaborative process.
- Ensures that information is made available as per the document checklist.
- Establishes an outline plan for the review day and, if required, to modify this according to any particular issues that may emerge during the review.
- Helps the team develop a pen-picture at the beginning of the day of the person whose care and treatment is being reviewed.
- Is alert to any issues of concern regarding the welfare and safety of the person and to respond immediately and appropriately to issues that require prompt or urgent action and / or escalation.
- Ensures that the team is able to have discussions with the clinicians currently responsible for the person's care and treatment and also those who may be supporting them.
- Enables the team to challenge aspects of the person's current and future care and treatment.
- Clarifies and summarises the findings and recommendations of the review panel both on the day and in a subsequent report.
- Agrees a timescale for recommendations, naming the individual responsible and following agreed actions through after the review and ensuring they are embedded in the CPA process.

Section 10

Discharge steps and standards

Leaving Hospital – Hospital Discharge Steps and Standards

A Care and Treatment Review (CTR) will often identify that a person doesn't need to be in hospital for their care and treatment, and may make recommendations about the discharge planning process. It is important to note that the CTR is not a discharge planning meeting. Discharge planning is a routine clinical activity, managed through CPA, and once it is agreed by the team around the child, young person or adult, and their family, plans should be made for discharge. A CTR will scrutinise these plans.

Discharge steps and standards help to check that everything is in place for discharge to happen, and are written for anyone involved in supporting the process of discharge from hospital. There is also an easy read set of the discharge standards in the pack for the person having the CTR.

Some steps towards leaving hospital should always happen at given times, like planning for discharge from the time you arrive in hospital.

Other steps may vary from person to person, so some boxes are blank for dates to be added.

The standards are for everybody. You will find some useful links to other forms and information that will help in planning someone's discharge.

It is everyone's right to be involved in decisions about their own plans for leaving hospital. Information to help someone with this is called an 'Independence Pack'. An easy read Leaving Hospital Planner and Independence Pack can be found at: <http://www.changepeople.org/blog/february-2016/independence-pack>

The hospital planner can be used to help people track their own progress towards leaving hospital and keeping updated about what is going on.

Where people are assessed as lacking capacity to take a specific decision at a specific time in relation to their discharge plan a Best Interests process is followed as set out in the Mental Capacity Act 2005 and its Code of Practice.

Taking the right steps to leave hospital

Step	What should be happening?	By when?	Who will help me?
1. Getting the basics right from the start for me and my family	Me, my family and support team are told who my community CPA care coordinator is and who my hospital discharge facilitator is. The inpatient team will work with the community team, me and my family to learn more about me.	Before I go into hospital	Social worker or community nurse Hospital team
	I am helped to understand why I have been admitted to hospital and what needs to happen before I can be discharged home. This may take time, need ongoing support and should happen when I am ready.	When I go into hospital	Named hospital nurse Team in hospital Advocate
	The hospital team will produce a plan within four weeks to say what treatment I will get before I can leave hospital and what will change for me in hospital. This will be shared with me and my commissioner.	Within four weeks	Hospital team, named nurse My CPA care coordinator
	I am told who the lead link person in hospital is for support and communication with my family.	When I go into hospital	Named hospital nurse
	My family carers will be offered a Carers Assessment and support.	When I go into hospital	Social worker
	Someone will look at my living arrangements to try and make sure I don't lose my housing or right to benefits while in hospital. This will make it easier for me to leave hospital later on.	When I go into hospital	Social worker Landlord

Step	What should be happening?	By when?	Who will help me?
2. Person centred planning to get my future care right	There needs to be a good understanding of me to plan for my future. This includes my interests, my likes and dislikes, who I would like to live with and what I want from my life. This should be through a person centred profile or a life plan. <u>Examples of planning for my future</u> ⁴ .		Advocate Family and/or those closest to me. All the people who provide my care, treatment and support
	Planning what works for me and keeps me and others safe: We plan for how to meet my needs and wishes in the community, while keeping me and others around me safe and well. This could be through a 'Support Planning' meeting. My Care Programme Approach (CPA) Meeting may provide a place to start to plan for my future needs.		All the people who provide my care or treatment Family if I wish Advocate
	Other things that need to happen to plan for what I need A <u>Home Identification Form</u> ⁵ is filled in to help say what sort of housing I need. I am involved in deciding my housing needs. <u>Building the right home guidance</u> ⁶ for commissioners to support thinking about a range of options.		Hospital discharge facilitator Community care coordinator
	All of these things go into a person-centred service specification, a list of all my needs and wishes, to help the commissioner buy my future care. <u>Citizenship: a guide for providers</u> ⁷ – is available through this link and may be helpful when developing the service specification.		Community care coordinator Social worker Commissioner

⁴ <http://www.learningdisabilities.org.uk/help-information/learning-disability-a-z/p/person-centred-planning/>

⁵ <http://www.housingandsupport.org.uk/site/hasa/templates/general.aspx?pageid=476&cc=gb>

⁶ <https://www.england.nhs.uk/learningdisabilities/natplan/>

⁷ <http://www.centreforwelfareform.org/uploads/attachment/527/citizenship-a-guide-for-providers-of-support.pdf>

Step	What should be happening?	By when?	Who will help me?
3. Who pays? Sorting out the money	<p>All of the assessments needed for funding my future care are completed. These may include continuing health care and social care funding assessments. If I am on a Section 3 of the Mental Health Act in hospital I am entitled to a package of care from health and social care. This is called Section 117 Aftercare.</p> <p>If it is not clear who will pay for my care in the future, all the steps need to be gone through early enough so that it doesn't hold up my discharge from hospital later on. NHS England has produced a guidance document on 'Who Pays'.⁸ I am asked if I want a personal budget and given clear information to help me decide. If I get Continuing Healthcare money, I have a right to a personal health budget if I want one. Information on personal health budgets⁹.</p>		Commissioner Social worker
4. Finding the right support provider for me	<p>The commissioner uses the person-centred specification to buy the support that I need. Or I can use my personal budget to find the right support and get help to do this.</p>		Commissioner Social worker Personal budget agencies
	<p>Me and my family are involved in choosing the right support provider – this could be through a panel meeting.</p>		Community care coordinator/ Inpatient team
	<p>I know who will be supporting me when I leave hospital and will be involved in recruiting my staff (my family may be involved too)</p>		Community care coordinator Provider
	<p>My staff are trained, including Personal Assistants (PAs) to support me.</p> <p>My staff are involved in person-centred support planning and risk assessments with me, my family, community and inpatient teams.</p>		Community care coordinator Inpatient Team Support provider
	<p>I have a plan for how my health, social care, education or employment needs will be met in the community. The right package of support from the community team and primary care is in place to support me when I leave hospital.</p>		Community care coordinator Support provider Local specialist team/ GP

⁸ <https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf>

⁹ <https://www.england.nhs.uk/healthbudgets/>

Step	What should be happening?	By when?	Who will help me?
5. Housing and adaptations Making sure my housing meets my needs	The right housing is found for me using my person centred specification, which me and my family are happy with. Help on finding housing ¹⁰	Step 5 happens alongside step 4	Community care coordinator Support provider Housing officer
	Me, my family and someone from my team who knows me well will visit the accommodation so that we can advise on making the house right for me.		Community or inpatient team member
	If I am going to be a tenant, agreements are signed.		Community care coordinator
	If I need any changes or adaptations made to my housing, this will be done so that it does not hold up my discharge from hospital.		Community care coordinator
6. Getting ready to leave hospital	My Leaving Hospital plan is underway, and I may be going out of hospital on leave to visit my new home. The arrangements for how this is funded are agreed so that the visits can take place when I am ready.		Hospital discharge facilitator Community care coordinator
	A discharge meeting (usually a CPA) will be set up.		Hospital discharge facilitator/Community CPA care coordinator
	In preparation for leaving hospital, my care coordinator is helping me, my staff and family decide if and how to record my needs in case I am ever at risk of going into hospital again. Guidance and information on this register.		Community care coordinator Inpatient team
	I am safeguarded by making sure the right legal framework is used to support my discharge into the community and my involvement in decisions about me. This could include the Mental Capacity Act, Best Interests, Deprivation of Liberty, Ministry of Justice, Court of Protection, Mental Health Act, The Children Act, Children and Families Act, and others. Useful information on rights and the law: <ul style="list-style-type: none"> • BILD resources: from parenting to workforce. • Advocacy toolkit on human rights. 	Before discharge but also throughout being in hospital	Responsible clinician (RC) Future Community team Approved mental health professional Social worker Advocate

¹⁰ <http://www.housingandsupport.org.uk/life-begins-at-home>

Step	What should be happening?	By when?	Who will help me?
	Where I lack capacity, in advance of leaving hospital the responsible commissioner for the community package needs to establish whether the proposed care plan amounts to a Deprivation of Liberty (DoL). If it does amount to a DoL, this needs to be authorised in advance through a standard authorisation issued by the Local authority, if it is in a hospital or care home. This authorisation would be through an order of the Court of protection for a hospital or care home for a 16 or 17 year old, or 18+ year old who is not in a hospital or care home.	As early as possible in the process	Responsible clinician (RC) Future community team Responsible commissioner Local authority
7. Leaving hospital and support afterwards	I leave hospital.		Hospital discharge facilitator Community care coordinator
	There is a plan to follow up and keep in contact with me to see how things are going – the first visit is within one week of leaving hospital.	Within 1 week of discharge	Community care coordinator Inpatient team Responsible doctor
	Review meeting dates are set which include me, my family, paid carers and professionals who support me.	Plan agreed at last MDT before leaving	Community care coordinator
	I know how to get extra support if I need it and this is set up. I have all the support I need to enjoy living in the community.		Community care coordinator
	My community care co-ordinator and responsible doctor keep checking to make sure I am OK.		Community care coordinator Doctor

If the person cannot decide for themselves, Best Interest decisions will be made applying the Mental Capacity Act 2005 and its code of practice.

Discharge Standards

Standard	How will it be measured?
<p>1. I have a named discharge facilitator in hospital, who is a member of my multidisciplinary team (MDT). This person will help me with my discharge planning - with me and the people I choose.</p>	<p>This person is named on my admission document.</p>
<p>2. I have a named CPA community care coordinator from the community team. This person makes sure all my health and social care needs are met after I leave hospital and works closely with me and others to plan my discharge, and have an important role in carrying out actions agreed as part of my CPA and CTR meetings.</p>	<p>Named on my admission and discharge documents.</p>
<p>3. I have a named social worker who will support my discharge into the community. (This person may also be my CPA Care Coordinator)</p>	<p>Named on my discharge plan.</p>
<p>4. I am supported to be involved in my discharge planning and in making plans for my future with the people who are involved in and important to my care and support. I will have a copy of a discharge plan that is easy to understand, that shows the stages in my discharge plan, who is responsible for what, and by when. <u>An easy read Leaving Hospital Planner and an Independence Pack.</u>¹¹</p>	<p>'Me and my family' will give feedback about how people responsible for my care involve us in discharge planning. There will be a questionnaire for us to fill in from the provider. My discharge plan will show how involved I am too.</p>
<p>5. Keeping in touch with friends and family: While I am in hospital I will have support to maintain my relationships with the family and friends I choose to. This will help me when I leave hospital.</p>	<p>There will be a questionnaire for us to fill in from the provider, written in a way we can understand.</p>
<p>6. I will have a named advocate who is independent of the people who provide my care. This person knows me well and helps me speak up or speaks up for me.</p>	<p>This person is named on my discharge plan and on my admission document.</p>
<p>7. While I am in hospital and before I am discharged, I will have full and regular reviews of my medication to make sure I am not taking medicines that I don't need and to find other ways of helping me.</p>	<p>Medication reviews will be shown on my discharge documents, letters to or from my GP, responsible clinician and community team.</p>
<p>8. Meetings held to plan for my future will include my hopes and wishes and will include the people I want to be there. Meetings will be easy to understand so I can take part. Information will be provided in a way I can understand. Future plans will also support any needs I have that are caused by my experiences before or in hospital (eg. trauma). Plans will include what extra support needs I have because of this while supporting me to be as independent as possible.</p>	<p>I will give feedback about how this goes.</p> <p>There will be a questionnaire for me to fill in from the provider, written in a way I can understand.</p>

¹¹ <http://www.changepeople.org/>

Standard	How will it be measured?
<p>9. The Responsible Clinician (RC) will support my discharge, offering advice and guidance to the discharge facilitator and both inpatient and community multidisciplinary teams (MDT) during my admission. The RC will be active in dealing with the Ministry of Justice if this applies to me & applying any relevant legal frameworks and working with others to do this (for example the local authority). The RC will work closely with me and my family to support my future community package. The RC will make sure actions from Care and Treatment Reviews are carried out. The RC will also work with the community team doctor who will provide my future health care.</p>	<p>'Me and my family' will be able to ask the RC how all these things are going.</p>
<p>10. Planning for my future life outside of hospital while I am in hospital. Plans put in place to support me in hospital will also support me to make a good move into the community. This could include being supported to take more risks as I grow in confidence, skills and independence.</p>	<p>Care plans will show how I am gaining in confidence, skills and independence for leaving hospital.</p>

Notes

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Notes

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