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# Care (Education) and Treatment Review policy

COVID addendum

Version 11 October 2021

# Contents

# Introduction

This addendum has been produced by the national NHS England and NHS Improvement Learning Disability and Autism Programme. It provides information and guidance for commissioners, providers and their clinical and non-clinical teams, and expert advisers to Care & Treatment Review and Care Education & Treatment Review panels[1].This addendum has been developed to support the delivery of effective and safe C(E)TRs during the COVID-19 (or any other) pandemic. It will be updated as required.

This addendum provides guidance, best practice and considerations for carrying out C(E)TRs across all services – including services commissioned by NHS England and NHS Improvement, Clinical Commissioning Groups (CCG) commissioned services and Provider Collaboratives. It applies to all C(E)TRs for children and young people as well as adults.

This document replaces the 'Care, Education and Treatment Review policy COVID addendum Version 1, 11th January 2021'. The document should be looked at alongside the C(E)TR policy 2017.

# Context

As Government restrictions in relation to the COVID-19 pandemic have eased, we must now consider face to face or a hybrid approach as the default choice for conducting C(E)TRs. Only if national or local restrictions mandate that visiting a hospital is prohibited should a virtual only C(E)TR be conducted.

A hybrid approach is where part of the C(E)TR is virtual and part is face to face at the hospital or community venue. With this approach it is expected that at least one panel member visits the hospital, meets the person and directly reviews their care and support. The face to face and virtual element should be conducted based on what would enable the person and their family to be involved in the C(E)TR. This

[1] shortened to C(E)TR where we refer to both, to CTR for adults or CETR for children and young people only

could mean that the virtual element and face to face element take place on different days.

This guidance builds upon the Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages ( Coronavirus » Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages (england.nhs.uk) ) guidance issued to the system in relation to COVID-19, learning gathered from the period of implementation of C(E)TRs through the pandemic and taking into account the latest Government guidance on the easing of COVID-19 restrictions.

The addendum also clarifies several interim measures specifically for CETRs for children and young people who are a group at particular risk of admission to an inpatient setting due to the impact of the pandemic. They should be read in the context of the substantive C(E)TR policy and supplementary guidance detailed herein.

A full C(E)TR policy refresh has now commenced along with work on the key lines of enquiry (KLOEs). Relevant recommendations from the review of independently chaired C(E)TRs led by Baroness Sheila Hollins published on 21st July 2021 ( Independent Care (Education) and Treatment Reviews - GOV.UK (www.gov.uk) )will inform this refreshed policy; as will the learning from the pilot of revised C(E)TR KLOEs that took place pre-pandemic and learning from the COVID-19 period.

# 1. General principles

Continuation of C(E)TRs have remained a priority during the pandemic period:

- C(E)TRs are an embedded and essential part of the pathway of care for children, young people and adults with a learning disability, autism or both in inpatient CCG, NHS England and NHS Improvement Specialised Commissioning and Provider Collaborative commissioned mental health or learning disability and autism provision and in the community.

- C(E)TRs have an important contribution to make in:
  i. ensuring people are not in settings or conditions that expose them to increased risk of harm

ii. ensuring that whilst in hospital people's quality of life is not unduly impacted
iii. facilitating discharge from an inpatient care setting
iv. preventing unnecessary admissions to inpatient care
v. bringing together vital services across health, education and social care to help address barriers to providing the right support and finding solutions
vi. Providing a degree of independent scrutiny and challenge where necessary to care and treatment plans

- Whilst we remain in a pandemic we may need to adapt the way C(E)TRs are undertaken, we now expect **face-to-face or hybrid C(E)TRs to be the default choice on all occasions** unless local or national rules in relation to COVID-19 prohibit visits to hospitals or community venues. It is incumbent on local systems to ensure there is a robust process in place that will support reviewers to fulfil this role safely.

- The learning from virtual C(E)TRs during the COVID-19 pandemic will be useful in improving the ways that C(E)TRs are carried out, such as a hybrid approach facilitating the involvement of professionals and family members who cannot attend in person, but they do not replace the many benefits gained by one of more members of the C(E)TR panel visiting the person having a C(E)TR.

# 2. Returning to 'face to face' C(E)TRs and adapting where necessary

## 2.1 Views of people taking part in C(E)TRs through the COVID-19 period

- A survey of participants in C(E)TRs was carried out in July 2020. It showed that although virtual C(E)TRs 'had a place'; the majority of people who had a C(E)TR in relation to their own circumstances told us that they would have preferred a face-to-face C(E)TR.

- The learning has shown that, for some people, and in some circumstances, the use of virtual technology has been a positive experience. In relation to Community C(E)TRs, it has been reported in some areas that this has enabled better attendance of professionals at short notice.

- On the other hand, many people, families and panel members have found the virtual C(E)TRs more difficult.

- Virtual C(E)TRs do not replace the need for face-to-face C(E)TRs so that Panel members can see the hospital environment, meet the person, talk to staff involved in their care. Whilst we want to retain the learning and benefits from virtual C(E)TRs, we are committed to a return to face to face reviews.

### 2.2 How this learning should shape the approach to C(E)TRs in the future

- In order to support the assessment and management of the risks in relation to face-to-face C(E)TRs, a risk template is included in part 13.

  The COVID-19 policy of the organisation that the C(E)TR relates to should be held by the lead contract holder and Host Commissioner (i.e. all hospitals where C(E)TRs may be held), so that it is available for commissioners carrying out C(E)TRs.

- The COVID-19 policies of the organisation responsible for carrying out the C(E)TR and the venue (hospital or community setting) must be followed.

## 3. Quality assurance

- During this difficult period, it is vital to retain a continued focus on quality assurance, including on the outcome of the C(E)TR and implementation of the actions that come out of the review. The increased vulnerabilities of individuals because of Covid restrictions also need to be considered.

- A quality assurance process should continue to be applied locally by commissioners (NHS England Specialist Commissioning, CCGs, Provider Collaboratives), and overseen regionally, which should ensure that actions agreed at a C(E)TR are being followed through or escalated where not.

- An outline framework for quality assurance, based on the 2017 policy is attached as Appendix 1.

# 4. Standards for community C(E)TRs

- Processes for community C(E)TRs should be part of a joined up and consistent approach to 'building the right support' in local areas. This is to ensure that children, young people and adults at risk of admission to mental health inpatient services (this includes all mental health inpatient services: mental health units and specialist units for people with a learning disability or autistic people; general CAMHS and adult mental health units) are known to commissioners, and that there are effective plans in place to support them and their families.

- C(E)TRs need to be part of a strong governance process that includes dynamic support registers (DSRs) and support eco-systems that have agreed effective joint working processes across different organisations. This must include all adult and children's services, mainstream and specialist services, from health, social care and education. Other key agencies, such as the Police and Probation, should also be involved where necessary. Local Multi-Agency Public Protection Arrangements (MAPPA) should be used where relevant. The DSR should be led by the local CCG. The DSR should be up to date at all times and the contingency plan for each individual must be available 24/7 to those professionals that need to know, ensuring information governance requirements are met.

- National and local government advice in relation to COVID-19 should be carefully followed in order to keep people safe during a C(E)TR. As restrictions ease or are re-introduced as part of a response to a local rise in infection rates, the commissioner will be responsible for making sure all panel members are aware of and abide by local policies regarding face-to-face attendance.

- It is essential that there is still a process that enables clear review and scrutiny before any inpatient admission. This should not only consider alternatives to admission, but also define clearly the purpose, expected interventions, risks, outcomes and timescales of admission, should an admission for assessment, care and treatment be required.

- Regional NHS England Learning Disability and Autism Teams must be informed by CCGs, NHS England and NHS Improvement Specialised

Commissioning and Provider Collaboratives of any admissions. The Regional team will then review the admission with the commissioner to ascertain whether the admission could have been avoided and agree actions on lessons learned.

- It is vital that if an admission to hospital in unavoidable then there is continued oversight of the care and treatment throughout the person's admission. This would include, but not be limited to, the commissioner's oversight visits at least every 6 weeks for children and every 8 weeks for adults and the person's local community team/s to ensure that the care and any treatment necessary is resourced appropriately, on schedule and that all are working towards an agreed discharge plan which includes a planned discharge date and regular review of where the individual is on the 12 point discharge plan. It is expected that the person's allocated worker from community services, eg Care Coordinator, visits them at least monthly.

- Physical visits and meeting the person are vital elements of quality assurance and safeguarding in relation to C(E)TRs. A hybrid approach to C(E)TRs including virtual elements and face-to-face visits are likely to provide sufficient assurance.

- Commissioners should discuss with participants the use of technology to enable virtual elements of C(E)TRs to take place. There may be occasions where face-to-face C(E)TRs are still not possible, in those circumstances a virtual C(E)TR should take place with the input of usual participants to explore all options available for provision of treatment and care in the community.

  The use of Skype, WebEx, Microsoft Teams or other secure technology alternatives should be considered to enable the participation of members including the family. Microsoft Teams is our preferred platform for C(E)TRs.

## 5. Standards for inpatient C(E)TRs

- National, regional and local government advice on COVID-19 should be carefully followed in order to keep people safe. Additionally, local provider and commissioner policy will need to be applied in relation to face-to-face

attendance by panel members as restrictions are easing. This should be linked to the level of restrictions in place at that time.

- Commissioners are responsible for ensuring panel members attending the C(E)TR are equipped with the appropriate personal protective equipment (PPE), in line with national, regional and local guidance. The preferred option would be that any PPE required is provided by the venue (community setting or hospital) upon arrival. If this is not the case then the commissioner needs to source an alternative method of PPE provision for the panel members.

- Technology used to enable virtual meetings should be used alongside a risk assessed approach – as set out in part 13 – to support the face-to-face C(E)TRs element.

- Commissioners need to ensure that family members, experts by experience and clinical experts are enabled to join the meeting through technological means for virtual elements of C(E)TRs.

- Physical visits and meeting the person are vital elements of quality assurance and safeguarding in relation to C(E)TRs. A hybrid approach to C(E)TRs including virtual elements and face-to-face visits are likely to provide that assurance. A hybrid C(E)TR is likely to be over more than one day. This could be achieved by the panel member (Expert by Experience or Clinical Expert) visiting the hospital setting before the day of the C(E)TR meeting element which can be held virtually. This will enable the Panel member to meet the person concerned if they want to, spend time on the ward to observe, talk to staff and generally form an opinion as to what life in this hospital is like and the quality of care provided. This will then inform in part the wider C(E)TR meeting. It is recommended that if this approach is adopted at least half a day is allowed for the face-to-face visit. Whatever the approach taken it is vital that one or more Panel members be able to spend quality time meeting the person, observing the care and support and the environment where they live and spend their days. This will include any ‘extra care areas’ or ‘seclusion’ environments.

- To mitigate risk as much as possible whilst maintaining face-to-face C(E)TRs consideration should be given to minimising travel of Panel

members. If a person is placed at a hospital or community setting outside of their Region, then the Clinical Expert and/or Expert by Experience that will be visiting the hospital should be commissioned from the Region where the person is geographically.

- An example planner for an inpatient C(E)TR is set out in Appendix 2 to guide the key components of the day and activities beforehand, taking account of planning for a virtual C(E)TR. Note that agendas need to be composed around enabling the person to be at the centre of the C(E)TR process so must include any reasonable adjustments such as timings to enable them to participate as much as they can or choose. Regular breaks should be scheduled for the virtual component as some people have reported that they find virtual C(E)TRs tiring and intense.

## 6. Additional interim measures for children and young people in response to COVID-19

We are responding to concerns about an increase in admissions of children and young people with a learning disability, autism or both in inpatient mental health settings by asking local systems to implement the following additional interim arrangements with immediate effect.

We anticipate these measures will be introduced as an interim measure at least until the pandemic abates.

1. **Rapid review of Dynamic Support Register (minimum standards) to:**
    a. ensure standard (referral) criteria for entry onto the DSR for 'at risk level' – to identify children and young people at risk of admission
    b. identify children and young people who are likely to become at risk of admission without immediate intervention, support and care
    c. give particular attention to autistic children and young people who make up the largest number of admissions – including those who have been admitted to specialist inpatient care without a community CETR taking place and those people who are diagnosed with a learning disability and/or autism post admission.
    d. ensure a two-way information flow between the DSR and CETRs.

2. **Ensure community CETR compliance to agreed standard**

    a. Admission without a community CETR should be **exceptional** and in line with the current CETR policy (see point 4 regarding root cause analysis (RCA).

    b. Local commissioners should ensure there is compliance to a minimum of the agreed standard (75% of children and young people who are admitted will have had a community CETR).

3. **Post-admission CETRs** – the following interim changes reflect the urgency of the situation. Post-admission CETRs will:

    a. be held by exception, where a valid community CETR has not been possible

    b. take place within **five** working days (one week), rather than 10 working days (two weeks) as per usual CETR policy.

    c. be co-chaired by CCG and specialised commissioners.

4. **RCA will be completed to understand the circumstances of any admission without a community CETR or where the CETR did not support admission. This will:**

    a. explore why a community CETR was not possible or where admission was not supported by the CETR

    b. determine whether the child or young person had been identified on the DSR

    c. inform system changes to ensure CETR compliance and better identification through DSRs.

**Please note:** It is envisaged that CCGs, Provider Collaboratives and NHS England Specialised Commissioning will need to work together to organise CETRs within the prescribed timescales, by local agreement.

# 7. Information/patient records review as part of a C(E)TR

- Access to the patient's records for a virtual C(E)TR can be more problematic. Remember the key principles of good information governance in terms of considering how much information needs to be shared, with whom and when.

- The Commissioner should review the previous C(E)TR record and action plan, along with updates (if this is not the person's first C(E)TR) and make them available to the panel. This should be done at the start of the day, or before the start of the day, at the Commissioner's discretion. This is important and provides a quality assurance function for the C(E)TR.

- At this time, it may also be useful to circulate a brief outline or pen picture of the person, reflecting their strengths, needs, wishes and who they are as a person.

- Clinical experts may need to review records/prescription cards. As on a routine C(E)TR, this is usually carried out on the day. A comprehensive clinical case summary could be requested (often the most recent tribunal report is helpful).

- For details on what documents the panel may wish to review at a C(E)TR, please consider:
  - for adults: a checklist in section five of the CTR policy (2017) CTR code and toolkit
  - for children and young people: section five of the CETRs for children and young people toolkit
  - Reports from the Commissioners oversight visits
  - C(E)TR Key Lines of Enquiry (KLOE)from previous C(E)TRs.

- The Commissioner will screen and identify **if** information **is** required ahead of the day (eg if the previous C(E)TR KLOE indicates a specific area of focus), and to manage what gets distributed ahead of the day to whom. See section 11 below on information governance and relevant organisational policies.

- The C(E)TR enquiry or interviews during the day may lead the Panel to want to review particular records during the day, which will be requested from providers.

## 8. Key Lines of Enquiry for community and inpatient C(E)TRs

New Key Lines of Enquiry (KLOEs) will be published as part of the refreshed C(E)TR policy. In the interim, the existing published KLOEs should be followed, with the addition of a specific COVID-19 question to consider:

- the individual's risk of COVID-19 – both the risk of contracting COVID-19 initially, and the risk to them if they do contract it – and what is in place to support and protect them
- the impact of any additional restrictions bought about by COVID-19 (eg limited visits from family or outings, impact on discharge from hospital)
- the potential distress that this may cause, leading to the possibility of increased restrictive interventions (eg increase in psychotropic medication)
- how to ensure the rights of the person are being upheld.

See Appendix 6 for a COVID-19 KLOE template developed by the South West region that can used be at the C(E)TR.

## 9. Engagement of the child, young person or adult in the virtual components of their C(E)TR

- It is important that people participating in a virtual C(E)TR are given support to plan for their review meeting and can engage in a way they want to on the day.

- A new resource has been produced in plain English and easy read to support people attending virtual C(E)TRs, and is available via these C(E)TR pages.

- This covers areas such as consent for a virtual C(E)TR and supporting choice on the day as to how someone wants to be involved in their own review.

- It provides a useful guide for support staff and families as well as the person having the review.

- Panels should consider that it might be confusing and intimidating for people and their families to be confronted by lots of strangers on a screen. Possible solutions include wearing name badges which show names and roles. The chair could wear a different coloured badge to show they are the chair.

- The person should be able to participate with a family member, friend or staff member of choice if this is what they want. The panel should put the person at ease, chat informally and avoid clinical language. They should give choice about having cameras on or off, having a break, asking a question, ending a conversation and so on. People should not feel under pressure to speak in front of a large group.

## 10. Remuneration for expert advisers

- It is important that experts by experience and clinical experts are paid for their time spent on a C(E)TR. This includes any preparation time, as well as time spent on the C(E)TR due to virtual C(E)TRs being carried out in an adjusted way.

- This should take account of any pre-reading time that is expected, or discussion time that follows a C(E)TR. It is expected that expert advisers will receive payment for this in line with a routine C(E)TR (a day).

## 11. Information governance

- The use of virtual C(E)TRs can present information governance issues that need to be managed.

- When sharing patient information in preparation for C(E)TRs, the minimum required for the purpose of the review must be disclosed.

- NHS Mail accounts must be set up by regional Learning Disability and Autism Teams for Experts by Experience and Clinical Experts in order to share the safe and secure sharing of information relating to C(E)TRs.

- Wherever possible, you should ensure data is collated and sent as a single disclosure (as opposed to many separate emails) and via a secure method. This could be through designated secure areas on Microsoft Teams or via secure email:
  - Sharing nhs.net-to-nhs.net is automatically secured and encrypted.
  - If sharing with a non-nhs.net account, please make sure to include in the subject line the term **[SECURE]**, including the square brackets. This will enforce encryption.

- It is the Commissioner's responsibility to ensure personal data is securely transferred to an appropriate secured repository upon receipt, and emails are subsequently deleted. Once the C(E)TR has taken place and the patient data is of no further use, it must be deleted and any written notes destroyed.

- Appendix 3 sets out the issues and solutions to ensure that the virtual process is managed in line with information governance requirements.

## 12. Use of Dynamic Support Registers (DSR)

- It has been demonstrated that those local areas which are most successful in reducing unnecessary admissions through Community C(E)TRs are often those with a well-functioning DSR (might also be known as 'at risk of admission register' or dynamic support systems).

- Knowing the names of children and adults who are at risk of being or who have been admitted to an inpatient setting has always been an essential part of the Building the Right Support policy. That way, local areas and commissioners know who they need to focus on to make sure they are getting the right support in the community or in an inpatient setting, and there are plans in place for discharge.

- It is a policy requirement and expectation that all local areas should have a DSR in place.
- Some good practice examples have been developed and tested in some regions. These are published on our website.

- Local systems are expected to have DSRs that make sure people on their registers are getting support appropriately.

- Systems are asked to undertake some specific additional action in relation to children and young people as part of the interim measures. Please refer to section 6.1 on interim children and young people arrangements for further information on DSR for this group.

## 13. Risk assessment for return to face-to-face C(E)TRS within inpatient settings

Due to COVID-19 currently, C(E)TRs have been undertaken virtually via Microsoft Teams or equivalent. There are concerns that this has impacted upon the quality of C(E)TRs; particularly in terms of not seeing the person, the environment and being able to gain an understanding of the organisational culture.

As the pandemic is in a different stage we can start to return to 'business as usual' for C(E)TRS, while retaining some of the positives from the use of virtual processes.

While recognising that the current pandemic means we may need to adapt the way C(E)TRs are undertaken, we expect face-to-face or hybrid C(E)TRs to be the default choice in all occasions unless the local or national rules in relation to COVID-19 prohibit visiting hospitals or community venues. There remains a responsibility to protect panel members, patients, participants and others when resuming face-to-face C(E)TRs.

NHS Employers' guidance on supporting health and wellbeing of staff provides helpful tools and advice for use alongside the commissioning organisations' own policies, and those of the provider. Additionally, the guidance for visiting healthcare settings during the COVID-19 pandemic should be adhered to.

Table 1 below sets out the potential risks and mitigating actions to support with C(E)TRs returning to face-to-face safely; Table 2 gives a risk assessment template.

## Table 1: Risk areas to consider and possible mitigations to consider in relation to carrying out a face-to-face C(E)TR within an inpatient service

| Risk/issue | Initial risk: | Risk/issues description | Mitigating actions | Risk after mitigating action: |
|---|---|---|---|---|
| Active case of COVID-19: potential risk of transmission of COVID-19 | High | There is a confirmed case of COVID-19 on the site/building due to be visited for the C(E)TR | Do not undertake an 'in person' C(E)TR if there is a confirmed case of COVID-19, unless it is deemed a priority and essential.<br>Follow on site infection prevention procedures if conducting the C(E)TR in person, including the wearing of personal protection equipment.<br>If in place Government track and trace procedures should be followed when visiting all sites for C(E)TRs. | Low |
| Potential transmission of COVID-19 | Medium | There could be the potential for COVID-19 transmission without any one person showing signs of COVID-19 (from staff and patients on site, or from the C(E)TR panel member or other C(E)TR participants visiting). | The C(E)TR panel must comply with policies and procedures for: infection prevention and control, social distancing and visiting professionals (those of NHS England and NHS Improvement, the CCG and the organisation/ site being visited).<br>Consider the number of C(E)TR panel members and attendees required to be on site.<br>C(E)TR panel member(s) due to attend in person should not attend if they are showing any potential symptoms of COVID-19, that is temperature, persistent cough, loss of taste or smell. If any of these symptoms exist, they should follow national guidelines on isolation and testing for COVID-19.<br>If no symptoms exist C(E)TR panel member(s) can attend site in line with current national/local guidance including the following of infection prevention guidelines and PPE guidance of the site to be visited, this should include being able to be bare arms below the elbow to enable effective hand washing. If any C(E)TR panel member is unable to wear a face mask they should not attend an on-site C(E)TR. | Low |

| Risk/issue | Initial risk: | Risk/issues description | Mitigating actions | Risk after mitigating action: |
|---|---|---|---|---|
| Suitable meeting room: available for the C(E)TR | High | Does the organisation have a suitable meeting room for the C(E)TR panel to meet, can the panel maintain social distancing in the meeting room | The commissioner should enquire with the organisation/ site to be visited about availability of suitable rooms to enable social distancing to take place during the C(E)TR, they should also obtain the organisations policy for visiting professionals during COVID-19 and ensure this is available to C(E)TR panel members .<br><br>NHS England and NHS Improvement, CCG or Provider Collaborative policy for COVID-19 should be followed by all attending the C(E)TR.<br><br>C(E)TR panel members must wear face masks whilst on site, they should comply with social distancing guidelines, follow infection prevention guidelines and should comply with good hand hygiene throughout the day. | Low |
| COVID-19 confirmed in staff or patients or C(E)TR panel or attendees after the C(E)TR | Low | There could be a notification of a case of COVID-19 within the organisation or from the panel or those attending the C(E)TR after the C(E)TR has been completed | If the organisation reports a COVID-19 case after the C(E)TR they should seek advice from their infection prevention team regarding if to inform the C(E)TR panel or attendees who visited.<br><br>If a C(E)TR panel member or attendee develops symptoms after a C(E)TR they must inform the commissioner or chair of the C(E)TR who will advise the accountable organisation (CCG, NHS England and NHS Improvement or Provider Collaborative) in line with policy). The C(E)TR panel member or attendee demonstrating symptoms must follow national guidance, self-isolate and undertake a COVID-19 test. | Low |

## Table 2: Example risk assessment template

| **Risk assessment template to be completed** | | | | |
|---|---|---|---|---|
| **C(E)TR date:** | | **Where will the C(E)TR take place** | | |
| **Patient ID:** | | **Expected duration of visit:** | | |
| **Date of risk assessments** | | **Signed off by: responsible commissioner – Name** | | |
| | | **Date of sign off:** | | |
| **Check** | **Risk identified?** | **Measures to reduce risk** | **Responsible person** | **Is risk reduced to acceptable level?** |
| Confirm whether person or anyone in the service has suspected or confirmed COVID-19 | | | | |
| Consider whether the C(E)TR panel member is from a high-risk group in line with national guidance (BAME/pregnant/clinically vulnerable). | | | | |
| Consider travel arrangements for C(E)TR panel member(s) attending the unit. | | | | |

| | | | | |
|---|---|---|---|---|
| Confirm suitable room identified for C(E)TR that has been cleaned in preparation for visitors. | | | | |
| Confirm professional visitor policy has been received from host organisation and any procedures required to be adhered to are known to C(E)TR panel members. | | | | |
| C(E)TR panel member is trained to use appropriate PPE and willing to wear this (if panel member is unable to wear a face mask then they should not visit on site). | | | | |
| C(E)TR panel members informed if they need to bring their own food and drink. | | | | |
| C(E)TR panel members informed to follow social distancing rules, eg >2 metres away. | | | | |
| C(E)TR panel members confirm that neither they nor any household member has symptoms or has tested positive to COVID-19. | | | | |
| Confirm that C(E)TR panel member is aware of the risks in relation to travelling. | | | | |
| Confirm appropriate PPE is available for C(E)TR panel. Either from the venue or self-supplied/commissioner supplied. | | | | |
| Confirm that C(E)TR panel members have read and understood the PPE procedures including how to use any PPE. | | | | |
| Confirm that there are not any urgent external factors to consider such as local lockdowns or other changes to restrictions locally or nationally. | | | | |

# Appendix 1: Quality assurance

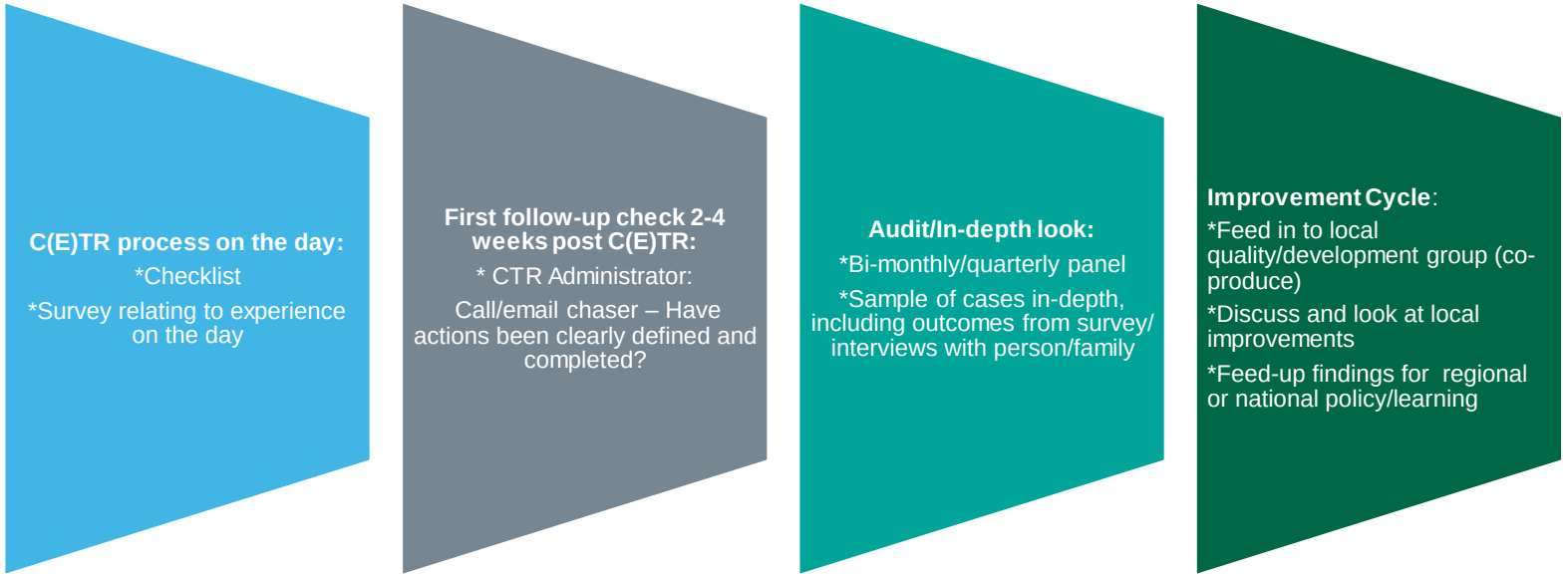


Figure 1: Opportunities for quality assurance of the C(E)TR process

Principles for the quality assurance process are that:

- It is owned locally by those who implement C(E)TRs – ie CCGs and specialised commissioning teams/provider collaboratives.
- It feeds into learning and an improvement cycle locally (local quality board).
- It is based on C(E)TR standards and principles as set out in the C(E)TR code and toolkits, with a priority focus on the patient and family experience and outcomes and ensuring that the actions from a C(E)TR are followed up.

- Oversight is required from regional teams who will carry out an annual audit of CCG/specialised commissioning/provider collaborative quality assurance activity, alongside sampling to test out local systems quality assurance processes.

## Appendix 2: Example planner for a hybrid inpatient C(E)TR

| Activity | Content | Who is there |
|---|---|---|
| Before the day | Ensure the person has access to the consent and planning documents in a format they can understand and that any support required for the person to make a capitated decision is provided. If the person is 16 years of age or above and it is suspected that the person may lack capacity then a Mental Capacity Act assessment should be conducted and a Best Interest decision be made if the person lacks capacity to consent to their C(E)TR. If the person is under 15 then parental consent should be obtained.<br>Commissioner to obtain information from the venue (hospital or community setting) and decide which member/s should visit the hospital in person. This should be based on the individual circumstances of the person subject to the C(E)TR.<br>Commissioner to arrange for the member of the Panel (Expert by Experience or Clinical Expert) to visit the hospital.<br>The member of the Panel (Expert by Experience or Clinical Expert) will visit the hospital. The Panel member will meet the person concerned if they agree, spend time on the ward to | |

| Activity | Content | Who is there |
|---|---|---|
| | observe, talk to staff and generally form an opinion as to what life in this hospital is like and the quality of care provided.<br>Check the person is able to prepare for the day and has the support they need.<br>Set up meeting times with professionals to maximise participation; likewise, with families unless they wish to participate throughout. If the person lacks capacity to consent, then their advocate must attend.<br>Set up breakout rooms in Microsoft Teams, so the Panel have room for smaller or private meetings and to review paperwork.<br>Commissioner must ensure that all relevant documents from the 'document checklist' are available to the Panel in a usable format. In additional there should be reports available from the Commissioner Oversight Visits.<br>Learn about using breakout rooms in Microsoft Teams (link to our website here gives advice on this), and ensure panel members are aware and comfortable with using the technology. | |
| Start of the day | Introductions and set ground rules – eg no talking over each other, avoid using chat box, no fancy backgrounds, try to capture important comments in person's own words, raise hand for questions.<br>Agree plan for the day – how it will be managed and where/how people will be met with individually. | All participants |

| Activity | Content | Who is there |
|---|---|---|
| Morning | Individual and group meetings. This will include allocated time for the Expert who visited the hospital to feedback to Panel colleagues. | Scheduled participants |
| Lunchtime | Identify and agree what records the panel want to review with the team | Panel |
| Afternoon | Individual and group meetings. | Scheduled participants |
| | Review records | Panel member(s) |
| Late afternoon | Panel gets together to draw together key actions for discussion with participants. | Panel members |
| End of day | Discussion with all participants on key outcomes and actions including follow up and who is doing what by when. | All |
| Finally | Panel debrief | |

## Appendix 3: Managing virtual C(E)TRs in line with IG requirements

| Area | Issue | Solution |
|---|---|---|
| Use of pooled equipment | Digital equipment may be shared by more than one person. | 1. Responsibility of any user to ensure no C(E)TR records are saved to the desktop or are accessible to ongoing users of the equipment.<br><br>2. Hygiene protocol, e.g. cleaning down equipment before use by another individual. |

| | | |
|---|---|---|
| Privacy and confidentiality | Device security<br><br>Conversations being overheard.<br><br>Handwritten notes may be read by others. | 1. Strong password logins should be used on devices such as laptops to increase security.<br><br>2. Ask panel members to use a quiet, private room for the C(E)TR. If there is the possibility of other people entering this room, the panel member should wear headphones and be mindful of what they say. Other people should not be able to hear the C(E)TR or view notes. Conversations should not be recorded or shared with others.<br><br>3. Handwritten notes should be kept securely after the C(E)TR and destroyed once the report has been written, in line with policy e.g. shredded. Chair to remind panel of this. |
| Privacy and confidentiality | Use of Microsoft Teams chat box – messages stay on the system and can be viewed by anyone who has taken part. | 1. Advise that **only non-confidential and no person identifiable information** should be shared through the Microsoft Teams chat function.<br><br>2.The chat function can be used to support effective management of the meeting, eg to plan breaks, for technical problems, etc. |

# Appendix 4: Best practice examples and tips

### Community C(E)TRs in North Yorkshire and the Vale of York CCG: a good practice example

Throughout the COVID-19 period, the CCG was able to retain a good focus on community C(E)TRs and managed to prevent four out of every five potential admissions. Some of the key elements to achieving this were:

- **Good working relationships between health and social care**: the CCG lead believes that the C(E)TR 'PERSONAL' principles are very close to the principles of social work, and this helped gain buy-in from all agencies which was key.
- **No admission without a Community C(E)TR**: the CCG held a strong line that going into hospital without either a community C(E)TR – or if that is not possible, a local area emergency protocol meeting – is unacceptable.
- **Taking a proactive approach to Community C(E)TRs**: a referral system has been set up that the local authority uses to refer children, young people and adults for them to be added to the DSR. There is time set aside every Monday to discuss the DSR with other agencies, and three 'huddles' a week with health (the local trust) and social care. Throughout COVID-19, the threshold for triggering a community C(E)TR was lowered, with a red, amber, green rating system being used.
- **C(E)TR buy-in from education and social care**: the CCG insists on education and social work professionals attending the C(E)TR, saying there is no point going ahead without them there. Good relationships and understanding of the process and how to trigger a community C(E)TR is seen as key to making the system work.

# Appendix 5: Top tips for chairing a COVID-19 C(E)TR

1. Select panellists according to their experience and skillsets. This can add more expertise to the discussion.

2. You (the chair) should ensure you have received and read the key documentation beforehand. This includes the previous C(E)TR KLOEs (if this is not the first C(E)TR), which will highlight key areas for discussion.

3. Check that appropriate consent has been given and family members invited if this is what the person wants. Make sure any barriers to participation are removed, ege.g. familiarity (or lack of) with using video calls.

4. Remember that the person should be central to the day. Build the agenda around the person's wishes and availability wherever possible: the 'nothing about me without me' principle. Be flexible about when the person and family want to meet you and provide opportunities for individual discussion separate from the main group. If possible, have two panellists involved so that one can take notes and verify what has been said.

5. Set an agenda with the person (and family if involved). The person may wish to provide an update or to discuss notes they have prepared.

6. Approach the agenda with flexibility and focus on what is important to the person and family if involved, making reasonable adjustments to support this.

7. Ask the panel about any reasonable adjustments they require before the meeting starts.

8. The person's lead professional or care co-ordinator and host commissioner should be available to give a verbal update at the earliest opportunity.

9. Focus on the key documents to make best use of time. Scrutiny of documentation can be more difficult virtually.

10. Ensure discussions focus on constructive challenge and exploration rather than revisiting old narrative. The C(E)TR should add value to a person's life.

11. Ensure a debrief with the panel at the end of the day to reflect, collect feedback and share good practice.

## Virtual platform tips

1. **Waiting room function (Microsoft Teams)**: participants to check if they can bypass the waiting room in advance of the meeting and make the administrators aware if this is not possible.

2. **Screen backgrounds**: remember that backgrounds can be engaging for some, but very distracting for others. Please check participants are comfortable with screen backgrounds – particularly the person who is having the C(E)TR.

3. **Breaks**: before the meeting starts, agree when breaks will be held; but let people know they can use the hand raise function if they need a break during the meeting too.

4. **Muting**: ask all participants to mute themselves when not speaking.

5. **Participation and chat function**: chairs need to be mindful of who is present in the meeting. Remember that the chat function can be viewed by all participants at any point in the day, and that it can be very distracting for people.

6. **Sharing of information**: advise that only non-confidential and no person-identifiable information should be shared through the Microsoft Teams chat function. The chat box can present information governance issues, as chats remain on people's Microsoft systems. The chat function can be used to support effective management of the meeting, eg to share the running order.

7. **Hand raise function**: ask all panel members to use the 'hand raise' function on Microsoft Teams if there is something they want to say, to alert the chair.

# Appendix 6: COVID-19 specific questions for a C(E)TR (developed by the South West region)

**Please note:** these questions are not a checklist; they are intended to be a reminder of important questions to ask.

Particular risk areas to consider are:

- Is the person from a Black, Asian or minority ethnic (BAME) group?
- Is the person overweight or underweight?
- Does the person have a respiratory condition?
- Does the person have diabetes?
- Is the person prescribed Clozapine?

If the answer to any of the above is 'yes', ask questions around:

- How this higher vulnerability to COVID-19 is being managed
- The frequency and adequacy of medical assessment and support

It is also important to establish:

- How is the person being supported to maintain contact with their friends/family? Is this working? When did the family last see or speak to the person?
- How are they accessing an advocate during this time? When did the person last see their advocate? How often do they see them?

If there are any issues at all with regards the person being able to communicate effectively with their family or advocate, then this should be RAG-rated as red with an immediate action created for the case manager and/or commissioner.

- Has the person shown any symptoms of COVID-19 or had it?

- How many people/staff have been infected/are infected?
- How many deaths have there been on the ward? In the hospital as a whole?
- If there have been any deaths, what bereavement support has been offered to the person?
- What is the plan if the person gets ill, or if other people on the ward get ill?
- What nursing/medical support is available to the provider to adequately assess the person's physical health? Who is providing the medical assessment – GP, nurse, psychiatrist? Have they had any specific training in relation to COVID-19?
- Is the provider able to check temperature and oxygen saturation?
- Is the person able to comply with guidance on hand and respiratory hygiene (covering mouth if coughing or sneezing and washing afterwards)?
- What testing is happening on the ward? In the hospital as a whole?
- Does the person have a COVID-19 specific hospital passport indicating heightened health risks, COVID-19 specific interventions and advanced directives? Is the COVID-19 'grab and go' guide being used?
- What has been done to ensure the person understands about keeping safe in the COVID-19 pandemic? Is there easy-read information available specific to them?
- What outside exercise is the person getting? Are they able to go out of the hospital grounds?
- If they are not getting outside, has a vitamin D supplement been considered?
- What protective kit is the person able to get? Who is paying for this?
- Are family member(s) able to visit?
- Are any restrictions now in place re: service delivery and patient's rights, eg leave and returning from leave with regards to testing?
- Are any blanket policies in place that may impact on people's individual rights?

- Has the person been placed in isolation? If so, is the person able to consent? If not, what is the legal framework? How is this being managed? (NB – long term segregation is not seclusion, so there should be evidence of personalised interventions and planning around contact, etc.) What if they refuse to be isolated?
- Has there been increased use of prn medication, or changes in prescribed psychotropic medication through this period?
- Are there any changes to staffing? What are the current staffing levels?
- What are the changes to the person's routine, activities, treatment, support?
- Do you have any concerns about the impact of these changes?
- What impact has COVID-19 had on the running of the hospital – eg activities, ward rounds, therapeutic interventions, care programme approach, C(E)TRs?
- Do staff have the protective kits they need/might need to work?
- Do the staff/hospital need any additional support? If so, who have you informed and what action has been taken to get this support?
- Are community teams in touch with people, including family members?
- How is the DSR being utilised during COVID-19

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