Learning disability and autism - Framework for commissioner oversight visits to inpatients

January 2021

Commissioner oversight visits Guidance: Minimum expectations during the COVID-19 pandemic

During the Level 5 response, it is still important for commissioners to maintain good oversight of the care of patients in mental health inpatient settings,

The principle of assuring commissioners that the patients they are responsible for are safe and their wellbeing is safeguarded remains the same.

The minimum expectations for commissioners in implementing this guidance are:

* Commissioner oversight visits will continue with adjustments for COVID-19 on a risk-based approach: Section 15 of the guidance gives information about the additional measures for carrying out commissioner oversight visits during Covid-19 during the level 5 incident.
* Commissioners will use their best endeavours to ensure that face to face visits take place, safely, with a minimum requirement that the commissioner will use telephone and/or virtual methods of communication with people that they commission care for.
* Visits should be prioritised and enhanced for those identified in services where quality concerns have been raised, or where the service has a Care Quality Commission rating of inadequate or requiring improvement.
* There is no change to the frequency of commissioner oversight visits during the COVID-19 pandemic; i.e virtual visits should take place at least every eight weeks for adults, and at least every six weeks for children and young people.
* There have been no changes to requirements in relation to safeguarding during the COVID-19 pandemic.

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1. Background
	1. The NHS Long Term Plan made a commitment to improve the quality of care within an inpatient setting for children and adults with a learning disability, autism or both. We must have robust and effective systems in place to identify and promptly address any concerns relating to quality of care and individual safety at the earliest possible opportunity.
	2. In response to the [Care Quality Commission Thematic Review of Restrictive Practices, Seclusion and Segregation interim report](https://www.cqc.org.uk/publications/themed-work/interim-report-review-restraint-prolonged-seclusion-segregation-people) published on 21 May 2019, [a written statement (ref HCWS1569)](https://questions-statements.parliament.uk/written-statements/detail/2019-05-21/HCWS1569) was published by Caroline Dinenage, Minister of State for Care. This statement included a commitment to stronger oversight arrangements for people with a learning disability and autistic people who are in specialist mental health, learning disability or autism specific inpatient services as follows:

“Where it is essential that someone is supported at distance from home, we will make sure that those arrangements are adequately supervised. We cannot have people out of sight and out of mind. That is why we are introducing stronger oversight arrangements.

“Where someone with a learning disability or an autistic person is an inpatient out of area they will [be] visited every six weeks if they are a child, and every eight weeks if they are an adult, on site. The host clinical commissioning group will also be given new responsibilities to oversee and monitor the quality of care.”

1. Introduction
	1. This guidance has been produced through working alongside people with a learning disability and autistic people who are currently, or have previously been inpatients, families with lived experience, providers, and commissioners.
	2. The guidance is to be used by commissioners and case managers to support implementation of best practice in relation to the commissioner oversight visits. An accessible version will follow publication of this guidance that informs children, young people, adults and their families about what to expect in relation to the visits, and how to raise a concern if the visits are not taking place.
	3. For the purposes of this document, ‘individual ’ is used throughout to refer to the person with a learning disability, autism or both who is in a specialist hospital setting. Also, the term ‘commissioner’ is used throughout to refer to the person that has responsibility for organising and paying for the individual’s care and treatment pathway.

This commissioner may be employed by a clinical commissioning group (CCG), an NHS England and NHS Improvement regional specialised commissioning team, or an NHS-led provider collaborative. It is this person who will be responsible for carrying out the commissioner oversight visits as described within this document.

* 1. In developing this framework, it is important that we learn from serious failures of care, such as those at Whorlton Hall, Winterbourne View and others. This will ensure that people with a learning disability, autism or both, who are in hospital and in need of care and treatment are safe, have a good experience of care and are not exposed to abusive or criminal behaviours.
	2. It is also vital that the approach to commissioner oversight visits learns from and complements (but does not duplicate) other types of interventions, such as care (education) and treatment reviews, care programme approach and contract reviews.
	3. In this guidance we emphasise the importance of relationships, trust and listening, and the commissioner spending time with the individual. Some of the feedback we have had from inpatients was that they value contact with their commissioner, and they can call and speak to the commissioner

Other feedback was that the individual didn’t know who their commissioner was, or if they visited, they went in the office with staff or didn’t spend time with the individual. Individuals gave some excellent tips on how to make these visits work better which we have incorporated into this guidance in Section 8.

* 1. Feedback from some commissioners was that some areas already have systems to ensure that individuals are visited or contacted regularly, e.g as part of specialised commissioning clinical reviews (or through provider environmental reviews).

However, regular, personal individual contact does not appear to happen consistently, and some individuals may not want to speak with their commissioner at those times. This guidance therefore aims to reinforce the commissioner-individual relationship and quality/regularity of personal meetings.

* 1. This guidance is based on the principles of the existing NHS England and NHS Improvement initiative [Ask Listen Do](https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/). This is about changing how things are done so that people with a learning disability, autistic people and families have their voices heard and encounter a better experience of services. It recognises that many people and their families do not feel their concerns and complaints are listened to and/or acted upon.
1. What are the settings where oversight visits should take place?
	1. These visits relate to specialist mental health, learning disability or autism inpatient services that care for people with a learning disability, autism or both. This includes inpatient services commissioned by CCGs, NHS England and NHS Improvement, or through NHS-led provider collaboratives (independent as well as NHS providers).
2. Who are the Oversight Visits for?
	1. These visits are intended to take place for:

ALL children and young people who are admitted to inpatient mental health, learning disability and autism services, who are visited in line with the Standard Operating Procedure (SOP) for Direct Commissioning, regardless of diagnosis. This standard also applies to provider collaboratives.

Adults with a learning disability, or who are autistic who are admitted to secure services commissioned by NHS England and NHS Improvement, or an NHS-led provider collaborative. This is in line with the SOP for Direct Commissioning.

Adults with a learning disability, or who are autistic and who are in hospitals commissioned by CCGs. Through the development of this guidance it has been agreed that commissioner oversight visits should take place not just for those individuals who are ‘out of area’ but for ALL inpatients, in line with the NHS England and NHS Improvement standards for specialised commissioning individual visits outlined above.

* 1. Further work in relation to definitions and metrics will follow the publication of this guidance to enable national monitoring of the implementation of these visits. However, it is expected that locally and regionally, systems will be developed and implemented to monitor compliance (see Section 14 below).
1. How often should the oversight visits take place?
	1. Once a person is admitted as an inpatient to hospital the visits will take place at least every **six weeks** for those aged under 18, and at least every **eight weeks** for an adult (aged 18 and over) with a learning disability, autism, or both.
	2. These visits must not replace or substitute for any other requirement to visit an individual (e.g in response to concerns or for other reasons such as discharge planning), which should go ahead as usual.
	3. When arranging the visits, the commissioner will need to consider timings of other key reviews, or meetings such as care (education) and treatment reviews, mental health act tribunals, care programme approach reviews or looked after children visits.
2. Who carries out the oversight visit?
	1. The commissioner (CCG, NHS England and NHS Improvement, or lead provider) who is responsible for arranging and funding the person’s care in the inpatient service is directly responsible for carrying out the visit. This is sometimes referred to as the ‘placing’ commissioner.
	2. For adult secure and children and adolescent mental health services (CAMHS) tier 4 inpatient services, this responsibility will either sit with NHS England and NHS Improvement regional specialised commissioning teams, or an NHS-led provider collaborative. For adult non- secure inpatient settings, the CCG is responsible.
	3. The NHS Act 2006, as amended by the Health and Social Care Act 2012, states that commissioners have a duty to monitor the quality of services, securing continuous improvement in the quality of services provided to individuals.[[1]](#footnote-1)
3. Purpose of the oversight visits
	1. The purpose of the commissioner oversight visits has been developed with people and families in line with the Ask Listen Do principles, as follows:

|  |  |
| --- | --- |
| **Ask** | Meet with the individual face-to-face and have a relaxed conversation about how they are doing and how they are being cared for. (Support with communication may be needed to enable this to happen.) |
| Develop a relationship that builds trust. |
| Ask for feedback from families and advocates or others the individual wants to be involved and who know the individual best. |
| Where individuals have significant difficulties with verbal communication, the commissioner should explore with families and others who know the individual best about their communication needs, and about how you can make reasonable adjustments to support the individual to participate in the oversight visit. |
| **Listen** | Hear from the patient about their experiences of their day-to-day care, and see the service through their eyes.  |
| Hear from the individual and others about any concerns or worries they have. |
| Spend time with the individual to see what their day is like (and with staff who support the individual day-to-day by doing this). |
| Be observant of the individual’s physical and mental wellbeing, and the environment (including the physical and staffing environment). |
| **Do** | Agree with the individual what action you will take, when/how you will feedback to them, and when your next meeting will be. |
| Raise any concerns about the care with appropriate people who have oversight of the service (eg Care Quality Commission, local authority, host commissioner). |
| Raise issues or concerns directly with the service that can be resolved – follow these up afterwards. |
| Act on any issues that require commissioner attention. |
| Feedback to individual by an agreed date. |

1. Top 10 things individuals want commissioners to do

|  |
| --- |
| 1. Ask me if the date and time are okay, and for anything I need you to know about meeting me. Give me enough time.
 |
| 1. Make sure you come if you tell me you are. (Don’t let me down.)
 |
| 1. Listen to me and be with me without any distractions, such as working on your laptop or making/receiving phone calls.
 |
| 1. Get to know me better with face-to-face meetings, in a comfortable room with coffee and tea, not over a telephone.
 |
| 1. I should be able to choose who supports me in these meetings, if I want them to. I may be capable of having the meeting on my own; this decision will made by me. If I am a child or young person, my family should be involved (unless there are legal reasons not to).
 |
| 1. I may want my family or somebody else involved – please ask me. If I am a child or young person, my family should be involved (unless there are legal reasons not to).
 |
| 1. I need to be involved in deciding what the actions are. Please do this together with me not afterwards. We need to set the date for the next meeting before you go. If I am a child, or young person, my family should also be involved (unless there are legal reasons not to).
 |
| 1. I need you to leave me a copy of the actions before you go.
 |
| 1. Ask me how I want to be kept informed after the visit.
 |
| 1. Come back and see me on time.
 |

1. Things to do before the oversight visit
	1. Consent is not required for the placing commissioner to visit a service or individual whose care they are directly commissioning (in line with the Mental Capacity Act 2005; see point 9.3 below).
	2. However, it is good practice – and leads better outcomes – if the individual has been able to discuss the visit in advance, and for those with parental responsibility in this process for a child under 16 to be involved.[[2]](#footnote-2)
	3. The capacity of the individual for understanding and participating in the visit should be considered in line with the Mental Capacity Act 2005 at the point of seeking agreement to visit. The five principles of the Mental Capacity Act[[3]](#footnote-3) should support this. Make sure that reasonable adjustments or forward planning are in place to support the person’s communication needs and participation.
	4. Part of the preparation is also to establish who else the individual will want to be involved in their visit. This could include family or advocacy, but there may be times where an individual does not want their family to be contacted.

For children and young people, the [Children and Families Act 2014](https://www.legislation.gov.uk/ukpga/2014/6/part/3/enacted) provides a clear basis for local authorities, and general principles for others, including gathering “the views, wishes and feelings of the child, and his or her parent, or the young person”. It is vital that parents of children and young people are involved.

* 1. Consider how best to involve family carers, as it may not be practical for them to visit every time. This could be via telephone, videoconference or using a carers’ feedback form.[[4]](#footnote-4)
	2. A template letter to support commissioners when making contact with families is provided in Appendix 1.
	3. Learning from Whorlton Hall has shown that a flexible approach to visiting individuals brings the most effective outcomes. It is therefore important to establish with the provider and individual in advance that not all visits will be planned, and a visit may sometimes occur outside of routine office hours. There is a real benefit to purposefully planning the visits at different times so that a better picture of day-to-day life can be developed.
	4. With support from the provider as needed:
* Take account of the individual’s communication needs and preferences in advance of the visit, making reasonable adjustments as appropriate (Equalities Act 2010).
* Check whether the individual would like to be supported by someone else they know well.
* Check with the individual how/if they want their family or others involved.

Ensure the environment in which you will meet is conducive to relaxed and open conversation (See ‘Top 10 things’ from individuals, above).

* 1. Ensure that actions agreed through previous visits or other meetings with the individual are known, so that actions since that occasion can be updated
1. Things to consider/do during the oversight visit
	1. Create an informal and relaxed atmosphere. (See section 8 above.)
	2. Be aware that people with a learning disability and autistic people may give the answers that they think people want to hear. They may be more acquiescent and appeasing in their responses and find it difficult to 'complain' or report issues of concern. Remember that the individual is in a less powerful position.
	3. Do not take answers at face value or accept a response that you yourself find uncomfortable without exploring further. Always seek – possibly over several visits – to find ways of further exploring and checking the validity of responses. Making consistent effort to build a trusting relationship with the individuals over time may enable them to be more open in their discussion. Do not press people to divulge things if they clearly uncomfortable doing so.
	4. Remember that if things are not going well the individual may be reluctant to share this as they have to stay there – so maintain professional curiosity during the visit.
	5. Reassure the individual at the outset of each discussion about confidentiality, what can be kept confidential and what would need to be shared with others.
	6. Go at the person’s pace – be led by them. Note further reasonable adjustments that may be needed for future visits. Check with the individual at the beginning how they will indicate they want to stop or take a break.
	7. The recording form in Appendix 1 gives a simple structure covering the person’s experience of the service, their safety and wellbeing, treatment, and progress through the pathway.

A useful question to ask is what it is like at different times of day in the hospital; what sort of activities the person does; what are the best and worst bits about their hospital stay; who does the individual talk to if they have a problem; and how easy it is to get problems sorted out.

Ask if they have concerns about any of the other individuals (this may indicate if there are issues of concern). Some ideas for further questions to ask are set out below:

* What’s a typical day like?
* How are you feeling about your care?
* What are you finding difficult about being in hospital?
* Are there things that you find helpful/good about being in hospital?
* How do you keep in touch with family and friends?
* What did you like doing before you came into hospital?
* Can you do some of the same things here?

What is a good/bad day like for you?

* 1. Inform the provider that the individual’s room will need to be seen (with the individual’s consent.)
	2. Towards the end of the meeting, agree and write down any actions to be taken afterwards; when and how these will be fed back to the individual (and any other people the individual chooses); and when the next meeting will be (see Template 1 in Appendix 1).
	3. Give the individual and provider a copy of this record and keep a record.
1. Things to consider after the oversight visit
	1. Share with others who need to know. Consider:
* CQC
* CCG host commissioner
* NHS England and NHS Improvement contract holder
* Local authorities for safeguarding concerns (both the individual’s home local authority, and the host local authority where the unit sits geographically)

The CCG/NHS England and NHS Improvement–designated safeguarding professional/lead (see Appendix 2 for the table from the ‘Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework’ on relevant legislation).[[5]](#footnote-5)

All health professionals have a duty of care to individuals/service users, and should they suspect a safeguarding concern, they should raise this via the relevant local authority in line with the Care Act 2014, as well as the host commissioner. The chair of the local safeguarding adult board should include the host commissioner as a partner when investigating any concerns that have been raised.

* 1. Share anonymised information with the host commissioner only. Person-identifiable information should never be shared unless there is a very good reason to do so, and the organisation’s Caldicott guardian has signed this off. Communication should be proportionate and appropriate to the level of concern.

Those sharing intelligence should also take in to account General Data Processing Regulations (GDPR), particularly when sharing information regarding individuals, or where it is possible to identify an individual due to high profile.

* 1. Even if something seems minor, it is important that the information is shared, as minor issues can add up to a collective picture to the relevant authorities with responsibility for the quality of the service (the host commissioner or Care Quality Commission [CQC]). The commissioner has a duty of care to share these concerns. Additionally, it might not be minor to the individual: it is important this is understood and acted on.
	2. Intelligence shared could relate to (but not limited to):
* concerns about use of restrictive practice
* concerns about lack of application of liberty protection safeguards
* concerns relating to staffing ratios
* concerns relating to treatment of individuals by individual or multiple staff and a lack of person-centred care
* concerns in relation to drug errors or failure to provide the appropriate prescribed medication
* repeated failure to deliver agreed actions as part of C(E)TRs or CPA
* lack of activity
* concerns about a person’s physical or mental health needs being met
* poor use of documentation e.g care planning, or failure to personalise care, or to involve the individual or their family in the care planning process
* concerns regarding the inpatient environment, e.g health and safety and medication concerns
* concerns of immediate risk of harm to individuals or staff which must also be escalated to local authority safeguarding services
* lack of involvement of families or of incidences where families are regularly being excluded from units

concerns in relation to whether an individual’s human rights are being upheld. (See useful information for health and social care professionals on human rights in healthcare from the British Institute of Human rights.)[[6]](#footnote-6)

* 1. Make sure it is known who the host commissioner is for each service or contract holder for NHS England and NHS Improvement-commissioned services (or NHS-led provider collaborative). Regional leads can help identify these – contact details are below:

**List of regional leads**

|  |  |  |
| --- | --- | --- |
| **Region** | **Regional lead for learning disability and autism** | **email address** |
| North East and Yorkshire | Claire Swithenbank | Claire.Swithenbank@nhs.net |
| North West | Claire Swithenbank | Claire.Swithenbank@nhs.net |
| East of England | Susan Fox | Susan.Fox11@nhs.net |
| Midlands | Robert Ferris-Rogers | R.Ferris-Rogers@nhs.net |
| South East | Alison Leather | Alison.Leather4@nhs.net |
| South West | Kevin Elliot | Kevin.Elliot@nhs.net |
| London | Heidi Peakman | H.Peakman@nhs.net |

* 1. 11.6 CQC are interested in improvement actions that come out of these visits and will be asking about these on their inspections, so share anonymised information with the local CQC inspector.
	2. Feed back to the patient as agreed on actions taken (and family as appropriate).
1. The provider role
	1. The provider of the care and treatment has an important role in facilitating the visits. The provider role includes the following:
* Making sure there is a welcoming environment for the visits.
* Supporting the individual at the visit in line with the their wishes. This may include support around communication, e.g a speech and language therapist and/or tools to support communication.
* Responding to concerns raised by individuals through the visits, including escalations as required and specific actions (e.g this could be setting up a medication review or initiating a health check).
* Feeding back to the commissioner and individual on actions taken.
* Liaising with others, such as the advocate or family, as required.
* Using the learning and improvement actions that come out of the visits, ensuring there is an overview of these from all visits, and that they are seen as a learning and improvement opportunity.

Having this learning evidence ready to demonstrate improvements made on CQC or at contract review meetings.

* 1. A communication plan will be put in place with regards to informing providers of host commissioner arrangements and commissioner oversight visits. However, at a local level, CCGs, NHS England and NHS Improvement, and NHS-led provider collaboratives should be advising their providers of these new expectations.
1. Escalation of concerns
	1. It is important that concerns identified through the commissioner visits are managed in line with normal escalation routes set out within the respective commissioning organisation. Safeguarding concerns should be raised as soon as possible during or after a visit.
	2. Where inpatient services commissioned by CCGs are spot purchased, this can often lead to units where individuals’ care is commissioned by multiple and dispersed CCGs – often from multiple transforming care partnerships (TCPs) and even regions.
	3. While the placing commissioners will have responsibility and oversight for those whose care they commission, often there is no opportunity to share intelligence between commissioners about care quality or concerns, or triangulate any issues identified.
	4. The host commissioner guidance [click here](https://www.england.nhs.uk/learning-disabilities/care/) sets out the roles and responsibilities of the host commissioner and how a proportionate and appropriate response is taken to quality concerns. It is important that the person carrying out the commissioner oversight (six/eight week) visits is familiar with this guidance.

**Flowchart for escalation of concerns**

* 1. Please see below flow chart as a guide to escalation of concerns. It is important that the commissioner is familiar with and acts in line with their organisational policies. See NHS England and NHS Improvement policy on safeguarding children, young people and adults.[[7]](#footnote-7)

Commissioner oversight

 (6/8 week) visit

There are

concerns

There are no concerns

Record visit and actions, copy to individual and feed back on actions to individual

Immediate actions taken with provider

Record Visit

Report to local authority – both

HOST and HOME local authority and CCG safeguarding

Report to CQC/host commissioner/ NHS England and NHS Improvement contract holder

Feed back to individual and family on actions

Copy to individual and feed back on any actions agreed

Consider sharing with CQC/host commissioner/

contract holder

NO

YES

Are these Safeguarding concerns?

1. Oversight and reporting
	1. NHS England and NHS Improvement are developing a process for the reporting of commissioner oversight (six/eight week) visits.
	2. In the interim it is expected that regions and local areas are monitoring implementation of these visits.
	3. Through engagement on developing this guidance it has been suggested that there should be oversight by a senior lead in quality, such as the CCG, regional chief nurse or director of quality; and that there should be reporting on this at an existing quality meeting within the CCG or specialised commissioning team.

Commissioning organisations should determine themselves how the implementation of the guidance should be overseen by an executive quality role within the organisation, and agree reporting at a local level.

**NOTE 1 – Regulations that apply: Legal basis for the visit**

* 1. The NHS Act 2006, as amended by the Health and Social Care Act 2012, says that commissioners have a duty to monitor the quality of services, securing continuous improvement in the quality of services provided to individuals. This includes outcomes which shows:
		+ - 1. The effectiveness of the service
				2. The safety of the services
				3. The quality of the experience undergone by individuals (NHS Act 2006, s13E and s14R).
	2. The legal basis for the visits is under the NHS Act 2006 Duties, as well as a duty to safeguard children, young people and adults who are using NHS services.
	3. Should it be required, the providers can enable the commissioner to access individual records as part of the review without consent pursuant to the following provisions of the GDPR:

**Article 6 (1) e** – General public data: Processing is necessary for the purpose of a task in the public interest.

**Article 9 (2) i** – Sensitive data: Processing is necessary for reasons of public interests, in the area of public health ensuring high standard or quality of health care.

1. Commissioner oversight visits during the COVID-19 pandemic
	1. This section gives information and guidance to commissioners and inpatient care providers about additional issues for consideration and additional measures for carrying out commissioner oversight visits during COVID-19. It will be updated as required.

There will need to be consideration in relation to the new four-tier coronavirus alert scale that is sorted into categories, depending on infection rate of the virus, and making it clear which rules should be followed according to the location.

Additionally, local policy will need to be understood in relation to face-to-face attendance by commissioners as restrictions are easing or being re-introduced as part of a response to a local rise in infection rates.

* 1. The expectation is that commissioner oversight visits will continue with adjustments for COVID-19. If a risk assessment finds face-to-face visiting is not safe, adjustments may include making contact by telephone or online rather than a visit. The principle of assuring commissioners that the individuals they are responsible for are safe and their wellbeing is safeguarded remains the same. Commissioners should always try to ensure they see/speak directly to the individual.
	2. Visits should be prioritised and enhanced for those identified in services where quality concerns have been raised, or where the service has a CQC rating of inadequate or requiring improvement.
	3. There is no change to the frequency of commissioner oversight visits during the COVID-19 pandemic; i.e virtual visits should take place at least every eight weeks for adults, and at least every six weeks for children and young people. There may be a need for additional assurance about an individual’s wellbeing because face-to-face visits are not taking place; the commissioner should consider whether there is a need for more regular contact.
	4. CCGs should develop a local process for carrying out face-to-face commissioner oversight service visits, when safe to do so and within COVID-19 guidance on visiting [www.england.nhs.uk/coronavirus/publication/visitor-guidance/](http://www.england.nhs.uk/coronavirus/publication/visitor-guidance/). A Risk Assessment Template (example provided at Appendix 3) should be used to assess the risks of undertaking a face-to-face visit, but these should be weighed against the risk of not visiting if there are concerns about the individual’s safety and wellbeing.
	5. Establishing and building a trusting relationship with the individual in inpatient care is an essential component of the commissioner oversight visit, and this might be more difficult in a virtual visit.

It is important to think about adjustments that might help: e.g making the visit shorter or longer, depending on what feels comfortable; chatting rather than asking questions; paying attention to facial cues; informal interaction like having a virtual coffee. Learning from Whorlton Hall demonstrates the importance of doing this.

* 1. There have been no changes to requirements in relation to safeguarding during the COVID-19 pandemic. The safety of individuals remains of paramount importance and, if safeguarding concerns or issues are raised, we would expect them to be reported and managed in the same way as usual.
	2. There may be additional safeguarding risks for people in an inpatient setting during COVID-19. Commissioners are expected to be particularly alert to any potential safeguarding issues, especially given that they may not be seeing the person face-to-face. If undertaking a virtual visit, the commissioner must ensure that they know when the individual was last seen face-to-face and by whom, e.g at a care, education and treatment review or a previous oversight visit, seen by a family member, advocate or professional.

With consent from the individual, where appropriate, it is important to gather feedback from relevant people, including the family, on their views of the individual’s safety and wellbeing. The commissioner should consider how they will gather information about the ‘feel’ of the inpatient unit that they would usually get from a face-to-face visit, e.g how they are welcomed, observing the environment and staff/individual or staff/staff interactions.

* 1. Where there is a safeguarding concern, a face-to-face visit should be made, working closely with the family and Care Quality Commission (CQC). If there is a need to visit, those involved would follow the necessary process, including a risk assessment, for ensuring that remains as safe as possible.
	2. NHS England and NHS Improvement and the CQC continue to work closely together when there are safeguarding concerns in relation to a provider setting.
	3. The use of Skype, WebEx, Microsoft Teams or other secure technology alternatives should be considered for the visit that will best enable the participation of the individual. Microsoft Teams is the preferred platform for NHS England and NHS Improvement visits. Feedback has indicated that, generally, teleconferences were found to be the most difficult for people to engage with.
	4. Virtual commissioner oversight visits potentially create some additional information governance issues:

| **Area** | **Issue** | **Solution** |
| --- | --- | --- |
| Privacy and confidentiality | Conversations being overhead | The commissioner should ensure that they use a, private room for the virtual visit. Other people should not be able to hear the conversation or view notes. The able commissioner should check at the start of the visit that the individual is in a quiet, private place where they cannot be overheard. |
| Privacy/freedom to speak | Inpatient may be accompanied by a staff member on the call | The commissioner should check at the start of the meeting that the individual is happy that the staff member is there/ should discuss whether the person can manage the technology on their own/ is able to have access to technology without supervision. |
| IT security | That the IT technology used is not secure | Ensure that the technology is secure NHS England and NHS Improvement’s preferred technology is Microsoft Teams |
| IT security | The chat box functions can present confidentiality | Advise that only non-confidential and no person-identifiable information should be shared through MS Teams chat function (or other systems’ chat functions) |

* 1. In preparing for the virtual visit, the commissioner should: consider any additional measures that will allow the individual they are responsible for to participate fully; that they are given support to plan for the meeting; and that they are able to engage in the way that works best for them.

This may include: checking with the provider that they are able to support the individual to prepare; that IT equipment will be available, and that the individual is confident about using it; and consideration of other communication methods to support the visit, e.g letter writing before the meeting, visual aids, drawings, video diaries.

* 1. The commissioner should let the inpatient know that the virtual visit can be a phone call or online, and that they can choose what is best for them; e.g they do not need to use the video function on an online visit if they do not want to.
	2. Before the visit takes place, the commissioner should check the individual’s preferred ways of communication and preferences in terms of participation and be clear on any reasonable adjustments required.
	3. Before the visit, the commissioner should check the person’s last C(E)TR report and use the visit as an opportunity to update and check on progress.
	4. The individual can have a family member, friend, advocate or staff member attend the visit, if this is what they want. The commissioner should check that the individual has given consent, as appropriate, for other people to take part.
	5. The commissioner should check before the visit that family members and others have suitable IT equipment available to them. If the family cannot participate on the day, the commissioner should gather their views separately by letter, phone call or online. Families can play a crucial role in supporting commissioner visits, e.g by recording video conversations for sharing with the commissioner (with appropriate consent); by supporting non-verbal communication; and by providing support to the individual during the visit.
	6. During the virtual visit, remember that screen backgrounds can be engaging for some but very distracting for others. Please check with all participants in the call, especially the person in inpatient care, asking what they prefer.
	7. At the beginning of the virtual visit, the commissioner should check that the individual is happy to talk to them and make it clear that that they can stop at any point. The commissioner should record that the individual has given their consent to take part.
	8. The commissioner should try to put the person at ease; chat informally; wear a name badge; avoid clinical language; and give choice about having cameras on or off, having a break, asking a question and ending the conversation.
	9. The commissioner should record the virtual visit using the Recording Form (included at Appendix 1), making clear that the visit was done virtually.
	10. Any concerns from the virtual visit should be escalated in line with the process set out in Section 13.
	11. A risk assessment will need to be completed to support the decision about whether a face-to-face visit or virtual visit is most appropriate.

Below is an example:

|  |
| --- |
| **Face to face commissioner oversight visit: Risk Assessment Template**  |
| **Commissioner visit date:** |  | **Where will the visit 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 orconfirmed Covid-19 |  |  |  |  |
| Consider whether anyone taking part in the visit is from a high-risk group in line with national guidance (BAME/Pregnant/clinically vulnerable) |  |  |  |  |
| Consider travel arrangements for person attending the unit. |  |  |  |  |
| Confirm suitable room identified for visit that has been cleaned in preparation forvisitors |  |  |  |  |
| Confirm visitor policy has been received from inpatient organisation and any procedures required to be adhered to are known to visitors |  |  |  |  |
| Visitors are trained to use appropriate PPE and willing to wear this |  |  |  |  |
| Visitors informed that they need to bring their own food and drink |  |  |  |  |
| Visitors informed to follow social distancing rules, e.g. >2 meres away |  |  |  |  |
| Visitors confirm that they or any householdmember do not have symptoms or havetested positive |  |  |  |  |
| Confirm that visitors are aware of the risks in relation to travelling |  |  |  |  |
| Confirm appropriate PPE is available for visitorsEither from the venue or self-supplied / commissionersupplied |  |  |  |  |
| Confirm that visitors have read and understood the PPE procedures including how to useany 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: Useful templates

**Template 1: Recording Form**

A Template Recording form follows which is designed to be ‘person-friendly’ and support the recording of actions in the closing minutes of the meeting, so that a copy can be left with the individual before leaving. These should be simple actions written in plain English and discreetly worded. The form can be sent in advance, so the individual has time to prepare their section. If any individuals prefer a plain form without Photo symbols, this template can be amended.

**My commissioner visit: Actions from our meeting (with images)**

|  |  |
| --- | --- |
| Identitycard | My patient number:My date of birth: |
|  | Date and time of today’s meeting: |
|  | My hospital and ward name or place: |
|  Insert commissioner photo | My commissioner or case manager seeing me is:Best way to contact my commissioner/case manager: |
|  | My home area:My Clinical Commissioning Group: |

|  |  |
| --- | --- |
|  | **About today’s visit** |
|  | **How am I getting on here? What’s it like?**  |
|  | **What’s happening about my discharge?****What is helping or stopping me from leaving?** |
|  | **If my family, advocate or another person I chose are involved, what do they think?** |
| Insert commissioner photo | **What does my commissioner/case manager think?** |
|  | **Next steps** |
|  | **My commissioner will do these things to help in the next six/eight\* weeks:** |
|  | **Was I happy with today’s meeting (and others involved)? If not, what needs to be different next time?** |
|  | Date and time of next meeting: |
|  | Any other comments  |

**Template 2: Invitation letter for family**

Commissioner header and contact details

Dear …………………,

Next visit to your family member on (time/date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I’m pleased to invite you to the meeting on the above date as your family member says they would like you to take part if possible / as the parent of a child or young person who is currently in hospital (please delete for appropriate option).

This is part of regular Commissioner Oversight (6/8 Week) visits which I am required to carry out. It will be an informal and personal meeting to see how your family member is doing and whether there is any more I can do to improve their stay in hospital. The meeting has no set length but should not be less than one hour and may be more depending how it goes.

You are very welcome to come to the meeting, but if this isn’t practical you are also very welcome to take part another way, such as by phone, videoconference or using the enclosed carers’ feedback form.

Please let me know if you would like to attend or be part of the meeting in some way on the above date, or if you’d like me to contact you another time. You’re welcome to contact me before the meeting if there is anything you would like me to know before I go. Otherwise I’d be happy to follow up with you at your convenience.

With many thanks and best wishes…

Appendix 2

**Legislation and Mandatory Reporting ref ‘Safeguarding Children, Young People and Adults at Risk in the NHS: safeguarding accountability and assurance framework’.**

NHS England and NHS Improvement – Updated August 2019

|  |
| --- |
| **Legislation for**  |
| [The Crime and Disorder Act 1998](https://www.legislation.gov.uk/ukpga/1998/37/contents)[Female Genital Mutilation Act 2003](https://www.legislation.gov.uk/ukpga/2003/31/contents)[Mental Capacity Act 2005](https://www.legislation.gov.uk/ukpga/2005/9/contents)[Convention on the Rights of Persons with Disabilities 2006](https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html)[Mental Health Act 2007](https://www.legislation.gov.uk/ukpga/2007/12/contents)[Children and Families Act 2014](http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted)[Modern Slavery Act 2015](http://www.legislation.gov.uk/ukpga/2015/30/contents/enacted)[Serious Crime Act 2015](http://www.legislation.gov.uk/ukpga/2015/9/contents) |
| **Safeguarding Children** | **Safeguarding Young People Transitioning into Adults, including Children in Care** | **Safeguarding Adults** |
| [United Nations Convention on the Rights of the Child 1989](https://www.unicef.org.uk/what-we-do/un-convention-child-rights/) |  |
| [Children Act 1989](http://www.legislation.gov.uk/ukpga/1989/41/contents) and [2004](http://www.legislation.gov.uk/ukpga/2004/31/contents) | [The Care Act 2014](http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted) |
| [Promoting the Health of Looked After Children Statutory Guidance 2015](https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2) |  |
| [Children and Social Work Act 2017](http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted)  | [Care & Support Statutory Guidance- Section 14 Safeguarding](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf) |
| [Working Together to Safeguard Children Statutory Guidance 2018](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf) |  |
| [Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019](https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2019/january/007-366.pdf) | [Looked After Children: Knowledge, skills and competences of health care staff 2015](https://www.rcpch.ac.uk/sites/default/files/Looked_after_children_Knowledge__skills_and_competence_of_healthcare_staff.pdf) | [Adult Safeguarding: Roles and Competencies for Health Care Staff 2018](https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2018/august/pdf-007069.pdf) |

Appendix 3

NHS ENGLAND AND NHS IMPROVEMENT

PLACING COMMISSIONER OVERSIGHT VISITS CHECKLIST WHEN VIRTUAL VISITS ARE REQUIRED DUE TO COVID-19 – (this includes some key theme questions from the carers monitoring form for hospital services)

Feedback Questionnaire for Families or Carers of people in an inpatient setting to support Commissioners Oversight Visits

A copy of this form can be sent to the family or carer prior to the virtual commissioner’s oversight visit scheduled telephone/video call.

|  |  |
| --- | --- |
| **Name of the person in hospital** |  |
|  **Name of the family member or carer filling in this form:**  |  |
|  **Relationship to the person in hospital:** |  |
| **Date of Contact:** |  |
| **Name of hospital:** |  |
| **Name of commissioner and contact details** |  |

|  |  |
| --- | --- |
| **Name of the person in hospital** |  |
|  **Name of the family member or carer filling in this form:**  |  |
|  **Relationship to the person in hospital:** |  |
| **Date of Contact:** |  |
| **Name of hospital:** |  |
| **Name of commissioner and contact details** |  |

|  |
| --- |
| **3. Do you have any concerns about your family member/the person in hospital or the service?** |
| * Mental health concerns?
* Physical health concerns?
* Medication increase/ changes or any side effects?
* Physical appearance?
* Restrictions in relation to covid-19?
* Changes in behaviour?
* Anything else?
 |
| **4. Have you noticed any changes recently to staffing, support, activity, communication?** |
| * Are reasonable adjustments being met by the hospital during the pandemic?
* Have activities been maintained?
* Is there consistency of staffing?
 |
| **5. Have you received any communication from the hospital about the care, policy, support or changes being made in relation to COVID 19?** |
|  * Education – what are the arrangements?
* Do you have contact details for Mon-Fri weekend and out of hours?
* Are you kept well informed/ do you have regular updates? / is this via phone, video call or emails, where you asked your preference?
* What arrangements are being made to enable the person to have access to fresh air & exercise?
* Have you been informed of the plan should the person test positive for COVID 19 or anyone else within the inpatient environment?
* Do you have a named person to update you from the hospital, how often does this occur? Is it enough?
* What is not working well?
* Have you been supported to be involved in C(E)TRs through COVID 19 What would improve this experience?
 |
| **6. Is the service supporting the person to have regular contact with you?** |
| * What’s working well?
* What has been positive for you and family members?
* What could be better / done differently?
 |
| **7. Is there anything you would like to ask?** |
|  |
| **8. Any other concerns/ comments?** |
|  |
| **9. Any recommendations?** |
|  |
| **10. Summary of Actions to be taken following individual, family/carer feedback**[Think ASK, LISTEN, DO](https://www.england.nhs.uk/wp-content/uploads/2018/10/ask-listen-do-for-organisations-and-practitioners-v1.pdf)**Please ensure you feedback any actions and outcomes to the individual** |
|  |

**Relevant reference documents or links:**

Framework for Commissioner Oversight Visits to Inpatients and COVID-19 addendum guidance due to be published Autumn 2020

Host commissioner guidance due to be published Autumn 2020

Link to the full carers monitoring form for hospital services: <https://bringingustogether.org.uk/wp-content/uploads/2019/06/carers-monitoring-form-Final.pdf>

COVID-19: Visiting people in a mental health, learning disability and autism inpatient settings letter from Ray James, Director of Learning Disability and Autism, and Claire Murdoch, National Mental Health Director: <https://www.england.nhs.uk/coronavirus/publication/letters/>

NHS England and NHS Improvement

Skipton House

80 London Road

London

SE1 6LH

This publication can be made available in a number of other formats on request.

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4. <https://bringingustogether.org.uk/wp-content/uploads/2019/06/carers-monitoring-form-Final.pdf> [↑](#footnote-ref-4)
5. <https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-children-young-people-adults-at-risk-saaf.pdf> [↑](#footnote-ref-5)
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7. <https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-children-young-people-adults-at-risk-saaf.pdf> [↑](#footnote-ref-7)