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Care, Education and Treatment Review policy

COVID-19 addendum

Version 1, 12th January 2021

Contents

Introduction

This guidance 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 Education and Treatment Review [C(E)TR] panels. This guidance 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, as well as clinical commissioning group (CCG) commissioned services.

This is not a standalone document but should be looked at alongside the C(E)TR policy 2017.

Context

This guidance has been developed building upon the original guidance on Demand and Capacity issued to the system in relation to COVID-19, and learning gathered from the period of implementation of C(E)TRs through the pandemic.

Feedback was collected on C(E)TR delivery through COVID-19, on both the challenges and the positives. This was collected through regional NHS teams as well as a questionnaire completed by commissioners, clinical experts, experts by experience, families and children, young people and adults who have experienced C(E)TRs through COVID-19. More than 170 people responded to this questionnaire.

It is positive that throughout the COVID-19 pandemic there has been a commitment to making sure C(E)TRs are still carried out, and a willingness to adapt in how they have been carried out.

The guidance also clarifies several interim measures specifically for C(E)TRs 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, and are detailed below.

A full C(E)TR policy refresh is due to commence in Autumn 2020 along with work on the key lines of enquiry (KLOEs). Recommendations of the independently chaired C(E)TR led by Baroness Sheila Hollins – the report from which is expected in early 2021 – will feed into this refreshed policy; as will the learning from the pilot-of revised C(E)TR KLOEs that took place pre-COVID.

The learning from the COVID-19 period will also feed into the policy refresh. It is anticipated that the policy and new tools will be published in 2021, along with a strengthened approach to quality assurance.

1. General principles

Continuation of C(E)TRs has 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-commissioned or NHS England and NHS Improvement (specialised commissioning/provider led collaborative) commissioned mental health or learning disability and autism provision.

- 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. facilitating discharge
  iii. preventing unnecessary admissions
  iv. bringing together vital services across health, education and social care to help address barriers to providing the right support and find solutions.

- While recognising that the current COVID-19 rules and guidance mean we will still need to adapt the way C(E)TRs are undertaken, we expect all local areas to continue to make sure there is a robust process that fulfils this role.

- There will be a return to holding C(E)TRs as usual when restrictions allow face-to-face meetings to happen within government guidelines. The learning from virtual C(E)TRs during the COVID-19 period will be useful in improving the ways that C(E)TRs are carried out, such as 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. Adapting where necessary and return to 'normal' C(E)TRs

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

- A recent survey carried out in July 2020 of C(E)TRs through COVID-19 showed that although virtual C(E)TRs are not a true replacement for face-to-face ones, we have learned a lot about smarter working, and as COVID-19 restrictions lift, a blended approach based on this learning and individual preferences may be the best approach.

- This learning has shown that, for some people, and in some circumstances, use of virtual technology has been a positive experience. For example, 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. For some people, attending their own C(E)TR is easier and less stressful when it is virtual. This has been particularly noticeable and helpful for some young people who shy away from attending large meetings about their care.

- On the other hand, many people, families and panel members have found the virtual C(E)TRs more difficult. Seventeen of the 174 survey responses came from people who 'received' C(E)TRs (all of whom were adults), and of these 17:
  - 10 found the virtual C(E)TR to be worse
  - 3 felt it was as good as a face-to-face C(E)TR
  - nobody thought it was better
  - 4 were not sure.

- Of the remaining 157 responses, the split was:
  - 71 found virtual C(E)TRs to be worse
  - 60 felt they were as good as face-to-face
  - 10 thought virtual C(E)TRs were better
  - 16 were not sure.

2.2 How this learning should shape the approach to C(E)TRs moving forwards

- The intention is to take this learning into the new C(E)TR policy – due in 2021 – to make sure the approach taken is best for the individual concerned and the desired outcomes. It is also essential to recognise the importance of a C(E)TR outcome being informed by a visit to the person in an inpatient service which considers that person, their environment and their interactions within it.

- Some areas have taken an approach to C(E)TRs that includes both virtual and face-to-face meetings. This accommodates families and others who have commitments that would make it unreasonably difficult for them to attend in person, and takes account of individual preferences.

- 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 as Appendix 3.

  The COVID-19 policy of the organisation that the C(E)TR relates to should be collated by the lead contract holder or host commissioner, 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 must be followed – ie CCG, us, or provider led collaborative.

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 restrictions also need to be considered.

It is very important that the commissioner keeps track of how long it has been since they last saw the person face-to-face. They should ensure that through C(E)TRs, commissioner oversight visits and other reviews or meetings, this contact occurs at least once every six months for an adult, or every three months for a child or young person.

- It is essential for actions coming of a C(E)TR to be a result of consensus, reached through discussion with all parties at the end of a C(E)TR, and that where there are differences of opinions that these are noted.

  Where these differences of opinion might impact the outcome of the C(E)TR for the person, this should be escalated through the lead commissioner to the regional learning disability and autism programme lead for resolution. There is also the possibility of holding subsequent virtual meetings, where there have been disagreements. This must be agreed by all and the organising region/hub must be notified prior to this meeting happening.

- These discussions provide an opportunity to test out the degree to which recommendations are SMART,[1] and to agree how these recommendations will be taken forward; by whom; by when; and how they will be followed up.

- A quality assurance process applied locally by commissioning, and overseen regionally, 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 make sure that children, young people and adults at risk of admission to specialist inpatient care are known to commissioners, and that there are effective plans in place to support them and their families.

[1] Specific, measurable, achievable, realistic and timely.

C(E)TRs need to be part of a strong governance process that includes dynamic support registers (DSRs) and support systems and agreed effective joint working processes across different organisations.

- National and local government advice 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 chair will be responsible for making sure all panel members are aware of and abide by local policy 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 no alternative be appropriate.

- Commissioners should discuss with participants the use of technology to enable virtual C(E)TRs to take place, where face-to-face C(E)TRs are still not possible or not preferred. A virtual C(E)TR should happen with the input of usual participants and 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 the preferred platform for our C(E)TRs.

  The survey found teleconferences to be the most difficult for people to engage with, so they should not be used unless no other alternative is suitable.

- In exceptional circumstances, the use of the local area emergency protocol or a joint care programme approach and C(E)TR could be considered.

- Particular effort should be made to ensure that family members, experts by experience, advocates and clinical experts are enabled to join the meetings through technological means, or face-to-face.

- The chair should ensure that they gain the views of members who have been unable to attend on the day.

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 or the chair 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.

- Technology used to enable virtual meetings should be used alongside a risk assessed approach – as set out in Appendix 3 – to support face-to-face C(E)TRs wherever possible.

- Particular effort should be made to ensure that family members, experts by experience and clinical experts are enabled to join the meetings through technological means, or face-to-face. When participating remotely, participants should be supported to access video technology whenever possible.

- Physically visiting the inpatient environment and seeing the patient is a very important element of quality assurance and safeguarding in relation to C(E)TRs. A mixture of virtual C(E)TRs and face-to-face visits is likely to provide that additional assurance. This may include having one panel member present on site rather than the whole panel, for example, to ensure that there is a presence within the inpatient environment, and that the patient is met with face-to-face.

- An example planner for an inpatient C(E)TR is set out in table 1 below, to guide the key components of a day and activities beforehand, taking account of planning for a virtual C(E)TR. Note that regular breaks should be scheduled as people have reported that they find virtual C(E)TRs tiring and intense.

Table 1: Example planner for inpatient C(E)TR

Activity	Content	Who is there
Before the day	– Ensure consent has been given and family have been invited if the person wishes; also that preferences for how to participate have been gathered. – Check the person is able to prepare for the day and has the support they need and access to consent and planning paperwork. – Set up meeting times with professionals to maximise participation; likewise with families unless they wish to participate throughout. – Set up breakout rooms in Microsoft Teams, so panel can split for individual private meetings and to review paperwork. – 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. – Agree plan for the day – how it will be managed and where/how people will be met with individually.	All participants
Morning	– Individual and group meetings.	Scheduled participants
Lunchtime	– Identify and agree what records the panel want to review with the team	Panel

Activity	Content	Who is there
Afternoon	– Individual and group meetings. – Review records	Scheduled participants 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	

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 until 31 December 2020 and will be reviewed at that time.

1. **Rapid review of DSR (minimum standards) to:**
    a. ensure standard (referral) criteria for entry onto the DSR for 'at risk level' – and 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 C(E)TR taking place
    d. ensure a two-way information flow between the DSR and C(E)TRs.

2. **Ensure community C(E)TR compliance to agreed standard**
    a. Admission without a community C(E)TR should be **exceptional** and in line with the current C(E)TR policy (see point four 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 C(E)TR).

Please note: There will be draw-down funding available on a locally agreed basis to support individual interventions that will potentially lead to an avoidance of admission. Speak with your regional learning disability and autism leads about how to access this.

3. **Post-admission C(E)TRs** – the following interim changes reflect the urgency of the situation. Post-admission C(E)TRs will:
    a. be held by exception, where a valid community C(E)TR has not been possible
    b. take place within five working days (one week), rather than 10 working days (two weeks) as per usual C(E)TR 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 C(E)TR. This will:**
    a. explore why a community C(E)TR was not possible
    b. determine whether the child or young person had been identified on the DSR
    c. inform system changes to ensure C(E)TR compliance and better identification through DSRs.

Please note: It is envisaged that CCGs and specialised commissioning will need to work together to organise C(E)TRs 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 chair 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 chair'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 C(E)TR policy (2017) CTR code and toolkit
  - for children and young people: section five of the C(E)TRs for children and young people toolkit
  - and as usual (for both), the C(E)TR lines of enquiries and the previous C(E)TR report.

- The chair's role is to screen and identify **if** information **is** required ahead of the day (eg if the previous C(E)TR report 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

In late 2019 a new set of C(E)TR KLOEs were developed and piloted. The feedback from this and two upcoming reports (CQC thematic review of restrictive practice and the Independently chaired Care (Education)TR report from Baroness Sheila Hollins) will inform the further revision of the KLOEs. This will be published as part of the refreshed C(E)TR policy in 2021.

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

9. Engagement of the child, young person or adult in their virtual 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 or staff person 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, etc. 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. Access to digital equipment

- To support the practical implementation of virtual C(E)TR operations throughout the COVID-19 period, additional digital equipment has been sourced and distributed to CCGs, specialised commissioners, providers and experts by experience.

  This followed a requirements-gathering exercise in March/April 2020, and is underpinned by a memorandum of understanding with the NHS England and NHS Improvement regions.

  NHS mail accounts have also been set up for panel members (eg experts by experience) to ensure the safe and secure sharing of information relating to scheduled virtual C(E)TRs.

12. Information governance

- The use of virtual C(E)TRs brings 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.
- 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 chair'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.
- Table 2 below sets out the issues and solutions to ensure that the virtual process is managed in line with information governance requirements:

Table 2: 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. 2. Hygiene protocol, ie cleaning down equipment before use by another individual.
Privacy and confidentiality	Conversations being overheard. Handwritten notes may be read by others.	1. 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. 2. Handwritten notes should be kept securely after the C(E)TR, and destroyed once the report has been written. 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. 2.The chat function can be used to support effective management of the meeting, eg to plan breaks, for technical problems, etc.

13. Use of DSR

- It has been demonstrated that those areas which are successful in reducing unnecessary admissions through community C(E)TRs are often those with a well-functioning DSR (which is a new name for the ‘at risk of admission register’).

  Knowing the names of children and adults who are at risk of being, or have been admitted to an inpatient setting has always 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.

- Our policy is that all 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. A national stocktake exercise has been conducted to identify the gaps in DSRs, which will inform the focus of a project in 2020/21 along with a core principle guidance.

- A national training package is being developed in 2020/21 to support and embed good practice.

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

- As noted above, 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.

Appendix 1: Quality assurance

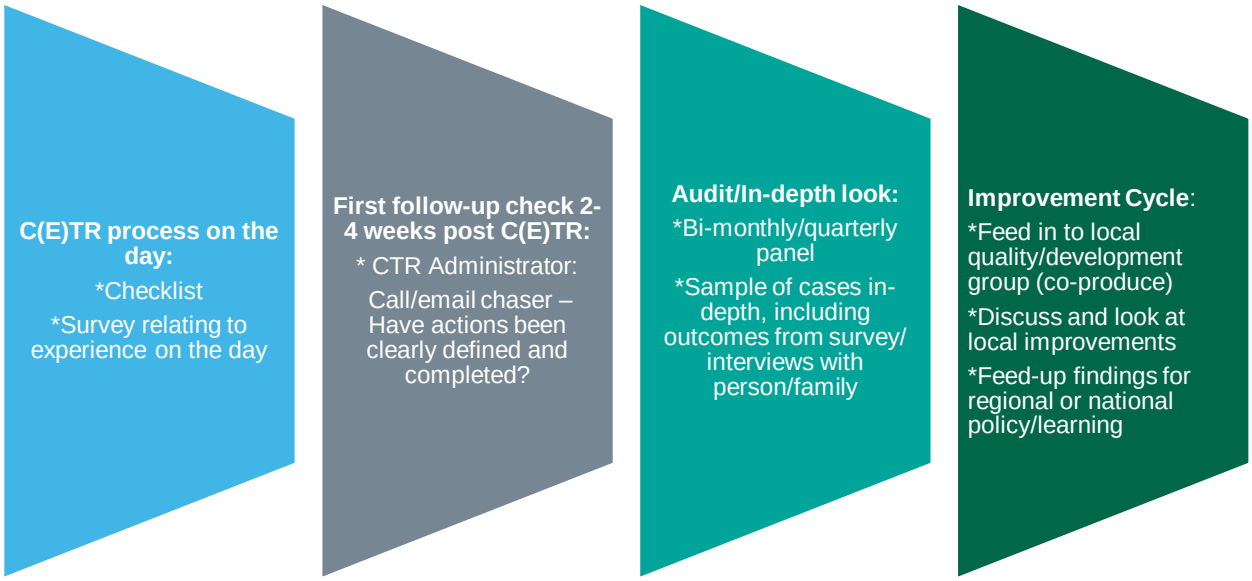

Figure 1: Opportunities for quality assurance of the C(E)TR process

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: 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.

Top tips for chairing a COVID-19 C(E)TR

1. Select panellists according to their experience and skillsets. This can add more specialism 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 template (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, eg 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.

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.

- 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?
- 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?

Appendix 3: 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 process.

This means resuming face-to-face C(E)TRs as soon as is practicable and safe to do so, and where this is the preference of the person whose C(E)TR it is. 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 3 below sets out the potential risks and mitigating actions to support with C(E)TRs returning to face-to-face meetings safely; Table 4 gives a risk assessment template.

General points to consider when considering whether to hold a face-to-face C(E)TR in relation to the person whose C(E)TR it is:

- The personal preference of the person having the C(E)TR (and their family, if applicable).
- Length of time since last face-to-face visit for the person (eg has there been a recent face-to-face 'commissioner oversight visit'?)
- Are there concerns that require a physical presence at the C(E)TR? (eg could part of the panel attend, to have someone who has set eyes on the service and person?)

Table 3: 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 cross transmission of COVID-19	High	There is a known active confirmed case of COVID-19 on the site/building we will be visiting for the C(E)TR	Not undertake face-to-face visits if there is an active COVID-19 case unless adequate measures can be taken and need for face-to-face is deemed priority. Government track and trace policy should be followed when visiting all sites.	Low
Potential transmission of COVID-19	Medium	There could be potential COVID-19 transmission without any one person showing signs of COVID-19 either on the site, the panel member or participant visiting.	The panel would comply with NHS England and NHS Improvement or CCG policy as well as the organisations policy on infection prevention and social distancing for visiting health professionals. Consider the number of panel members required to be on site. Panel member(s) due to attend to consider if they are showing any potential signs of the virus: temperature, persistent cough, loss of taste or smell. Panel member would not attend site if any signs exist. If no signs panel member(s) would attend site in line with current national/local guidance including PPE guidance. Panel members to ensure bare arms below the elbow. If panel members are unable to wear a mask they should not attend on site.	Low
Suitable meeting room: availability for the C(E)TR	High	Does the organisation have a suitable meeting room for the panel to meet, can the panel maintain social distancing.	The commissioner will enquire with the organisation about availability of rooms to enable social distancing to take place prior to the C(E)TR and obtain the organisations policy for visiting professionals during COVID-19. Follow NHS England and NHS Improvement or CCG policy for respective C(E)TRs Panel members will wear masks whilst on site, will strictly comply with social distancing guidelines and will utilise good hand hygiene throughout the day.	Low

Risk/issue	Initial risk:	Risk/issues description	Mitigating actions	Risk after mitigating action:
Food and drink whilst on site for a C(E)TR: potential source of cross contamination	Low	In C(E)TRs often panel members are offered drink and potentially food on site.	Food and drink will not be accepted: panel members will bring own food and drink for the C(E)TR.	Low
COVID-19 confirmed in staff or patients after the C(E)TR (organisation staff, patients or panel members)	Low	There could be a notification of an active case of COVID-19 within the organisation or from the panel or associate after the C(E)TR	If the organisation reports an active case after a C(E)TR they should seek advice from their infection prevention team regarding if to inform the C(E)TR panel who visited. If a panel member develops symptoms after a C(E)TR they will need to inform commissioner or chair who will advise the accountable organisation (CCG or NHS England and NHS Improvement) in line with policy and the site(s) the panel members visited in line with NHS England and NHS Improvement or CCG policy.	Low

Table 4: 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 panel member 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 C(E)TR that has been cleaned in preparation for visitors.				
Confirm visitor policy has been received from host organisation and any procedures required to be adhered to are known to panel members.				

Panel member is trained to use appropriate PPE and willing to wear this (if panel member is unable to wear a mask then they should not visit on site).				
Panel members informed that they need to bring their own food and drink.				
Panel members informed to follow social distancing rules, eg >2 metres away.				
Panel members confirm that neither they nor any household member has symptoms or has tested positive.				
Confirm that panel member is aware of the risks in relation to travelling.				
Confirm appropriate PPE is available for panel. Either from the venue or self-supplied/commissioner supplied.				
Confirm that 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.				

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