



Care and Treatment Review: Policy and Guidance



Easy Read Version



Care and Treatment Reviews (CTRs)

This booklet tells you about **Care and Treatment Reviews (CTRs)**.

CTRs are for people with a learning disability and started in October 2014.

They are part of NHS England's goal to make people's care better.

CTRs aim to stop people being admitted to specialist Learning Disability and Mental Health hospitals when they don't need to be there.

They also try to make sure that when people **are** admitted to specialist hospitals, it is for a short time.

CTRs are not for when people go into general hospitals because they are physically hurt or ill.



Background



This CTR policy builds on the work of the Improving Lives Team and on what we learned from using CTRs from October 2014 to March 2015.

The aim is to make CTRs 'business as usual' in England.



CTRs are **person-centred** and based on the needs of the person. This means that people with a learning disability and their family are included in looking at and asking questions about a person's care and treatment.

CTRs make sure that:

- people with a learning disability and their family are **listened to** and are **equal partners** in their care and treatment.
- people's care and treatment plans say clearly what they are trying to improve and how this should happen.
- people get the right support and treatment at the right time to be able to stay in their own home whenever possible.
- people **only** become inpatients in Learning Disability and Mental Health hospitals if that is the only place they can safely receive care and treatment.
- everyone works together to help the person move back to the community as soon as possible.



Why do we need CTRs?



- For many years governments have been closing long-stay hospitals and providing services in the community.
- There are many people with a learning disability that are still in specialist hospitals without an agreed date for when they will leave.
- We know there is a need for the right support for people to live in their own home or community, in a place that is **not** a hospital.
- NHS England has developed the CTRs as a way of checking on people's care and treatment and to involve all parties in the process.
- They aim to overcome any blocks to people getting the right care in the right place at the right time.

Why do we need the CTR policy, guidance and tools?



- Policy, guidance and tools help people with a learning disability and their family to **understand** and be **part** of CTRs.
- Safeguards make sure that professionals are registered and have checks for any criminal records.
- Everybody involved in a CTR should be clear about their **roles** and what happens before, during, and after the CTR.
- The NHS and its partners are using CTRs to ask questions and sometimes challenge the care given to a person to make sure that **they have the best quality of life.**

When does a CTR happen?



A CTR happens when a person is at risk of being admitted to a specialist hospital.

The CTR looks for **other things that can be done** to prevent the person going into hospital when it is not necessary.

If the person **does** have to go into hospital, the CTR checks their assessment, treatment and the plan for them being discharged.

CTRs makes sure a person is not admitted to hospital when they don't need to be. It makes sure that hospital stays are **as short as possible.**



Who are CTRs for?

CTRs are for people who are **at risk** of going into specialist hospital



Or

People who are **already** in a specialist hospital.

They are **not** for people with a learning disability who are in an ordinary hospital for treatment of a **physical illness** (things like: a broken leg, needing to have an operation or heart problems).

People at risk of admission to hospital

- Local services are often aware of those people with a learning disability who are at risk of being admitted to hospital.
- Long stays in hospital can be unhelpful to the person and their families. They can lead to the person losing touch with their community.
- The commissioner will work with local providers to **identify** those people who are at risk of admission.
- This will help to keep track of people's care, look at gaps in service and decide how best to support people to live in the community.



These are **some** of the reasons a person may be at risk of being admitted to hospital:

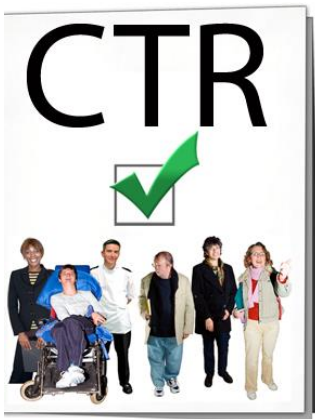


- Life changes such as the death of someone close
- Having been abused
- Unstable or untreated mental illness
- Drug and alcohol problems
- Admissions to hospital in the past
- Behaving in ways that challenge services
- Being supported by a changing staff team
- Having no fixed address
- Being in contact with the police and courts
- Having no family carers or advocates
- Having no plans to help move from children's services into adult learning disability services.
- Being in specialist residential schools.
- Having recently been discharged from a long stay hospital.

So a person is at risk:



- where they place themselves or other people at risk of harm
- where their placement or tenancy is at risk of breakdown and this would put the person or other people at risk
- where hospital admission is being seen as an option.



CTR - before admission to hospital

At the beginning of the CTR pathway, there are **2 options**:

1. to set up a CTR **before** the person goes into hospital where there is a known planned admission. This is call a **Community CTR**.

or

2. to hold a '**Blue Light**' meeting when the situation is so urgent that there is not time to plan a Community CTR.



A Community CTR should look at **alternatives** to hospital admission.

This might mean the person having support from health teams, respite services, and self-advocacy and carer groups.



The Plan

Admissions to hospital should be based on a **clear plan**.

The plan should say:

- **what issues** need to be assessed
- what this would **add** to what is **already** known
- **why** this assessment must be in **hospital**.





Before the person goes into hospital there should be plans for them to be supported in the community at a later stage.

This should be based on a **risk assessment**.

This must balance the **safety** of local communities against the **rights** of the person.

'Blue Light' meeting



A 'Blue Light' meeting helps a commissioner stop a person going into hospital when they do not need to.

Where an admission is urgent, there is not always time for a CTR before the person goes into hospital.

A meeting should be set up to think about whether admission for assessment and treatment in hospital is necessary.



If it isn't necessary then the meeting should look at what alternative support could be put in place.

When the person is admitted to hospital, a CTR will be held **within 10 working days**.

CTR - after Admission



Where hospital care and treatment **is** needed, the CTR will make sure there is a clear plan for assessment, treatment and discharge.

A **discharge date** will be set.

CTR – Inpatient 6-monthly review



The **six monthly CTR** looks at the safety, care and planning for people who are living in specialist hospitals.

It looks at the **reasons** for a long hospital stay.

It looks at whether the person is receiving the **right treatments**.

It looks at **barriers** to the person leaving hospital.

It looks for ways to make sure the person could get support in the community.

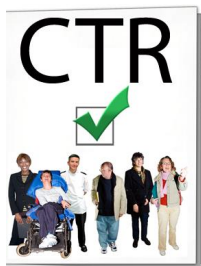
It agrees **what** needs to be done and **when** this needs to happen.

The right to ask for a CTR



These people can ask the commissioner for a CTR:

- The **person** who receives services
- The person's **family or carer**
- The **commissioner**
- The person's **advocate**
- The community or hospital multidisciplinary team



They can ask for a CTR where:



- there are concerns about a service or the person's safety and wellbeing
- there is no clear discharge date and plan.

Who takes part in CTRs?



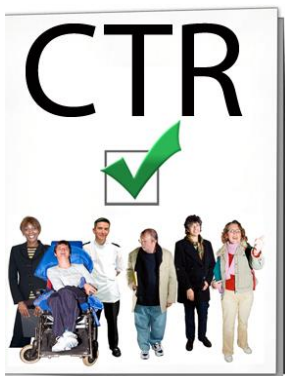
- People with a learning disability
- Their families
- Commissioners of services for people who are at risk of going into hospital or who are inpatients in hospitals
- Experts by experience who are people with a learning disability or family carers
- Independent clinical staff like doctors, psychologists or nurses.

How do CTRs work?



CTRs offer people in hospital another opinion of their care and treatment.

They bring a different view by having an **Expert by Experience** and an **Independent Clinical Expert**.



CTRs aim to:

- **listen** to the person and their family
- understanding why people think that they should be admitted to hospital for care and treatment

OR



- understand **why** a person is being given care and treatment in hospital
- offer a challenge where a person is not being helped to move out of hospital as fast as they could or where there are better alternatives to being admitted to hospital.

CTR pathway standards

These standards aim to prevent unnecessary admissions to hospital.



They support an effective care treatment path in the community **and** in hospital.

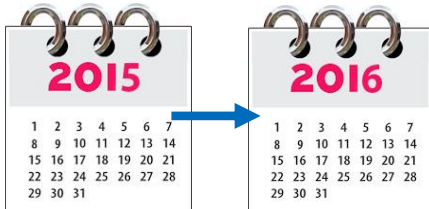
1. There will be a **register** of people who are at risk of admission which is kept by each local Clinical Commissioning Group.
2. There will be an agreement for the **safe sharing of information** with local learning disability teams about people on the register.
3. The register will help make sure there are **reviews, care planning and risk assessment** for people to assure that they are getting the right support at the right time.
4. There will be an **identified lead** in health, education and social care for each person.





5. Where a person is likely to be admitted to hospital they will have a Community CTR **before** they go in to see if there are any better ways in which they can receive the care and treatment they need.

6. If a person **is** admitted to hospital, there must be a clear reason for it. The CTR will make sure there are clear aims for the person's care and treatment and that there is a discharge plan.



7. If a person has been in hospital for 6 months then another CTR **must** take place. The person, their family or team member can **ask** the commissioners of their care for a CTR if they are not happy.



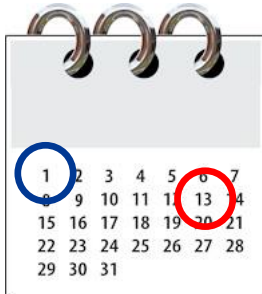
8. Personal information can only be used for this process if the person agrees. If the person does not agree they will not be on the register.

9. If the person does not have the capacity to make this decision for themselves then people will need to discuss what is in their best interests.

Urgent admissions to hospital

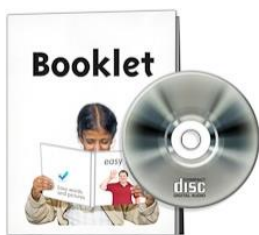


- **Not** all admissions will be known about in advance as sometimes there is an urgent problem that needs supporting.
- When a person needs to go into hospital urgently a **Blue Light meeting** will take place.
- This meeting will include professionals who know and support the person.
- It will include the person if they want to and family members or advocates if appropriate.
- If a person goes into hospital following a Community meeting, they **must** have a CTR **within 10 working days**.



Before a CTR:

- The commissioner sets up the CTR.
- The commissioner will write to the person, family members and others involved in their care and treatment.
- The family may have reasons why are not be able to come to the review. **Video or phone equipment** can be used so they can take part.
- The person needs to be supported by easy read information and by people who understand their communication needs.

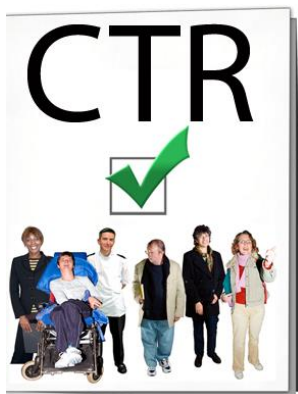




- The commissioner must get **consent** from the person who is going to be reviewed.
- The person's **capacity** to give consent needs to be assessed.
- If the person is **unable** to consent then a best interests meeting will decide if a CTR will help them.
- People who are not able to consent should **still** be as involved as much as possible in a CTR and have an independent advocate with them.
- Everybody involved will be sent information about the review so that they are fully involved in the process.
- Independent clinical experts and experts by experience will be chosen.
- The commissioner, the clinical expert and the expert by experience that make up the panel will have CTR Training.



What happens in a CTR?



- The panel will be made up of the commissioner, one expert by experience and one clinical expert.
- Each CTR will take about a day.
- The review team will meet at the start of the day and plan the CTR. They will make a short summary (or 'pen portrait') of the person.

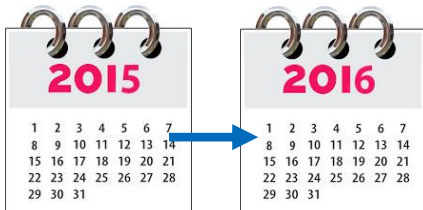


- The Responsible Clinician and Ward Manager should be at the CTR.
- Reviewers will meet the person whose care and treatment is being reviewed.
- The CTR should be in a place where the person feels comfortable.
- The person should be supported by someone **they** have chosen.
- Information should be easy to read.
- Reviewers will meet family unless they do not **want** to take part or the person does not **want** them to.
- The CTR will look at records such as:
 - care plans
 - person centred plans
 - health plans.
- The reviewers will meet staff who support the person as well as the clinician in charge.
- The 'aftercare' team who will support the person in the community - such as the community nurse or social worker - should be there.
- The reviewers will be looking to see whether there are **better alternatives** to hospital.
- They will look for ways to support the person to live in the community.
- The panel will think about the review findings together.



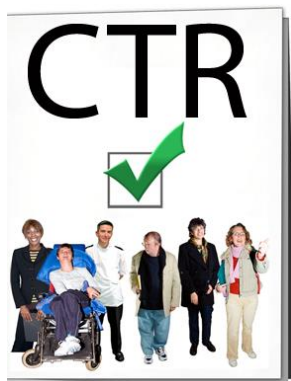
- They will meet everyone at the end of the review to talk about what they think and what should be the next steps.
- The commissioner will write up the CTR in an easy to read form.
- The report will say:
 - **who** is responsible for each action
 - **when** it needs to happen by.

After a review



- The commissioner will follow up the recommendations of the review and any concerns.
- They will send a letter thanking members for taking part.
- Where the person is admitted to hospital, they **must** have a CTR within 6 months and every 6 months after this.
- Carrying out CTRs can be difficult and sometimes upsetting. Panel members will be able to get support if they need it.

CTRs and other frameworks



Access to specialised services

Any person who is at risk of admission due to their mental health needs should have a CTR.

Access assessments find out the best placement for the person's mental health needs and the type of security needed. This depends on the risks to the person and the risks they present to others.

The CTR and the Access Assessment will work together to make more options available for care and treatment.

Care Programme Approach

CTRs work **alongside** CPA.

The Care Programme Approach (CPA) helps people who need support from different agencies and are at higher risk.

CTRs and CPA look at the same kind of things but CTRs are more independent and person centred. CTRs will give extra information for a CPA care plan.

Education, Health and Care Plans (EHCPs)

EHCPs are plans for children and young people with learning disabilities in full-time education.

CTRs will work alongside the EHCPs.



CTRs can review the EHCP. They can also make sure that an EHCP happens if there isn't one already.

The CTR can make sure there is a care plan and a lead person for making sure that the plan is carried out.



Mental Health Tribunals

These are for people kept in hospital under the Mental Health Act or who are restricted in how they can live in the community.

Tribunals are an important way of reviewing whether someone needs to be kept in hospital for their care and treatment or whether this could happen somewhere else.



CTRs can help give better information to a tribunal.

Clinical Disagreements

Clinical staff sometimes disagree about the plans for care and treatment of people's mental health problems or the management of challenging behaviour.

Disagreements **must** be sorted out before making planning decisions for the person.

If people cannot agree then this needs to be looked at by the NHS resolution process.



This is where independent professionals help decide what is the best care and treatment for the person.



Escalation of Concerns

This is when the review team complain or raise concerns with a person higher up in an organisation.

Concerns may be about:

- staff members, lack of skills around person-centred care and restraint
- poor conditions or lack of interesting and enjoyable things to do
- not enough resources to meet a person's needs or to have a social life
- people not being able to understand and meet physical health needs.



If there are people who have concerns about the quality of a service and/ or provider, the commissioner should:

- raise concerns with NHS England and make sure actions are followed up.
- use local reporting structures such as safe guarding to report these concerns.



NHS England will make sure the action planned in CTRs will happen.