Community of Practice – 02 (16/06/2021)

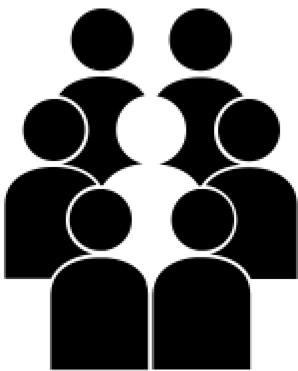
Care Education and Treatment Reviews

NDTi
National Development Team for Inclusion

This Community of Practice (CoP) is made up group of people who share a concern or a passion for improving the lives of people through the CETR programme, and who are keen to learn how to make this process the best it can be through regular community meetings. We ask what is working well, what needs addressing. We seek to find solutions and take action as a community - be it getting more information or trying out new or different ways of working.

Key points from the latest meeting.

Topic 1. Increase in using independent chairs – within London



Concerns in London Area around rising number of independent CTR Chairs with questions arising about how positive this is.

EbyEs being asked to become C(E)TR chairs, which has been done with robust training and support. Although there are questions about where the accountability lies, and what responsibility they have.

In some areas the use of independent chairs has increased due to the number of C(E)TRs being requested.

Accountability was raised as an issue when independent C(E)TRs e.g., report return dates, delays to processes although in some regions there were examples of where the independent chair is more efficient than the internal chairs.

With provider collaboratives coming there is a need and want for a clearer picture of how quality of C(E)TRs will be measured and who will be accountable for this.

There needs to be an update on quality assurance with the C(E)TR policy refresh.

Local teams are supporting independents although training is needed to help support. In the East of England it was noted that there is a use of both internal and external chairs. That quality is held within the region and that there is no external to the region quality, where maybe there should be. In the SW&SE there is mix of chairs. In the SE Adult secure services, they use experienced internal chairs but also use delegated chairs where a conflict may occur – and when needed.

In the SW and with children and young people they use more delegated chairs because of the culture/practice here. It was highlighted that the there is a quality to the independent chairs from the SE/SW working with NDTi to provide support and training.

In the midlands – the adult provider collaboratives use Delegated Chairs and have a positive impact. Case managers are required to attend even if not chairing. With CAMHS, these reviews tend to be case manager led.

There is a call for training for independent panel members and chairs on policy refresh. There is not a lot of refresh training around and this would be good to rectify.

It was highlighted that action points arising from C(E)TR reports are not being followed up and that this has become more difficult since moving to virtual C(E)TRs. Virtual C(E)TRS have also been acknowledged for highlighting the breakdown in communication between relevant parties.

To what extent do independent chairs have authority has been highlighted as it makes it difficult for chairs to instruct services or to ask the more complex/difficult questions.

Co-Chairs are mixed across the regions but would be an ideal mix for the service user

SE/SW worked closely with NDTi to build regional guidance document around chairing virtual C(E)TRS.

The quality of the meeting comes down to how well the collaboratives work with the chair. Comes down to availability and time to have communication. Depends on how involved the case manager is.

Need to get smarter about actions in a C(E)TR. We need more policy that makes people do things

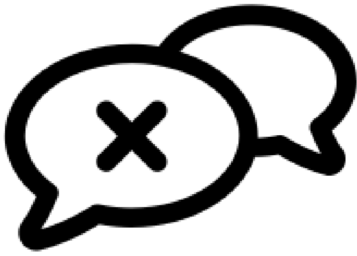
It was recognised that there is pressure for commissioners to achieve targets and that can lead to the overuse Independent Chairs.

In some areas of London when the QA process was done there were lots in problems with quality of C(E)TRs. Maybe need a time to have a stock take – holding people into account – used to be in place but now there is a loss of authority. Time to do a refresh.

Questions arising.

- What are the standards and expectations around independent chairs?
- Who checks the quality of C(E)TRs conducted by external chairs?
- When things go into provider collaboratives – where does the independence lie?
- What about the turn around time – as external chairs are paid by the day – commissioners and ‘internal’ chairs have a time scale to complete. How does this work?
- If the case is complex – should the commissioner be doing it?

Topic 2. Decline to Consent



It was raised that one region was finding high rates of people declining to consent to a C(E)TR and the COP member wanted to know if others are finding this?

The experience was varied across regions with some having very few people who decline CETRs.

The reasons for a C(E)TR Consent being declined varied. Some people found that when people are starting this journey, they are unsure of what process is. It is important to make sure people have info about what a C(E)TR is. For some it was about who was explaining the C(E)TRs to the person. If the person explaining is unsure it passes onto the patient who then decline. Especially in ED clinics. Having the correct people in services explaining to service users, maybe offer more training to services to educate what C(E)TRs are aimed to achieve.

Best interests are a last resort. Sometimes though person just does not want to take part on the day.

The commissioner/ Chair needs a good relationship with hospital. The MDT need good communication. Try to get consent 2 weeks in advance so there is time to go back to the person if they initially declined.

There are areas where there are fewer C(E)TRs and because of this, there is not enough practice of staff engaging with individuals about the process. Need good relationship with hospital, staff need to know what it is and how to support someone to prepare. It is hard working remotely as you cannot pop into to discuss the process with person. Need it to be timely and to be informed. More information needs to be shared by providers to help them support service users to make a more informed decision regarding their health and C(E)TRs

Have a rolling programme to gain consent– every 6 months. It needs to be made clear to patients that this is to help them – it is a positive thing and not a tick box exercise. It is also useful to explain that the individual doesn't need to sit through the whole day. That they can have an allocated time which suits them to take part.

With the move to virtual C(E)TRS this has in some areas increased the number of people consenting to a C(E)TR

Engage case managers to engage with managers and individuals. There is a level of education needed and given to certain providers around the process.

It was recognised that those who have just been admitted can decline as feel overwhelmed.

The consent form and CTR planner good for brief overview but if don't want to engage then won't even look – it is the relationship that matters between the person who is having a C(E)TR and a person they trust, explain it in an encouraging and positive way.

When people are resistant. The options are either easy read or more in depth there is a real need for something in between. Some people find the easy read offensive and the other too much

Topic 3. Pre-Admission CETRS

It was highlighted that there is a real struggle to manage the 90% target for pre – admission C(E)TRs the question as asked – is anyone achieving it – and if so how you do it as the Midlands are not anywhere near it.

The change from 10 days to 5 and 75% to 90% has led to a lot of areas missing targets and would it be possible to look at this again. It was suggested that nationally no region coming in at over 50%.

If notified on the day/day after that it needs to be done, then capacity and flexibility problems especially as CCGs need to involved make it harder. Working with colleagues around DSRs and community aspects – then burden is on spec comm – the biggest issues are around resources in the community.

There is also pressure on the providers to get all the paperwork ready and families to attend a C(E)TR within 5 days of admission. The quality of C(E)TRs has been questioned as it is so soon into the admission. The person will have only just entered the service, and it can be hard for families, and they will have been through a lot with family member being admitted.

Some units do 5 day CPA and try to align them together with the CTR – one less meeting. In that time frame not all the documents are there to be reviewed and it is unlikely the responsible clinician will have had time to sit down with the individual.

In the NW, in CAMHS C(E)TRs it was hard to get info about community C(E)TRs maybe 1 in 10. To do the work, it meant that there was a need to work closer with the CCG rep and talk to them daily about their patients. Any CAMHS admission has a root cause analysis done through the regional team which highlights and continues to highlight the same themes like lack of capacity, resource and infrastructure in the community.

Connect better with the CCGs to identify service users that are need a community C(E)TR and not miss any target dates.

There is a capacity issue within the community which does lead to community C(E)TRs being missed.

As a response to the point about the increase in target. It was explained that 80% of CYP who have a pre-admission C(E)TR end up avoiding admission, and that's why the pre-admission, community, C(E)TR is the "gold standard". A post admission C(E)TR needs to happen quickly to try and minimise the length of stay. The aim is that very few people would need a post-admission C(E)TR. There have been previous conversations where the CYP Director wanted an admission without a C(E)TR to be reported as a "never event". Turned to 10 days to encourage community C(E)TR. The post admission C(E)TR should be an unusual occurrence and not the norm. In places where there is a good dynamic support register – there are fewer admissions or deemed no other option for the child.

The Dynamic risk register should pick up people that are at risk of admission and avoid post C(E)TR.

Actions

Pull together some concerns around the 5 days pre-admission C(E)TR and feedback to the National Team

Seek response to points raised today from people in the National Team

Invite someone from Quality Assurance to attend next meeting

Webpage

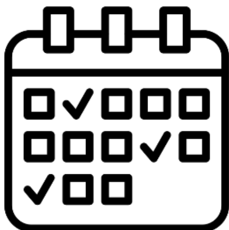
The webpage is now available and is there for the sharing information, good practice, links and notes.

If you want to add anything to this page -please email alex.brooks@ndti.org.uk

The webpage can be accessed here:

https://www.ndti.org.uk/resources/cetr-community-of-practice-resources

Next Meeting



14th July 2021

All information and agendas will be shared on the webpage – an email reminder will be sent ahead of the session.

If you have any topics you would like discussed – please let Alex know alex.brooks@ndti.org.uk