Draft national template and protocol for 6/8-week commissioner visits – Version3
August 6th, 2019 (for testing)

1. Background

In response to the Care Quality Commission Thematic Review of Restrictive Practices, Seclusion and Segregation interim report published on 21 May 2019, a written statement was published by Caroline Dinenage, Minister of State for Care. (Ref HSCS1569). This statement included a commitment to stronger oversight arrangements as follows:

2. Introduction

2.1 The responsible commissioner is to follow this protocol and guidance in carrying out the minimum 6/8-weekly visits.
2.2 This framework sets out principles and guidance for local areas to use and examples of best practice to be considered.
2.2 These visits are to take place for CCG commissioned patients who are in hospital "out of area" (see definition in Appendix One) and for all Secure and CAMHS inpatients (in line with the "standard operating procedure," which sets out the requirements of case managers in NHS England)
2.3 Once a child, young person or adult is admitted to hospital the visits will take place every: **6 weeks** for those aged 18 years and under and **8 weeks** for an adult (over 18 years of age) with a learning disability, autism, or both.

3. Purpose of the Visits

3.1 The purpose of the 6/8 weekly visits is primarily to hear from the patient about their experience of services, and to see the service through the patient's eyes. The visit will also prioritise hearing from family and advocacy.
3.2 The visit is to check on their safety, current care, and involvement of the patient and their family in decisions about their care and treatment.
3.3 The visits are also intended to hear from frontline care staff who often know the patient best and spend time on the ward environment as part of a normal day.
3.4 The visits will have regard to whether the patient's human rights are being protected and respected.

4. Regulations that apply

4.1 The NHS Act 2006, as amended by the Health and Social Care Act 2012, places a duty on commissioners to promote the involvement of each patient, their carers and representatives in decisions about their care and treatment (NHS Act 2006 s13H and s14U). 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:
(a) the effectiveness of the service
(b) the safety of the services
(c) the quality of the experience undergone by patients((NHS Act 2006 s13E and s14R).
Commissioners also have a duty to promote the NHS constitution (on the Commissioning Board in s13C and on CCGs in s14P)
This protocol will support the commissioner to meet their statutory functions.

4.2 The Human Rights Act 1998 places a legal duty on public authorities to protect and respect an individual's human rights in everything they do. This includes ensuring that services being procured for an individual are protecting and respecting these rights. This protocol will support this legal requirement (https://www.bihr.org.uk/thehumanrightsact).

4.3 The legal basis for the visits is under the NHS Act 2006 duties set out above as well as a duty to safeguard children, young people and adults who are using NHS services.

4.4 The Mental Capacity Act 2005 (MCA) is designed to empower people to make their own decisions wherever possible, and to protect those who may lack the capacity to make their own decisions about their care and treatment by ensuring that decisions are taken in their best interests, and in particular giving proper weight to their wishes and feelings, values and beliefs. The visits should be conducted in the patient's best interests, in accordance with the MCA, if the patient lacks capacity to make decisions about the visits. If the patient has capacity to make their own decisions about the visits, then they should only be conducted with the patient's consent.

Principles
The visits:

- **are set out to check on the safety and wellbeing of children, young people and adults who are placed out of their local area in a specialist inpatient unit.**
- **may trigger additional actions or referrals, such as safeguarding, C(E)TRs or second opinion requests.**
- **will not replace/repeat a C(E)TR but the commissioner should make themselves aware of the outcome of the previous C(E)TR.**
- **will be booked to take account of when other review processes are due to take place to ensure these are coordinated.**
- **will be person centred: to facilitate maximum involvement of the patient in the visit.**
- **will identify how much involvement the person and their family have in their own care and treatment which is an indicator of quality (and a legal right)**
- **will lead to ACTION where there are concerns.**

- **will make clear what follow up action there will be and how this will be communicated with the patient, their family and advocate, as well as the service and how this should feed into other review processes.**

Standards- Must be met
1.The visit involves meeting face to face with the patient
2. The visit involves meeting face to face with frontline staff (i.e. support workers who spend most time with the patient)
3. The visit involves meeting with or speaking to family or providing a means for family to speak to or provide information to the commissioner (e.g. carer's form) The method needs to be flexible to enable family involvement.
4. The visit will involve gaining feedback from the patient's advocate.
5. It is expected that the visit will take around half a day with time spent on the ward/unit environment.
6. The visit will be recorded on this form and submitted to the STP/TCP quality lead and collated for quality assurance purposes.
7. The initial visit should be planned well in advance, with a guarantee that all those concerned are given adequate notice.
8. The service or patient will record the visits in their care record

Good practice- should be met:
1. The visit will involve an independent expert by experience who works alongside the commissioner
2. the initial visit will take place at a time that suits the patient, and if follow up visits take place due to a prolonged stay in hospital, then the times of visits should vary, so that the environment is seen both during the week, at the weekend or evening.
3. if the initial visit raises concerns (e.g. safeguarding; CQC involvement), the commissioner is to consider subsequent visits being unannounced, but carried out in such a way as to cause the patient as little anxiety as possible (this will vary according to the individual)
4. If the initial visits raise concern it is vital the commissioner liaises with other involved agencies including other commissioners, CQC and that there is a coordinated approach
4. The "Bringing Us Together" Carer's form is to be used before the visit and will provide an informative view from family https://bringingustogether.org.uk/wp-content/uploads/2019/06/carers-monitoring-form-Final.pdf
5. The visit is to be carried out by someone who has a good understanding of what it is like in an inpatient setting, someone who is inquisitive and understands human rights and autism (e.g. something as simple as wearing perfume may trigger distress)

5. Guidance for the Visit-

- Arrange the visit at a time that is suitable for the person you are visiting to facilitate face to face contact.

- Consider timing in relation to other review meetings or events.
- Gather any relevant information prior to the visit: most recent C(E)TR report; CQC inspection report; any complaints information from the patient, or family, or information on any other concerns raised regarding the service
- Ensure you have received the patient's one-page profile so you can have an understanding of them, their likes/dislikes/ how to support/strengths and their communication needs.
- Make the visit as informal as possible
- Spend time observing in the patient's ward/clinical environment
- Find common interests and engage in discussion on this (e.g. sport; pets; TV)
- Use open questions for example- "tell me about your day" "what do you like about *x* ward?" "what don't you like about *x* ward?" "what makes you feel safe?" "what makes you happy?" "What makes you sad?" "Do you ever feel unsafe?" "what do you do if you are unhappy about something?" ask staff how they communicate with the patient.
- If you identify any concern/s report as appropriate to a senior manager on site, the contract manager/lead commissioner, Local Authority (where inpatient unit is sited and also the home Local Authority of the patient)

Date of visit		**Visit time: start/finish**	
Place of visit/address:		**Person(s) making the visit**	
Name/ID of patient:		**DOB:**	
Patient feedback			
Staff feedback- frontline staff			
Staff feedback- other			
Family feedback			
Advocacy feedback			
General observations			
Safety comments			
Care and treatment comments:			
Future planning comments			
Conclusions			

Recommendations	
Follow up actions Date of follow up	
Other comments	
Comments on appropriateness of the environment and care and treatment	

Appendix One- Out of Area Definition

The below section is an extract from the NHS England publication **"Technical Guidance Annex M Joint Technical Definitions for Performance and Activity 2018/19."** This is to be used as the working definition.
(NB discussions are underway looking at how this definition relates to geographical boundaries and TCPs- further information to follow)

An Out of Area Placement occurs when a patient with assessed acute mental health needs who requires non-specialised inpatient care (CCG commissioned), is admitted to a unit that does not form part of the usual local network of services.
The national definition, published by DH in 2016, focuses on continuity of care. Due to the significant variations in the Trust geographies and the need for some flexibility

in relation to local decisions on service models, the approach to defining an out of area placement necessarily requires local and clinical interpretation, supported by a set of key principles.

A placement is likely to be considered to be out of area if:

- *Clinical continuity cannot be ensured by the sending provider, e.g. the person is placed at a different provider that does not form part of an integrated care pathway with the person's "home" CMHT, so the person's care coordinator cannot be actively engaged throughout the course of the inpatient admission to plan for and support discharge.*
- *The person is dislocated from their usual support network of family and friends and cannot easily be visited.*
- *There are associated costs being paid by the sending provider.*

***N.B.** an OAP can also occasionally occur within a "home" provider spanning a very large geography where the same dislocation from the "home" CMHT takes place, where clinical continuity cannot be ensured and where dislocation from friends and family occurs. This does not mean that the admitting unit necessarily needs to be geographically closest to the patient, but rather it means that the location of the admission should not negatively impact the individual's experience, quality or continuity of care.*

There are some circumstances in which an out of area placement may be appropriate. These includes when:

- *The person becomes acutely unwell when they are away from home (in such circumstances, the admitting provider should work with the person's home team to facilitate repatriation to local services as soon as this is safe and clinically appropriate).*
- *There are safeguarding reasons such as gang related issues, violence and domestic abuse.*
- *The person is a member of the local service's staff or has had contact with the service in the course of their employment.*
- *There are offending restrictions.*
- *The decision to treat out of area is the individual's choice e.g. where a patient is not from the local area but wants to be near their family and networks.*

This list is not exhaustive. There are other reasons why treatment in an out-of-area unit may be appropriate. In these cases discharge and/or return to an appropriate local unit should be facilitated at the earliest point where this is in the individual's best interests. An OAP is inappropriate if the reason is non-availability of a local bed.