

Independent Care (Education) and Treatment Reviews

Views of commissioners and clinicians

Overview

- Independent Care (Education) and Treatment Reviews (IC(E)TRs) are meetings intended to improve the treatment of people with a learning disability or autistic people in long-term segregation.
- IC(E)TRs build on the existing programme of Care (Education) and Treatment Reviews (C(E)TRs) but introduce the roles of an independent chair (appointed by the Department of Health and Social Care) and a Mental Health Act reviewer (appointed by the Care Quality Commission).
- We interviewed 10 NHS commissioners and 7 clinicians who had been involved in IC(E)TR meetings to find out what they thought of the meetings' planning, running on the day and the meeting recommendations.
- They told us that meetings had not been well planned at first but this had improved. Meetings were generally felt to have been well run, though there were mixed views about the effectiveness of the independent chair of the IC(E)TR.
- However, while the written recommendations from IC(E)TR meetings were generally seen to have been good, many participants had concerns about whether they could or would be implemented. Some participants wanted more central support for this to happen.
- Some participants also thought that the establishment of IC(E)TRs was an implied criticism of their own role or performance.
- A key question is what, if any, changes can be made to the IC(E)TR process to maximise engagement and buy-in from the commissioners and clinicians who will ultimately be responsible for implementing any recommendations made.

Why we did the research

IC(E)TRs were established to provide independent scrutiny and review of the care of people with a learning disability or autistic people in long-term segregation in inpatient settings. IC(E)TRs built on the existing programme of Care (Education) and Treatment Reviews (C(E)TRs) but introduced the roles of an independent chair (appointed by the Department of Health and Social Care) and a Mental Health Act reviewer (appointed by the Care Quality Commission). In addition, the review panels included the commissioner of the patient's services, an expert by experience and a clinical expert. Patients and their family members could also attend IC(E)TRs.

The first phase of IC(E)TRs began in November 2019 and by 31 December 2022 (when this research concluded), a total of 169 IC(E)TRs had been carried out.

In February 2021, the Department of Health and Social Care commissioned The King's Fund to carry out a process evaluation of the operation of IC(E)TRs. At the time, IC(E)TRs had been paused because of Covid-19 but the intention was to restart them in June 2021.

Research was focused on commissioners and responsible clinicians since these were the groups about which the Department of Health and Social Care had least information with respect to IC(E)TRs. We also intended to include the views of patients and family members in the research. However, despite extensive efforts, it was not possible to recruit patients and family members, and a key perspective is therefore missing from any evaluation of IC(E)TRs

What we did

We completed interviews with 10 commissioners and 7 clinicians, who between them had taken part in at least 36 IC(E)TRs. Commissioners and clinicians had taken part in IC(E)TRs involving a range of providers, patient types, levels of security and modes of delivery, and had been involved in both virtual and face-to-face IC(E)TRs.

We asked questions designed to explore participants' experiences of IC(E)TRs, focusing on three stages of their process of delivery: planning for and scheduling the review panel; delivery of the IC(E)TR on the day (either online or in person); and delivery and receipt of the recommendations for the patient generated during the IC(E)TR.

We asked participants about what worked well and what worked less well, and what changes they would like to see to improve the process, both for panel members and for the patient.

What we found

Not all the clinician and commissioners in our research were clear about the purpose of IC(E)TRs. IC(E)TRs were felt to have potential for improving a patient's situation but many participants felt that this potential was not being fully realised.

Participants could see the logic of including all of the relevant roles in an IC(E)TR panel but did not always see their individual value being demonstrated in the meetings they attended. Participants expressed mixed views about the role of the independent chair in an IC(E)TR. They could see the potential value of the role but did not necessarily believe it had been realised. The role of the independent chair also raised queries about the purpose of commissioners in the IC(E)TR meeting.

There was a lot of initial negative feedback about the planning of IC(E)TRs. At its worst, this could lead to a preoccupation with process over purpose, and there was a risk that the patient's family was marginalised. However, the planning of IC(E)TRs was thought to have improved over time.

IC(E)TR meetings tended to run smoothly and aspects that proved difficult initially – such as getting the required attendance – were again acknowledged to have improved over time.

The written recommendations from IC(E)TR meetings were generally seen to have been timely and appropriate, but many participants had concerns about whether the recommendations could or would be implemented, and there was disappointment that IC(E)TRs did not confer the extra power to facilitate this.

What this means

Because the planning of IC(E)TR meetings focused on the availability of the independent chair, there is a risk that it may have unintended consequences, including a lesser focus on the availability of family or carers.

It may be difficult to effectively monitor and evaluate the roll-out, development and ultimately impact of IC(E)TRs because of a lack of centralised data, information and oversight. Some commissioners and clinicians were also disappointed that there was too little central support for, and monitoring of, how the recommendations were implemented.

Our research suggests that different clinicians and commissioner hold different 'mental models' of IC(E)TRs. Some see IC(E)TRs as a 'catalyst' for significant change, at least for some patients, but feel frustrated because IC(E)TRs do not

have the extra 'clout' necessary to make sure that the recommendations are fully implemented. Others feel that IC(E)TRs offer the potential to 'validate' what they consider to be already effective care but are concerned at feeling 'done to' by the process.

Some participants also perceived the IC(E)TR process to involve implied criticism of current commissioner and/or clinician roles. Whether or not this criticism is reasonable, it is an issue because if commissioners and clinicians feel disengaged or hostile to the process, it may be that recommendations are less likely to be implemented.

A key question is therefore: what, if any, changes can be made to the IC(E)TR process to maximise engagement and buy-in from the commissioners and clinicians who will ultimately be responsible for implementing any recommendations made.

About this report

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To read the full report, *Independent Care (Education) and Treatment Reviews*, please visit www.kingsfund.org.uk/publications/independent-care-treatment-reviews-commissioners-clinicians.

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