Care and Treatment Review: Policy and Guidance

With policy and guidance on Care, Education and Treatment Reviews for children and young people

Easy Read Version | 2017
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Foreword from Gavin Harding

I wish there had been Care and Treatment Reviews (CTRs) when I was in an assessment and treatment unit.

People have a right to a CTR if they are in hospital for a mental health problem or behaviour that challenges services. Or if they are at risk of going into one. They and their families can ask for one if they need one.

CTRs can help people get support in the community instead of in hospital.

The policy makes sure local services know about the people who are likely to need extra support - so they don’t go into hospital unless there is no other choice.

CTRs are about being person-centred. They think about the person first and how it feels to be in their situation.
Easy Read CTR Policy

We had lots of feedback from people with learning disabilities, autism, their families, providers, experts by experience and professionals.

Their feedback helped to change CTRs so they can work even better.

We have made our information for people and families better, so their voices are heard.

Gavin Harding MBE
The Policy

This policy tells you about Care and Treatment Reviews (CTRs) and how the policy changed in 2017.

CTRs are part of NHS England’s plan to make people’s lives better.

When we say people, we mean children, young people and adults, who have learning disabilities, autism or both.

CTRs are for people who have been, or may be about to be admitted to a specialist mental health or learning disability hospital. When the policy talks about hospitals, it means this type of hospital.

CTRs aim to reduce admissions and unnecessary stays in hospitals.

The CTR is person-centred to make sure the care and treatment needs of the person are met. And that the person and their family are involved in this care and listened to.
Principles

CTRs follow **PERSONAL** principles:

- Person centred and family centred
- Evidence based
- Rights led
- Seeing the whole person
- Open, independent and challenging
- Nothing about us without us
- Action focused
- Living life in the community

The CTR Policy is part of NHS England’s plan, called **Building the Right Support**. This says what NHS England is doing in the **Transforming Care** programme, to change the way services are provided.

Thousands of CTRs have been carried out and a lot has been learned about how they can be made better. This is why the CTR Policy is changing. Between August and October 2016 hundreds of people who have been involved in CTRs said what they thought would make the policy better.
The new policy is changing because of what people said. It focuses on the quality of CTRs and changes that will help them work as well as possible.

Children and young people

Reviews for children and young people will now be called Care, Education and Treatment Reviews (CETRs).

There is a new part in the policy about CETRs for children and young people.
CTRs and support in the community

CTRs are part of NHS England’s plan called Building the Right Support.

This shows the need for local registers for people who are at risk of admission to hospital. These registers allow services to share information and plan for extra support in the community. This helps to cut down the risk of going into hospital.

Local registers also show which people may need a community CTR as this also plays a big part in making sure people only go into hospital when there is no other choice. A community CTR will always check what extra support can be given in the community first.

People have to give their consent to say they agree to be included on these registers.
Key lines of enquiry

The 4 big questions in a CTR are:

1. Is the person safe?
2. Is the person getting good care now?
3. What are their plans for the future?
4. Does the person need to be in hospital for their care and treatment?

Key lines of enquiry

An important change in CTRs has been key lines of enquiry (KLOEs). They give the CTR panel a new way of making sure these four questions are answered.

Each KLOE has one key question followed by other questions that find out more. The CTR panel looks for evidence to help decide what the answers are. KLOEs help the panel produce recommendations or actions that go into the CTR report.
Policy aims

**CTRs aim to:**

- Empower people and their families to be listened to about their own care and treatment
- Check that people are safe and have good quality care. Also that their care and discharge plans are good quality and progressing well
- Make sure people only go into hospital when their care or treatment cannot be safely provided in the community and it is the right place to be
- Review the care, treatment and discharge plans of people who go into hospital in an emergency or crisis
- Check why people are admitted to hospital and that people have good care plans and good discharge plans for leaving hospital. It helps to solve any problems
- Work with the person, their family and others to support people well in the community
- Make sure local services are involved - social care, Special Educational Needs SEN team, school or college. So that all issues can be addressed and solutions found
Easy Read CTR Policy

- Support a person-centred challenge to care and treatment plans
- Look at **barriers to progress** and say how these could be overcome
- Result in a **plan** that has **clear actions**. And a **named person** who will do each action within a certain time. The chairperson, who is the person’s commissioner, makes sure this happens.

**Why use these policies, standards and tools?**

To enable people and their families to understand and be **involved**.

To make sure every CTR is carried out well.

To make sure everyone knows what should happen and when.

To measure how well these things are happening.
Aims of a CTR

CTR s are used when a person is at risk of being admitted to a specialist learning disability or mental health hospital.

The CTR looks for alternatives to admission so that going into hospital is the last answer.

This is supported by local registers so commissioners can make sure the right support is provided in the community. This reduces the risk of going into hospital.

If the person has to go into hospital, it follows the person through their time there until they leave. It does this to check people are safe, have good quality care, and can leave hospital as soon as possible.

Scope of the policy

The policy is for people who may be admitted to, or are patients in, any specialist learning disability or mental health hospital. It is for people with learning disabilities, autism or both.

It is not about going into a general hospital for a physical illness or for people on an acute mental health pathway when this is part of their pre-planned crisis care.
There is a new part of the policy and guidance for Care, Education and Treatment Reviews (CETRs) for children and young people.

The policy is based on the idea that people should be supported to live in the community whenever possible.

**Policy context**

CTRs began in October 2015 when the policy came out. The policy has now changed.

The new Policy was published in March 2017.

CTRs bring extra challenge and checks to people’s care. They are carried out by a CTR panel. There are three people on each panel:

1. An expert by experience. This is a person with learning disabilities, autism or both, or a family carer with experience of services.

2. A clinical expert. This is someone qualified to work in health care. It might be a nurse, psychologist or psychiatrist, for example.

3. The person's commissioner. The commissioner pays for the person’s care. The commissioner makes sure that all the right things happen before, during and after a CTR.
**CTRs and the Care Programme Approach (CPA)**

CPA is a way of making sure that people who use mental health services get the care and support they need. CTRs cover many of the same areas as CPA but are different in these ways:

- They are independent of people’s care. This means they are not carried out by people who provide the person’s day to day care

- They provide independent challenge and check that people are safe and receiving good quality care

- They check plans and give extra support to sort out any problems that can hold up the progress of the person’s care. And discharge if they are in hospital

- They produce recommendations or actions which should be used in CPAs and in CPA plans

- CPA helps to make sure CTR actions are carried out.
### CTR PERSONAL principles and the standards

For children and young people’s CETRs and adult CTRs.

#### 1. Person-centred and family-centred

<table>
<thead>
<tr>
<th>Image</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Person centred" /></td>
<td>The person and their family will be given information about the CTR.</td>
</tr>
<tr>
<td><img src="image2.png" alt="Consent" /></td>
<td>The commissioner will make sure the person has given consent to having a CTR or that a best interests decision has been made before the CTR. Also that people named by the person are invited.</td>
</tr>
<tr>
<td><img src="image3.png" alt="My Care and Treatment Review" /></td>
<td>The person will get support to get ready for their CTR, using the “My Care and Treatment Review” and “My CTR Planner”.</td>
</tr>
<tr>
<td><img src="image4.png" alt="Reasonable adjustments" /></td>
<td>Reasonable adjustments should be made to make sure the person is as involved as they want to be.</td>
</tr>
<tr>
<td><img src="image5.png" alt="Panel meeting" /></td>
<td>The panel will meet the person and their family carer if taking part.</td>
</tr>
<tr>
<td><img src="image6.png" alt="Support after CTR" /></td>
<td>The person and their family get support to understand what will happen after a CTR.</td>
</tr>
</tbody>
</table>
## 2. Evidence based

<table>
<thead>
<tr>
<th>CTRs use <strong>key lines of enquiry (KLOE)</strong>. The CTR will look for evidence to support its findings and write these in the KLOEs. The CTR checks that the best ways of working have been followed. This will be written in the KLOEs. Information to answer KLOEs will be gathered by providers and commissioners <strong>before</strong> the CTR.</th>
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## 3. Rights

Where the person’s human rights are **not** being upheld, this will be written in the KLOEs. Action will be taken.

The CTR will ask about **independent advocacy** and **legal representation** for the person.

## 4. Seeing the whole person

The CTR will ask about the person’s overall health and wellbeing, not just their mental health or behaviour. The person chooses if they want to invite people important to them such as family carers or advocate. Staff who **support** the person also take part.

The CTR should take about a day to complete.
## 5. Independent and challenging

<table>
<thead>
<tr>
<th>The CTR panel has three people: the person’s commissioner (the chairperson), an expert by experience and a clinical expert.</th>
</tr>
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<tbody>
<tr>
<td>The chairperson will make sure everybody knows what the CTR is about.</td>
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<tr>
<td>The review team will have CTR Training.</td>
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<tr>
<td>The panel will provide information about themselves and introduce themselves to the person.</td>
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<tr>
<td>Where a CTR panel does <strong>not</strong> agree, people's different views will be written in the KLOE.</td>
</tr>
<tr>
<td>The CTR will write down the reasons for, and the expected outcomes, of an admission.</td>
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<tr>
<td>The CTR will ask questions when care and treatment is <strong>not</strong> in line with good ways of working.</td>
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<tr>
<td>The CTR will ask whether the person’s care and treatment could happen in a non-hospital setting.</td>
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<tr>
<td>A follow-up CTR will check if any actions from before have not been done. It will ask why.</td>
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</tbody>
</table>

## 6. Nothing about us without us

| Every person will be supported to take part in their CTR where possible. |
After the CTR, the chairperson will write a **report**. It will be sent out **within two weeks of the CTR**.

### 7. Action based

If a CTR panel thinks that someone is **not safe**, the chairperson will discuss it, write it in the KLOE and raise a concern.

The CTR will look for any gaps in the person’s care and treatment. The panel will make sure treatment and discharge plans are in place.

The outcomes of the CTR will be in the CPA care plan.

The CTR will name the people who will make sure recommendations go into other plans – such as Education Health and Care Plan, Risk assessments, etc.

CTRs will check that planning for discharge begins as early as possible.

The commissioner will make sure actions from the CTR are carried out on time.

If this does not happen, the commissioner will explain **why**.
8. Living life in the community

If there are any reasons why the person’s care and treatment cannot be carried out in the community, this will be written in the KLOE.

The CTR will look for risk assessments and plans to keep the person and others safe.

The CTR will look at whether the person has support to be part of their community.

Consent and using information

CTRs and any use of personal information, will need the consent of the person, parent or someone allowed to give that consent.

If there are concerns about the person’s capacity to consent, this needs to be assessed in line with the law about capacity. This can lead to a decision in the person’s best interest.

The commissioner will check that the person has been asked for consent.

The CTR will say what information will be shared, with whom, how and why.
Easy Read CTR Policy

Where a person has capacity to consent, this means:

- The person understands **why** information is needed, **what** information will be shared, with **whom, how and why**.
- They choose to give or not give their consent.
- They understand they can **change** their mind, at any time, whether to give consent.
- They understand **what** happens if their consent is withdrawn.
- If a person does **not** consent, not having a CTR does not affect the person’s day to day care.

The booklet ‘**My CTR Planner**’ helps the person understand the CTR and consent.

**CTR process – before, during and after**

CTR should be **positive, good quality** and bring about the **best outcomes** for the person.

**Before a CTR**

The commissioner will check that the person has been asked for **consent** and given the chance to invite family and others to the CTR.
If taking part, the person’s family will be given all the information needed about and for the CTR. If the family cannot come, video or phone communication can be used.

The commissioner will find a place where the CTR can take place.

Everyone involved will be sent information about the CTR. This does not include personal information about the person being reviewed.

The commissioner will make sure the skills and experience of the expert advisers are right for the person having the CTR.

Panel members will complete CTR training.

The review panel will be sent review tools before the CTR.

The person and family will be sent names and roles of the panel.

An administrator will be needed to do the planning and communication for the CTR.
At the CTR

The CTR panel will include a commissioner, one expert by experience and one clinical expert.

The commissioner will chair the review and write down findings and recommendations as actions.

The review team will make sure they have a good understanding of the person and what they think.

The panel will say what the reasons are for the CTR, the CTR principles and the plan for the day.

The person, family and advocate should be at the CTR if taking part, or supported to take part in another way.

The responsible clinician, named nurse and CPA care co-ordinator must be at the CTR.

Care staff who support the person should be at the CTR.
The CTR takes about a day. Some CTRs may take place over several days.

The CTR should be in a place where the person feels comfortable. The person should be supported by someone they choose and able to take part in the way they choose.

CTR panel members will meet the family if they are taking part.

If families cannot be at the CTR, meetings can be done by video link, phone, email or on a different day.

Care plans, person centred plans, positive behaviour support plans, etc will be reviewed.

The care team should be interviewed, such as: community psychiatrist, community nurse, social worker.

The panel will ask if there are better alternatives to hospital. If the person is in hospital the panel will always ask whether the person could be discharged from hospital. And try to overcome any barriers.

Everyone will meet again at the end of the CTR to talk about findings, recommendations, and who is doing what by when.
Easy Read CTR Policy

The commissioner will send a report to everyone involved within **2 weeks of the CTR**.

The report will say **who** will do each action and **by when**. Everyone should understand **what** will be happening, and **how** this will be followed up.

The commissioner will raise any quality or safeguarding concerns and make sure they are followed up in the right way.

The team will challenge poor ways of working and support a move towards community-based care.

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**Key Lines of Enquiry responsibilities**

The CTR will use **KLOEs** to guide the review.

Each KLOE has a key question followed by other questions to gather information.

Each KLOE will look for evidence.

Each KLOE will record what the person and family say.
**Easy Read CTR Policy**

**Going into hospital**

A CTR **does not** decide whether to admit or to discharge someone from hospital.

If a clinician decides that a hospital admission is needed for a person who is a risk to themselves or others, a CTR cannot stop this.

A CTR **can** make recommendations about other options in non-urgent cases.

**Monitoring and intervention**

Local services should know about people who may be at risk of admission to hospital.

This is so people are supported to remain in the community whenever possible.

An important part of this is setting up local **registers** of people who are at risk of admission to hospital without the right support.

A register has to:

- work across health, education and social care to bring about a better understanding of people who need this support.
- help commissioners decide what services a person may need to stay out of hospital.
Things that can place someone at risk of admission may include:

- Significant life events such as bereavement or abuse
- Unstable / untreated mental illness
- Previous experience of admissions
- Being affected by the Mental Health Act or Deprivation of Liberty Safeguards
- Behaviour which is seen as challenging
- Having staffing or support problems
- Being unknown to services
- Having no fixed address
- Being in contact with law services.
- Being in crisis at Accident & Emergency
- Having no family carers or advocate
- Having drug and alcohol problems
- Poor transition from child to adult services
- Being placed in ‘52-week’ residential schools
- Having recently been discharged from long stay hospital
- Receiving services from Youth Offending teams
- Receiving Continuing Healthcare Funding.

These things should be considered if:

- The person is placing themselves or others at serious risk of harm
- A community placement or tenancy is breaking down and affects the safety of the person or other people
- Hospital admission is possible.
Community CTR

A Community CTR should start when a hospital admission is being considered.

The CTR looks at whether the person needs to go into hospital or whether their needs could be met in the community.

Where there is a crisis and no time to set up a CTR, a fast response is needed to stop the person being admitted. A meeting should be set up with the person, their family and those around them to think about support which could be put in place.

A Community CTR asks what extra support can be put in place for the person and family to avoid going into hospital.

If hospital is possible, there should be a plan that says what issues need more assessment, what it would add, why an assessment must take place in hospital and what hospital would add to this.

Admission should only happen when not to do so would place the person or others at risk of significant harm. This should balance the safety of others against the person’s rights.
## Post-admission CTR

If an adult goes into hospital without having a Community CTR, there should be a CTR **within four weeks** of admission.

The CTR will:

- Check whether care and treatment can be provided in the community.
- Find out the **reason** for admission and what will be gained, the treatment plan and check planning has begun for discharge.

## CTRs in hospital

These CTRs are about the safety, care and planning for people who are in hospital.

For adults in non-secure settings, this will happen after **6 months**.

For people in secure settings, this will happen after **12 months**.

The CTR will look at the **reasons** for a long stay in hospital, barriers to discharge and ask whether hospital is meeting the person’s needs. A hospital CTR always asks if the person’s care can be given in the community.

The CTR will look at how to overcome barriers, agree actions and timelines.
Follow up after a CTR

The commissioner should check that recommendations or actions take place after a CTR. Each action need to say:

- **What** should happen
- **By who**
- **By when**

The person and family or advocate as needed should be kept informed of what is happening. Including how any problems are sorted out.

The panel should be provided with findings and reports from any previous CTRs.

The care-coordinator should make sure CTR recommendations are brought into the CPA.

Feedback from CPA meetings should be agreed at the end of the CTR.

Right to ask for a CTR

A request for a CTR can be made by: the person, their family or carer, the commissioner, advocate or the team supporting the person.

A CTR can be requested at **any** point where there are concerns.
Requests for CTRs should be made to the CPA care coordinator.

They should first try to deal with the concerns that have led to the request.

If the person still feels a CTR is needed, the care coordinator will contact the commissioner.

### Leaving hospital

Many things can get in the way of a person leaving hospital:

- Legal and funding issues
- Concerns about risk in the community
- Lack of housing or disagreements over plans.

The CTR checks for clear treatment pathways and planning for discharge from when the person is admitted.

### 2 First tier tribunals

For people treated under the Mental Health Act, **tribunals** can discharge people, recommend leave or supervised community treatment, and decide on delayed or conditional discharge. CTRs can improve the information and the quality of care and treatment plans that will come before a tribunal.
Access to specialised services

People at risk of admission should have a Community CTR before any decision is made.

People from education, health and social care should take part in the CTR or CETR.

Where hospital admission happens through the courts or prison, a post-admission CTR will happen.

If a Community CTR supports admission to hospital, NHS England specialist commissioning should be asked for an access assessment for admission.

Access assessments decide what the best hospital placement would be. These have three different response times:

1. **Emergency** – response and assessment within 24 hours.

2. **Urgent** – a verbal response is given within 24 hours and an assessment within 4 weeks.

3. **Routine** – initial response within 14 working days and assessment within 1 month.

Bringing together the CTR and the Access Assessment improves the range of treatment available and widens support.

It makes sure alternatives have been looked at before the person goes into hospital. The council’s social care team and the SEN team and Clinical Commissioning Group (CCG) must be part of the CTR.
Disagreements and escalation of concerns

Clinical Disagreements
Where there are disagreements that affect decisions on a person’s pathway, these must be resolved before future decisions are made.

The areas of disagreement should be detailed and these options followed:

- Local reconciliation panels should be used or set up involving the person’s responsible clinician, the clinical reviewer on the CTR panel and an independent clinical expert.

- This panel should be chaired by a Clinical Director from the local or NHS England team.

- An independent expert can advise the chairperson.

- The person concerned should be kept informed and be part of the process if possible.

Disagreements about future care
Where there are disagreements about responsibility for future packages of care between parties, this should be escalated to the relevant NHS England and/or CCG Director of Nursing or Chief Clinical Officer to resolve.

This will prevent the disagreement leading to a delay in leaving hospital.
Escalation of concerns relating to quality and safety

Where there are concerns, these should be discussed as a panel and with the providers, the person and family.

Who can escalate concerns

Concerns raised may be about:
- staff behaviour, skills or use of restraint
- infection prevention, or a place not providing good conditions for people to live in
- not meeting the person’s health or social needs

If there are concerns about the quality or safety of a service, the chairperson or responsible commissioner should:

- Make a written note of concerns and take these to the team
- Raise concerns with the provider, Care Quality Commission (CQC) and local council
- Make sure concerns are shared with NHS England or CCG

NHS England will expect the CCG and Specialist Commissioners to make sure that the CTR recommendations are carried out.

Complaints about CTRs

When complaints are made by the person, their family or providers, they will be dealt with in line with agreed complaints processes.
Part A – Care Education and Treatment Reviews for children, young people
Introduction

This part of the policy is about CETRs for children and young people. In many ways, a CETR is the same as a CTR. So this part is mostly about the things that make CETRs different from CTRs.

Care, Education and Treatment Review

For children and young people, care and treatment reviews are now called Care, Education and Treatment Reviews (CETRs).

The CETR panel should follow these principles:

- **(Child and young) P**erson centred and family centred
- **E**vidence based
- **R**ights led
- **S**eeing the whole person
- **O**pen, independent and challenging
- **N**othing about us without us
- **A**ction focused
- **L**iving life in the community

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Making sure children, young people and parent carers are at the centre of the CETR

The **Mental Health Act** says:

- People should have the chance to be involved in their own care and treatment.
- Children and young people should have the **least** possible separation from their family, friends and community, or breaks in their education.
- Parents and carers have a central role in decisions about their child.

The **Children and Families Act** says that local authorities must consider the views, wishes and feelings of children, young people and their parents when supporting children and young people with special educational needs or disabilities.

Services must listen to the wishes of the child and his or her parent, or the young person.

The child and his or her parent, or the young person, should have the support they need to **take part in decisions**.
Mental health services for children and young people

Any child or young person at risk of admission due to their mental health needs, should first have a Community CETR.

Agencies in the local area such as education, health and social care should be part of this review.

If a Community CETR results in a referral to a Children and Young People Mental Health Service (CYPMHS), the CETR will also help set up an access assessment. There is more about these on page 32.

3 Capacity to consent

Young people aged 16 or 17 are usually seen as able to decide on their own treatment.

Parents or someone with parental responsibility makes decisions for children under 16. Some children can consent to their own treatment if they have enough understanding to appreciate what is involved. Otherwise, someone with parental responsibility can consent for them.

Parents and others with parental responsibility should be fully involved in decisions unless this would harm the child’s well-being.

A CETR cannot take place without the consent of young people with capacity, or their parent or if they lack capacity, a best interests decision being taken.

If there is a refusal to agree to a CETR, the reasons for the refusal are discussed with the young person, the parent carers or their representative.
4 Who should be at a CETR?

When a crisis leads to a CETR, all agencies involved with the child, young person and their family must be involved.

The commissioner will set up and usually chairperson the review.

Where the child or young person has an Education Health and Care (EHC) plan or is having an EHC assessment, the Special Educational Needs (SEN) team must be invited.

If the child goes to school or a college, the head teacher should be invited.

Parent carers
Parent carers for children and young people should **always** be part of the review - unless there are reasons such as safeguarding concerns.

Children and young people
The child or young person should always be encouraged to take part in the CETR. They should be given information and support so they can do this.

Brothers and sisters
**Brothers and sisters** can play an important part in the CETR, if the person wants them to take part.
Children’s social care
Director of Children’s Services as well as any social worker involved with the family should be invited.

Adult social care and transitions team
For children and young people who have an EHC plan, or who are likely to need services as adults, adult social care should become aware of them as they begin ‘Prepare for Adulthood’ in year 9 of school.

From 16, young people’s transition to adult services will begin. The CETR should invite adult social care to take part.

Education department
Where the child has an EHC plan or is having an EHC assessment, the local area’s SEN team should always be involved.

Education provider (school, college or pupil referral unit)
Teaching staff often have good knowledge of a young person and can play an important role in a CETR.

CYPMHS /CAMHS
All those who have been involved from the Child and Young Person Mental Health Service or CAMHS service should part of the CETR.
Responsible Clinician and senior nurse
When children and young people are admitted to an ATU or specialist hospital, the responsible clinician and senior nurse should be at the CETR.

Youth Offending Team
If the person is known to this team, a team member should be invited.

Advocate
Any advocate involved with the young person or parent carer should be invited.

Health providers
Children’s and young people’s doctors, learning disability services and occupational therapists should be invited.

Speech and language therapists should also take part.

Voluntary sector organisations
These may provide services for children, young people and families and should be part of the CETR.
5 CETRs: Principles and standards

The principles and standards of CETRs are the same as for CTRs. See pages 15 to 19. Parent carers will usually make decisions for children under the age of 16, so they must be involved in the CTR before, during and after, unless there is a clear reason why this cannot happen. The child should also be involved if the parent is happy for them to take part. If a young person (age 16/17) is unable to consent, the best interests process needs to be followed.

6 CETRs and other assessments and reviews

Information in a CETR may be useful for other reviews.

Below is a list of assessments or plans children or young people may already have in place.

SEN support

Children and young people may have a special educational need through SEN provision in school.

People supported through SEN support should still have an assessment and plan as to how their special educational needs will be met in school.

Those whose needs cannot be met through SEN support usually need an assessment for an Education, Health and Care plan.

CETRs should involve Education representatives from the council as well as from school, college or pupil referral unit.
Education, Health and Care Plans (EHCPs)

EHCPs are for children and young people with special educational needs and disability, whose needs cannot be met through SEN support.

This process is not replaced by CETRs. A CETR may decide to review the EHCP, or start an EHC assessment.

CETRs should involve representatives from social care as well as from the education provider.

Children’s social care assessment and review

Children and young people and their families may receive services from social care. This should be part of the CETR.

Some children and young people may be known to the council because of safeguarding concerns, or because there is a child protection plan.

If so, case conferences will review the plan.

7 Contact between children, young people and their families

Children and young people have a right to family life. Hospital admission and separation from family can be difficult especially when they are far away.

Councils should think about paying travel costs to families so they can visit children and young people in hospital.
Children and young people may have communication needs which prevent the use of a phone.

Councils should consider how contact can be supported by Skype or Facetime.

**8 Advocacy**

Children and young people in hospital under the Mental Health Act have the right to an Independent Mental Health Advocate (IMHA). In the community, local authorities have a duty to provide information about advocacy.

**9 How often should CETRs happen?**

CETRs should happen _every 3 months for children and young people in hospital_.

They can happen more often than this if needed.

Any member of the CETR or those involved in the person’s care can ask for a CETR to happen sooner than planned.
10 Joint commissioning

Services tailored to the person’s needs can help the person make the transition back to their family or another community setting.

Local councils and CCGs can work together to deliver these services.

11 Young offenders

Services that support children and young people who are in contact with the law should also be involved in the CETR.

These might be services like:

- Youth offending teams
- Community teams for people with a learning disability and/or autism
- Adult mental health and forensic health services
- CAMHS – Child and Adolescent Mental Health Services
- Court, police and probation service
- Crown Prosecution Service
12 Key Lines of Enquiry

CETRs use Key Lines of Enquiry (KLOEs). KLOEs have one key question followed by other questions.

Each question asks for evidence to support the findings and recommendations.

There are different KLOE documents for community CETRs, inpatient CETRs and forensic CETRs for children and young people.

Identifying children and young people at risk of admission

The CETR begins when a child or young person is identified as at risk of being admitted to a specialist learning disability or mental health inpatient setting.

The CETR looks for alternatives to admission.

If they are admitted, it follows their admission, assessment and treatment and towards them being discharged.

The Children Act 1989 says local authorities must have a disabled children’s register.

These may help local CCGs and Transforming Care Partnerships as some of children and young people on the disabled children’s register may need to be on local registers of people at risk of admission.
Governance

Local Policy

Each CCG should develop a local policy with clear information about how it will carry out CTRs for adults and CETRs for children and young people.

13 Complaints, disagreements, and escalation of concerns

Clinical Disagreements

Where clinical disagreements occur that affect decisions on a person’s pathway, these must be resolved before future planning decisions are made.

Local reconciliation panels should involve the person’s Responsible Clinician the clinical reviewer on the CETR panel and an independent clinical expert.

This panel should be chaired by a Clinical Director from within the respective local or NHS England team.

Also, the national children and young people’s team at NHS England can offer advice and support.
Disagreements between parties on future plans

Where there are disagreements around responsibility for future packages of care between parties, this should be escalated to the relevant NHS England and/or CCG Director of Nursing or Chief Clinical Officer to sort out.

This can stop the disagreement leading to delays in the person leaving hospital.

The CETR templates will record concerns under each KLOE and note what actions are being taken.

The review team should escalate any concerns depending on what the concerns are, such as:

- CQC
- Local Authority Safeguarding team
- CCG Contracting team
- Local Quality Surveillance Groups (QSGs)
- NHS England contracting team
- Ofsted

Responsibility for escalating concerns

This is the same as in the CTR policy. See page 33.

Complaints about a CETR

This is the same as in the CTR policy and as detailed in the local CETR policy. See page 33.
Concerns about lack of engagement from necessary partners

All services involved in the care, treatment, support and education of a child or young person should be part of the CETR.

Local areas should set out in the policy how to manage where key agencies cannot, or will not take part.
## APPENDIX 1 - Discharge steps and standards

<table>
<thead>
<tr>
<th>Hospital Discharge Steps and Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>A CTR often finds that a person doesn’t need to be in hospital for their care and treatment.</td>
</tr>
<tr>
<td>It can also make recommendations about the person’s discharge plan.</td>
</tr>
<tr>
<td>A CTR is <strong>not</strong> a discharge planning meeting.</td>
</tr>
<tr>
<td>A CTR will look at these plans.</td>
</tr>
<tr>
<td>Discharge steps and standards check that everything is in place for discharging the person.</td>
</tr>
<tr>
<td>It is everyone’s <strong>right</strong> to be involved in decisions about their plans for leaving hospital.</td>
</tr>
<tr>
<td>The next pages set out the discharge steps and standards. A CTR will check that these things are happening.</td>
</tr>
</tbody>
</table>
# Taking the right steps to leave hospital

<table>
<thead>
<tr>
<th>Step</th>
<th>What should be happening?</th>
<th>When?</th>
<th>Who will help me?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Getting things right for the person and their family</td>
<td>The person, family and support team are told who their <strong>community CPA care coordinator</strong> and <strong>hospital discharge facilitator</strong> are. The hospital team will work with the community team, the person and their family.</td>
<td>Before they go into hospital</td>
<td>Social worker or community nurse</td>
</tr>
<tr>
<td></td>
<td><strong>The person</strong> is helped to understand <strong>why</strong> they have been admitted to hospital and what must happen before they are discharged home. This should happen when they are ready.</td>
<td>When the person goes into hospital</td>
<td>Hospital team, named nurse</td>
</tr>
<tr>
<td></td>
<td>The hospital team will produce a plan within 4 weeks to say what <strong>treatment</strong> the person will have before they leave hospital and what will change for them in hospital. This will be shared with the person and their commissioner.</td>
<td>Within four weeks</td>
<td>Advocate</td>
</tr>
</tbody>
</table>
### Easy Read CTR Policy

<table>
<thead>
<tr>
<th>The person is told who the hospital link person is who will communicate with their family.</th>
<th>When I go into hospital</th>
<th>Named hospital nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person’s family carers will be offered a Carers Assessment and support.</td>
<td>When admitted to hospital</td>
<td>Social worker</td>
</tr>
<tr>
<td>The person’s <strong>living arrangements</strong> will be checked to make sure they don’t lose housing or right to benefits while in hospital.</td>
<td>When the person goes into hospital</td>
<td>Social worker Landlord</td>
</tr>
</tbody>
</table>

2. **Person centred planning to get the person’s future care right**

<table>
<thead>
<tr>
<th>There needs to be a good understanding of the person to plan for their future.</th>
<th>Advocate Family and/or people closest to the person. People providing care and support</th>
</tr>
</thead>
<tbody>
<tr>
<td>This includes their interests, likes, dislikes, who they want to live with and what they want from their life.</td>
<td></td>
</tr>
<tr>
<td><strong>A person-centred profile or a life plan should be done.</strong></td>
<td></td>
</tr>
<tr>
<td>All plan with the person how to meet his or her needs and wishes in the community. This will keep the person and others around them safe and well. It could be done through a Support Planning meeting or My Care Programme Approach (CPA). <strong>Examples of planning for my future</strong></td>
<td>All the people who provide care or treatment Family if the person wishes Advocate</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Other things that need to happen:

A **Home Identification Form** is filled in to say what sort of housing the person needs. They are involved in deciding their housing needs.

**Building the right home guidance** for commissioners to think about different housing options.

All of these things go into a **person-centred service specification**, a list of all the person’s needs and wishes, to help the commissioner buy their future care.

### 3. Who pays?
**Sorting out the money**

All the assessments needed for **funding** the person’s future care are completed.

If the person is on Section 3 of the Mental Health Act in hospital they can have care from health and social care.

If it is unclear who will pay for the person’s care in the future, all steps need to be taken early so it does not hold up discharge from hospital.
The person is asked if they want a personal budget and given information to help them decide.
If they get Continuing Healthcare money, they have a right to a person health budget.

| 4. Finding the right support provider | The commissioner uses the person-centred specification to buy the support the person needs. Or they can get help to use their personal budget to find the right support. | Commissioner  
Social worker  
Personal budget agencies |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The person and their family are involved in choosing the right support provider.</td>
<td>Community care coordinator/Inpatient team</td>
</tr>
</tbody>
</table>
|                                      | The person knows who will support them when they leave hospital and will be involved in recruiting their staff.   | Community care coordinator  
Provider                                             |
|                                      | Their staff are trained to support them.  
Staff are involved in person-centred support planning and risk assessments with the person, their family, community and inpatient teams. | Community care coordinator  
Inpatient team  
Support provider                                        |
There is a **plan** for how the person’s needs will be met in the community. The right support from the community team and primary care is in place to support the person when they leave hospital.

<table>
<thead>
<tr>
<th>5. Housing and adaptations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Making sure the person’s housing meets their needs</strong></td>
<td></td>
</tr>
<tr>
<td>The right <strong>housing</strong> is found for the person using their person-centred specification.</td>
<td><strong>Step 5 happens alongside step 4</strong></td>
</tr>
<tr>
<td><strong>Help on finding housing</strong></td>
<td></td>
</tr>
<tr>
<td>The person, their family and someone from their team who knows them well will visit the accommodation so they can make sure the house right is right for them.</td>
<td></td>
</tr>
<tr>
<td>If the person will be a tenant, agreements are signed.</td>
<td></td>
</tr>
<tr>
<td>If the person needs changes made to their housing, this will be done so it does not hold up their discharge from hospital.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community care coordinator</th>
<th>Support provider</th>
<th>Local specialist team/GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community care coordinator</td>
<td>Support provider</td>
<td>Local specialist team/GP</td>
</tr>
<tr>
<td>Community care coordinator</td>
<td>Support provider</td>
<td>Housing officer</td>
</tr>
<tr>
<td>Community or inpatient team member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community care coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community care coordinator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Getting ready to leave hospital

The person’s **Leaving Hospital plan** is underway, and they may be going out of hospital on leave to visit their new home. Example of [easy read leaving hospital planner](#)

The arrangements for how this is funded are agreed so that the visits can take place when the person is ready.

<table>
<thead>
<tr>
<th>A <strong>discharge meeting</strong> will be set up.</th>
<th>Hospital discharge facilitator/Community CPA care coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person’s staff and family decide how to record their needs in case they are at risk of going into hospital again.</td>
<td>Community care coordinator Inpatient team</td>
</tr>
<tr>
<td><strong>The person is safeguarded</strong> by making sure the right legal framework is used to support their discharge into the community and involvement in decisions about them.</td>
<td>Before discharge but also throughout being in hospital Responsible clinician (RC) Approved mental health professional Social worker Advocate</td>
</tr>
</tbody>
</table>

Before discharge but also throughout being in hospital

Responsible clinician (RC)

Approved mental health professional

Social worker

Advocate
### 7. Leaving hospital and support afterwards

<table>
<thead>
<tr>
<th>Protection, Mental Health Act, Children’s Act and others.</th>
<th></th>
</tr>
</thead>
</table>
| **The person leaves hospital**                            | **Hospital discharge facilitator**  
**Community care coordinator** |
| There is a **plan** to follow up how things are going. The first visit will be within one week of leaving hospital. | **Within 1 week of discharge**  
**Community care coordinator**  
**Inpatient team**  
**Responsible doctor** |
| Review meeting dates are set with the person, their family, paid carers and professionals who support them. | **Plan agreed at last MDT before leaving**  
**Community care coordinator** |
| The person knows how to get extra support if they need it and this is set up. | **Community care coordinator** |
| The person has the support they need to enjoy living in the community. | |
| The person’s community care coordinator and doctor keep checking the person is OK. | **Community care coordinator**  
**Doctor** |
## Discharge standards for leaving hospital

<table>
<thead>
<tr>
<th>Standard</th>
<th>How measured?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> The person has a named <strong>discharge facilitator in hospital</strong>, who is a member of the multidisciplinary team (MDT). This person will help with discharge planning, working with the person and the people they choose.</td>
<td>Named on admission document</td>
</tr>
<tr>
<td><strong>2.</strong> The person has a named <strong>CPA community care coordinator</strong> (who may also be the social worker) from the community team. This person makes sure all the person’s health and social care needs are met after leaving hospital. They work closely with the person and others to plan for discharge. They also help to carry out <strong>CTR actions</strong>.</td>
<td>Named on admission and discharge documents</td>
</tr>
<tr>
<td><strong>3.</strong> The person has a <strong>named social worker</strong> who will support discharge into the community.</td>
<td>Named on discharge plan</td>
</tr>
<tr>
<td><strong>4.</strong> The person is involved in their <strong>discharge planning</strong> and in making plans for the future. With people who are involved in and important to their care and support, including family. The person has a copy of a <strong>discharge plan that is easy to understand</strong>, showing the discharge stages, and who is doing what by when. Easy read <strong>leaving hospital planner</strong></td>
<td>Provider asks for feedback in easy to understand way. Person and family say how well involved they are. The discharge plan will also show this.</td>
</tr>
<tr>
<td></td>
<td>5. <strong>Keeping in touch with friends and family</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>While in hospital the person will have support to maintain relationships with the family and friends they choose.</td>
</tr>
<tr>
<td></td>
<td>The care provider will ask for feedback in ways that are easy to understand.</td>
</tr>
<tr>
<td></td>
<td>6. The person has a <strong>named advocate</strong> who is independent of the people who provide the care.</td>
</tr>
<tr>
<td></td>
<td>The advocate knows the person well and helps them speak up.</td>
</tr>
<tr>
<td></td>
<td>This person is named on the discharge plan and admission document.</td>
</tr>
<tr>
<td></td>
<td>7. While in hospital and before leaving, the person has <strong>full and regular medication reviews</strong>.</td>
</tr>
<tr>
<td></td>
<td>To make sure the person is not taking medicines they don’t need and to find other ways of helping.</td>
</tr>
<tr>
<td></td>
<td>Medication reviews shown on discharge documents, letters to/from GP, responsible clinician and community team.</td>
</tr>
<tr>
<td></td>
<td>8. <strong>Meetings held to plan for the person’s future</strong> will include their hopes and wishes and the people they want to be there.</td>
</tr>
<tr>
<td></td>
<td>Meetings will be easy to understand so they can take part. Information will be provided in a way that is easy to understand.</td>
</tr>
<tr>
<td></td>
<td>Future plans will also support the any needs caused by experiences before or in hospital (e.g. trauma). Plans will include these extra support needs while supporting the person to be as independent as possible.</td>
</tr>
<tr>
<td></td>
<td>There will be a questionnaire to fill in from the provider, written in a way the person understands.</td>
</tr>
<tr>
<td></td>
<td>The person will give feedback about their plans over time.</td>
</tr>
</tbody>
</table>
9. **The Responsible Clinician (RC) who is usually the person’s psychiatrist** will support discharge, offering advice to the discharge facilitator and the multidisciplinary team (MDT) during the person’s admission.

   The RC will work actively with the Ministry of Justice if this applies.

   The RC will make sure actions from Care and Treatment Reviews are carried out.

   The RC will work closely with the person and family to support the future community package. The RC will also work with the community team doctor who will provide the person’s future health care.

| Me and my family will be able to ask the RC what is happening. |
| The RC will let the person and family see letters or documents about the care and treatment. |

| 10. **Hospital planning for the person’s future life outside of hospital** |
| Plans put in place in hospital will also support the person to make a good move into the community. This could include being supported to take more risks as the person grows in confidence, skills and independence. |
| Plans will show how the person is gaining in confidence, skills and independence for leaving hospital. |