NHS England

Dynamic support register and Care (Education) and Treatment Review

Policy and guidance

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- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Forewords

Roger Banks,
National Clinical Director for Learning Disability and Autism, NHS England

When the idea for the development of a care and treatment review was discussed around eight years ago, the driving force was to assist in unblocking apparent barriers to discharging people with a learning disability from hospital.

Over time it was also evident that a care and treatment review could be very effective in helping to explore alternatives to hospital admission when people were facing a crisis of care and support in the community – particularly for children, hence their development into Care (Education) and Treatment Reviews (C(E)TRs). The content and delivery of C(E)TRs has undergone considerable evolution over time, responding to increasing awareness of key issues to be addressed and how they can be used to maximum effect.

This revision of the C(E)TR policy and its combination with the policy for dynamic support registers (DSRs) are a strong reflection of an approach that does not see either of these as existing in isolation. They are part of an integrated, whole system approach to enabling greater and more focused awareness and empowerment of people with a learning disability and autistic people who may require proactive support, intervention and advocacy to maintain their health and wellbeing and quality of life in the place where they live.

This approach will only succeed where there is a shared commitment across organisations and key individuals to engaging with and supporting the highest standards of practice and quality in the delivery of DSRs and C(E)TRs. I hope that this revised and combined policy will direct and support such a commitment.

Conor Eldred-Earl,
Expert by Experience Advisor

I've faced crisis in my life. I narrowly avoided hospitalisation due to a lack of beds available rather than through proactive, caring approaches by professionals, and just because I avoided hospital does not mean things immediately became better or that support was provided. I was left alone, fending for myself for many more years.

These days I work for NHS England as an expert by experience on projects such as this policy with the desire of ensuring no one faces the hardships of this world alone. I truly wish Care (Education) and Treatment Reviews (C(E)TRs) as defined in this policy had existed when I was younger due to the difference they would have made for me and others. Thankfully they are here now and will help countless people, possibly even you reading this foreword.

This new combined policy has taken all the learning since the inception of the C(E)TRs and dynamic support registers (DSRs) and has been reaffirmed through consultation and engagement firmly steered by those with lived experience – be they individuals with autism and/or a learning disability, their parents/carers or siblings. Given this lived experience steer many of the changes made are focused on improving the experience and quality of C(E)TRs for those receiving them, and marrying it up with the DSR policy will ensure greater accountability and follow through in line with a commonly heard frustration of inaction following a C(E)TR.

There are many changes – from improving the frequency of reviews to strengthening the matching system, ensuring those who are diagnosed autistic and/or with a learning disability during their time in hospital get a rapid C(E)TR and providing greater protection to those who have their diagnosis challenged during admission.
I'm very excited that the new DSR policy will better enable local areas to identify and aid those who need support to deliver it in a pre-emptive manner to avoid hospitalisation unless absolutely necessary and then to ensure community involvement continues throughout the admission to discharge and beyond.

Regardless of the direction someone's life takes, this policy allows for far greater oversight, scrutiny and follow through, while keeping the individual, their family and all their needs – be they physical or psychological – at the heart of it.

In summary this policy is for you. Having autism and/or a learning disability should never be a limit to a fulfilling life. We will stand with you to ensure this; you are not alone.

Yvonne Newbold MBE, Founder of Newbold Hope, NHS Assembly Member, Mother

I never expect my heart to soar with optimism when I'm reading policy documents, but that's exactly what happened when I read the dynamic support register (DSR) and Care (Education) and Treatment Review policy and guidance.

For the past two years, I've been working with the DSR teams at NHS England who were tasked with the design and development of this new guidance. It's been heart-warming to see how much thought and careful consideration has gone into getting this right. At the heart of every decision has been the wellbeing of those it aims to help, and at every step along the way, they have consulted and listened to both the autistic community and the learning disability community, as well as their families.

I'm also a part of these communities, through my lived experience of parenting my non-verbal, autistic son who has a profound intellectual disability, and through the work I do with families of this cohort of children and young people who develop anxiety-led difficult or dangerous behaviours.

For far too long, the most vulnerable members of my community have had a very raw deal, made worse by both the lack of understanding and the lack of services able to offer any meaningful support. A complete shift in attitude and approach is long overdue, and this new policy and guidance could be that shift. It really has so much potential to create a more hopeful future for so many children, young people and adults as well as for their families. I'm particularly encouraged by the consistent themes throughout of both person-centred decision-making and the importance of involving family members wherever appropriate.

Reading through this policy has made me so proud of everyone who shared their experiences and insights, both learnt and lived, because together we have developed a framework that makes a real and significant difference.

However, no matter how well a policy is written, its success relies on how well it is implemented at a local level. If you are reading this in your role as a decision-maker, we are relying on you to do this well. Often it only takes one person with enough commitment and care to really make a difference to someone's wellbeing. Please be that person whenever you can. Thank you.

1. Introduction

Dynamic support registers (DSRs) and Care (Education) and Treatment Reviews (C(E)TRs) are essential elements of the pathway providing people with a learning disability and autistic people with appropriate support and care at the right time – so that they can lead the lives they want to and meet their ambitions and aspirations; and can stay safely and healthily in the community or return to this as soon as possible.

This document provides policy and guidance on both, DSRs and C(E)TRs, for implementation from 1 May 2023.

Building the Right Support (2015) and the NHS Long Term Plan (2019) set out what autistic people and people with a learning disability should expect when they need healthcare and support in the community. This includes specific intervention and support for their mental health needs and at times of crisis or particular difficulty for them and their family.

DSRs and C(E)TRs are central to the NHS Long Term Plan commitments by 2024 to:
- reduce the number of children and adults with a learning disability and autistic children and adults in mental health inpatient services
- avoid inappropriate admissions to mental health inpatient settings
- develop responsive, person-centred services in the community.

Early identification of people at risk of admission to a mental health hospital and their access to person-centred planning and support are essential for the prevention of avoidable admissions. If someone with a learning disability or an autistic person does need to be admitted, this should be for the shortest time possible and during their stay they should receive high standards of mental health and physical healthcare.

A key finding of the Norfolk Safeguarding Adults Board's review of the deaths of Joanna, Jon and Ben at Cawston Park in Norfolk and the subsequent safe and wellbeing reviews for all people with a learning disability and autistic people in hospital was insufficient attention to people's physical healthcare in hospital and support for meaningful activity and quality of life. Importantly, we have added a key line of enquiry quality of life question and strengthened the focus on physical healthcare in this revised C(E)TR policy; to support greater questioning and challenge around people's ability to participate in activities and exercise and have an active, individualised programme of care and support that promotes both their physical and mental wellbeing.

Note: Care and Treatment Reviews are intended for adults. Care, Education and Treatment Reviews include an educational element and are intended for children and young people. The term Care (Education) and Treatment Reviews (C(E)TR) is used when both approaches are being referred to.

2. Policy

2.1 Policy statement

This policy sets out the expectations for the implementation and use of DSRs and C(E)TRs across England. It is the responsibility of ICBs and their delegated directors to ensure its implementation from 1 May 2023.

In revising this policy we have:

- Considered the potential impact on people[1], including those with protected characteristics under the Equality Act 2010, and given particular attention to cultural sensitivities, health outcomes and the experiences of patients, communities and the workforce.
- Engaged and collaborated with people with lived experience, family carers, relevant government departments, The Association of Directors of Children's Services, Association of Directors of Adult Social Services, Local Government Association, voluntary and community sector, and other strategic partners including those who represent children, young people, adults and their families.
- Made changes to align it with the new NHS commissioning landscape following the creation of provider collaboratives, ICBs and integrated care systems (ICSs).

2.1.1 Dynamic support registers

Building the right support and the C(E)TR policy and guidance (2017) asked that local health commissioners work with their local partners, including social care and education, to develop and maintain a register of all people with a learning disability and autistic people, including those considered to be at risk of admission to a mental health hospital. This is now known as the dynamic support register (DSR).

ICBs should determine the geographical footprint a DSR should cover and whether it should be held at local system level or with the ICB centrally.

This policy supports local systems to use DSRs most effectively; consistency of DSRs across the country; and the sharing of DSR intelligence between care providers, social services and education settings to best inform an individual's care. It serves as a guide to professionals on their roles and describes the minimum standards that ensure these registers effectively identify and include, with consent, appropriate children, young people and adults (see section 3).

[1]Throughout this policy the term 'people' refers to children, young people and adults who have a learning disability, autistic people and those with both a learning disability and autism.

DSRs are the mechanism for local systems to:

- use risk stratification to identify people at risk of admission to a mental health hospital
- work together to review the needs of each person registered on the DSR
- mobilise the right support (eg a C(E)TR, referral to a keyworker service for children and young people, extra support at home) to help prevent the person being admitted to a mental health hospital.

The DSR enables systems to identify adults, children and young people with increasing and/or complex health and care needs who may require extra support, care and treatment in the community as a safe and effective alternative to admission to a mental health hospital. Additionally, they play a role in ensuring that people's needs are included in commissioning plans, financial plans, service delivery and development.

See part A for detailed guidance.

2.1.2 Care (Education) and Treatment Reviews

C(E)TRs were developed as part of NHS England's commitment to improving the care of people with a learning disability and autistic people in England. They were designed to bring an additional challenge and scrutiny to existing health and care review processes, an alternative perspective and expert insight.

For people at risk of admission or who are admitted to a mental health hospital, C(E)TRs are an essential person-centred process. They seek to ensure system partners are working with people and families to provide the right care, education and treatment to avoid the need for an admission to a mental health hospital, and ensure good care for all.

When an admission is essential for the person to get the healthcare they need, C(E)TRs provide the opportunity to check that their care and treatment are effective and that they are supported to leave hospital as soon as possible.

While the NHS is responsible for implementing C(E)TRs, the involvement of local authorities, education services and other partners, including housing and justice, in the process and its outcomes is essential.

C(E)TRs bring together the individual, their family/carer and the organisations responsible for commissioning and procuring services. This will include the responsible health commissioner[2] from the provider collaborative, NHS England or ICS, consultants, responsible clinicians, nurses, social workers, therapists, education commissioners and providers, other health, education and social care professionals with independent clinical opinion, and those with lived experience (people and families) from diverse communities.

[2]The responsible commissioner in relation to a patient admitted to a hospital or registered establishment is determined in accordance with NHS England's Who Pays? guidance.

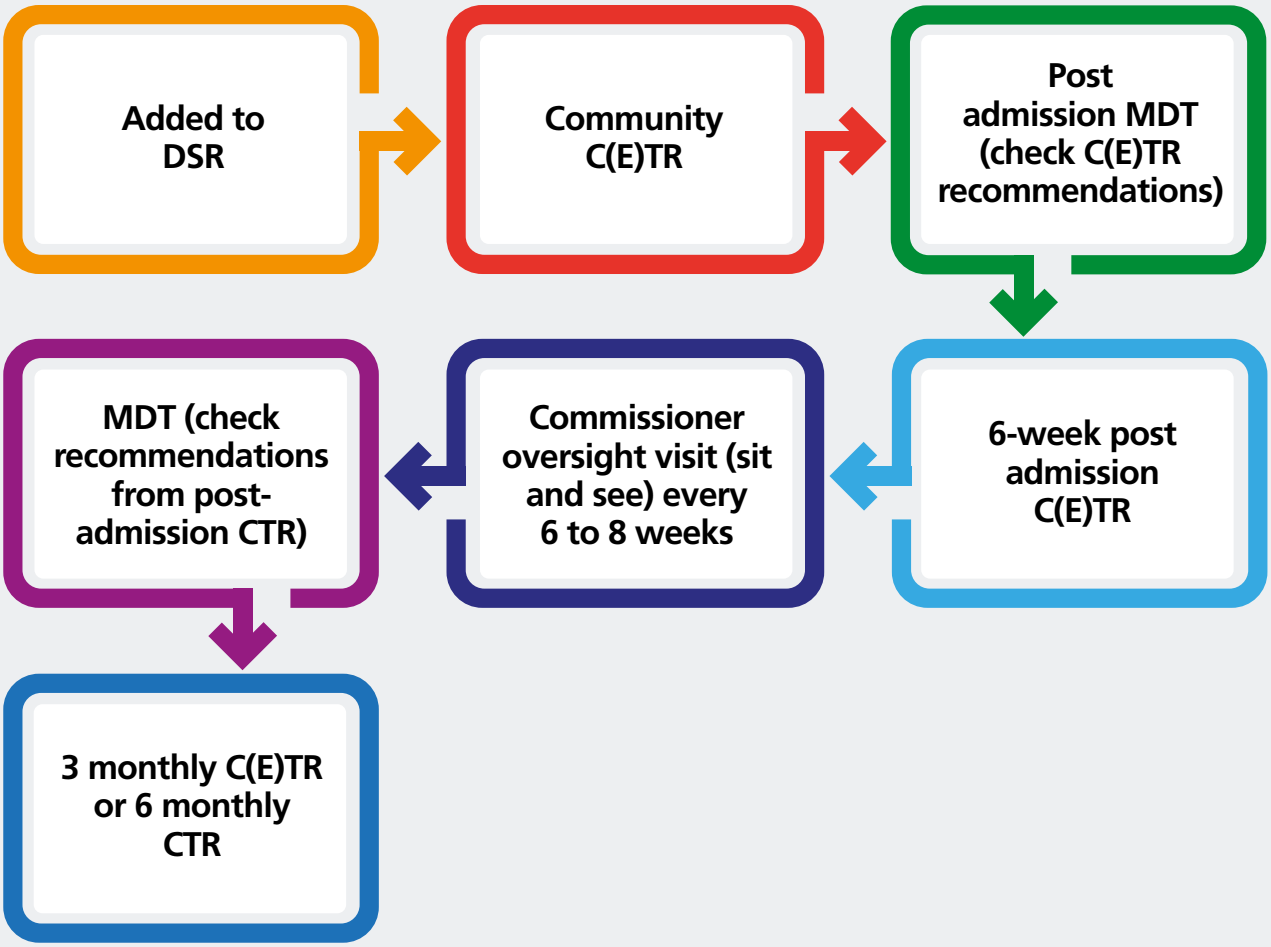
All autistic children, young people or adults and those with a learning disability are required to have a community C(E)TR if they have been admitted to or are considered to be at risk of admission to a mental health hospital. If they do not have a community C(E)TR they must have a post-admission C(E)TR within the required timescales – 28 days for adults and 14 days for children and young people.

Review C(E)TRs must be undertaken in accordance with the guidance set out in part B.

We have added oversight processes for senior system-level review of C(E)TR recommendations and progress for individuals who may hit certain thresholds. This is based on learning from recent safe and wellbeing reviews (see section 16.9).

See part B for detailed guidance.

Figure 1: Example timeline of review processes for a person admitted to a mental health hospital



2.2 Policy aims

This policy supports the effective implementation of DSRs and C(E)TRs in ICSs. It:

1. Supports effective use of DSRs to enhance the care of children, young people and adults across local areas.
2. Supports the delivery of C(E)TRs for children, young people and adults in the community and in mental health hospitals.
3. Ensures consistency in how DSRs are used and C(E)TRs undertaken across the country so that people and their families/carers know what they can expect wherever they live.
4. Empowers and supports people and their families to be listened to and to be equal partners in their care and treatment pathway.
5. Prevents people being admitted to mental health hospitals where this is avoidable through identifying community alternatives where appropriate.
6. Ensures that any admission is supported by a clear rationale for planned assessment and treatment, together with defined and measurable intended outcomes.
7. Provides regular scheduled review of the care and treatment of and discharge plans for people in mental health inpatient settings (or sooner by request where there is dissatisfaction with progress).
8. Ensures that all agencies work together and with the person and their family to support discharge into the community (or if the only option, to a less restrictive setting) at the earliest opportunity.
9. Ensures the involvement of all relevant organisations, including where appropriate children's social care, adult social care and the special educational needs (SEN) team, school or college so that all relevant issues can be fully addressed and solutions explored for the discharge of people into community-based settings or back home to their families.
10. Supports a constructive and person-centred process of challenge to current and future intended care and treatment plans where necessary.
11. Identifies barriers to progress and discharge, and makes recommendations for how these could be overcome.
12. Results in an agreed action plan at the end of the C(E)TR that has clear actions, each of which is allocated to a named individual together with a specific timescale.

13. Improves health outcomes through early access to the most appropriate services and the provision of integrated and holistic care.

14. Enables people and their families to understand the process and have an opportunity to be properly engaged.

The DSR guidance:
- describes a framework that local areas must follow
- sets out the minimum requirements for the use of a DSR in a local area; two relate specifically to children and young people (see section 3)
- sets out the minimum requirements for carrying out a DSR risk stratification – using a common red, amber, green (RAG) rating system (see section 4).

Local systems must work with their key partners – these include people with lived experience – to develop locally defined processes, pathways, criteria and roles responsible for key elements of the process.

2.3 Policy scope

For DSRs, the policy relates to all children, young people and adults with a learning disability and autistic children, young people and adults. As a minimum, those who are at risk of admission to hospital must be included on a DSR (subject to their consent) and inclusion on the register should be one of the triggers for a C(E)TR to happen.

For C(E)TRs, the policy relates specifically to children, young people and adults with a learning disability and autistic children, young people and adults who are facing potential admission to or are inpatients of any mental health hospital, and whose care is being commissioned by NHS England, a mental health learning disability and autism provider collaborative or an ICS.

The policy recognises that some people's route into a mental health hospital is through the criminal justice system (through the courts or from prison or a young offender's institution). They may be subject to a Ministry of Justice (MoJ) restriction order that means they may have to serve a minimum sentence. The policy includes people subject to MoJ restrictions once they have been admitted to hospital.

In these circumstances, although C(E)TRs cannot speed up the discharge process, they can check that the individual is safe and getting appropriate and effective care and treatment in the least restrictive setting based on their reason for admission to hospital (rather than prison), and that planning is underway for their discharge.

2.4 Consent

A review cannot take place or a name added to a DSR without the person's informed consent (see Shared decision making to comply with national legislation and policy). Consent must be formally documented.

The date consent to inclusion on the DSR was obtained is part of the DSR minimum dataset; consent should be checked at least annually and the dates it was checked added.

The responsible ICS must ensure that consent has been sought from the person for both the process and the information sharing that enables it. C(E)TRs take a person-centred approach and this requires the sharing of personal and sometimes sensitive information.

The person must be supported to make a decision about consent by people who know them well and understand their communication needs. Discussion should outline what and how information will be shared about them and their care, as well as why (referred to as fair processing). It should also highlight that information may need to be shared more widely, such as in the event of any safeguarding concerns (see Appendix 6). This discussion should be appropriately recorded, along with the decision.

The My C(E)TR Planner includes accessible information to help the individual understand the nature and purpose of the review.

2.4.1 People who lack mental capacity

If the person lacks mental capacity, informed consent should be sought from someone with parental responsibility, holder of a valid and applicable Lasting Power of Attorney[3] or a court appointed health and welfare deputy. If there is no lawful representative, a best interests decision should be taken on the person's behalf, applying the Mental Capacity Act (MCA) 2005 and its most recent Code of Practice.

Where people have fluctuating mental capacity, their capacity 'at the material time' of the decision should be assessed.

Any assessment of mental capacity is decision and purpose specific – in this case, it relates to the DSR or C(E)TR only. The purpose of sharing any information needs to be clear and recorded.

People who lack mental capacity should be as fully involved as they can be in any decisions about their care.

[3]Documented and registered at the Office of The Public Guardian.

2.4.2 Children and young people

Consent should be sought directly from young people aged 16 or 17; they are presumed to have sufficient mental capacity to decide about their treatment unless there is a reason and/or evidence to indicate otherwise.

Children under the age of 16 can consent to a CETR and their inclusion on the DSR if they are considered to have sufficient competence and understanding to fully appreciate what is involved (Gillick competence). Otherwise, consent must be obtained on their behalf from someone with parental responsibility. Regardless, parents and others with parental responsibility should be fully involved in decisions unless that would prejudice the child's wellbeing.

2.4.3 Where consent is not given

Each local system should have a process for:

- Explaining the implications of this decision to the individual (or their representative), and exploring the reasons for it with them and recording these. They should be assured that withholding consent will not affect their current care provision or any resources they are entitled to, and be made aware that they can change their mind at any time.
- Checking whether the person has adequate support from an advocate, or would benefit from this, to explore their options, rights and decision-making.
- Considering alternative approaches to independent review of a person's care, eg a desktop review with input from those with clinical expertise.
- Regularly reviewing and recording the person's wishes to ensure that they have an opportunity to participate in the process should they change their mind.

The responsible commissioner should escalate any person who declines a C(E)TR on two or more occasions to the ICS oversight panel (see section 18).

2.5 Information governance

The ICS is responsible for ensuring that people added to the DSR or people who have a C(E)TR understood how their data will be used (who, what, how and why) at the point they give consent to either process. This responsibility extends to unpaid carers where information about them is included on the DSR.

The ICS must also ensure local data sharing agreements are in place to allow the necessary data and information flow between agencies.

Part A:
Dynamic support registers

The DSR should be organised in such a way that adults, children and young people can be identified when their health and care needs are increasing or complex, and may require a multi-agency response, monitoring and prioritisation for extra support.

The proactive management of the DSR should enable the identification of people early enough to enable interventions that may prevent the need for a C(E)TR, but if required, trigger a community C(E)TR at the appropriate time.

Terms relating to DSRs are defined in the glossary (section 22).

3. Core standards for dynamic support registers

The following core standards underpin best practice to reduce avoidable admissions. They have been tried and tested in areas with well-developed registers.

1. The ICB learning disability and autism executive lead (usually a chief nurse or executive director for commissioning) have oversight of local DSRs to ensure effective collaboration between health organisations and local authority partners.

2. ICBs are accountable for DSRs across their footprint. The ICB can delegate this responsibility to a partner organisation, such as a local authority or NHS trust.

3. Every ICS/ICB has a named lead person with responsibility for the maintenance of the DSR. For children this is usually a commissioner for children and young people DSRs and for adults a commissioner for wellbeing.

4. Every ICB publishes its self-referral process for people who want to request their addition to the DSR (see section 7). (For children and young people this must be published on the SEND local offer website as a minimum.)

5. Every local area has a single point of contact for people who want more information about the register, including any self-referral processes.

6. Every local area has a standard process for gaining informed consent to be added to the register, or for a best interest decision to be taken. (Local areas need a process for people who do not consent to registration on the DSR but still want to access a C(E)TR.)

7. Every local area publishes its criteria for addition to the DSR – for 'at risk level', this is included in the local offer for children and young people.

8. Every local area has a standard process for reviewing a person's risk to understand their needs. A RAG rating on the DSR (see section 4) reflects a person's risk and activates a timely response to changing needs.

9. The DSR links to the local response, which must include multi-agency ways of working and processes and, as a minimum, referrals to access keyworker services and C(E)TRs. There are effective ways for information to flow between a C(E)TR and the DSR.

   As a minimum:
   - each time a C(E)TR takes place, the person's RAG rating on the DSR is reviewe
   - C(E)TR recommendations are recorded on the DSR.

   DSR stratification (see section 4) should involve review of community C(E)TR recommendations, and inpatient C(E)TR recommendations for those at risk of re-admission, plus any pertinent information from relevant meetings, eg multi-agency meetings and child in need meetings.

10. All children, young people and adults on the DSR should have a multi-agency care plan and risk management plan. These should identify the lead health or social care professional accountable for the delivery of each action. The plans must align with any C(E)TR recommendations. Where a plan is not in place, the lead professional is responsible for creating one with the person and the agencies involved.

11. Local areas with separate DSRs for children and adults have a clear process for moving children to the adult DSR.

3.1 Minimum requirements

DSRs must:

1. Identify children, young people and adults with a learning, disability, autism or both who are at immediate risk of admission to a mental health hospital, including those in urgent and emergency care (UEC) departments waiting for a mental health bed and those at risk of mental health hospital admission (best practice areas include other institutional care).

2. Identify children, young people and adults with a learning disability, autism or both who will be at immediate risk of admission to a mental health hospital if they do not receive urgent or immediate intervention.

3. Include a specific focus on identifying autistic children, young people and adults at risk of admission to a mental health hospital, including those who may not be known to mental health and learning disability services.

4. Ensure a clear link between the DSR and C(E)TRs so that children, young people and adults at risk of admission to a mental health hospital are offered a community C(E) TR in line with this policy.

5. Ensure a clear link between the DSR and the children and young people's keyworker service.

6. ICSs should work with all local authorities in the footprint to include on DSRs's children and young people who are in 52-week residential schools and colleges. They may be placed at a distance from home and their needs are likely to be significant when they return home or their education or placement changes. Their level of risk should be determined using the risk stratification process.

7. Include people discharged from a mental health hospital for a period of review. This period should be determined by the timing of post-discharge C(E)TRs/multiagency meetings, risk stratification process and any post-discharge plans.

8. Children, young people and adults who are placed out of area must remain on the DSR of the placing area or area with commissioning responsibility.

9. Professionals who work with people on the DSR should identify whether they have unpaid carers and if they do, note this on the DSR. This is so that the person on the DSR will be cared for should their unpaid carers no longer be able to provide care and/or need to reduce the level of care they provide (see section 9.5).

3.2 Minimum dataset to be captured

All local registers should capture the minimum dataset requirements. These are:

- identifiable information (name or NHS patient number)
- name of the lead health and/or social care professional responsible for the multi-agency care plan
- name of current service provider or support in place through a personal budget
- whether or not the person has a current care plan that includes contingency planning with a current risk assessment in place
- date of last review of care plans and risk assessment
- whether or not the person is at immediate risk of placement breakdown and/or admission (including their RAG rating)
- date community C(E)TR(s) held
- reason why the person is at risk of placement breakdown and/or admission
- whether the person has been offered a personal budget, personal health budget or integrated personal budget where this is appropriate.
- date consent given for inclusion on DSR.

4. Risk stratification

All local systems must have an agreed approach to the proactive monitoring of and intervention for people on the DSR, including where:

- the person places themselves or others at serious and/or significant risk of harm
- the person's community placement or tenancy, residential special school or care and support placement is at risk of breakdown and this would pose a significant risk to the safety and wellbeing of the person and/or others
- the person presents to the police
- the person presents to urgent and emergency care services
- mental health hospital admission is being considered
- the person was admitted to a mental health hospital in the last year
- the person was supported by a mental health crisis team in the last year
- one or more factors put the person at increased risk of admission (see Appendix 1).

For this, all local systems should use a RAG rating or similar locally agreed process to stratify the needs of those on their DSR. This is to ensure early identification of people whose needs may require a comprehensive response and to keep sight of those whose needs may escalate and require an enhanced, different or more specialist response. The DSR must include information on the following for all levels of risk:

- partners who need to be involved in a C(E)TR if required
- a person-centred plan that identifies needs, support being accessed and the lead professionals involved in the person's care
- review of carer needs (with appropriate consent)
- lead professional.

Table 1 outlines the required minimum support offer for each RAG rating.

RED There is an immediate risk that the person will be admitted to a mental health hospital.

The person and/or their family are experiencing a crisis and the risk of admission to a mental health hospital are not being or cannot be managed in the community.

Linked processes:
- a C(E)TR must take place (see part B)
- referral to the keyworker service (for people aged 0–25 years) if the person is not already known to this service.

AMBER There will be an immediate risk that the person will be admitted to a mental health hospital without urgent intervention.

There could be a significantly increased risk of the person becoming mentally unwell and/or placement/family breakdown.

Linked processes:
- multi-agency meeting and/or C(E)TR
- referral to the keyworker service (0–25 years), if not already known to this service.

GREEN There are some risks that could lead to the person being admitted or re-admitted to a mental health hospital; but currently these risks are being effectively managed.

Linked process:
- clear identification of partners who would need to be involved in a C(E)TR if required.

BLUE A separate rating must identify those children, young people and adults currently in inpatient services.

Linked processes:
- this rating should be used to identify people requiring commissioner oversight visits and inpatient C(E)TRs.

DSR risk stratification, like all other related processes in this policy, can only take place with informed consent (see section 2.4 for further guidance).

The risk stratification/RAG rating processes must take account of:

1. **The person's view** about their current situation, with advocacy support in line with this policy and legal entitlements (see section 16.8 and Appendix 5).
2. **The family's view** about the current situation, with support from local parent carer forums, special educational needs and disabilities advice and support services or other locally commissioned services.
3. **Risk assessment using locally developed tools**

We recommend use of the Cheshire and Wirral Partnership dynamic support database clinical support tool (see Appendix 2) or similar locally developed alternative to support risk stratification and RAG rating.

Cheshire and Wirral NHS Foundation Trust has developed a web-based training tool in the use of the DSR for health and social care staff. The training includes information about risk scoring people with a learning disability and autistic people and case studies from people who have been supported through the tool.

For further information: www.england.nhs.uk/learning-disabilities/dynamic-registers-and-dynamic-systems/dynamic-support-database-dsd-and-clinical-support-tool/

4. **Professional judgement,** which must include structured multi-agency assessment and regular review meetings.

Local areas should facilitate regular multi-agency review meetings to manage the DSR, stratify risk and agree appropriate cross-system actions and support. There must be a shared process of accountability with a clear structure of escalation for red/amber cases. This will involve named senior managers across health and local authority services.

5. Self-referral

Local areas should co-produce with system partners a process for people and families to self-refer for inclusion on the DSR, and publish this, as a minimum on the local offer website. Their inclusion will then be considered against locally developed criteria. A process for dealing with any disputes about inclusion will also be needed.

This process should be developed alongside accessible information and guidance about avoiding inappropriate admission to a mental health hospitals, the DSR and access to locally offered support. There should be a clear link to the information about right to request a C(E)TR, and people requesting C(E)TRs should be considered for inclusion on the DSR, depending on their level of risk and consent to this.

6. Consent for placement on the register

See section 2.4.

7. Data governance and information sharing

See section 2.5.

8. Transition planning

Systems should consider the benefits and challenges of holding one register for children and young people and one for adults, including how inclusion criteria will align.

Where two registers are held, when a young person will move to the adult register needs to be agreed.

Transitions team must have access to both registers and associated services.

9. Partnership working

Dynamic support systems and processes rely on effective partnership working between health, local authorities, education and social care partners. Notably, for children and young people, health commissioners and local authorities should work together to align the DSR with the disabled children's register[4].

9.1 Community Care (Education) and Treatment Reviews

Best practice areas suggest C(E)TRs are most useful when they happen for people who are identified within the amber part of the register as a means of early identification and prevention.

A community C(E)TR must take place when a person is identified as red on the DSR (at immediate risk of admission), unless a C(E)TR has already taken place.
There may be occasions when a C(E)TR is held for someone who has not consented to or is not part of the DSR. It is not mandatory for someone to be on the DSR to be able to have a C(E)TR, although the reasons why they are not should be explored.

The link between the DSR and C(E)TRs is further described in part B.

9.2 Keyworking

The local keyworker service should be linked to the DSR.

By March 2024 children and young people with a learning disability, autism or both aged 0–25 years with the most complex needs will have a designated keyworker. Initially, children and young people who are inpatients or at risk of being admitted to hospital (as a minimum those with a red/amber rating on the DSR) should have access to support from the keyworker service.

Keyworkers support children, young people and their families to avoid admission to a mental health hospital wherever possible. Where admission to hospital cannot be avoided, the keyworker should remain as a core member of the professional network throughout the person's period of admission, and be included in CETRs and support through to discharge.

[4]The Children Act 1989 requires that: Every local authority shall open and maintain a register of disabled children within their area (Schedule 2 Part 1(2)).

- The Children and Families Act 2014 states "A local authority in England must exercise its functions with a view to securing that it identifies (a) all the children and young people in its area who have or may have special educational needs, and (b) all the children and young people in its area who have a disability." (s22 of Part 3)

9.3 Housing

Planning around housing and accommodation for adults and children should be linked to the DSR.

Inappropriate housing can be a contributing risk factor for admission and delayed discharge (eg when a property does not meet the person's and their family's needs) and must be considered as such.

Accommodation needs should be considered as early as possible, eg at the point of admission, as they can take time to address and resolve.

Our housing webpage provides further information.

9.4 Personalised approaches

The DSR should prompt discussion of how personalised budgets and resources may support a person or their family.

Where possible, people with a learning disability and autistic people should be enabled to have either a personal health budget (PHB; health), a personal budget (social care) or an integrated budget (health and social care).

This is in line with the legal right for people who are eligible for continuing healthcare or Section 117 funding to have a PHB and the statutory requirements of the Care Act with regard to personal budgets and NHS Long Term Plan commitments. In addition, health and social care commissioners should consider making available flexible extra support that can be called on at short notice to prevent crisis or avoid hospital admission where possible.

9.5 Carer contingency planning

For persons with unpaid carers and stratified as red/amber on the DSR, professionals should discuss with the carer whether a contingency plan should be developed as part of the dynamic support offer; and if it is, support them to create it. Such plans describe the necessary actions should the carer no longer be able to provide care or needs to decrease what they provide.

With appropriate consent, relevant information from the contingency plan should be shared with those professionals who may need to action it.

Unpaid carers should be made aware of their right to a referral for a Carers Assessment (as set out in the Care Act 2014), what it involves and how this may support them in their caring role, and signposted to local health and wellbeing support offers.

9.6 DSR information and advice

Local partners should agree how people and families are made aware of the support available to them, eg through the local offer for children and young people[5] and the Care Act requirements for adults[6]. Under Section 4 of the Care Act 2014, the local authority must establish, co-ordinate and maintain a service(s) that provides accessible, up-to-date, accurate, comprehensive but proportionate advice and local information about care and support for people and support for carers. For this it is good practice to work closely with children, young people, adults and their families and carers. Much can be learned from their experiences of what is and is not helpful.

[5]Children and Families Act 2014 SEND Code of Practice 2015
[6]s1 Care Act 2014

Part B:
Care (Education) and Treatment Reviews

It is not mandatory for someone to be on the DSR to be able to have a C(E)TR, although the reasons why they are not should be explored.

A C(E)TR is a person-centred review to ensure the care (education) and treatment and support needs of the individual person and their family are met, and that barriers to progress and/or discharge are challenged and overcome.

10. Summary of key changes to the C(E)TR policy 2017

Key change	Description	Section
Dynamic support register (DSR) policy	The new policy for DSRs has been combined with the renewed C(E)TR) policy.	Sections 3 to 9
Increased focus on advocacy	The importance of advocacy for adults, child and young people pre-C(E)TR, during the C(E)TR and post-C(E)TR is recognised.	Section 16.8 And referenced throughout the policy
Increased focus on physical health	Advocacy should be facilitated throughout the process.	Section 16.9
Increased focus on quality of life	Increased focus in the C(E)TR key lines of enquiry (KLOE) on assessing whether physical health needs are being met.	Section 16.7 And referenced throughout the policy
Additional trigger points for C(E)TR	New question in the C(E)TR KLOE on quality of life and strengthened focus on participation in meaningful activity. Additional C(E)TRs should be carried out in the following circumstances: • six weeks after admission to hospital if a community C(E)TR has been undertaken • if a person moves between hospitals and/ or security level within the same hospital • if a person receives a diagnosis of a learning disability or autism during their admission in hospital • if a clinical review identifies that someone who has a diagnosis of autism or a learning disability has been incorrectly diagnosed and the removal of this diagnosis is proposed.	Section 13.1

Key change	Description	Section
Option for the same C(E)TR panel to undertake follow-up review	People should be consulted as to whether they would prefer the same panel (where possible) to undertake their next review. There may be cases where it is considered beneficial to use a different panel although the individual's wishes should be considered.	Section 16.6
Implementation of an oversight process via ICS oversight panels	Each ICS must develop oversight panels that convene at least quarterly and review the C(E)TRs of people for whom there is concern.	Section 18
Mandatory training for panel members	All C(E)TR panel members will be expected to complete mandatory C(E)TR induction training.	Section 16.3 Appendix 11
Payment structure for experts by experience and clinical experts	New suggested minimum rates of pay defined for expert by experience and clinical expert panel members.	Appendix 11

11. Principles

The 'spirit' in which C(E)TRs are carried out is rooted in principles of human rights, person-centeredness and co-production.

- **P**erson (child, young person or adult) 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.

Appendix 3 lists the principles and associated standards. The associated C(E)TR code and toolkit, which includes the principles and standards, sits alongside the policy to provide a solid framework for C(E)TRs to be delivered to a consistently high standard across England.

12. The C(E)TR panel

Panel members need to familiarise themselves with the principles and standards, and hold each other to account on these.

The C(E)TR panel must include:

Chair	The responsible commissioner. If they are unable to attend the review they must delegate authority to undertake this role to someone who can. Responsible for ensuring that all panel members feel able to contribute to the review and that their views are reflected in the final report and recommendations.
Independent clinical expert	Someone with a relevant health professional qualification and active registration with a relevant professional body. They should also hold professional indemnity insurance that covers them to practise on an independent basis.
Independent expert by experience	Someone with relevant lived experience or a family member of someone with relevant lived experience.

If the review is for a child or young person, the inclusion of a children's social care or education professional on the panel should be considered.

If the review is for a person with specific physical health needs or a complex medication regimen, the panel may need a further clinical expert (eg a pharmacist).

The ICB will be responsible for the recruitment and support of experts by experience (often through a locally developed expert hub) and clinical experts, where appropriate, delegating responsibility at a place-based level.

Appendix 11 provides information on recruiting and supporting panel members.

13. When are C(E)TRs triggered?

Note: The C(E)TR does not decide whether a person should be admitted to or discharged from hospital. This remains the responsibility of clinicians (or the courts/Ministry of Justice (MoJ) under Part 3 of the Mental Health Act 1983).

If a clinician judges that urgent admission to an acute mental health hospital is necessary for someone with a mental health problem who presents a risk to themselves or others, then a C(E)TR should not be used to delay or obstruct this process. However, a post-admission C(E)TR must still be undertaken in line with the timescales given in Table 2 below.

Similarly, a pending C(E)TR should not obstruct or delay the normal discharge/care planning processes that may allow a person to leave hospital.

13.1 Trigger points

Table 2 sets out when adults and children and young people should have a C(E)TR, with each type of review described in sections 14.1 to 14.7.

CTR pathway for adults in non-secure services, including acute mental health, rehab, assessment and treatment

Type of review	Maximum time for completion	Minimum frequency of repeat reviews	Notes
Community CTR	Prior to admission	6 weeks after admission and then 6 monthly (unless hospital transfer occurs)	Additional CTRs if other trigger points hit
No community CTR (or local area emergency protocol (LAEP)	Post-admission CTR within 28 days (20 working days)	6 monthly (unless hospital transfer occurs)	Additional CTRs if other trigger points hit

CTR pathway for adults in secure services via non-criminal justice route

Type of review	Maximum time for completion	Minimum frequency of repeat reviews	Notes
Community CTR	Prior to admission	6 weeks after admission and then 12 monthly (unless hospital transfer occurs)	Additional CTRs if other trigger points hit
No community CTR (or LAEP)	Post admission CTR within 28 days (20 working days)	12 monthly (unless hospital transfer occurs	Additional CTRs if other trigger points hit

CTR pathway for adults in secure services via criminal justice route (prison or court)

Type of review	Maximum time for completion	Minimum frequency of repeat reviews	Notes
Exempt from community CTR	Post-admission CTR within 28 days (20 working days)	12 monthly (unless hospital transfer occurs)	Additional CTRs if other trigger points hit

C(E)TR pathway for children and young people up to 25 if education health and care plan in place or if the young person remains in the CYP mental health tier 4 hospital (post 18 years)

Type of review	Maximum time for completion	Minimum frequency of repeat reviews	Notes
Community C(E)TR	Prior to admission	6 weeks after admission and then 3 monthly (unless hospital transfer occurs	Additional CETRs if other trigger points hit
No community C(E)TR (or LAEP)	CETR within 14 days (10 working days)	3 monthly (unless hospital transfer occurs)	Additional CETRs if other trigger points hit

CTR pathway (all ages) for person identified as requiring hospital transfer and/or change in security settings within the same hospital

Type of review	Maximum time for completion	Minimum frequency of repeat reviews	Notes
C(E)TR	Within 6 weeks of transfer	C(E)TRs to continue as per minimum timescales for relevant pathway	

C(E)TR pathway (all ages) for person diagnosed as autistic or having a learning disability while in hospital

Type of review	Maximum time for completion	Minimum frequency of repeat reviews	Notes
C(E)TR	Refer to post-admission timescales: 28 days (20 working days) for adults and 14 days (10 working days) for children and young people	C(E)TRs to continue as per minimum timescales for relevant pathway	

CTR pathway (all ages) for removal of a diagnosis of autism or a learning disability is being considered during an inpatient stay

Type of review	Maximum time for completion	Minimum frequency of repeat reviews	Notes
C(E)TR	C(E)TR to be undertaken prior to any diagnostic changes being formally made		Recommendations to consider impact of diagnostic changes and possible removal from Assuring Transformation for individual

Learning from the safe and wellbeing reviews, serious case reviews and serious incident reviews, along with views from stakeholders and partners, prompted a review of the triggers for a C(E)TR and the review timetables. The following circumstances are new triggers for a C(E)TR in this updated policy:

- six weeks after admission to hospital if a community C(E)TR has been undertaken
- if a person is transferred to another hospitals or to a setting within the same hospital with a different security level
- if a person receives a diagnosis of autism or a learning disability during their admission in hospital
- if a clinical review identifies that someone has been incorrectly diagnosed with autism or a learning disability and removal of the diagnosis is proposed.

13.2 Requesting a C(E)TR sooner than the minimum timescales (adults, children and young people)

A C(E)TR can be requested sooner than the timescales given in Table 2 by the following people:

- person in receipt of services
- person's family or carer
- responsible commissioner
- advocate for the person in receipt of services
- inpatient or community team supporting the person.

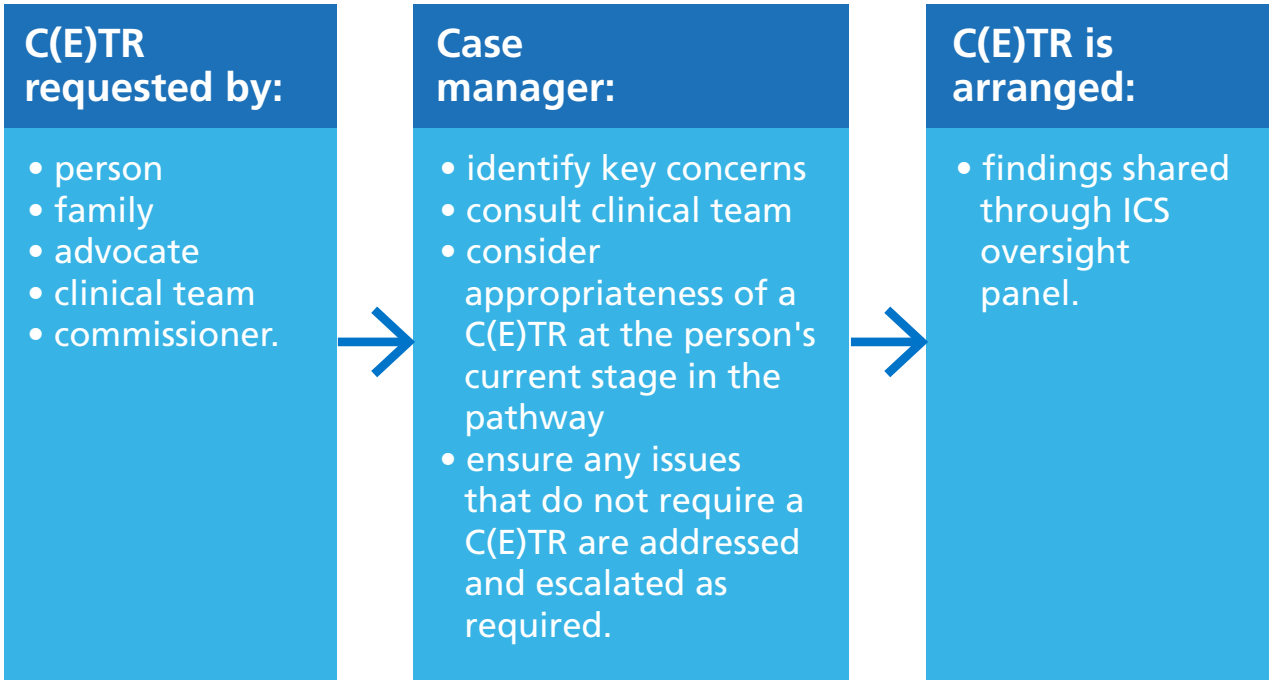
It can be requested:

- both for people living in the community and those who have been admitted
- whenever there are concerns about the suitability of a service, the treatment plan, the individual's safety and wellbeing and/or, for inpatients, there is no clear discharge or transfer date and plan.

Requests for C(E)TRs should be directed to the case manager or responsible commissioner. Their first response should be to address the concerns that led to the request as promptly and thoroughly as possible, including by arranging additional support if the concern relates to possible hospital admission; potentially avoiding the need for a review.

Local areas must have a process for requesting a C(E)TR; how decisions are reached and whether an appeal can be made where a request is denied; and how decisions are recorded and communicated to the person and their family.

Figure 2: Process for requesting a C(E)TR and managing the request



Where it is decided that a C(E)TR will not benefit the person but the applicant continues to feel one is necessary and appeals against the decision, the request should be escalated to the commissioner to consider in line with locally established protocols.

Note: C(E)TR requests should not be regarded as a form of complaint and should not be handled through usual complaints channels.

C(E)TRs undertaken outside usual timeframes will automatically be reviewed by the ICS oversight panel (see section 18).

14. Focus of each type of review

14.1 C(E)TRs – community

A community C(E)TR should be initiated where mental health hospital admission for a person is being actively considered or sought. This will help establish whether the person's care, education and treatment needs could instead be met effectively and safely in the community through additional and/or alternative support and interventions. All alternatives should be explored, including consideration of flexible individual payments through offering a personal budget, PHB or integrated budget (whether this has been offered should be checked) and resources used flexibly to meet people's needs.

Resources may include specialist health teams, local authority respite/short break provision (supported by specialist health teams), voluntary agencies, short breaks and self-advocate and carer organisations to provide peer support. The C(E)TR can ensure that the personal and long-term impact on quality of life and an individual's human rights are given high priority alongside the financial cost of appropriate intervention.

Hospitals should only be used when not to do so would place the individual or others at risk of significant physical, emotional or psychological harm. This decision should be based on a comprehensive risk assessment by a multidisciplinary team (MDT), adhering to locally agreed protocols, within the context of all appropriate legal and procedural frameworks. The risk assessment process should reflect levels of evidenced risk and must seek to balance the safety needs of local communities against the rights and freedoms of the individual.

A clear, detailed and outcome-focused care and treatment plan should be developed as part of the community C(E)TR for all individuals to be admitted to a mental health hospital. The plan should specify what issues require further assessment, the value of further assessment to the person's pathway of care and why this can only take place in a hospital setting.

Admissions for assessment and treatment should not be used as 'step-down' or intermediate placement while planning longer-term community support.

Planning for discharge and robust commitments to continuing support in a community setting should be firmly established and documented before admission.

Where a person is at the point of 'crisis' action is urgent and it is unlikely a community C(E)TR can be set up quickly enough to direct this. However, even in urgent circumstances an assertive, fast and measured review needs to be undertaken to safeguard against the person being admitted unnecessarily to an inpatient service. A meeting, possibly virtually, should be set up to engage the person, their family and all those around them to think creatively about what potential alternative supports and interventions could be put in place. This does not constitute a community C(E)TR and should not be referred to as such. Appendix 8 outlines the local area emergency protocol

(LAEP) that was used by Plymouth Clinical Commissioning Group to identify alternatives to hospital admission if appropriate. Should such people be admitted, the post admission C(E)TR process should be followed (see Table 2 and section 14.2).

Discussions around the person and family's support needs should consider the person's advocacy needs, ideally before any community C(E)TR takes place, such as when the person is identified on the DSR. Advocacy will support the person's involvement in and understanding of the C(E)TR process and its aim of avoiding admission whenever possible; it should also support family carer involvement whenever possible. Where admission to hospital is likely, the community C(E)TR can help to describe the ongoing advocacy support the person may need during their admission and following discharge. See section 16.8 and Appendix 5 for further information on advocacy.

14.2 C(E)TRs – post-admission if no community C(E)TR held

If a community C(E)TR has not been possible in advance of admission, a post-admission review is carried out – both for those detained under the Mental Health Act and those admitted informally.

This should be within 14 days (10 working days) for children and young people, and 28 days (20 working days) for adults.

The purpose of the post-admission C(E)TR is to:

- review the circumstances and route to admission to establish if hospital is the most appropriate setting for a person's care or if this could be provided in the community or another setting
- establish the purpose of admission, expected outcomes, timescales and expected length of stay
- ensure that planning is underway for discharge with preliminary timescales and any commissioning that may be required to support discharge (eg housing/workforce) begins as early as possible.

Best practice is to use root cause analysis at this point in the pathway (NHS England provides resources for this approach). Learning from unplanned admissions is essential to understanding how to prevent these. Root cause analysis should underpin service development and local C(E)TRs and DSR processes.

14.3 Review C(E)TRs – inpatient

These reviews focus on the safety, care and future planning for people who are admitted to and remain in specialist inpatient assessment and/or treatment services.

A person who has had a community C(E)TR but is still admitted to hospital should have a repeat review within six weeks if they remain an inpatient, and further repeat reviews according to the minimum frequency given in Table 2. These should establish the reasons for extended hospital stay, barriers to progression and discharge, and whether the correct or most effective treatments are being provided. They should be solution focused, looking to find ways to overcome barriers to discharge, and result in agreed actions, responsibilities and timelines, and how these will be monitored.

Ideally before the 'final' pre-discharge C(E)TR and certainly at that one, the panel should consider the person's advocacy needs when they leave hospital and what statutory entitlement exists for this (see section 16.8 and Appendix 5). A self-advocacy organisation may help people build friendships, networks and access to things that help them achieve their hopes and ambitions. Post-discharge advocacy is likely to work best when it is arranged before discharge, giving the person the opportunity to get to know or even choose their future advocate(s).

For people who are subject to Ministry of Justice (MoJ) requirements, the protocol in Appendix 10 supports effective working with the MoJ. It is based on learning from MoJ-related barriers to discharge or transfer and enables MoJ monitoring and oversight of C(E)TR outcomes for restricted patients with a learning disability, autism or both. The appendix also provides MoJ guidance on the information it needs to support the decision-making process for discharge. It is important that this is provided as early in the process as possible to avoid unnecessary delays from case workers needing to seek further information.

14.4 People in long-term segregation – independent care (education) and treatment reviews

On 5 November 2019, the Secretary of State for Health and Social Care announced the urgent review of the care of all people with a learning disability and/or autistic people in long-term segregation (LTS) in mental health hospitals. This work was overseen by Baroness Hollins.

People in LTS should have regular C(E)TRs as per the relevant inpatient pathway but are also entitled to have an independently chaired review (IC(E)TR). This is a one-off review that can take place when a C(E)TR would have been due, and should be aligned with the C(E)TR process and timescales to ensure consistency with recommendations.

For these reviews LTS is defined as:
'Nursing or caring for a person in enforced isolation, regardless of whether the procedures and requirements of the MHA Code of Practice 2015 for long-term

segregation are met. The enforced isolation must have been in place for 48 hours or more. It should still be considered segregation even if the person is allowed periods of interaction with staff and or peers.' (CQC Thematic review of the use of restraint, prolonged seclusion, and segregation for people with mental health problems a learning disability and/or autism 2019)

The Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC) together deliver IC(E)TRs. They follow the same process as for a C(E)TR and are co-ordinated by the responsible commissioner, but the panel is enhanced by:

- an independent chair appointed by DHSC
- a CQC Mental Health Act reviewer.

NHS England manages this process nationally, with the NHS regional lead responsible for reporting to the national team every six weeks to identify people subject to LTS and therefore entitled to an IC(E)TR.

14.5 Transfers from one hospital to another

When an individual is transferred from one hospital to another or to a setting within the same hospital with a different level of security (an increase or decrease), a C(E)TR should take place within six weeks of transfer (see Table 2). The focus of this review is the same as for any inpatient C(E)TR, with consideration of whether the clinical aims of the new admission are being met and whether there is a clear rationale for why care and treatment cannot be safely delivered in the community.

14.6 When a diagnosis is given during an inpatient stay

People who are diagnosed as autistic or as having a learning disability during their stay in an inpatient unit will need to be added to the Assuring Transformation database and are entitled to a C(E)TR. This review should be arranged in line with the post-admission C(E)TR timescales (10 working days for children and young people and 20 working days for adults) (see Table 2).

14.7 When the removal of a diagnosis is being considered during an inpatient stay

The assessment and formulation process when a person is admitted to an inpatient unit may lead the clinical team to consider removing or changing their diagnosis of autism or a learning disability. A C(E)TR should be undertaken before any final decision (see Table 2) to ensure the individual, their family and advocate have been included in the decision-making process and that the impact of the change on their care, education and treatment has been fully considered. Removal of a diagnosis will mean the person no longer meets the requirements to be included in the Assuring Transformation database.

15. Access to specialised children and young people mental health services (CYPMHS)

Any child or young person who is at risk of admission, given the nature of their mental health needs, should first have had a planned community CETR. All relevant agencies in the local area must be invited to participate in this review (including education, health and social care). (The exception is where admission would be via the criminal justice system, from court or prison, when a post-admission CETR only would apply.)

If the outcome of a community CETR is that referral to specialist NHS commissioning for access to a secure or CYPMHS bed is the appropriate option, the CETR will have established a foundation for the access assessment (as described in the NHS standard contract and service specification for NHS responsible commissioners for children and young people and adults). These assessments determine the most appropriate placement to meet the person's mental health need and provide the level of relational security they require.

For children aged under 18, integration of the CETR process and access assessment ensures the person's whole care pathway is considered and will help widen the range of treatment options and support available to the child, young person and their family. It further ensures that all alternatives to secure provision are explored before a secure setting is agreed as the appropriate placement.

16. The review process

This section should be read together with the C(E)TR code and toolkit.

The ICB will be responsible for overseeing implementation and co-ordination of C(E)TRs.

All reviews should be a positive and inclusive experience, adhere to a prescribed level of quality and result in the best outcomes for the person being reviewed.

The review process should complement the overall care pathway for the person, including the multidisciplinary team (MDT) process and commissioner oversight visits. While the C(E)TR meeting will likely take place on one day, preparation and follow-up work will be required to ensure the review best meets the needs of the person. The panel should be flexible about the agenda and as far as practicable meet the person at a time that is convenient for them.

The expectation is that C(E)TRs take place face-to-face. The opportunity to meet the person and see their environment is essential for understanding their day-to-day experience.

If a panel member has good reasons why they cannot attend in person, then a hybrid method (virtual and face to face) should be considered where there is no alternative and this will not undermine the quality of the review.

If family, carers or professionals from relevant agencies cannot attend in person, their virtual attendance should be considered on a case-by-case basis.

16.1 Sit and see

The responsible commissioner is required to undertake an oversight visit every six weeks for children and every eight weeks for adults they are commissioning services for, to ensure their safety and wellbeing.

At the last oversight visit before a planned C(E)TR, the commissioner should undertake a 'sit and see' observation to inform the C(E)TR.

The precise timing of planned C(E)TRs should consider when the person's next oversight visit is due, as well as other meetings, to ensure that they are receiving oversight of their care in a planned way.

16.2 C(E)TRs and multidisciplinary team approach

It is important to note the recent changes to the Care Programme Approach: NHS England position statement. While recommendations from C(E)TRs have previously been integrated into CPA meetings, this should continue within the MDT approach in the absence of CPA reviews.

C(E)TRs are not MDT reviews, though they will cover many of the same core areas and can inform the local MDT process.

The differences in C(E)TR emphasis and process are:

- provide a degree of independent scrutiny; they involve independent clinical experts and experts by experience
- challenge elements of the care and treatment plans where appropriate
- are chaired by and directly involve the responsible commissioner
- routinely involve local authorities.

It is important to define the relationship between C(E)TRs and MDT meetings. The outcomes of a person's C(E)TR should feed directly into the MDT process, and be used to inform revision of the MDT plan for that person.

The responsible clinician is responsible for completing MDT plans and sharing them with others, including the individual and their family. They also have overall accountability for the implementation of the agreed actions from a C(E)TR and for follow-up.

MDT meetings subsequent to a C(E)TR will review whether actions have been completed, with progress fed back to the C(E)TR panel chair at agreed intervals. The person and their family will also be kept updated on progress.

There can be benefits and challenges to holding a C(E)TR on the same day as an MDT review meeting. Generally, they should only be if this is the preference of the individual and their family. Information should be provided about the possible advantages and disadvantages of having both reviews on the same date. Advantages may include professionals and family being more likely to attend, and the person only having to have one day of meetings and not having to repeat any clinical updates. However, the MDT review could reduce the amount of time the C(E)TR panel have to talk to people individually and make observations on the ward. The focus of an MDT review will also be quite different to that of a C(E)TR and will not include independent scrutiny of the care the person is receiving.

16.3 Before the review

1. The responsible commissioner must ensure that informed consent has been sought from the person whose review it is (and for a child or young person, from those with parental responsibility as well as the child/young person) or for those who lack mental capacity, a holder of a valid and applicable Lasting Power of Attorney or a court appointed health and welfare deputy, both for the process and the required information sharing that enables it (see section 2.4: Consent and section 2.5: Information governance).

2. The person should be supported so that they understand the process, are giving informed consent and have time to consider their views and feelings, using My C(E) TR planner where appropriate. This should include a discussion about the best way to conduct the review, including whether running it over more than one day would best meet the person's needs.

3. Consideration should be given to equality and diversity, including any protected characteristics – both in the planning process and when appointing a panel to undertake the review.

4. Consideration should be given to involving an interpreter or British Sign Language signer, or someone who can communicate in the person's preferred communication method, to ensure the person and/or their family members are appropriately supported to engage in the review, and arrangements made accordingly.

5. The family, wherever appropriate, will be given information about the C(E)TR) process. This may involve the panel chair or one of the expert advisers telephoning them to discuss the process (the expert by experience may be best placed to do this, but this is not expected in every case).

6. The commissioner will liaise with the inpatient or local community service to find an appropriate venue for the review, one that makes it easy for the person and their family to take part. If the family cannot be at the review in person, secure live video communication or phone facilities should be made available to enable their participation.

7. All parties involved in the review will be sent information by the designated administrator explaining the process. A diverse range of expert advisers (both clinical experts and experts by experience) who meet the 'expert adviser' specification (provided in the C(E)TR code and toolkit) will be appointed.

8. In identifying both experts by experience and clinical experts, the responsible commissioner or their delegated co-ordinator should ensure that the knowledge, skills and experience of the experts are commensurate with the needs and diagnosis of the person and/or any particular issues that warrant enhanced expertise. For example, a psychiatrist's input may be useful for contentious medication issues, or a clinical psychologist where issues concern behaviour management or the need for psychological therapies.

9. Consideration should be given to whether an education and/or social care expert should be included in the C(E)TR panel.

10. Where the review will discuss issues of a particularly sensitive/emotive nature, the responsible commissioner should be aware of these when selecting potential reviewers and ensure they have appropriate support during and following the review.

11. All C(E)TR panel members will be expected to complete mandatory C(E)TR induction training provided via Health Education England.

12. Review panel members will receive information about who is sitting on the panel and they will be working with, and the appropriate review tools.

13. The person having the review and family members where appropriate will be sent the names, roles and, where possible, photographs of those on the review panel.

14. Where possible, a designated administrator should be identified to ensure timely and thorough co-ordination, forward planning and communication for C(E)TRs.

16.4 Who to invite to the review

The person whose review it is. It is vital that the person is fully supported to participate in their review in whatever way they prefer.

Parents or those with parental responsibility for children and young people. They should always be part of the review (unless there are exceptional circumstances or significant safeguarding reasons to prevent this; these should be clearly noted).

Family carers. Unless a person who has capacity determines they do not wish their family to be involved or there are exceptional circumstances or significant safeguarding reasons to prevent this, family carers and/or members should always be invited to participate in the review.

Siblings. Consider the engagement and involvement of siblings in the C(E)TR process. They often play a significant part in the lives, care and support of their brother or sister. They can also often bring a unique perspective about the difficulties that their sibling may be experiencing and what is important to and for them.

Commissioners responsible for the person's care following discharge (includes local authority colleagues or joint commissioners). Their involvement in the review is essential for planning for the future and understanding and resolving any barriers to progress.

Responsible clinician. The responsible clinician is an essential attendee. They are clinically accountable for the person's care and treatment and have an essential role in progressing recommendations.

Senior nurse/clinical staff. Those senior nurse and clinical staff who are involved in the daily care and treatment of the person should be invited and must attend the review.

Advocate. The involvement of a person's advocate in the review is essential, should they have one. An independent mental capacity advocate (IMCA), independent mental health advocate (IMHA) or professional advocate may also be needed for a person in the community who lacks friends and family to support them through the review process (see section 16.8 and Appendix 5).

Children and young people's keyworkers. By March 2024, all children and young people at risk of admission to hospital or in hospital should have a named keyworker. The keyworker should always be invited and must attend the CETR. Keyworkers can play an important part in the arrangement and delivery of, and follow-up from, CETRs. In particular, they can help ensure links with and strengthen the consideration of education in CETRs for children and young people who not in school.

Senior children's intervenors/senior intervenors. Senior children's intervenors work with young people with the most complex needs and discharge planning challenges, often those who have longer lengths of stay in hospital. Senior intervenors work with adults who are in the most restrictive types of care. Their role is to help facilitate discharge by working with systems to remove barriers. They should be invited to all C(E)TRs.

Social care

Children's social care. Each local area has individual arrangements for the organisation of children's social care provision, and it can be complex to ensure the right people are invited to the review. If the child or young person has a named social worker, the request to attend should be sent to them and their manager. If they do not, it should be sent to the director of children's services.

While it is important to ensure a social worker who knows the child and family is involved, it is as important to ensure that someone senior enough to make decisions about service provision and support is also part of the review.

Social care transitions team. Adult social care should be made aware of children and young people who have an education health and care plan (EHCP) or are likely to require services as adults, as they begin to 'prepare for adulthood' in year 9 of school. Young people begin to transition to adult services across health and social care from the age of 16 and both adult and children's social care should be invited to a young person's C(E)TR.

Adult social care. If the person has a named social worker, the request to attend a CTR should be sent to them and their manager. If they do not, it should be sent to the Director of Adult Social Care Services. While it is important to ensure a social worker who knows the individual is involved, it is as important to ensure that someone senior enough to make decisions about service provision and support is a part of the review.

Education

Local authority education department. Each local area has individual arrangements for the organisation of children and young people's education provision. It can be complex to ensure the right people are invited to the review – both those involved most directly in the child or young person's education and those who can make decisions about future provision, support or services.

Where the child has an EHCP or is having an education, health and care assessment, the local area's special educational needs (SEN) team – the team who oversee education placements and other decisions about education provision – should always be involved in a CETR. It is not enough to only invite someone from the child or young person's current education setting as they cannot make decisions about new or enhanced educational provision.

Education provider (multi-academy trust/school/college/pupil referral unit, etc). Those who provide a young person's education often have unique knowledge about and understanding of the young person. They are important contributors and must attend a CETR.

For some children and young people, education provision may have broken down because of behaviours that challenge or a mental health crisis, and this may in turn lead to the need for a CETR. Even if the child or young person is no longer receiving a direct service from a school, college or other type of education provider, their former education provider's contribution to a CETR will be invaluable.

Community teams

Children and young people mental health services (CYPMHS)/community mental health or learning disability team. All those involved with the child or young person from the CYPMHS, community mental health or learning disability team should be invited to the review. Again, they are likely to have essential information about previous support and intervention.

Housing authority or provider. Where appropriate Adults with a learning disability or autistic adults may live in their own home with care and support or a supported living arrangement, or will be going to live in their own home or a supported living arrangement when they are discharged. If so, a representative from the relevant team(s) should be invited to contribute to the review.

Youth offending team (YOT). Where appropriate For children and young people who are known to (or identified by) the youth offending service, any relevant and involved professional from the YOT should be invited. Local authorities will have different models for the oversight of YOTs, and it should not be assumed that YOTs are part of a wider children's services department and that an invitation to the director of children's services will be seen as an invitation to a YOT manager.

Key healthcare providers. A broad range of healthcare professionals is likely to be involved with people with a learning disability and autistic people, including community paediatricians for children and allied services such as learning disability services, occupational therapists and speech and language therapists. The review needs to understand the types of assessments and interventions a person has received to support their communication, particularly for those with behaviours that challenge.

Voluntary and community sector organisations providing services or support. where appropriate Voluntary and community sector providers may have access to information or assessments of help to the C(E)TR process.

16.5 How the review is conducted

1. The review will be carried out in a consultative and discursive manner, and has the aim of exploring solutions to care and treatment issues that avoid admission or unblock barriers to discharge. But at the same time it is based around a framework of important themes and specific issues to be inquired after and, if necessary, challenged (see section 16.7).

2. The C(E)TR review team have no regulatory powers but are empowered on behalf of the person with a learning disability or autistic person to ask questions based on a human rights and least restrictive framework. The team have a role in constructively but robustly challenging inappropriate or ineffective practice, passing on any concerns to relevant agencies, supporting cultural change and a shift to a community care model.

3. The review will be expected to take a minimum of a day to complete; the time needed for preparation (see section 16.3) and follow-up (see section 16.6) will be additional. C(E)TRs may be carried out over more than one day if this better meets the person's and their family's circumstances and is their preference.

4. The panel will meet everyone involved and set out the reason for holding the C(E)TR and the principles of a C(E)TR. They will discuss and agree the plan for the day with the current and future care team.

5. The review team will meet at the start of the day to discuss the plan for the day and how they will manage the review, and to ensure they have a preliminary shared knowledge of the person whose review it is. A one-page profile or similar 'pen portrait' will be provided (a one-page profile template is available in the My C(E)TR Planner booklet).

6. During the course of the day reviewers will meet the person whose care and treatment is being reviewed unless the person does not want to or they lack capacity and it has been assessed under the MCA that this is not in their best interests. This meeting should be held in an environment the person feels comfortable in and they should be supported by someone of their choice.

7. Reviewers will also meet the family unless they:
   a do not wish to participate
   b the person whose review it is has not consented to their involvement.

   Where family members wish to be accompanied by their advocate, this should be supported, subject to the consent of the person whose review it is and that the purpose of support from an advocate is in line with the principles and spirit of C(E)TR.

   If the person lacks capacity, a best interest decision will need to be taken on the involvement of the family and a family advocate.

8. The person and their family should be offered the choice of attending the review virtually, via secure video communication, rather than in person; this may be their preference or more convenient to them, particularly if they would need to travel long distances to attend in person. Meetings with them could also be held on a different day from the review day if this is more convenient to them.

9. Participants' language and communication needs should be considered.

10. The responsible clinician, senior nurse, advocate (should the person have one) and social care representatives must attend the review. For children and young people, their keyworker and social care and education representatives must also attend.

    Staff who provide direct day-to-day care and support to the individual, and often know them best, should be present at the C(E)TR; the review will seek information on specific diagnoses and formulations, including physical healthcare problems, the use of medication and any restrictive practices.

    Views and input from other relevant professionals should be sought if they cannot attend in person.

11. For those people who have been admitted, the C(E)TR is not an inspection of the mental health hospital. The review will seek a picture of the person's current inpatient care – the ward they are on and an understanding of the therapeutic interventions they are receiving.

12. Records will be reviewed (including care plans, person-centred plans, positive behaviour support plans, medication cards, communication passports, CPA review notes, health action plans, First Tier Tribunal reports). The service provider must provide all relevant information at the beginning of the day and where possible in a format that is clear to all members of the review team.

13. For those people who have been admitted, members of the 'aftercare' team should be interviewed, eg community psychiatrist, community nurse, social worker, education provider.

14. The review team will discuss with the wider professional team and the person whether there are more appropriate, effective and safe alternatives to hospital admission, and whether the person could be discharged from inpatient hospital care.

15. The review panel will meet everyone at the end of the review to present and discuss their findings and recommendations, and clarify who should be named as having responsibility for actioning each recommendation and within what timescale. The aim is for people to leave C(E)TRs with an understanding of what will be implemented, when and by whom, and how this will be followed up.

16. The chair is responsible for logging key findings and recommendations in the key lines of enquiry (KLOE) report (see section 16.7).

17. Before concluding the review the chair will discuss with the panel what communications additional to the circulation of the KLOE report may be needed after the day (eg if a concern is raised, to confirm that action has been taken).

18. The chair is responsible for nominating the most appropriate person to feed back the findings and recommendations to the person and/or their family in a format that meets their communication needs. The KLOE report should be circulated within two weeks of the review meeting.

19. Recommendations must be clear, time-limited, embedded and followed up through local systems such as MDT meetings and ward rounds, and any responsibility for action/escalation should be documented at the time of the C(E)TR.

20. The commissioner is responsible for raising and escalating any quality or safeguarding concerns with relevant agencies, and where necessary the relevant host commissioner.

16.5.1 Considerations for children and young people – maintaining contact between them and their families

People have a right to family life, and any period of admission and separation from family and friends can be difficult and stressful for all involved, particularly when the person is placed at a distance from their family and community. Children and young people must be supported to maintain contact with their family, friends and local community. The presumption should always be that families want to be in touch with their child and vice versa.

Some families, especially those whose child or young person is placed at a distance, may need financial help to visit their child. The provision of financial support to cover travel costs should be considered at the community or post-admission CETR if admission is agreed to be the appropriate option.

For children and young people who have communication impairments, particularly those with speech impairments that make phone calls difficult, careful consideration should be given to how contact can be supported, eg through use of media solutions such as Skype or FaceTime.

For more information on the importance of maintaining contact, please refer to the Keeping in Touch with Home report from the Challenging Behaviour Foundation and Mencap.

The legal framework around maintaining contact between children and young people and their families and communities is complex. Different legislation applies to different statutory organisations.

- **The UN Convention of Rights of the Child (1989)** article 9.3 states 'State Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interest.'
- **The Mental Health Act 1983 Code of Practice (Section 19)** sets out the requirements to support families to be informed, involved and in touch with their child or young person who is being assessed and treated.
- Local authorities are under a duty in the **Children Act 1989 (Schedule 2, paragraphs 10 and 15; and paragraphs 8A and 16)** to promote contact between families and children or young people who are children in need, who are looked after or who have been living away from home because they have been admitted to hospital for three months of more. They must help unite families if the authority's opinion is that this is necessary to safeguard or promote the child or young person's welfare.

16.6 Following the review

1. The person, family members and involved professionals will receive a letter thanking them for their involvement in the review process and clarifying how they will be kept updated.

2. Review team members will be offered debriefing/support; for the expert by experience this may be through a hub that supports their recruitment and training. Involvement in a C(E)TR can be a difficult even traumatic experience and all team members must have access to debriefing/support beyond the review day.

The commissioner is responsible for ensuring that:

- the draft report is agreed by the review panel and sent to those involved in the C(E)TR within two weeks (10 working days) of the C(E)TR taking place
- the report is communicated in line with NHS Information Security requirements
- the panel are provided with information about how they need to destroy any personal information they have been given in the course of the review; the method to be used will be discussed and agreed at the end of the review process
- panel members have been provided with a code of conduct in the handling of personal information and data that is subject to non-disclosure and requires secure handling.

3. The chair will feed back required data to the local/regional team on the outcome.

4. Individuals named against specific recommendations in the C(E)TR report are responsible for undertaking the agreed actions within the recorded timescales. Clinical accountability for these actions sits with the responsible clinician.

5. The responsible commissioner must retain overall oversight of the action plan agreed by the review panel. Where they have concerns that this is not being achieved, they will use the relevant contract management processes and/or escalate their concerns to the ICS oversight panel.

6. The commissioner will follow up any specific quality or safeguarding concerns the C(E)TR has identified and ensure that these are raised as appropriate through local reporting procedures and governance pathways, with feedback to the panel members as appropriate.

7. The person and their family will be informed of progress on actions, including towards discharge, by the commissioner or a nominated person (eg the keyworker).

8. The KLOE report (see section 16.7) will be submitted and stored securely as part of the individual's medical record as agreed locally (by the commissioner).

9. Following either a planned or unplanned pre/post-admission C(E)TR, where the outcome is admission to hospital, the individual must have a further C(E)TR within the defined period set out in Table 2 above (or on request).

10. For follow-up C(E)TRs, the person should be consulted as to whether they would prefer the same panel to undertake their next review. There may be some cases where it is considered beneficial to have a different panel, although the individual's wishes should be considered when deciding. If a panel does undertake a repeat C(E)TR for a person, they must ensure each C(E)TR is person-centred, individualised and impartial.

16.7 Key lines of enquiry responsibilities

The C(E)TR should combine free discussion and exploration of significant care and treatment issues at the same time as being based around a framework of important themes and specific issues to be inquired after and, if necessary, challenged.

In common with the approach taken by the CQC, the C(E)TR policy uses key lines of enquiry (KLOE) to guide and structure the review process alongside broader discussion and decision-making.

The C(E)TR KLOE guide the review so the final report provides information and evidence to enable a summary, and reflects to the person:

- Am I safe?
- What is my current care like?
- What is my daily life like?
- Are my physical health needs being met? (see section 16.9)
- Is there a plan in place for my future?
- Do I need to be in hospital for my care and treatment?

Each KLOE asks that relevant quotes from the individual and family are recorded to capture a more personalised understanding of the person and their views.

Each KLOE consists of a main question followed by examples of probe questions that reviewers can use to explore and gather information on the main issue. Each KLOE will also suggest sources of evidence that the team might look or ask for to substantiate their findings.

Though many KLOEs will apply across all people and settings, some of the probe questions are specific to children, people in secure settings, in a non-secure hospital or in the community.

The primary emphasis is on facilitating a comprehensive and focused discussion, not on the completion of pre-determined specific questions.

16.8 Importance of advocacy

People should always be supported to self-advocate wherever possible, as listening to people and their families, responding to their needs and choices, and ensuring people's legal and human rights are upheld are integral to the DSR and C(E)TR processes.

A key underpinning principle of advocacy is that it is independent of all other statutory and non-statutory services, including the service providing the person's care.

Independent arranged advocacy can include statutory advocacy – such as from an independent Care Act advocate (ICAA), independent mental capacity advocate (IMCA) or independent mental health advocate (IMHA) – general or community advocacy, and advocacy provided by a self-advocacy organisation.

Statutory advocacy covers specific things (see Appendix 5), but people with a learning disability and autistic people can also benefit from the support of peers (through a self-advocacy organisation, for instance) or general advocacy, to provide ongoing rather than episodic or issue-based support. The C(E)TR panel should feel confident to suggest this where appropriate and use the C(E)TR to explore how it could be provided.

The responsible commissioner should ensure that the chosen advocate(s), regardless of whether they are paid or unpaid, are invited to the C(E)TR and given adequate time to plan and prepare for this, such as having enough time to spend with the person before and after their C(E)TR, as well as on the day. Advocacy organisations will require adequate notice of the C(E)TR for the advocate to support the individual to prepare for the C(E)TR. If the person would like their advocate to be present for the whole C(E)TR, then this should be made clear to the advocacy provider.

If advocacy is not provided as appropriate the C(E)TR panel should raise their concern and make a specific recommendation to the person's commissioner and local authority to ensure this is resolved as a matter of urgency.

See Appendix 5 for more information about C(E)TR statutory advocacy entitlements.

Accessible resources to support the person and their advocate can be found at www.england.nhs.uk/my-ctr. Advocates can explore additional resources at www.england.nhs.uk/learning-disabilities/care/ctr/commissioners.

16.9 Importance of physical health

The C(E)TR review process must consider people's physical health needs on a par with their mental health needs. People with a learning disability and autistic people are more likely to die earlier than the general population and many of these deaths are avoidable (LeDeR annual report 2021). The safe and wellbeing reviews also identified gaps in care in relation to physical health and wellbeing.

The C(E)TR panel are in a unique position to review the physical healthcare the person is receiving as well as the skills and experience of the staff supporting them. The physical health section of the KLOE provides guidance on considering general physical wellbeing and medication (including STOMP and STAMP).

The skills and experience of the panel are important in considering the physical health of the person. It may be necessary to invite additional clinical experts to be part of the panel if there are specific or complex physical health or medication needs.

17. Leaving hospital: the discharge process and standards

Part of the C(E)TR's role is to ask whether people need to be in hospital for their care and treatment, and to identify and find solutions that overcome barriers to discharge from hospital.

As previously stated, the C(E)TR does not decide whether an individual is to be discharged or not. This is the responsibility of the treating clinician (responsible clinician for those detained under the MHA) and the decision will be taken through the usual review processes. Generally, it is not appropriate for a discharge decision to wait for a C(E)TR to first be convened.

However, what happens while a person is an inpatient lays the foundations for effective discharge. The community or post-admission C(E)TR are therefore essential for setting out clear treatment pathways and planning for discharge from the point of admission. It may also be advisable to hold a post-discharge community C(E)TR to ensure that within the community the recommendations made during the final inpatient C(E)TR are being adequately followed up.

Discharging autistic people and people with a learning disability from hospital is not always a straightforward process. Many factors can be barriers to or delay people leaving hospital, including legal and financial issues, multi-agency disagreements or concerns about supporting people whose behaviours are seen as 'higher risk' in the community, lack of housing or disagreements over future plans.

Appendix 7 provides a 12-point discharge plan, and the C(E)TR code and toolkit provide a set of discharge standards and a stepped model for discharge, to help commissioners and all involved navigate this process, and enable a better experience for children, young people and adults and their families.

It is a person's fundamental right to be fully involved in the planning for their discharge. Information to help someone with this is included in the easy read independence pack.

18. Assurance and oversight: ICS oversight panels

For many people, the C(E)TR process is helpful and supports their pathway, including into hospital and discharge. However, we recognise that despite having regular C(E)TRs, some people do not have an optimum experience: their length of stay can be long and/or extremely restrictive, and occasionally their discharge is delayed.

The safe and wellbeing reviews introduced the concept of an ICS oversight panel to oversee and scrutinise the reviews. System feedback is that this process is helpful and supports the ICS and ICB in understanding their population and ensures they are sighted on individuals who do not have good experiences; those who may be in the wrong place or whose discharge is delayed.

We intend to maintain the concept of a senior level ICS oversight panel as part of the C(E)TR process.

Each ICS must develop (or maintain) an oversight panel that includes:
- learning disability and autism senior responsible officer/ICS named executive lead
- at least one expert by experience
- medical director
- social care/local authority senior representative
- provider collaborative representation
- senior clinician with expertise in learning disability and autism.

Panels must convene at least quarterly (more frequently if helpful) and should review the C(E)TRs of people for whom concern has been expressed. This group must include, but is not exclusive to, people:
- with long stays:
  - for children and young people, with a stay of six months or longer
  - for adults, with a stay 12 months or longer (unless restricted by MoJ)
- in long-term segregation or who are regularly secluded or subject to very restrictive practices
- who are placed in units or wards that CQC rates as inadequate
- who have made complaints about care, or their family has, and these have not been resolved to the satisfaction of all involved
- for whom a safeguarding referral has been made
- who have requested escalation or their family has
- where the responsible clinician has requested escalation
- where the responsible commissioner has requested escalation
- where the advocate has requested escalation
- who have declined a C(E)TR on two or more occasions.

The ICS oversight panel should review the C(E)TR report and actions, assure themselves that the person is safe and well, and consider if any further action is needed to support the person's progress or discharge.

The panel should specifically consider:

- the care and treatment the person is receiving
- the person's physical health and wellbeing
- the person's safety; including to confirm appropriate measures have been taken in response to any safeguarding concerns
- for those whose discharge is delayed, whether all partners are working to support discharge as soon as possible
- for those subject to significant restrictions, whether measures are in place to reduce these as soon as possible
- for those considered to have been placed in the wrong environment, whether mitigating safeguards are in place to support their care and wellbeing
- whether the person's human rights are being upheld.

ICS oversight panels should also:

- take into account all quality assurance intelligence regarding the commissioner service, such as host commissioner reports and safeguarding information
- take ownership of any actions that may be needed as the result of a review
- escalate any issues that cannot be addressed at the ICS level to the relevant regional team
- evidence how review findings feed into the ICS delivery plan.

19. CETR alignment with other assessment and review processes for children and young people

Children and young people with a learning disability and autistic children and young people and their families are likely to experience a myriad of assessment and review processes through their life. Many of these assessment and review processes have similar principles: multi-agency, person-centred and outcome focused.

Given the bespoke purpose of a CETR, other assessments or reviews should not usually take place at the same time. However, as much of the information collected for and discussed in a CETR will be useful for other review processes (eg EHC review) and many of the individuals involved in a CETR will take part in other reviews, the sharing of this information should be considered, for efficiency and particularly to avoid repetition for the person. Discussions in a CETR may also lead to a need for other assessments or plan reviews, eg child in need plans or EHCPs.

Below is a non-exhaustive list of the assessments or plans that children and young people may already have in place:

Special Educational Needs (SEN) support

Some children and young people may have a special educational need that can be supported through the SEN provision provided in a mainstream school placement. Children and young people who are receiving SEN support should still have an assessment and plan in place as to how their special educational needs will be met in school (SEND_Code_of_Practice_January_2015). This is managed through the school rather than the local authority. Children and young people whose needs cannot be met through SEN support usually require an assessment for an EHCP.

CETRs should involve education representatives from the child or young person's local authority responsible for their educational provision as well as someone from their current education provider (school/college/pupil referral unit).

Education, health and care plans (EHCPs)

Education, health and care assessments and planning is the statutory assessment and planning process for children and young people with special educational and disability needs that cannot be met through SEN support. This process is not replaced in any way by the CETR but this may provide an opportunity to determine the need to review the EHCP, or to initiate an EHC assessment.

CETRs should involve representatives from the child or young person's local authority responsible for their educational provision as well as someone from their current education provider.

Children's social care assessment and review

Children and young people and their families may have been assessed by and be in receipt of services or provision from social care.

Disabled children and young people are considered to be 'children in need' under s17(10) of the Children Act 1989. This entitles them to an assessment as a child in need. Local authorities will have their own eligibility criteria in relation to their services for children in need, and their disabled children's services. Some children and young people, after having an assessment of need, may not be considered to meet the threshold for service provision and may not be known further to social care. If a child or young person is receiving a service from the local authority, this will mean they have had an assessment of need, and it has been determined they do meet the threshold for provision, and are being provided with service(s) that will be being reviewed.

Services may be provided under a range of different legislation, depending on the nature and type of provision. For some children and young people receiving regular overnight short break, or shared care support, this may be provided under either s17 or s20 of the Children Act 1989. If provision is provided under s20 of the Children Act 1989, then the child will also be considered a looked after child (LAC) and will have regular LAC or child in care reviews.

Section 17(ZA) of the Children Act 1989 requires local authorities to assess whether young carers within their area have support needs and if so, what those needs are.

Section 17(ZD) of the Children Act 1989 requires local authorities to assess (if certain conditions are met) whether a parent carer within their area has support needs and if so, what those needs are.

Some children and young people may be known to the local authority because of safeguarding concerns, or because there is a child protection plan in place. If this is the case, then regular case conferences will be taking place to review the plan.

20. Disagreements, escalation of concerns and complaints about the C(E)TR process

20.1 Concerns about lack of engagement from necessary partners

A successful C(E)TR requires meaningful engagement and participation from all agencies involved in the care, treatment, support and education of the individual. The urgent nature of many C(E)TRs, particularly community C(E)TRs, may make it challenging for agencies to participate and engage fully, but unless they do the development of a clear plan that best supports the person is unlikely.

The ICS should consider how it will manage situations where key partner agencies are unable or unwilling to engage and participate. Each ICB will have a lead for learning disability and autism, a lead for children and young people and a lead for mental health. Their support should be sought in developing local protocols that enable effective partnerships and manage challenges.

20.2 Clinical disagreements

Clinical disagreement about the appropriate pathway for a person must be resolved before planning decisions are made. Local reconciliation panels should be used or set up. These should be chaired by a clinical director (medical or nursing) from the local or NHS England team, and comprise the individual's responsible clinician, the clinical expert on the C(E)TR panel and an independent clinical expert.

20.3 Disagreements about who is responsible for providing care

Disagreements between parties about responsibility for future packages of care should be escalated to the relevant senior offices to resolve, including the director of nursing or chief clinical officer and relevant social care senior director. This is required to prevent the disagreement leading to a lengthy inpatient stay where an individual is ready for discharge (leading to a delayed transfer of care).

20.4 Escalation of concerns

Concerns may be raised by anyone – the person, their family and professionals. Concerns may be about:

- staff members:
  - their conduct, including their use of physical or chemical restraint
  - competency in providing person-centred care
  - quality of their documentation
- environmental conditions, eg:
  - lack of personalised accommodation
  - lack of appropriate environmental stimuli
- lack of resource to meet a person's needs, eg:
  - inability to access a social environment
  - inability to meet physical health needs through attending primary and secondary care

- inappropriate restriction of contact between a child or young person and their family and/or friends.

For concerns about the quality or safety of a service and/or provider, the C(E)TR chair or responsible commissioner should:

- note them in the relevant area of the KLOE report, and record the actions being taken
- feed these back to the review attendees, including family and reviewers
- ensure relevant data is appropriately captured and reported
- raise any concerns with the appropriate organisation/individual, eg the provider, CQC, local authority lead commissioner for establishment, as well as local forums, and ensure relevant paperwork is completed and actions are taken to ensure maintenance of high quality care
- ensure they are shared through the relevant NHS England or ICS internal reporting mechanisms, such as quality surveillance groups (QSGs), to ensure that where an area is commissioned by several commissioners relevant concerns are shared appropriately.

The relevant route to escalate concerns will depend on the nature of the concern (or disagreement) but routes include:

- CQC
- local authority safeguarding team
- ICS contracting team
- provider collaborative lead
- local NHS QSGs
- NHS England contracting team
- Ofsted.

20.5 Complaints relating to the C(E)TR process

Complaints from a person, their family or providers about the C(E)TR process will be dealt with in line with usual NHS complaints processes.

The first point of contact for complaints or concerns should usually be the C(E)TR chair (or the responsible commissioner in the event they are the delegated chair). They should seek to resolve any issues and agree any remedial actions.

If they cannot do so, the concern/complaint should be escalated as set out in the local NHS policy. This will be made available to the people attending the C(E)TR.

Where complaints are not resolved to the satisfaction of all concerned parties, the person should be referred to the ICS oversight panel for review (see section 18).

Information to support people with a learning disability, autistic people, their family or carers to make a complaint are available through the Ask Listen Do project.

21. Roles and responsibilities - provider and commissioning functions

21.1 Provider collaboratives (provider function)

Providers have existing responsibilities set out in the C(E)TR policy. These are:

- Ensure that the C(E)TR process is implemented as set out in this policy; this includes engaging with the community C(E)TR carried out before admission (unless the risk of delaying admission by doing so is deemed too great).
- Work in partnership with:
  - ICSs and commissioners to facilitate C(E)TRs
  - people, their family, carers and partners before, during and after the C(E)TR
  - local authorities to deliver discharge/transfer plans.
- Support people with a learning disability and/or autistic people and their families through the C(E)TR process, including by promoting their understanding of the review process, and with consent and best interests as appropriate, by ensuring adequate time and preparation for this.
- Implement agreed relevant C(E)TR recommendations; take actions from C(E)TRs into ward rounds/other clinical meetings.
- Use learning from C(E)TRs and the independent opinion to improve the quality of the services they provide.
- Audit the C(E)TR process and outcomes, and people's experiences of C(E)TRs.
- Act on relevant concerns flagged by a C(E)TR and report actions back to the panel chair, the person and their family.
- Challenge any blockages the C(E)TR identifies that are the result of funding or community barriers outside the provider's control.

21.2 Provider collaborative – NHS lead provider (commissioning function)

- Ensure that people who are entitled to a C(E)TR have been added to the DSR.
- Ensure that all providers within the collaborative are aware of the C(E)TR policy and their responsibilities.
- Ensure adherence with agreed guidance and standards, with specific responsibility for ensuring completion of the post-admission and repeat C(E)TRs in line with policy.
- Chair the C(E)TR or delegate authority to an appropriately recruited chair.
- Facilitate access to clinical experts and experts by experience to C(E)TRs in line with the policy.
- Ensure any immediate actions resulting from reviews are followed up.
- Track and monitor delivery of C(E)TR recommended discharge/transfer plans.
- Take an active role in the community C(E)TR carried out before admission (unless the risk of delaying admission by doing so is deemed too great).

- Ensure that a quality assurance process is in place for monitoring delivery and implementation of C(E)TR recommendations – providing assurance to the regional team.
- Respond to concerns escalated on an individual C(E)TR basis or where C(E)TR intelligence highlights broader concerns.

21.3 NHS England regional teams

- Maintain an overview of concerns raised by C(E)TRs, including those that have resulted in alerts to safeguarding and CQC through ICS oversight panels.
- Respond to escalated concerns relating to a multi-site independent sector provider for which the region has oversight responsibility.
- Ensure that a quality assurance process is in place for monitoring delivery and implementation of C(E)TR recommendations – providing assurance to the national team.

21.4 Local authorities (adults and children)

- Ensure the local area engages in C(E)TRs for local children, young people and adults known to them.
- Ensure any allocated actions resulting from reviews are followed up and reported on.
- Work in partnership with ICSs/NHS England to enable successful implementation of policy and guidance.
- Ensure any allocated actions resulting from reviews are followed up and reported on.
- Ensure where the person lacks capacity and is being discharged into the community with a comprehensive care plan that this follows the deprivation of liberty (DoL) safeguards authorisation process.

22. Glossary

Approved mental health professional	Mental health professional who has received specific training in the legal aspects of mental health assessment and treatment and been approved by a authority to carry out certain duties under the Mental Health Act.
Clinical expert	Someone with a relevant health professional qualification and active registration with a relevant professional body. They should also hold professional indemnity insurance that covers them to practise on an independent basis.
Dynamic support	Dynamic support describes a range of personalised support and services that are flexible and respond to the changing needs of a person and their family to avoid inappropriate admission to a mental health hospitals.
Dynamic support processes	Dynamic support processes are the pathways to provide timely and multi-agency dynamic support to children and adults who are autistic, have a learning disability or both and their families/carers, to provide support that reduces escalation into crises, to support in times of crises and to avoid inappropriate admission to a mental health hospital.
Dynamic support register (DSR)	The register a local area uses to identify individual children, young people and adults with a learning disability, autism or both who are at risk or may become at risk of admission to a mental health inpatient setting without specific and timely dynamic support. The original name for this – at risk of admission register – continues to be used in some areas. In some areas the DSR is known as the dynamic support database (DSD).
Dynamic support systems	Dynamic support systems are the way in which different people, teams and organisations work together to deliver dynamic support and services in a timely and person-centred way to children, young people and adults who need them and their families.
Expert by experience	Someone with relevant personal lived experience or a family member of someone with relevant lived experience.

Keyworker	A named keyworker for all people with a clearer multidisciplinary team (MDT) approach to both assess and meet the needs of people, to reduce the reliance on care co-ordinators and to increase resilience in systems of care, allowing all staff to make the best use of their skills and qualifications, and drawing on new roles including lived experience roles. (Not to be confused with the children and young people's keyworker scheme – see below.)
Children and young people's keyworker	By March 2024, all children and young people with a learning disability, autism or both at risk of admission to a mental health hospital or in hospital should have a named keyworker. This keyworker should always be invited to attend the CETR. Keyworkers can play an important part in the arrangement, delivery and follow-up of CETRs, particularly by supporting links with and strengthening the role of education in CETRs where children and young people are not in school.
Key lines of enquiry (KLOE)	Framework for C(E)TRs, outlining areas of assessment, need and challenge.
Long-term segregation (LTS)	A situation where, to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multidisciplinary review and a representative from the responsible commissioning authority determine that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis (Mental Health Act 1983)
Place	A geographical area within an ICS that works to join up budgets, planning and service delivery for health and care services. The boundaries of a place are often co-terminous with local authority boundaries.
Responsible clinician	The clinician with overall responsibility for the care and treatment of a patient who is being assessed and treated under the Mental Health Act.

Responsible commissioner	The individual representing the responsible organisation paying for the services a person receives. This can be the ICB, a provider collaborative or NHS England.
Stop The Over-Medication of People with a Learning Disability, Autism or both (STOMP)	The Over-Medication of People with a Learning Disability, Autism or both (STOMP) Launched by NHS England and the Royal College of Paediatrics and Child Health in 2018 to support the appropriate use of medication and specifically stop the inappropriate use of psychotropic medication for autistic people and people with a learning disability.
Supporting Treatment and Appropriate Medication in Paediatrics (STAMP)	Launched by NHS England and the Royal College of Paediatrics and Child Health in 2018 to support the appropriate use of medication and stop the inappropriate use of psychotropic medication for autistic children and children with a learning disability.
Unpaid carer	Anyone, including children, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support, and is not paid for the care they give.

Appendices

Appendix 1: Factors that may place someone at risk of admission to a mental health hospital

Note: This is not an exhaustive list.

- Increasing and unstable/untreated mental illness.
- Significant behaviours that challenge.
- Pain or distress from physical health issues (both diagnosed and undiagnosed).
- History of admission(s).
- Presenting 'in crisis' at A&E department.
- Not previously known to learning disability services.
- Supported in an unstable environment or by a changing staff team.
- Recently discharged from a long-stay hospital bed.
- In acute ward settings with mental health needs, including disordered eating/avoidant restrictive food intake disorders.
- Undiagnosed in a mental health hospital but may receive a diagnosis during their admission.
- No effectively planned transition from child to adult learning disability services.
- No fixed address.
- No family carers/advocates.
- Family carer crisis/breakdown.
- Family showing increasing concern and challenge to ensure needs that prevent a mental health crisis are being met.
- Drug and/or alcohol addiction.
- Subject to the Mental Health Act, deprivation of liberty (DoL) safeguards or liberty protection safeguards (LPS).
- In contact with the criminal justice system.
- In receipt of services from youth offending teams.
- In receipt of continuing healthcare funding.
- Significant life event and/or change, such as bereavement or abuse.

Some factors may have been heightened by the COVID-19 pandemic and associated response.

These factors will not necessarily lead to inclusion on DSRs but should be carefully considered alongside other identified needs.

The C(E)TR policy previously identified children and young people in 52-week residential schools as being at particular risk of admission to a mental health hospital; these children should now be routinely included on DSRs.

Appendix 2: Cheshire and Wirral Partnership dynamic support database clinical support tool – adult and child

Name:

NHS Number:

NHS Cheshire and Wirral Partnership NHS Foundation Trust

Dynamic Support Database Adult – Risk rating tool

Question	Options	Possible Score	Risk score	Details/ comments
Type of Accommodation	Hospital			
	Living independently			
	Living with parents/carers			
	Nursing home			
	Residential accommodation			
	Supported living			
	Other			
Name of current provider				
Deprivation of Liberty (DOLS)	Yes			
	No			
Court of Protection	Yes			
	No			
Any significant life events in the last 6 months? If so please specify details.	Yes	2		
	No	0		
Does the person have an unstable or untreated mental health condition?	Yes	3		
	No	0		
Does the person have an unstable or untreated physical health condition?	Yes	2		
	No	0		
Has the person had previous admissions in the last 2 years?	Yes	1		
	No	0		
Date of previous admissions				
Does the person present significant behavioural problems?	Yes	3		
	No	0		
Is the person being supported in an unstable environment or by changing staff team?	Yes	3		
	No	0		
Is the person previously known to CLDT?	Yes			
	No			
Is the person in contact with the criminal justice system?	Yes	2		
	No	0		

Has the person presented in crisis as Accident and Emergency in the last month?	Yes	2		
	No	0		
Does the person have family/carers/advocates?	Yes			
	No			
Does the person have a history of Drug or Alcohol misuse in the last two years?	Alcohol	2		
	Drugs	2		
	Both	2		
	Neither	0		
Was the person's transition from children's services effective in the last 12 months?	No	1		
	Yes	0		
	Not applicable	0		
Is the person placed in specialist 52-week residential school?	Yes	1		
	No	0		
Has the person been recently discharged from long stay in hospital in the last 2 years? ***(Long stay is considered to be 6 months or more).***	Yes	2		
	No	0		
Total		**0 - 4 = Green**		
		5 - 7 = Amber		
		8+ = Red		

Local area emergency protocol

If admission cannot be avoided where will admission take place?		**If other please specify name and address**	
MDT Meeting Date			
Avoidance Admission Meeting Date			
Community Care and Treatment Review Date			
Revised RAG Rating			
Post Admission Care and Treatment Review Date		**Admission Date**	
Planned Discharge Date		**Actual Discharge Date**	

Completed by

Completed by (Clinician)	
Date Completed	

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Name:

NHS Number:

NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Dynamic Support Database Clinical Support Tool (Child)

Question	Options	Possible Score	Risk score	Details/ comments
Type of Accommodation	Hospital			
	Living independently			
	Living with parents/carers			
	Nursing home			
	Residential accommodation			
	Supported living			
	Other			
Name of current provider				
Deprivation of Liberty (DOLS)	Yes			
	No			
Is the CYP of CIN, CP, or LAC Status?	Yes			
	No			
Any significant life events in the last 6 months? If so please specify details.	Yes	2		
	No	0		
Does the CYP have an unstable or untreated mental health condition?	Yes	3		
	No	0		
Does the CYP have an unstable or untreated physical health condition?	Yes	2		
	No	0		
Has the CYP had previous admissions in the last 2 years?	Yes	1		
	No	0		
Date of previous admissions				
Does the CYP present significant behavioural problems?	Yes	3		
	No	0		
Is the CYP being supported in an unstable environment or by a changing staff team?	Yes	3		
	No	0		
Is the CYP previously known to LD-CAMHS/CAMHS?	Yes			
	No			
Is the CYP in contact with the criminal justice system?	Yes	2		
	No	0		
Has the CYP presented in crisis at either: Accident and Emergency, or Emergency Social Care Provision in the last month?	Yes	2		
	No	0		

Does the CYP have family/carers/advocates?	Yes			
	No			
Does the CYP have a history of Drug or Alcohol misuse, in the last two years?	Alcohol	2		
	Drugs	2		
	Both	2		
	Neither	0		
Has the transition from LD-CAMHS/CAMHS to CLDT/AMHT started and if so has it been effective?	No	1		
	Yes	0		
	Not applicable	0		
Is the CYP placed in specialist 38 or 52 week residential school or other specialist educational provision?	Yes	1		
	No	0		
Has the CYP recently left a residential school in the last 2 years?	Yes	2		
	No	0		
Total		**0 - 4 = Green**		
		5 - 7 = Amber		
		8+ =Red		

Local area emergency protocol

If admission cannot be avoided where will admission take place?		**If other please specify name and address**	
MDT Meeting Date			
Avoidance Admission Meeting Date			
Care, Education and Treatment Review Date			
Revised RAG Rating			
Post Admission Care and Treatment Review Date		**Admission Date**	
Planned Discharge Date		**Actual Discharge Date**	

Completed by

Completed by (Clinician)	
Date Completed	

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Appendix 3: C(E)TR principles and standards

These standards support the implementation of the C(E)TR policy, in the community and in hospital. The C(E)TR code and toolkit sets these out with additional criteria that support best practice.

The panel members need to familiarise themselves with the principles and standards and hold each other to account on these. Additionally, the standards will form the basis for quality assurance activity.

Principle 1 – Person-centred and family centred

Standard 1.1 The person and their family will be given information about the C(E)TR in advance.

Standard 1.2 Before a C(E)TR, the responsible commissioner will ensure that the person has given consent or if the person lacks capacity, that a best interests decision has been made.

Standard 1.3 The person will be supported to get ready for the C(E)TR using the 'My Care (Education) and Treatment Review' and 'My C(E)TR Planner' booklets.

Standard 1.4 Reasonable adjustments should be made to the C(E)TR process as required to ensure that the person is fully involved, present and able to participate as they wish.

Standard 1.5 The panel will make time available to meet separately with the person and their family carer. This could be meeting them all together or separately according to the person's wishes.

Standard 1.6 Following a C(E)TR the person and their family are supported to understand what will happen next.

Principle 2 – Evidence based

Standard 2.1 C(E)TRs use a standardised, structured approach to the review of a person's care by using specifically designed key lines of enquiry (KLOE).

Standard 2.2 The C(E)TR will look for evidence to support its findings and note these on the KLOE template.

Standards 2.3 Specifically, the C(E)TR will look for evidence that clinical and best practice guidance has been followed; this will be recorded on the KLOE template.

Standard 2.4 Information to help answer the KLOEs will be gathered together before the C(E)TR takes place.

Principle 3 – Rights led

Standard 3.1 Where there is concern that the person's human rights may not be being upheld appropriately this will be identified on the KLOE template and relevant action taken.

Standard 3.2 The C(E)TR will ask about the provision of advocacy for the person and ensure any recommendations are included in the KLOE document.

Standard 3.3 The C(E)TR will ask about legal representation for the person (eg at tribunals).

Principle 4 – Seeing the whole person

Standard 4.1 Each C(E)TR should take a minimum of a day to complete. There may be occasions where the review takes place over more than one day to ensure that the needs of the person are taken into account.

Standard 4.2 The C(E)TR will include the people who are important to the person being reviewed.

Standard 4.3 People who are, or who will be, supporting the person should be part of the C(E)TR – including local authority representation and advocacy.

Standard 4.4 The review will ask about physical health, mental health and quality of daily life.

Principle 5 – Open, independent and challenging

Standard 5.1 The review panel is made up of three people and will include: chair (the person's commissioner or person with delegated authority by the commissioner); and two independent advisers – an expert by experience and a clinical expert.

Standard 5.2 The chair should be able to demonstrate that they have worked in partnership with the panel members including agreement on the content of the report.

Standard 5.3 The C(E)TR panel will ensure that they have provided basic information about themselves to the person (eg name and photograph) and introduced themselves fully when they meet the person.

Standard 5.4 Where a C(E)TR panel does not reach agreement, the differing opinions will be noted in the KLOE template.

Standard 5.5 The chair will ensure at the beginning that everybody who takes part knows what a C(E)TR is about.

Standard 5.6 The review team will have completed mandatory C(E)TR training.

Standard 5.7 The panel members will all declare if they have any conflicts of interest.

Standard 5.8 The C(E)TR will ensure that the reasons for, and the expected outcomes of, an admission/continued admission are clearly recorded.

Standard 5.9 The C(E)TR will question aspects of care and treatment that are not consistent with good practice or evidence-based guidelines.

Standard 5.10 The C(E)TR will keep asking whether the person's care and treatment could be delivered in a non-hospital setting.

Standard 5.11 A follow-up C(E)TR will always check why any actions previously agreed have not been carried out.

Principle 6 – Nothing about us without us

Standard 6.1 Every person will be supported to fully engage in their own C(E)TR wherever possible, considering how the person is supported to use their preferred method and/or tools of communication.

Standard 6.2 At the C(E)TR a person will be identified who will communicate the progress on actions to the person and their family/carers following the C(E)TR.

Standard 6.3 Following the C(E)TR, the commissioner will write a report about the review in words that all involved can understand. The commissioner will make sure the person, their family/carers and others who need a copy get the report within two weeks.

Principle 7 – Action focused

Standard 7.1 C(E)TRs check that people are safe. When a C(E)TR finds that people may not be safe, the chair will discuss this with the person, record on the KLOE template and raise concerns to the relevant authority or agency.

Standard 7.2 The C(E)TR will identify gaps in the person's care and treatment. The panel will make SMART recommendations to address these gaps in order to ensure appropriate treatment and discharge plans are in place.

Standard 7.3 The person's keyworker will make sure that the outcome of the C(E)TR is reflected in their relevant care plan and will be followed through within the planning process.

Standard 7.4 The outcomes of the C(E)TR will identify the named individuals in the person's care team who will make sure the C(E)TR recommendations are embedded in other relevant assessment and planning processes along with clear timescales, for example education, health and care plan; children in need plans, risk assessments, etc.

Standard 7.5 C(E)TRs will identify whether long-term planning to support discharge (eg housing or where bespoke care packages may be required) is being considered and planned for at the earliest opportunity including the engagement of competent service providers.

Standard 7.6 The commissioner is accountable for follow-up after a C(E)TR and ensuring recommended actions are being carried out on time. Where actions are not carried out, the commissioner will explain to the person and their family why this is.

SMART recommendations mean that the recommendations should be:	
Specific	What exactly should happen and the name of the person responsible for ensuring that it is carried out.
Measurable	How will people know if the recommendation has been implemented satisfactorily?
Action-focused	Recommendations should be in the form of clear tasks to be carried out by named persons.
Realistic	Recommendations have to be possible to achieve not merely aspirational or outside the remit or capabilities of the persons named.
Time-framed	There should be a specific stated date by which the recommendation is to have been implemented or reviewed.

Principle 8 – Living life in the community

Standard 8.1 A record of the reasons why the person's care and treatment cannot be carried out in the community will be made on the KLOE, where this is the outcome of a C(E)TR.

Standard 8.2 The C(E)TR will look for evidence of up-to-date, positive and proactive risk assessment and risk management plans that address the safety of the person and of others now and in the future.

Standard 8.3 The C(E)TR will ask about the person's circle of support and how the person is being enabled to be part of their local community (including any advocacy provision).

Appendix 4: C(E)TR – sit and see observation

Reviewing the service and environment: The following questions can be used to identify any potential causes for concern regarding quality and safety of the service.

The environment

Methods for gathering this information

- The following KLOEs can be captured during a commissioner oversight visit or a one-off quality visit by a team of individuals to support these reviews.
- Most sit and see visits should last no less than three hours – to ensure a meaningful overview of the setting and care can be gathered.

Ref:	The following questions have been taken from the NHS England: The 15 Step Challenge	Comments	Actions taken
2.1	**Using your senses – Consider what can I hear, smell, see, feel, touch?** • How does this ward/unit make me feel, how does it smell? • What is the atmosphere like? • What interactions are there between staff/ patients/visitors? • Is there visible information that is useful and re-assuring to people? What is it? • What have I noticed that builds my confidence and trust that this is a safe and welcoming environment? • What makes me less confident? **Things to look out for** • Welcoming reception area. • Welcome signs (including accessible signage). • Acknowledgement on arrival – eye contact, smiles, a greeting. • Information available, clear and visible. • Contact information for relatives and visitors is visible. • Visiting times are evident. • Information about who the staff team are and who the ward manager is. • Is there evidence that the ward is accessible including easy read information being available?		

2.2	**Safety** • What do I notice about safety issues? • Do staff on this ward appear to think that safety is important? • What information tells me about the quality of care here? • What tells me that staff are concerned about safety and preventing harm (eg infections, falls)? • How are medicines managed on the ward? • What have I noticed that builds my confidence about safety on this ward? • What makes me less confident? • Does the service use CCTV? • Is the environment well maintained, what condition is the environment in, including the bedrooms and bathrooms? **Things to look out for** • A clean and well-maintained environment. • Hand gels are available and used. • Clear information about infection prevention and control and evidence of staff implementing procedures. • Rubbish/dirty items and linen are disposed of appropriately and not visible. • Food in fridges is within expiry date. • Can I see information that says the ward is improving in identified areas? Is the information clear and understandable? • Equipment and environment appear to be well maintained. • Protected times/areas for staff to manage drugs and essential equipment. • Support offered to people who require assistance with eating. • Patients always have access to drinks. • Security and fire procedures are evident.		

2.3	**Caring and involving** • What behaviours can I see that do or do not inspire confidence? • Do staff appear to know their patients well? • How have the staff made me feel? • What can I understand about patient experience on this ward/unit? • Are there any indicators that patients and carers are involved in their own care? • How is dignity and privacy being respected? • How are staff interacting with patients (eg do they talk in lower tones when having private conversations)? • Can I observe good team working taking place? • Is people's clothing in good condition? **Things to look out for** • Staff are communicating and interacting positively with patients. • Staff are always available for patients. • Patient feedback is displayed. • Patients are dressed to protect their dignity. • Information for patients and carers is available in a clear and user-friendly format. • Information that empowers patients (eg to choose their own meals, day activities). • Signs that equality/diversity needs are being met and reasonable adjustments implemented. • Visitors have access to chairs and space to visit. • Information about how to complain and compliment is visible and in an accessible format. • Signage for how to access advocacy is visible and in an accessible format.		

2.4	**Well organised and calm** • Does the ward/unit feel calm or chaotic (even if it is busy)? • Is essential information about each patient available for staff? • Does the unit/ward look well organised, clean and uncluttered? **Things to look out for** • An uncluttered, clean environment, including nurses' station/office, hallways and communal areas. • Clear accessible signage to rooms, toilets, etc. • Well maintained, appropriate (eg non-slip), clean condition of walls, floors, windows and ceiling. • Staff have easy access to patient information: it is visible and organised. There is a transparent and communal information board located in the office (eg patient status at a glance board). • Patient boards show evidence of co-ordination between different departments. • Equipment stored tidily and is managed, eg colour-coded, staff return equipment after use, stock cupboards are clearly labelled – including visible management (photos of content).		

Appendix 5: C(E)TR advocacy entitlements

Advocacy and C(E)TRs

We have updated the policy in relation to advocacy in light of a review of inpatient advocacy for people with a learning disability and autistic people carried out in 2021/22.

The first principle is that people should always be supported to self-advocate whenever possible, as listening to people and their families, responding to their needs and choices and ensuring people's legal and human rights are upheld are integral to the C(E)TR process. Independent advocacy has a vital role in ensuring all of this happens – whether the person is living in the community and at risk of admission, is an inpatient or has left hospital.

The person's views, wishes and preferences must be central in decision-making and people's preferred communication methods should be respected. This means that if people do not use words to express themselves, advocates and others involved in their C(E)TR must still do all they can to understand how the person is communicating their experience of their care, treatment and for children and young people, their education. If the person's 'voice' is not being heard, the panel should explore how they can be supported to express their wishes and make relevant decisions, not just in relation to their C(E)TR.

Family carers can be advocates too

Many people choose a family member to advocate with or for them, and where a person lacks capacity to make decisions, this is especially important as a family member may understand their relative's communication better than anyone else.

Where a family member is an advocate, the C(E)TR should explore whether that person feels adequately supported in their role, providing an appropriate recommendation if not, eg the provision of a family advocate, steps to improve how the person's formal advocate and family member work together, or steps to improve how the service perceives and supports the family member's advocacy role.

People can and at times should have an advocate who is paid to be their advocate (see below) as well as family members advocating for them – this can work really well.

Having a family member who is an advocate is generally not a reason to withhold arranged independent advocacy, which is often a statutory entitlement.

If the person has chosen not engage with an advocate, the C(E)TR panel should also explore this closely to ensure the person is supported to understand the many benefits of doing so, and that their rights to advocacy are being communicated and upheld.

Accessible resources to support the person and their advocate can be found at www.england.nhs.uk/my-ctr. Advocates can explore additional resources at www.england.nhs.uk/learning-disabilities/care/ctr/commissioners/.

Independent advocacy

A key underpinning principle of advocacy is that it is independent of all other statutory and non-statutory services, including the service providing the person's care.

Independent arranged advocacy can include statutory advocacy – such as independent Care Act advocacy (ICAA), independent mental capacity advocacy (IMCA) or independent mental health advocacy (IMHA) – general or community advocacy, and advocacy provided by a self-advocacy organisation. Please see below for a summary of statutory entitlements.

Statutory advocacy covers very specific things, but people with a learning disability and autistic people can also benefit greatly from the support of peers (through a self-advocacy organisation, for instance) or general advocacy, to provide ongoing rather than episodic or issue-based support. The panel should feel confident to suggest this where appropriate and use the C(E)TR to explore how it could be provided.

The panel chair should ensure that the chosen advocate(s), regardless of whether they are paid or unpaid, are invited to the C(E)TR and given adequate time to plan and prepare for this, such as having enough time to spend with the person before and after their C(E)TR, as well as on the day. Advocacy organisations will require adequate notice of the C(E)TR (at least a month ideally) to allocate the advocate, for the advocate to get to know the person if necessary and then support them to prepare for the C(E)TR. A specific time slot on the day should be offered if the advocate cannot be present for the whole C(E)TR.

If the person would like their advocate to be present for the whole C(E)TR, then this should be made clear to the advocacy provider.

In the community

Consideration of the need for, and access to, advocacy services is vital for all age groups, not least for children and young people and their families, who may have no experience of the hospital system, the legal system or their legal rights. This is as relevant when admission is being considered as when a person is in hospital.

Discussions around the person and family's support needs in relation to a community C(E)TR should consider the person's advocacy needs given the person's risk of being admitted to hospital. Ideally, these needs should be reviewed before a community C(E)TR takes place, such as when the person is identified on the DSR, so that the person has advocacy support during their C(E)TR. This will support the person's understanding of and involvement in the C(E)TR process and the aim of avoiding admission whenever possible. It should also support family carer involvement whenever possible.

Where admission to hospital is likely, the community C(E)TR can help to describe the advocacy support the person will need throughout this and following discharge.

While a right to statutory advocacy to support people in their community C(E)TR is clearly desirable, it is not currently explicit in the legislation or relevant codes of practice that this must be done for a C(E)TR (save for certain exceptions where an advocate must be appointed for other reasons – see statutory entitlements below).

However, best practice would be to allow for a positive and flexible approach to supporting people in this situation with either access to an ICAA or IMHA. Care Act advocates may get involved if the C(E)TR as a result of a care and support assessment, care and support planning process, care and support review or a safeguarding enquiry. They are able to provide support if the care and support process may lead to a stay in an NHS funded placement, even if the person has friends or family involved.

Support from a self-advocacy organisation (or family advocate where appropriate) or community advocacy can also help people with understanding processes and their rights, making decisions and feeling better supported in their lives, and thereby contribute to reducing the risk of admission.

The C(E)TR panel should make time to explore the person's ongoing access to advocacy, including independent advocacy, and make necessary recommendations where they feel this could work better. This should take a holistic, person-centred approach to the person's needs of advocacy for their C(E)TR as well as their ongoing care, treatment and any concerns about how services are listening and responding to the person's needs. The panel should try and establish who in the person's circle of support at home as well as in hospital is further advocating for that person's needs.

Ideally before the 'final' pre-discharge C(E)TR and certainly at that one, consideration should be given to the person's advocacy needs when they leave hospital and what statutory entitlement exists for this. The panel may also wish to consider whether other forms of advocacy could support the person when they leave hospital, eg a self-advocacy organisation may help people build friendships, networks and access to things that will help the person achieve their hopes and ambitions. Post-discharge advocacy is likely to work best when it is arranged before discharge, giving the person an opportunity to get to know or even choose their future advocate(s).

Advocacy recommendations or actions

If advocacy is not provided where it would have been as appropriate to do so, the C(E)TR should flag this as a concern, with a specific recommendation for the person's commissioner, the advocacy provider and commissioning local authority to ensure this is resolved as a matter of urgency.

Health and social care agencies must work closely (with the advocacy provider as involved) to ensure people receive advocacy that is appropriate to their needs.
Summary of statutory entitlements
A person's statutory right to advocacy can take many forms; these should be reasonably adjusted to meet the specific needs of people with a learning disability and autistic people.

Publicly-funded providers must comply with the public sector equality duty (Equality Act 2010) by paying due regard when carrying out their functions to eliminating discrimination and advancing equality of opportunity. For example, self-advocacy organisations led by autistic people and/or people with a learning disability offer mutual and/or peer support and friendship, which can complement the support a statutory advocate provides. Statutory advocates specialise in providing advocacy in specific situations.

Local authorities are responsible for ensuring the provision of a range of independent advocacy for people of all ages. They are required to commission:

- advocacy under the Children Act 1989
- advocacy under the Care Act 2014
- independent mental health advocates (IMHAs)
- independent mental capacity advocates (IMCAs)
- independent Care Act advocates (ICAAs)
- paid relevant person's representatives (paid RPRs)
- NHS complaints advocacy.

Section 26A of the Children Act 1989 and associated regulations and guidance also impose on local authorities the duty to make arrangements for the provision of advocacy services for care leavers making or intending to make representations under section 24D of the Children Act 1989 and for children making or intending to make representations under section 26A of the Children Act 1989.

Local authorities have a duty to provide information about advocacy services and offer help in obtaining an advocate in certain situations.

Local authorities must provide advocacy services for a looked after child, a child in need or a care leaver directly making or intending to make a complaint on their own behalf. Children and young people should be able to secure the support of an advocate when making or intending to make representations for a change to the service they receive or the establishment they live in, without this having to be framed first as a specific complaint. Rights to advocacy do not extend to a parent or another person making a complaint on behalf of a child.

Independent mental health advocates

People of all ages are eligible for support from an IMHA if they are:

- detained under certain sections of the Mental Health Act 1983 (MHA)
- liable to be detained under the MHA, even if not actually detained, including those currently on leave of absence or for whom an application or court order for admission has been completed
- a conditionally discharged restricted patient, eg under section 117 of the MHA
- subject to guardianship
- subject to a community treatment order.

People can have an IMHA regardless of whether friends and family are supporting them as well.

The Care Act 2014 places a duty on local authorities to provide access to independent advocacy for adults over the age of 16 who have no appropriate individual(s) – carer, family or friend – to support their involvement and where they would otherwise struggle to be involved in care and support 'processes'.

People aged 16 or over who lack capacity to make particular decisions and who have no appropriate friends or family to represent them may be entitled to an IMCA.

If through care and support assessment or planning it is likely that the person will be admitted to an NHS-funded hospital (including assessment and treatment units) for 28 days or more or a care home for eight weeks or more, the local authority must provide independent advocacy (even for those who have an 'appropriate individual' to support them) if it is satisfied that advocacy would be in the best interests of the individual. ICAAs are often involved when someone is being discharged from hospital.

Some advocates can be the person's IMHA, IMCA and ICAA at different points in their life; the benefit of an advocate changing role is that the person will not need to get to know someone new.

Where someone is eligible, IMCAs provide support in relation to decisions about where someone is going to live, about serious medical treatment and if a liberty protection safeguard (LPS) is being sought. They might also provide support in safeguarding situations, although Care Act advocacy is most likely to be provided in safeguarding situations.

Relevant person's representatives (RPRs), who may be paid, provide support and representations to people under an LPS authorisation (formerly a standard authorisation) in all matters relating to their deprivation of liberty (DoL). The RPR can support the person to challenge the LPS.

Where a person lacks capacity to consent to those restrictions, an IMCA can be instructed to work with them alongside their RPR or as their RPR. The standard authorisation system applies to patients in hospitals and people in care homes; the LPS (when enacted) will apply to a wider range of living situations.

Note: There is the potential for some people to have an array of advocates. If the person and their family (where involved) feel this is not working as well as it could, the C(E)TR panel may want to discuss this and propose an arrangement that better meets the person's needs, for the placing commissioner and local authority to progress.

Appendix 6: Safeguarding responsibilities within C(E)TRs

All professionals who work with vulnerable children and adults have a responsibility to act appropriately if they have reason to believe that the individual has suffered or is likely to suffer significant harm.

The Care Act 2014 section 42 defines a vulnerable or at-risk adult as anyone over the age of 18 who:
a) has needs for care and support
b) is experiencing, or is at risk of, abuse or neglect, and
c) as a result of those needs is unable to protect themself against the abuse or neglect or the risk of it.

It also requires the local authority to make (or cause to be made) whatever enquiries it thinks necessary to decide whether any action should be taken in the adult's case and, if so, what and by whom.

For those being cared for in hospital, it is likely that they have suffered traumatic and possibly abusive experiences within their life, and throughout their journey in the education and care system. The use of restrictive practices is likely to have an adverse impact on their human rights, wellbeing and for many adds additional trauma to their experience.

There are clear processes in place for commissioners, providers, professionals and families to raise safeguarding concerns if they have any in relation to the person they are caring for or their family member.

If C(E)TR panels have concerns about the safety and wellbeing of a person, the chair – along with the other panel members – should consider these issues seriously to determine what additional actions may be necessary. The chair should always ensure that there is a collaborative discussion with the other panel members to help determine consensus about an appropriate way forward, while remaining clear that each panel member also has an individual and professional responsibility to raise safeguarding concerns if they believe they are present.

If the chair (and/or panel) believe there are safeguarding issues relating to the care provided to the person, they will take responsibility for alerting the provider, commissioner and where appropriate the individual and family, and make the referral. They are also responsible for ensuring there is immediate feedback regarding the issues to the commissioner (if they have delegated authority) and the provider so appropriate internal escalation processes can also be triggered.

Different levels of seriousness of safeguarding issues may require a different level of response. While every circumstance needs to be considered individually, below are some suggested levels of response for issues.

Situation	Suggested response	Responsible individual
There are serious concerns about the safety and wellbeing of the person. Chair/panel considers it is unsafe for the person to remain in their current situation.	C(E)TR should be halted. Immediate escalation to regional director of nursing, commissioner and provider. Urgent referral made to the local authority on the day of the review. The panel are required to remain until a response mitigates the risk and ensures the individual is appropriately safeguarded. Ensure CQC is appropriately notified.	Chair (alongside responsible commissioner if authority has been delegated)
There are serious concerns about the safety and wellbeing of the patient that need urgent attention. Chair/panel does not think the concerns pose such imminent and urgent risk to the person that they are likely to require a move that day.	Issues to be immediately identified with relevant individual/providers. Referral made to the local authority on the day of the review. Review concludes and its clear recommendations and actions include the safeguarding concerns and actions. Chair and panel are assured that some immediate steps are being taken to safeguard the individual. Ensure CQC is appropriately notified.	Chair (alongside responsible commissioner if authority has been delegated)
At the conclusion of the review, the chair/ panel believes there are safeguarding concerns about the individual that require a response but they are not at risk of immediate significant harm.	Review concludes and clear recommendations are made. Issues to be identified with relevant individuals/provider immediately and before the chair/panel leaves the review. Referral made to the local authority the following day.	Chair (alongside responsible commissioner if authority has been delegated)
In the days following the C(E)TR and after consideration, the chair/ panel feels there are safeguarding issues that need further scrutiny/ redress.	Chair communicates this to the provider/ commissioner/relevant individuals. Chair makes the safeguarding referral.	Chair (alongside responsible commissioner if authority has been delegated)

Appendix 7: 12-point discharge plan (part of Assuring Transformation dataset reporting requirements)

The NHS Long Term Plan confirms that every area will "implement and be monitored against a 12-point discharge plan to ensure discharges are timely and effective." NHS Long Term Plan 3.36

The 12-point discharge plan is a tool that should be used to support commissioners, partners, the individual and their families to ensure appropriate steps are in place to support a timely discharge.

Some individuals may not need every element of the plan utilised to support their discharge, but it is a helpful prompt to ensure that steps are being appropriately considered at the earliest possible stage so there are no delays to discharge due to last minute considerations of planning, commissioning or managing legal processes.

Progress of individuals against the discharge plan is monitored via the Assuring Transformation dataset.

1.
- Person in active treatment - start discharge planning.

2.
- Person identified as ready for discharge - person centred service specification outline to be commenced.

3.
- Capacity assessment to be completed (community accommodation and support).

4.
- Risk assessment - community based risk assessment to be completed.

5.
- Service specification complete - ready to be advertised/tendered.

6.
- Procurement process to be undertaken (where required).

7.
- Accommodation search to be identified and secured and adaptions completed.

8.
- 8.1 Funding (for discharge support) to be agreed and in place.
- 8.2 Additional funding (other relevant funding agreed and in place - where required).

9.
- 9.1 Workforce provision - ensure provider staff are recruited.
- 9.2 Workforce provision - community multidisciplinary team personnel identified.

10.
- 10.1 Legal framework - Mental Health Tribunal (if appropriate).
- 10.2 Legal framework - Court of Protection (if required).
- 10.3 Legal framework - Parole Board application (if required).
- 10.4 Legal framework - Ministry of Justice application (if required).

11.
- 11.1 Community move/discharge - communicate and commence transition plan.
- 11.2 Community move/discharge - s17 leave underway as part of transition to community placement.

12.
- Discharge.

Appendix 8: Local area emergency protocol

In circumstances where an admission is unplanned, urgent or someone is in 'crisis' it is recognised that a C(E)TR may be, on a practical level, very difficult to set up due to short time scales, level of risk and the need for urgent action.

The aim of the local area emergency protocol (LAEP) is to provide the commissioner with a set of prompts and questions both to prevent people with a learning disability or autistic people from being admitted unnecessarily to a mental health hospital; and where there is a clearly supported clinical indication for admission to ensure that the intended outcomes and timescales are clear.

It is also intended to help identify barriers to supporting a person to remain in the community and to make clear and constructive recommendations as to how these barriers could be overcome by working together and using resources creatively.

It is important to note that the LAEP does not replace the community C(E)TR and should only be used by exception. Where a community C(E)TR has not taken place, the pathway for a post-admission C(E)TR must be followed.

This protocol describes when this response is needed and suggests who should attend and what should be discussed. Organisations need to agree to using this protocol locally to support prioritisation of their time and resource to respond both flexibly and at short notice to a request for a meeting.

For NHS England specialist commissioned services, a referral for an access assessment may happen alongside this protocol if it is felt that the individual may need to be admitted to a secure service or children and young people's mental health service (CYPMHS).

The protocol

Anyone involved in the care of a person with a learning disability, autism or both, and who is at risk of being admitted to hospital unnecessarily, can raise concerns about them. This ordinarily should lead to a community C(E)TR being arranged. This protocol is to be used where there is no prior knowledge of the escalating risk of admission or the time to set up or hold a C(E)TR.

The lead commissioner will be responsible for ensuring that a LAEP meeting is organised and chaired.

Every effort must be made to involve the individual and/or their representative/advocate and family to gain their views on options for treatment and support and what could help avoid admission to hospital. The format of the LAEP is therefore most likely to be a virtual meeting to allow people to participate at short notice, but it can be a face-to-face meeting.

It is important for all involved to agree to a 'no blame' principle, to give individuals or services the confidence to speak up should they face difficulties fulfilling their contracted role(s).

Role	Involvement
Person being considered for admission	To give a first-hand account of issues and what would help. Listening to the person is essential and should be prioritised and facilitated.
Family member(s)	To give additional information. Listening to the family's views, ideas and wishes should be prioritised and facilitated.
Psychiatrist	To provide feedback on assessed clinical needs and risks. Role in MHA processes.
Community learning disability nurse	Co-ordination role; provider of clinical information. Children's social worker, care manager; involvement in assessment and care planning.
Social worker IMHA/IMCA/independent advocate	As appropriate – to advocate for the individual.
Commissioner	To provide funding for alternatives to institutional care.
GP	To ensure effective support around health needs as required.
School/education provider/ commissioner	To ensure education considerations are fully understood.

Protocol steps

1.
- The chair is made known to people and the current situation is shared.

2.
- Understanding the person.
- The needs and wishes of the person are identified, including hearing from the person and if appropriate, their family, relevant carers and clinicians.

3.
- The current risks are identified.

4.
- Care, education and treatment needs.
- Options considered (see preference list on page 95).

5.
- Current resources and potential resources are identified.

6.
- Decision made and support plan agreed. Responsible people are identified to follow up.

Questions that help focus discussions

1	Gather a pen picture. 'Understanding me?'
2	What are my and my family's/carers' views of the current situation?
3	What are my symptoms? How is my physical health? Does any of this mean I need to be in hospital? Have I had an annual health check and do I have a health action plan?
4	What are the current issues and risks and how can I stay safe and keep others around me safe?
5	What's working well/what doesn't work? (Everyone's views, including about what has helped me before.)
6	What support has been/can be put in place so I can stay in the community?
7	What treatment am I currently receiving, including medication, therapy, diet and care? Does this need reviewing? Is it helping?
8	Can the care, education and treatment I need be given in a community setting?
9	What additional support is needed to keep me/others safe in the community?
10	What resources are available/can be created or used in a different way to support me?
11	What additional support does my family/carers need? Has there been a carers assessment?
12	Do I have advocacy to support me to understand my care and treatment?
13	What is the reason for considering inpatient admission?
14	What would the outcomes of an admission be for me?
15	What would the impact of admission be on me and others around me? (For example, moving away from home and the people I know to a new environment.)

The outcomes of this meeting should be recorded as per local policy and lead to an updated care plan and risk assessment (or education, health and care plan (ECHP) for a child or young person).

Preference list
No placement should take place 'out of area' without the commissioner's agreement.

The preference order for support arrangements is:

Preference 1	Support the person at home (with the relevant help given there). Additional support packages will be considered favourably by commissioners.
Preference 2	Support the person in a local non-inpatient unit, using residential nursing or via a short break service.
Preference 3	Admit the person to an inpatient service in their local ICS area. Note that mental health needs should be met in acute mental health services and underlying physical health needs in acute hospitals.

Out-of-area placements should be avoided if at all possible. The commissioner needs to approve out-of-area placements in line with the contracting process. These will only be considered when the move is justified by clinical need and/or risk management, and all other avenues have been exhausted. Any such agreed placement should be time limited.

Any gaps in local delivery that mean needs cannot be met locally should be reported to the relevant commissioner.

Follow-up
If an individual is at risk of admission and does not have a care pathway, they should be allocated a lead professional or keyworker to follow-up the agreed care plan. For an individual under 25, this may trigger a review of their ECHP.

The revised care plan will require regular review by the keyworker to ascertain its effectiveness and quality. The individual will now be placed on the local DSR that identifies people who are at risk of admission, if they consent and are not already on it.

Should an individual be admitted following a LAEP meeting, a full C(E)TR will need to take place within 10 working days for children and young people and within 20 working days for adults.

Appendix 9: Data to monitor C(E)TR pathway implementation and outcomes

The effectiveness of C(E)TRs will be measured using local, regional and national anonymised datasets, alongside tools such as feedback questionnaires and local audit.

Most of the required data can be accessed via existing routes, including the Assuring Transformation dataset.

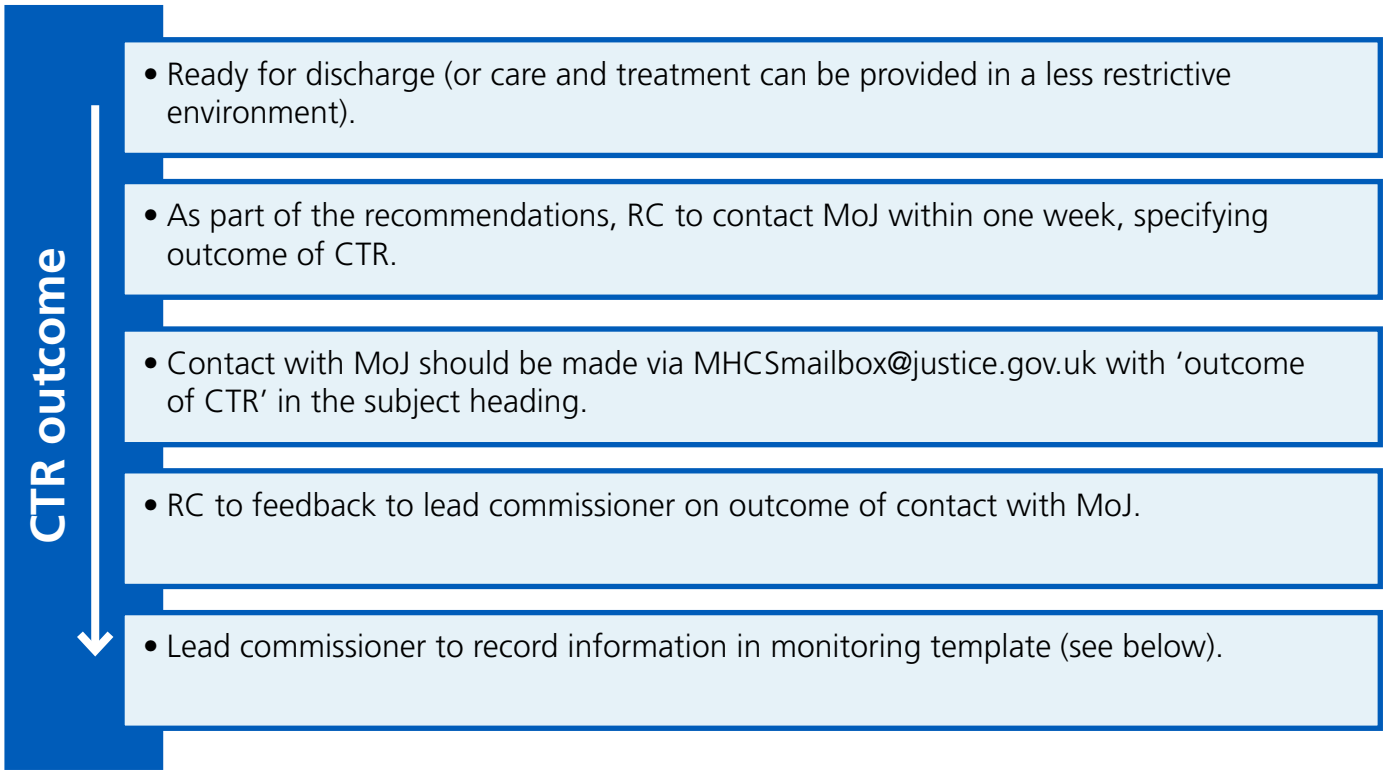
Regional learning disability and autism teams will require access to anonymised C(E)TR information to quality assure the C(E)TR process. Using the information gathered they will seek to determine:

- if each area has a DSR and a way to monitor its effectiveness in ensuring provision of additional support and/or predicting admissions
- whether the C(E)TR policy is being adhered to
- whether the C(E)TR standards are being met
- whether or not people are admitted following a community C(E)TR and, for those admitted, whether length of stay following C(E)TRs are falling
- rates of admission among people whose admission was previously avoided through the provision of additional support, and of re-admission following discharge from an inpatient setting
- whether C(E)TRs are a positive experience for people and their families
- whether people and families have an improved experience of care and support following a C(E)TR
- whether C(E)TR intelligence is being collated and acted on in response to concerns raised about the quality of care, both at individual and collective levels (eg regarding specific providers).

Appendix 10: CTR policy – restricted patients

This appendix concerns patients subject to Ministry of Justice restrictions. Please refer to https://www.gov.uk/government/publications/mentally-disordered-offenders-the-restricted-patient-system in conjunction with the flow chart below for guidance.

CTR flowchart for restricted patients



Monitoring template for patients subject to MoJ restrictions

The responsible commissioner should use this template to track outcomes and follow-up for restricted patients.

Reference number	C(E)TR date	C(E)TR outcome	Provider name	Responsible clinician name	Responsible commissioner referral date to MoJ	Type of referral (request for leave, discharge)	Date of response from MoJ	Narrative reopens	Any escalation

Appendix 11: Support for C(E)TR panel members and their requirements

Recruitment

ICSs and provider collaboratives should ensure that panel members are recruited through a robust process that includes shortlisting and interviewing against a set of core competencies.

Clinical experts should be able to provide evidence of qualification and a current registration with their relevant professional body.

Individuals should be subject to usual pre-employment checks as per the local HR policy for any roles that include working with vulnerable adults and/or children and young people.

Induction

Panel members will be required to undertake mandatory training prior to commencing their role and should be offered additional skills training modules as identified as part of their induction process. Shadowing an experienced C(E)TR panel (subject to consent of the person and their family) should also be considered as part of the induction to ensure a greater understanding of the expectations of the role.

Training requirements

Health Education England is working with partner agencies to develop a suite of C(E)TR training modules. These will include core, mandatory and skills modules that will be available to all panel members at no cost to local systems. For existing panel members, they will be expected to undertake the mandatory modules within six months of the release date of the training. New panel members will be expected to undertake the mandatory training prior to commencing their role.

Conflicts of interest

Due to the independent nature of the expert by experience and the clinical expert, conflicts of interest are an important consideration in the C(E)TR process. Panel members are responsible for declaring any potential conflicts of interest as soon as they become aware of them. They should do so by raising any potential conflict with the commissioner immediately so that it can be discussed and, where required, an alternative panel member sought as soon as possible.

Examples of conflicts are:

- previously having worked with the person in a clinical capacity
- previously having worked for the provider
- having been an inpatient at the hospital
- having a family member who has been or is an inpatient at the hospital
- having a family member who has been or is under the clinical care of a member of the MDT.

Ongoing support and supervision

Local areas should ensure that panel members are offered regular supervision and support, in addition to the debrief process. This could be in the form of a monthly peer support group or on a one-to-one basis. For subcontracting arrangements, this can be undertaken by the employing organisation.

Reasonable adjustments

It is essential that panel members are asked about any reasonable adjustments they require prior to undertaking the review. This is particularly important for the expert by experience role where panel members may be autistic or have a learning disability. Their sensory and communication needs will be an important consideration when undertaking the review and they (or their supporter) should be given the opportunity to share this information in advance. Adjustments may need to be made with the sharing and allowed reading time of any documentation as well as considering whether some of the review may be better undertaken using a hybrid model (part face to face and part through online platforms).

Payment

Payment for panel members is made in several different ways:

- For reviews commissioned by NHS England or provider collaboratives, experts are required to be 'employed' for tax purposes.
- For reviews commissioned by ICSs, experts are required to invoice for payment and are responsible for their own tax arrangements.
- In some areas, third-sector organisations have a 'subcontracting arrangement' for experts by experience.

The suggested minimum rates of pay have been increased as shown below.

Role	Suggested new minimum rate of pay
Expert by experience	£250 per review (previously £150)
Clinical expert	£350 per review (previously £300)

These rates should not be viewed as a 'day rate'. They are for the whole review, including any advance reading requirements and panel follow-up actions. For experts by experience they reflect the NHS England policy for working with patient and public voice partners.

The role of the expert by experience and clinical expert should be equally valued for the different skills and experience they bring to the panel.

It is recognised that the clinical expert will be professionally accountable for their role within the C(E)TR in accordance with the requirements of the professional body that they hold active registration with.

Expenses

Expenses are also claimed in several ways:

- Experts who are employed should contact their recruiting manager to clarify the process for claiming expenses from the employing organisation.
- Other panel members who invoice for payments should contact the commissioner to confirm what they can claim expenses for and the agreed amount (such as for mileage).