

CETR



Dynamic Support Register and Care (Education) Treatment Reviews & Policy Update – Key Changes

January 2023

Combining Key Policies

- NHS Long Term Plan (January 2019) commitment “to review and strengthen existing Care (Education) and Treatment Review (C(E)TR) policies”
- The C(E)TR policy is combined with other key policies that support the care and treatment of Autistic people and people with a Learning Disability. This publication includes Dynamic Support Register (DSR) guidance.
- Publication of the policy is 25th January 2023
- Implementation of policy **from 1st May 2023**
- Draft Mental Health bill (2022) includes section 125A and 125D in relation to C(E)TRs and DSRs
- Please ensure you refer to the published policy for full details

Link to full policy can be found [NHS England » Care, Education and Treatment Reviews \(CETRs\)](#)

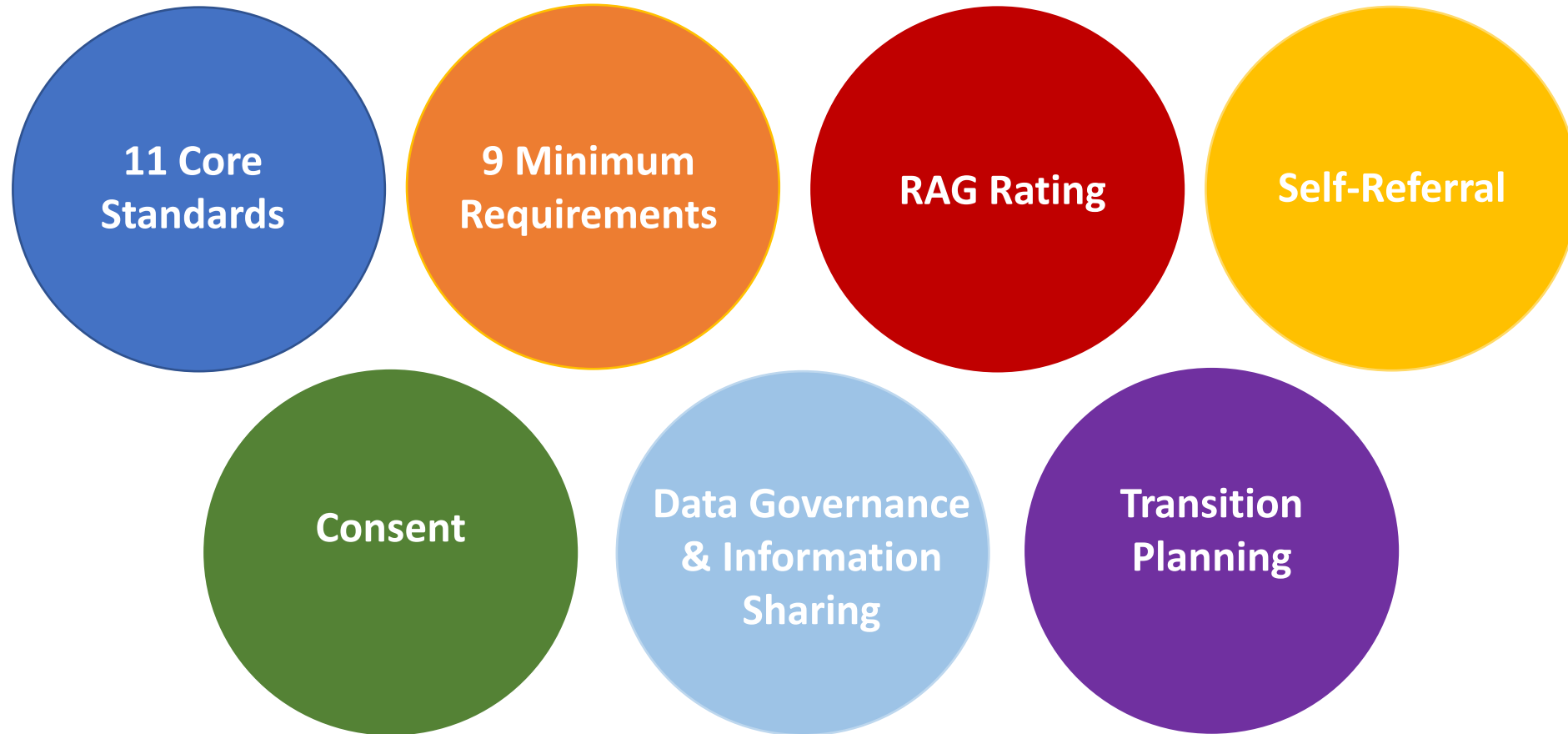


Overview of Key Changes

- Updated DSR guidance
- C(E)TRs seen as a process rather than a 'one day event'
- Additional 'trigger points' to conduct some C(E)TRs
- New Key Lines of Enquiry (KLOE) document – more person centred and follows the person
- Increased focus on physical health
- Increased focus on quality of life
- Requirement for local teams to monitor quality as well as frequency of C(E)TRs
- Mandatory training for all panel members
- Suggested new minimum rates of pay



Updated DSR Guidance



Updated DSR Guidance – 11 Core Standards



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 reviewed
 - C(E)TR recommendations are recorded on the DSR.

The Dynamic Support Risk Stratification should involve review of community C(E)TR recommendations, and inpatient C(E)TR recommendations for those at risk of readmission, plus any pertinent information from relevant meetings, e.g. 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

Updated DSR Guidance – 9 Minimum Requirements

Dynamic Support Registers 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 DSR'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. CYP and Adults who are placed out-of-area should remain on the placing area's, or area with commissioning responsibility's, DSR.
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

Updated DSR Guidance – RAG Rating

All systems should have a clear way to stratify the needs of those on their DSR and we expect all DSRs to use a RAG rating or similar locally agreed process.

Red	<p>There is an immediate risk of admission to a mental health hospital</p> <p>The person and/or 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</p> <p>Linked processes:</p> <ul style="list-style-type: none">○ A C(E)TR must take place○ Referral to the Keyworker Service (aged 0-25), if not already known
Amber	<p>There will be an immediate risk of admission to a mental health hospital without urgent intervention</p> <p>Therefore could be a significantly increased risk of becoming mentally unwell and/or placement/family breakdown</p> <p>Linked processes:</p> <ul style="list-style-type: none">○ Multi-agency meeting and/or C(E)TR○ Referral to the Keyworker Service (aged 0-25), if not already known
Green	<p>There are some risks which could lead to the person being admitted or re-admitted to a mental health hospital; these risks are being effectively managed.</p> <p>Linked processes:</p> <ul style="list-style-type: none">○ Clear identification of partners who would need to be involved in a C(E)TR if required
Blue	<p>A separate section must identify those children, young people and adults who are currently in inpatient services.</p> <p>Linked processes:</p> <ul style="list-style-type: none">○ This rating should be used to identify those requiring commissioner oversight visits and inpatient C(E)TRs.

Updated DSR Guidance

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

Consent

- Inclusion on the DSR will require the informed consent from the person (or someone with parental responsibility, or Lasting Power of Attorney or deputyship for them).

Data Governance & Information Sharing

- 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.

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.

- 8 • | Transitions team must have access to both registers and associated services.

Actions for ICBs:

Ensure DSRs meet the required criteria by 1st May 2023 for:

- Core Standards;
- Minimum Requirements;
- RAG Rating;
- Self-Referral;
- Consent;
- Data Governance & Information Sharing; and
- Transition Planning.

C(E)TR Trigger Points

Adults

Service Type	Pre-admission	Additional CTR Trigger	Regular CTR schedule
Non-secure	Community CTR completed	6 weeks post admission	6 monthly
	Urgent Admission with LAEP or no Community CTR	Within 4 weeks of admission	6 monthly
Secure (via non-Criminal Justice Route)	Community CTR completed	6 weeks post admission	12 monthly
	Urgent Admission with LAEP or no Community CTR	Within 4 weeks of admission	12 monthly
Secure (via Criminal Justice Route)	<i>Exempt from Community CTR</i>	Within 4 weeks of admission	12 monthly

CYP

Service Type	Pre-admission	Additional CTR Trigger	Regular CTR schedule
CYP (up to 25 if EHCP in place or if young person remains in CAMHS services post 18 years)	Community C(E)TR	6 weeks post admission	3 monthly
	Urgent Admission with LAEP or no Community CTR	Within 2 weeks of admission	3 monthly

C(E)TR Trigger Points – Additional for Adult & CYP

Hospital transfer or change in security setting

- C(E)TR to take place no later than 6 weeks post-transfer

Diagnosis of Autism or Learning Disability whilst in hospital

- C(E)TR to take place within 4 weeks for Adults and 2 weeks for CYP

Proposal to remove diagnosis of autism or learning disability

- C(E)TR to be undertaken prior to any diagnostic changes being formally made

Actions for ICBs & Provider Collaborative (PC):

- Ensure processes for post-admission C(E)TRs, within the required timeframes, are in place for all new admissions by 1st May 2023; and
- Prepare for new C(E)TR requirements for: hospital transfers, diagnosis within hospital or removal of diagnosis



Commissioner Oversight Visits – 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.

Sit and see template available here -



Actions for ICB & PC:

- Review all current inpatients and ensure Commissioner Oversight Visit prior to planned C(E)TR is identified to include "Sit and See" and this form is provided to panel members prior to C(E)TR taking place by 1st May 2023



New focus within Key Lines Of Enquiry

Advocacy

People should be encouraged to access a self-advocate, and advocates should be invited to C(E)TRs

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

Physical Health

An increased focus on assessing whether physical health needs are being met. 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

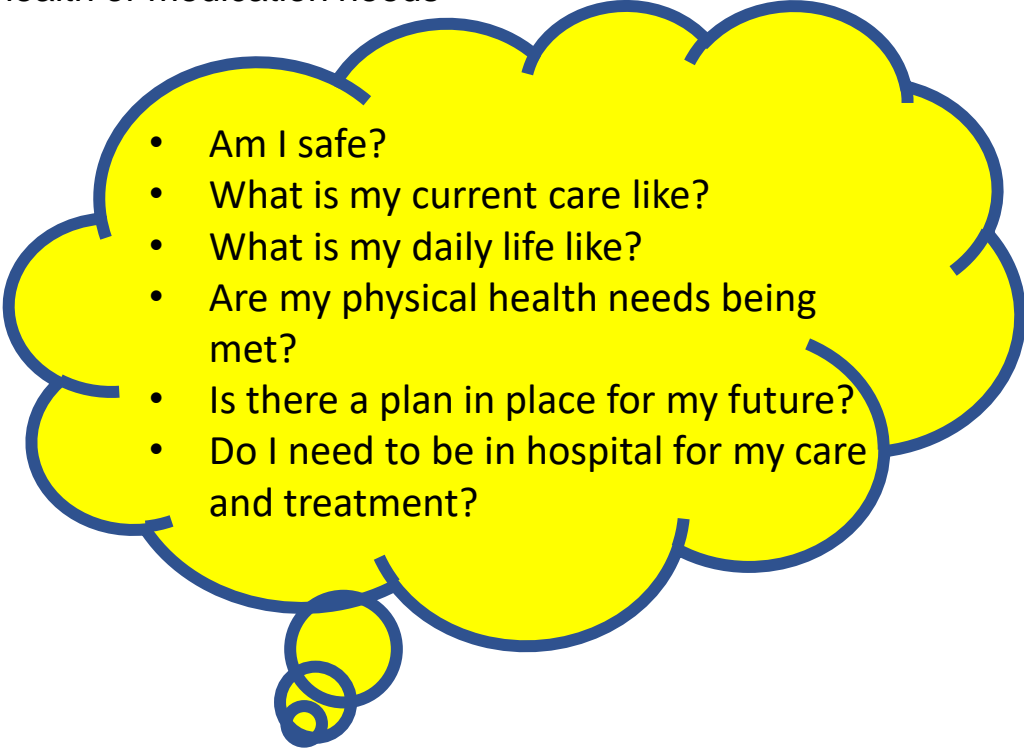
Quality of Life

There is also a new question on quality of life and a strengthened focus on participation in meaningful activity

N.B. A refreshed KLOE document is to be published

Actions for ICB & PC:

- Review all current inpatients to ensure advocacy support has been offered, and advocates are invited to all C(E)TRs
- Ensure physical health and quality of life is reviewed in readiness for next C(E)TR
- Facilitate implementation of updated KLOE document (when published)

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

As part of the review:

- Commissioner chairs the review and is responsible for logging key findings and recommendations in the key lines of enquiry (KLOE) report
- The review panel meets with 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.
- Recommendations should be clear, time-limited, embedded and followed up through local systems. The report will make clear who is responsible for each action and when.

Following a review:

- Individuals named against specific recommendations as part of the review remain responsible for undertaking agreed actions within the recorded timescales. Clinical accountability for the actions sits with the Responsible Clinician
- Commissioner must retain overall oversight of the action plan agreed by the review panel
- Commissioner will follow up on any specific quality or safeguarding concerns identified during the C(E)TR and ensure that these are raised as appropriate through local reporting procedures

Actions for ICBs & PC:

- Establish clear mechanisms to enable confirmation of implementation of all recommendations for each C(E)TR, providing assurance to the regional team

Assurance and Oversight – ICS Oversight Panels

Safe and Wellbeing Reviews introduced the concept of an ICS Oversight Panel, feedback from systems was that this process was helpful, subsequently we intend to maintain the concept of a senior level ICS Oversight Panel as part of the C(E)TR process.

Panels must convene at least quarterly (more frequently if helpful) and should review the C(E)TRs of people for whom there is concern.

N.B. These lists are not exclusive and the policy should be referred to for full details of requirements

Membership	Eligible Patients <i>(must include but not exclusive to)</i>	Considerations for the panel
<ul style="list-style-type: none">• LD&A SRO / ICS Executive Lead• Expert by Experience• Medical Director• Social Care / LA Senior Representative• PC Representative• Senior Clinician with expertise in LD&A	<ul style="list-style-type: none">• Long length of stay• Long Term Segregation / Regular Seclusion• People in units that are CQC rated as 'Inadequate'• People with open complaints made by them, families or carers• Those with a safeguarding referral• People who have been requested to be escalated	<ul style="list-style-type: none">• Overall care and treatment• Physical health, safety and wellbeing• Discharge planning progress• Take ownership of any actions that need to happen after the review• Escalate to Regional team as required• Evidence how findings feed into ICS delivery plan

Actions for ICBs:

- Schedule ICS Oversight Panels to take place, at least quarterly, to take place from May 2023

Assurance and Oversight – NHSE Regional Team



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

Proposed regional process for quality assurance of C(E)TR recommendations implementation are to be brought to the Regional Learning Disability and Autism Board meeting in June 2023 for approval.

C(E)TR Panel Logistics

- 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
- The expectation is that C(E)TRs should now be taking place face-to-face. If a panel member has significant reasons why they are unable to complete the C(E)TR in person then a hybrid method may be used. If family, carers and professionals are unable to attend in person virtual attendance should be on a case by case basis

Actions for ICBs and PC:

- Begin planning to ensure the ability to offer the same panel for repeat C(E)TRs from May 2023
- All C(E)TRs to take place face-to-face from May 2023, any exceptions to this are to be on a case by case basis

Mandatory Training for Panel Members

- Health Education England (HEE) are 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 6 months of the release date of the training.
- New panel members will be expected to undertake the mandatory training prior to commencing their role.

Actions for ICBs & PC:

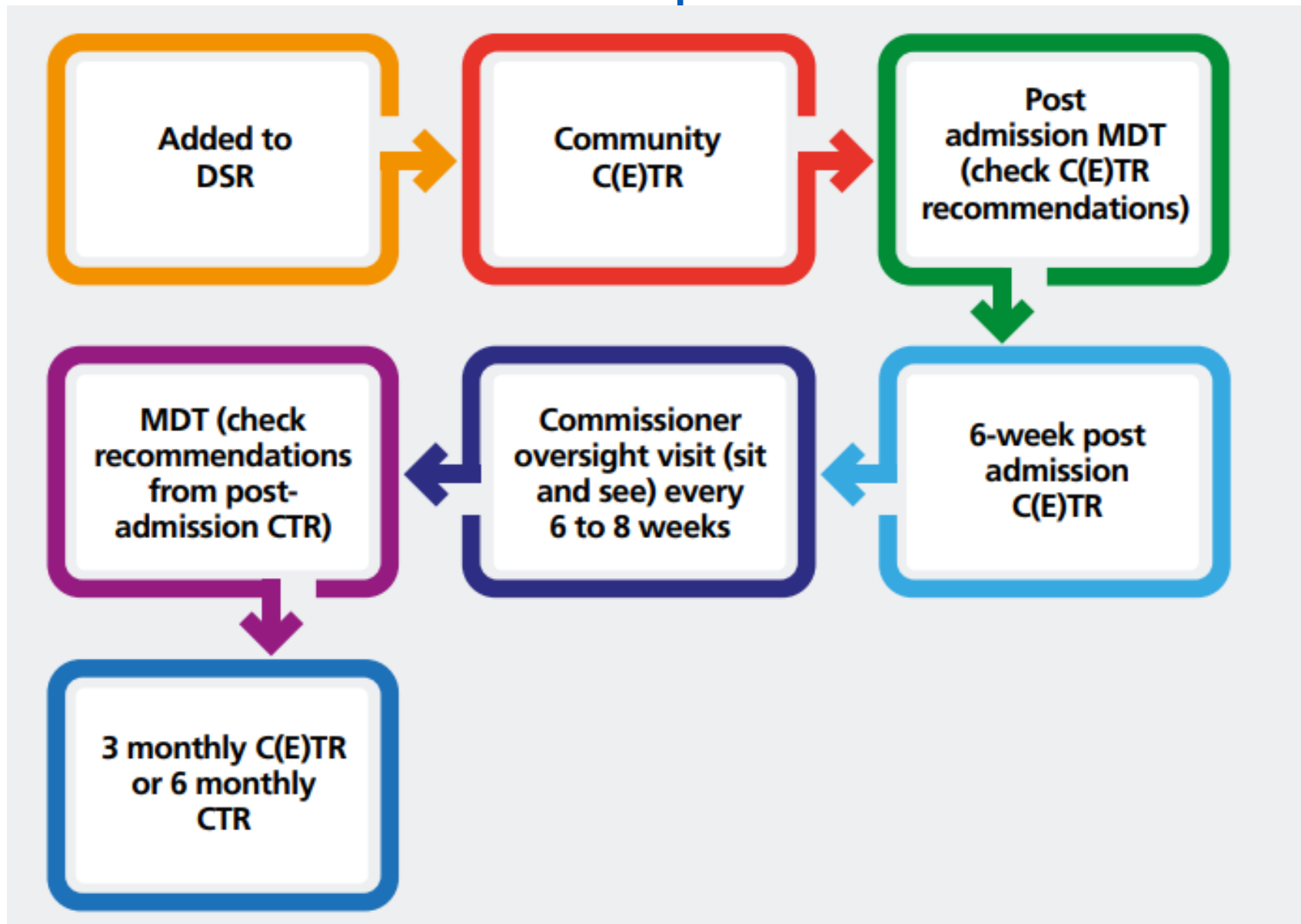
- Inform all panel members of new national mandatory training requirement and the timeline for release and completion
- Provide information to panel members to support completion of training (once this has been published)
- Monitor panel members' completion of mandatory training

Suggested New Payment for Panel Members

- As part of the consultation for this policy update, a decision has been taken to review the current suggested minimum rates of pay for experts:
- These rates of pay should not be viewed as a 'day rate'. They are for the whole review and include any pre reading requirements and any follow up actions taken as a panel.

Role	Previous rate of pay	Suggested new minimum rate of pay
Expert by Experience	£150 per review	£250 per review
Clinical Expert	£300 per review	£350 per review

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



Example of possible Adult Inpatient pathway

Pre-admission		Post-Admission				
		Week 1	Week 2	Week 3	Week 4	Thereafter
Event	<div>Patient Identified to service</div> <div>Patient at risk of admission</div>	<div>Patient admitted</div>				
DSR	<div>Patient added to DSR</div>	<div>Moved to Blue on DSR</div>				<div>DSR RAG rating reviewed and updated upon discharge</div>
C(E)TR	<div>LAEP / no community C(E)TR takes place</div>	<div>Schedule post-admission C(E)TR to take place within 4 weeks' time</div>			<div>Post-admission C(E)TR takes place</div>	<div>C(E)TRs take place 6 monthly for non-secure patients and 12 monthly for those in secure services</div>
Commissioner Oversight Visit		<div>Schedule Commissioner Oversight Visits to take place</div>		<div>Commissioner Oversight visit takes place (including sit and see)</div>		<div>Commissioner Oversight Visits take place 8 weekly (including sit and see prior to next C(E)TR)</div>

Example of possible CYP Inpatient pathway

Pre-admission			Post-Admission						
Event	Patient Identified to service	Patient at risk of admission	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Thereafter
			Patient admitted						
DSR	Patient added to DSR	Moved to Amber/Red on DSR	Moved to Blue on DSR						DSR RAG rating reviewed and updated upon discharge
		Community C(E)TR takes place	Schedule post-admission C(E)TR to take place within 6 weeks' time					Post-admission C(E)TR takes place	C(E)TRs take place 3 monthly
			Schedule Commissioner Oversight Visits to take place				Commissioner Oversight visit takes place (including sit and see)	Commissioner Oversight Visits take place 6 weekly (including sit and see prior to next C(E)TR)	
		Referral to Keyworker service (if not already known)	Post-admission MDT (check C(E)TR Recommendations)						
Commissioner Oversight Visit									
Other									



Any Questions?