



Care (Education) and Treatment Reviews

The role of health and social care providers

‘Transforming Care isn’t just about reducing beds, it’s about changing a whole person’s life with good quality services in hospital, and good quality services in the community that will prevent unnecessary admissions. Care (Education) and Treatment Reviews help to make sure that happens.’

Gavin Harding MBE, Learning Disability Adviser, NHS England

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request from england.improvinghealthquality@nhs.net.

Equality and Health Inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- 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.

Contents

1. Introduction.....	5
2. The role of providers.....	6
3. When does a C(E)TR happen?	6
4. Supporting C(E)TRs to happen well	7
5. Providing the necessary documents.....	8
6. The 'PERSONAL' principles of C(E)TRs	9
7. Supporting the person and their family	11
8. Making C(E)TRs part of what you do.....	12
9. Pro-active about good advocacy	12
10. C(E)TR Provider Planning	14
11. Ensuring the quality of C(E)TRs	18
12. Applying the learning from C(E)TRs	19
13. Becoming a C(E)TR panel member.....	19
14. Reporting CTRs to the Mental Health Services Data Set (MHSDS).....	20
15. Hospital Discharge Good Practice Standards.....	22
For more information	24

1. Introduction

This booklet has been written to help health and social care providers ensure that Care (Education) and Treatment Reviews improve the lives of people they support.

C(E)TRs were developed as part of NHS England's commitment to improving the care of people with a learning disability, autism or both in England as part of Transforming Care. CTRs are for adults who have been, or may be about to be, admitted to a specialist mental health/learning disability hospital in the NHS or independent sector. The equivalent system of review in England for children and young people is called Care Education and Treatment Reviews or CETRs. C(E)TR is used to refer to both.

Fundamentally, a C(E)TR aims to identify how each person can have the best quality of life possible, and how care and treatment can fully support this aim. In the belief that 'hospitals are not homes', a C(E)TR will consider whether the person needs to be in hospital or how this can be minimised, and how the right services can be put in place for people to live safely in their communities. In looking at the person's care and treatment it enables a view to be taken about what progress has been made in relation to this.

C(E)TRs bring together those responsible for commissioning and providing services (nurses, social workers, education commissioners and other health, education and social care professionals alongside strategic commissioners where appropriate) with independent clinical opinion and the lived experience of people with learning disabilities, autism or both and families from diverse communities.

The aim of the C(E)TR is to bring a person-centred and individualised approach to ensuring that the care and treatment and differing support needs of the person and their families are met and that barriers to progress are challenged and overcome. To this end, as well as the commissioner and a clinical expert, the panel includes an expert by experience. This may be a person with a learning disability, autism or a family carer with experience of services. It is this independent and diverse blend of expertise that makes a C(E)TR unique.

A care provider may at times feel under the spotlight during a C(E)TR. While considering the quality of a person's care and treatment is obviously paramount, the C(E)TR is actually about **all** the factors that affect whether and why a person should, or should not be, in hospital. This might be due to factors outside the care providers' control. As the care provider, you also have a right to bring some constructive challenge where such barriers exist, with the shared aim of improving someone's life. A C(E)TR should be about **everyone** working together as equals, with the person and their family at the centre of this process.

The information and tools which follow are based on CTR/CETR policy and the CTR/CETR Code and Toolkit, which can be downloaded from the NHS England website, along with a range of easy read resources and other materials www.england.nhs.uk/ctr.

Information is also provided on how to submit information on CTRs that are undertaken to the Mental Health Services Data Set (MHSDS). It is really important that CTR information is captured in MHSDS as this enables NHS England to monitor whether the care and treatment of patients is being reviewed in line with national guidance.

2. The role of providers

The C(E)TR policy outlines the overall responsibilities of providers as to:

- Ensure that the C(E)TR process is implemented as set out in the pathway
- Work in partnership with commissioners to facilitate C(E)TRs
- Support people with a learning disability, autism or both and their families in the C(E)TR process including with understanding the review process, and with consent
- Work in partnership with people, their family carers and partners co-productively before, during and after the C(E)TR
- Ensure agreed recommendations for providers are implemented from the C(E)TR
- Utilise the learning from C(E)TRs and the independent opinion, to improve the quality of services provided
- Take actions from C(E)TRs into CPA and ward rounds/other clinical meetings
- Carry out audits of 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 chair of the panel, the person and family
- Provide challenge to blockages identified within the C(E)TR that are the result of funding or community barriers outside of the provider's control

3. When does a C(E)TR happen?

The service provider should help to ensure that C(E)TRs happen on time and that people are supported to request one if they wish.

A **Community C(E)TR** should be organised when a hospital admission is being considered. A Community C(E)TR asks what extra support can be put in place for the person and family to avoid unnecessary admission to hospital. In 4 out of 5 cases, it has been found that a Community C(E)TR has prevented admission to hospital at that time. Except where a clinician has determined an urgent need for admission to an acute mental health facility as part of a pre-determined crisis management plan with clear timescales for discharge, if there is a crisis and no time for a C(E)TR, a fast response is needed to consider if admission can be avoided. A meeting should be set up with the person, their family and those around them to explore what alternative support could be put in place.

- **For adults in non-secure settings, CTRs should happen every 6 months.**
- **For adults in secure settings, they happen every 12 months.**
- **If an adult does not have a CTR before being admitted to hospital, one should take place within 4 weeks of admission (or 2 weeks for children and young people under 18 years old.)**
- **CETRs should be every 3 months for children and young people in hospital.**
- **Anyone involved in the person's care, including the person, their families and support team, can ask for a CETR to happen sooner than planned.**

Requests for C(E)TRs should be made to the person's care coordinator. They should first try to deal with the concerns that have led to the request. If it is felt that a C(E)TR is needed, the care coordinator will contact the commissioner.

4. Supporting C(E)TRs to happen well

The service provider needs to provide all the documents required for the C(E)TR panel on the day.

The C(E)TR combines discussion with exploration of all aspects of a person's care and treatment, within a framework of themes and issues to be addressed and, if necessary, challenged. Findings are gathered in conversations and meetings, by seeing where the person lives and by looking at the person's care notes, which the provider should have ready on the day.

In common with the approach taken by the Care Quality Commission, the CTR/CETR policy uses Key Lines of Enquiry (KLOEs) to guide and structure the review process. Each KLOE template varies slightly depending on who the C(E)TR is for (adult or child/young person) and where it takes place (community, low secure or medium secure hospital), but they all follow the same structure.

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

The Key Lines of Enquiry provide information and evidence to enable a summary and feedback for the person that says:

- Am I safe?
- What is my current care like?
- Is there a plan in place for my future?
- Do I need to be in hospital for my care and treatment?

The 10 KLOEs that an adult CTR seeks to address are:

1. **Does the person need to be in hospital?**
2. **Is the person receiving the right care and treatment?**
3. **Is the person involved in their care and treatment?**
4. **Are the person's health needs known and met?**
5. **Is the use of any medicine appropriate and safe?**
6. **Is there a clear, safe and proportionate approach to the way risk is assessed or managed?**
7. **Are any autism needs known and met?**
8. **Is there active planning for the future and for discharge?**
9. **Are family and carers being listened to and involved?**
10. **Are the person's rights and freedoms being protected and upheld?**

KLOEs for a CETR also follow this format, with one further KLOE which is

11. **Are any specific issues for children or young people being addressed?**

5. Providing the necessary documents

For a hospital C(E)TR the responsibility for producing the documents is with the provider. For a community C(E)TR, the commissioner is responsible for providing the documents.

The C(E)TR chair should ensure that all written and verbal information provided will be kept private and confidential within the C(E)TR. The C(E)TR panel will not take any of these documents away with them nor make copies to take away. These are the documents that should be prepared ahead of the day for the C(E)TR panel and put in to a pack:

- Risk assessments
- Mental Health Act papers
- The most recent Mental Health Act Tribunal report
- Social circumstances report
- The community service specification
- The last four weeks of progress notes
- Safeguarding reports from the last year
- Incident forms where restraint was used, either since admission or last C(E)TR
- Health Action Plan
- Person centred care plan
- Positive Behaviour Support Plan and other care plans
- Education, Health and Care Plan
- Communication Passport
- Hospital Passport
- Medication Chart
- Mental Capacity Assessments
- Ministry of Justice documents, where appropriate

6. The 'PERSONAL' principles of C(E)TRs

The provider should help the C(E)TR panel uphold these principles:

C(E)TRs are based on a set of principles that are summed up in the word PERSONAL:

1. **P**erson centred and family centred
2. **E**vidence based
3. **R**ights led
4. **S**eeing the whole person
5. **O**pen, independent and challenging
6. **N**othing about us without us
7. **A**ction focused
8. **L**iving life in the Community

1. **Person centred and family centred**

The person, their family and advocate if invited, should be at the centre of the C(E)TR. The C(E)TR checks that the people who provide the person's care are working in a person and family centred way. That people get all the information and support they need to have an active part in the C(E)TR before, during and after. In the way that works best for the people involved.

2. **Evidence based**

The C(E)TR Panel should all be able to see and hear information to help them understand what is working or not working about the person's care. And that care is carried out to a high standard. This is so they can decide with the person and others if anything needs to change or get better.

3. **Rights led**

The person has the right to be treated as an equal in their C(E)TR and to have all the support they need to take part. The C(E)TR should uphold the person's rights. Rights are things like choice, contact with family, independent advocacy and being able to say what one thinks. Other rights are being treated well, and having a good quality of life. And respect for one's personal life and beliefs.

4. **Seeing the whole person**

A C(E)TR is not just about a person's mental health or how they behave. It is about seeing the whole person. Their quality of life, likes, dislikes, choices, hopes and fears.

5. **Open, independent and challenging**

Each person on the C(E)TR panel can say if something does not seem right about the person's care. They can ask questions and say if something needs to change to make it better. Together the panel will decide what needs to happen to make it right.

Recommendations will go into the CTR report that is agreed by the panel after the C(E)TR.

6. Nothing about us without us

The person, and their family carers if taking part, should be fully involved in the C(E)TR. From giving consent, to getting ready, taking part, getting a copy of the C(E)TR report and knowing what is happening afterwards. The C(E)TR report should also be written in words the person will understand.

7. Action focused

The C(E)TR report after the meeting should have clear actions. Actions are things that need to be done. The actions should be easy to understand. The report will say who needs to do each action and when it should happen by. The actions should improve the care the person receives now and in the future. The commissioner will check these things are happening and that the person knows the reason if any action cannot be carried out on time.

8. Living life in the community

C(E)TRs are about what is needed to help people live well in their communities. When someone is in hospital, a C(E)TR will ask if they need to be there, or if their care can be provided safely in the community. It will also look at how people are supported to access the community while they are in hospital. The C(E)TR will check there are good plans in place to keep the person and others safe in the community. The C(E)TR will also check that the plans still give the person the chance to lead as full and independent a life as possible.

Ensuring the C(E)TR upholds these principles

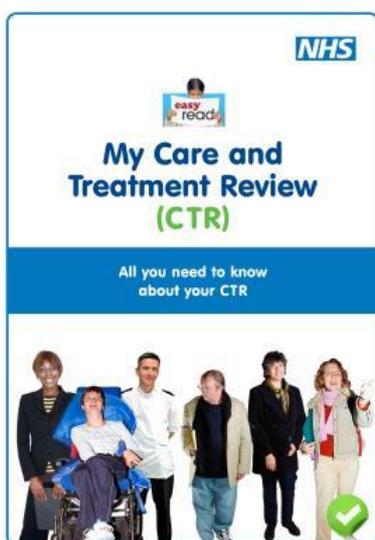
Everyone, including providers, should be able to say to the C(E)TR Chair if they feel that any of these principles are not being upheld, giving clear reasons and suggesting how any issues might be resolved.

7. Supporting the person and their family

The service provider should support the person to give informed consent to the C(E)TR, check that family carers have been invited if the person wishes this and it is appropriate, support the person to prepare for their C(E)TR, take part in it, understand the C(E)TR report and know what the progress of recommendations are. Families should also be fully involved and informed as appropriate.

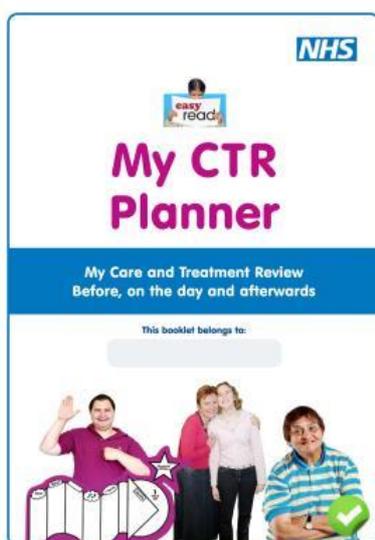
Materials to support the person to take part

The following booklets can be downloaded from the NHS England website www.england.nhs.uk/ctr. They are available with and without Photosymbols to suit people's needs.



My Care and Treatment Review - information about:

- What a Care (E) and Treatment Review does
- The C(E)TR panel
- Community C(E)TRs
- Hospital C(E)TRs
- How often they happen and right to request
- Getting ready, on the day and afterwards
- The C(E)TR report
- Good standards for leaving hospital



My CTR Planner - tools for the person to use:

- Information about consent
- A consent form with sections for choosing whether to invite a family carer, advocate or other important person, and whether the person wants the C(E)TR on the same day as another care meeting or not
- A template form for planning what the person would like to say on the day
- Tips about taking part on the day
- C(E)TR feedback form
- Space to summarise the actions from the C(E)TR report in a way the person finds easy to understand.

8. Making C(E)TRs part of what you do

A C(E)TR isn't just about what happens on the day. Service providers should support good planning, communication, support, action and follow up.

A C(E)TR allows providers to show due accountability for the care and the treatment they provide to the person, as well as providing the review team with the evidence base for the service being delivered. It should be based around what the person's needs and wishes and what they will benefit most from.

C(E)TRs were designed to take a full day to allow time for panel members to meet everyone, accommodate the person's needs, read notes and come to some decisions. In practice, sometimes they take less than a day. This works for some people e.g. because it helps them get ready for a CPA on the same day. Other people may find it too much to have two meetings in one day. Some people like to be in their C(E)TR from start to finish. But others might not even know if they want to take part in it until the day.

This is why a C(E)TR should be based around the needs of the person. Everyone should feel able to challenge this if it is not.

It helps to ensure that more than one room is available on the day so the person and family can meet panel members as informally as possible. Providers should also support the person to show panel members where they live and things they enjoy doing. There is a template form on page 13 to help with C(E)TR planning and support, and embedding recommendations into the person's care.

A good recommendation sets a realistic goal with as short a time frame as possible, and says who will carry it out by when. The care provider's role is to carry out recommendations relating to the person's current or future care within that service, or any responsibility in a transition from that service. It includes supporting people and families to enquire about the progress of any recommendations, whether or not it relates to your particular service. Providers also have a duty to report as agreed on the progress of their actions to the commissioner, the person and their family.

C(E)TR recommendations should be incorporated into the CPA process.

A process for feeding back to the commissioner, the person and their family as appropriate, following a C(E)TR or CPA meeting, should be agreed at the end of the C(E)TR.

9. Pro-active about good advocacy

The provider should ensure that the person understands and is able to make use of good advocacy support throughout the C(E)TR process.

Advocacy is about supporting people's rights and wishes at every stage of a C(E)TR, from planning to being represented as an equal on the day, to ensuring that the person knows what is happening afterwards and is able to speak up if there are any concerns. It is not just about having a voice, it's also about feeling part of a C(E)TR, listened to, worthwhile and encouraged to engage with the services and support being provided.

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Providers should support the person to understand different kinds of advocacy and its benefits, and be pro-active if they feel that the person's advocacy arrangements need some review, additional investment or support.

An advocate from a specialist organisation brings skills, knowledge and independence to the process. This can either be to speak on the person's behalf or to support the person to self-advocate for themselves. Advocacy organisations can often provide training to self-advocates to support this. Informal advocacy, from a family member, friend or member of staff, can work well if the person is appropriately supported to explore their views on a topic, and this is communicated in an impartial way. Informal advocacy is only a substitute for formal advocacy when the person is happy with it, it is independent and its benefits are clear. The quality of any advocacy is evident from how the person's wishes are expressed and the quality of understanding and involvement the person has in the C(E)TR and their care, including decision-making.

The quality of advocacy support people receive is a recurring concern in C(E)TRs and it can become an issue for a number of reasons, such as:

- The person may refuse an advocate if he/she does not know what advocacy is
- They may not like the advocate offered to them
- The advocate may not have enough time to get to know the person
- Having a statutory advocate may not be right for that person

Some top tips for helping people to access good advocacy for their C(E)TR are:

1. Support the person to understand what advocacy is and why it is important
2. If an advocate was refused, find out why and if it can be resolved
3. Make sure advocacy time is protected from staff pressures or other appointments
4. Make sure advocacy is planned into each stage of the C(E)TR process
5. Make reasonable adjustments like providing a quiet or otherwise adapted space to meet, or being able to meet outside of the hospital if possible
6. Support the team and the family to work together in providing advocacy support for the person, if this is of benefit.

10. C(E)TR Provider Planning

This section suggests ways of integrating CTR planning into your work.

ACTION
ONGOING
<p>The person should understand what their C(E)TR is about, how it can help them, and what progress is being made as a result of it. There are two booklets for the person (available with or without Photosymbols) to support this. One booklet provides CTR information, the other is a planner which provides forms for consent, preparation, on the day and afterwards. They can be downloaded from www.england.nhs.uk/my-ctr.</p> <p>Staff, advocacy and/or family support if appropriate, should be offered to help the person plan for and monitor their C(E)TR progress.</p> <p>Staff should practice a rights based approach to ensuring that the person is at the centre of their C(E)TR from start to finish e.g. www.humanrightsinhealthcare.nhs.uk</p> <p>DH Easy Read Mental Health Act – www.nhs.uk/easy-mentalhealthact</p>
<p>If the person is in hospital, the provider and staff should use Discharge Steps and Standards (see Section 15 for best practice) to ensure discharge is progressing well.</p> <p>The person should be involved and supported to produce an accessible discharge plan e.g. a downloadable example planner is available at www.changepeople.org/blog/february-2016/independence-pack</p>
AT LEAST TWO WEEKS BEFORE THE C(E)TR
<p>Consent to a C(E)TR and to family/advocacy involvement if appropriate is gained – to give people, families and advocates time to make arrangements.</p> <p>Raise any issues with the C(E)TR chair promptly. The signed C(E)TR Consent Form is copied and sent to the C(E)TR chair and care coordinator. If the person lacks capacity and does not have a legal appointee, a Best Interests Process and documentation is followed.</p>
<p>If the person isn't sure about taking part in their C(E)TR, reassure them that they can decide any time up to and including the actual day.</p> <p>If the date isn't good for the person, push back on this. If the person is still unsure about taking part, consider how else the person can ensure their voice is heard e.g. in writing, or audio/video recordings about life now, what is good or could be better, and hopes for the future. The person's attendance is the ideal, but if it is not possible, the other materials can be used on the day instead.</p>

Ensure practical arrangements for the day are made and confirmed with the C(E)TR chair and others e.g. a suitable room or two rooms to enable the C(E)TR panel to meet with more than one person at a time, food and drink arrangements, along with any regulations the panel needs to know about getting into the building and travel information.

If it will help the person feel at ease on the day, ask the CTR Chair for appropriate one-page profiles of the panel members, if not already supplied.

THE WEEK BEFORE THE C (E)TR

Get the documents ready which the C(E)TR panel may ask to see – it is best to do this before the day of the C(E)TR. The document checklist is in Section 4 of this document.

If the person has had a C(E)TR before, you should **review what happened last time with the person** and what progress has been made since. Support the person to prepare what they would like to say and any questions they have for the panel.

Support the person to prepare for their C(E)TR. There is a document for this in the person's C(E)TR Planning booklet, which should be written in the person's own words (or pictures) where possible.

If the person has communication difficulties, other methods should be used to ensure their views are captured. If the person wishes, involve family carers and/or advocacy in helping to complete the profile. **The person should bring this document to their C(E)TR meeting if they are happy to do so.**

Reflect on what **you** think is working or not working for the person and possible solutions, in case your views are sought on the day. This is about what you think, not a team opinion. You can ask to speak to a panel member if not directly invited. Your views will be treated confidentially.

ON THE DAY OF THE C(E)TR:

Support the person to take part in the way they feel most comfortable e.g. meeting members of the panel privately, choosing to have a family carer, staff member or advocate present, or choosing to meet panel members on their own.

The person should be able to meet the panel in the best way for them, and have the opportunity to decide about this on the day. For example, the person might feel more comfortable meeting panel members in a different room from where the C(E)TR is taking place and/or might like to show the panel around where they are living. You should support this to happen if so. The person should be supported to attend the closing meeting if they wish.

Ensure the person's wishes are respected and that the person is happy with the way the C(E)TR is carried out.

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Support the person to present and discuss their C(E)TR planning document in the way they wish and check what support they would like in this, if any.

The C(E)TR should respect how the person chooses to take part e.g.:

- The person and family if appropriate should have time to plan for and take part in the way that suits them;
- The C(E)TR should be a positive experience for the person and family;
- Whoever the person has chosen to attend or support them are given every opportunity to attend (this can be by phone or in writing if unable to attend on the day).

Staff should feel able to share their views in confidence and respect is shown for their views.

Immediate actions identified by the CTR are noted, along with the responsible person. Any immediate actions required of the provider are actioned urgently and the CTR Chair, care coordinator, person and family (if appropriate) are kept informed.

WITHIN A WEEK OF THE C(E)TR:

Reflect on the C(E)TR with the person and other staff as needed. Record any queries or concerns and flag them up with the C(E)TR chair. The person's CTR planner contains a sample feedback form that anyone can use.

Ensure the person is supported to fill in the **feedback form** in their C(E)TR Planner booklet by someone they choose, if they wish. Copies are sent to the C(E)TR Chair and Care Coordinator.

The C(E)TR report should be received within **2 weeks** by post. If not, ask the C(E)TR chair for a copy which can be circulated to everyone who took part, including family carer/advocate if relevant.

Support the person to understand the report and to write the C(E)TR actions in their own words in their C(E)TR Planner booklet if this will be helpful.

Relevant CTR recommendations and actions should be acted on and carried forward into CPA and/or other care meetings for regular review.

WITHIN 3 MONTHS OF THE C(E)TR:

C(E)TR actions needing to be completed should be reviewed in a care meeting e.g. CPA. This should include:

1. The progress of required actions against the given timeframe and if there are any barriers, how they will be addressed;
2. The progress of reporting on actions by named staff to CTR chair or other designated contact(s);
3. How the person, their advocate and family carer (if involved) are being involved and kept up to date of this progress;
4. What further steps are required;

ONGOING DISCHARGE PLANNING – also see section 15

Hospital teams should make links with local services where the person is moving to e.g. Voluntary organisations, self-advocacy groups, local services, doctors, dentist, education etc. to enable them to link with the person and make contact while they are in hospital. Consider creating a Circle of Support with the person linking to information about how they work and can be developed (lots on the internet). A Circle of Support is about building strength arounds the person for the future (and with familiar, reassuring parts of the past) which is ambitious and has the person at the centre. Previous support might bring a valuable dimension to the group along with old friends the person may want to engage with again.

ONGOING ANALYSIS AND REPORTING OF CTRs

Providers should have a process in place for taking an overview of C(E)TR reports for people in their care, and what can be learned from this. See Section 12 of this booklet.

Monthly CTR reporting is included within Mental Health Services Data Set (MHSDS) data submissions. See section 14.

11. Ensuring the quality of C(E)TRs

The service provider has a role in ensuring that the C(E)TR is carried out in a way that supports the person at every stage, and that C(E)TR recommendations are carried out on time.

Each section of this document contains advice that contributes to the quality of a person's C(E)TR. The C(E)TR panel has a fundamental role in ensuring the quality of the process which providers should also support. The Chair of the C(E)TR is responsible for ensuring the quality of the process as follows:

- The C(E)TR is based on the principles and standards in the C(E)TR policy;
- It is independent, fair, rigorous and constructive;
- It ensures that everyone gets to have their say;
- It ensures that the views and wishes of the person whose care and treatment is being reviewed, and their family members if involved, are clearly established and are at the centre of the reviews discussions.
- It ensures that both experts are fully involved and treated as equal members of the team. They bring important skills to the C(E)TR and to the drafting of the report, which should be a collaborative process. Ensures that information is made available as per the document checklist.
- It establishes an outline plan for the review day and, if required, to modify this according to any particular issues that may emerge during the review.
- It helps the team develop a pen-picture at the beginning of the day of the person whose care and treatment is being reviewed.
- It is alert to any issues of concern regarding the welfare and safety of the person and to respond immediately and appropriately to issues that require prompt or urgent action and / or escalation.
- It enables the team to have discussions with the clinicians responsible for the person's care and treatment and those who may be supporting them.
- It enables the C(E)TR panel to challenge aspects of the person's current and future care and treatment.
- It clarifies and summarises the findings and recommendations of the review panel both on the day and in a subsequent report.
- It agrees a timescale for recommendations, naming the individual responsible and following agreed actions through after the review and ensuring they are embedded in the CPA process.
- It allows providers to show due accountability for the care and the treatment they provide to the person, and provides the review team with the evidence base for the service being delivered.

12. Applying the learning from C(E)TRs

Providers should be able to identify common themes or trends from C(E)TRs carried out in their services, and implement the learning from this.

By its very nature, a C(E)TR is about the care and treatment of an individual person. However, since they began in 2015 each provider will have supported numerous C(E)TRs to be carried out in their service. As part of their continuing development, providers can learn a great deal from taking an overview of the contents of C(E)TR reports and ensuring that this learning is used to improve the services they provide. This is a useful adjunct alongside service-wide learning from CQC inspections which can be aggregated and used to inform wider strategic planning in a given locality/region.

There is an expectation from C(E)TR panels and commissioners that this is happening and services may be asked to evidence their overall C(E)TR learning and outcomes, for example as part of their contract arrangements.

Providers should consider any themes or learning they can derive from C(E)TRs, in order to enhance the services they provide. The KLOEs provide a helpful structure for evaluating the effectiveness of care and treatment; as evaluated from the point of view of the person using the service. NHS England has produced a simple Excel tool, which allows C(E)TR recommendations to be aggregated under these headings, available from www.england.nhs.uk/ctr.

See also Section 14 Reporting CTRs to the Mental Health Services Data Set (MHSDS).

13. Becoming a C(E)TR panel member

As part of their continuing professional development, service providers should support staff who wish to become C(E)TR clinical experts.

The clinical expert in a C(E)TR helps other panel members understand clinical notes and offers professional opinion. For this reason, the clinical expert should hold a professional health qualification, such as Doctor (Psychiatrist), Psychologist, Nurse, Occupational Therapist or Speech and Language Therapist. All panel members have to be independent and impartial.

The Clinical Expert offers a different perspective to the existing clinical team and will engage the person, their family and their local team in discussion to identify if there are barriers to discharge or to identify what support would enable the person to live their life in the community. The Clinical Expert, where required, advises the other members of the team on matters such as the Mental Health and Capacity Acts, diagnosis, mental and physical health issues, treatment options and their evidence base. Conflicts of interest should be declared e.g. it would not be appropriate to act as a clinical adviser for a C(E)TR in a service where you have ever worked. For more information, see the C(E)TR Code & Toolkit at www.england.nhs.uk/ctr

14. Reporting CTRs to the Mental Health Services Data Set (MHSDS)

Details on all patient CTRs should be captured in MHSDS to enable NHS England to monitor whether the care and treatment of patients is being reviewed in line with national guidance. Providers are required to submit patient CTR data to MHSDS.

An Information Standards Notice (ISN) has been issued for the MHSDS (DCB0011), which mandates monthly submission from all services that give care to in-scope¹ adult and child and adolescent mental health, learning disability or autism patients. Full guidance on data requirements and how to submit can be found at <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/how-do-i-submit-data-to-the-mental-health-services-data-set>

CTR data should be included in MHSDS submissions using the MHS202 Care Activity table (linked to MHS201 Care contact). Where a CTR has taken place this should be recorded using the Coded Procedure and Procedure Status (SNOMED CT) data item. The following national codes should be used to record the type of CTR (i.e. inpatient, community or post admission)

MHSDS Table	MHSDS Data Item Name	National code	Notes
MHS202 Care Activity	Coded Procedure and Procedure Status (SNOMED CT)	1060751000000101	SNOMED code for Community CTR (procedure). Defined as a CTR taking place in the community where a person is facing potential admission to a specialist learning disability or mental health inpatient setting. Where the patient is subsequently admitted to hospital, a Community Care and Treatment Review is defined as one which is undertaken up to 2 weeks before the inpatient admission.
MHS202 Care Activity	Coded Procedure and Procedure Status (SNOMED CT)	1060761000000103	SNOMED code for Post admission Care and Treatment Review (procedure). Defined as a CTR taking place within 4 weeks of the date of admission (or 2 weeks after the date of admission for children/ young people under 18).

¹ For further information on the scope of MHSDS please see the latest MHSDS Requirements Specification at <https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0011-mental-health-services-data-set>.

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MHS202 Care Activity	Coded Procedure and Procedure Status (SNOMED CT)	1060741000000104	SNOMED ² code for Inpatient Care and Treatment Review (procedure). Defined as a CTR taking place at any point more than 4 weeks after the date of admission (or 2 weeks after the date of admission for children/young people under 18 years) .
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Organisations whose local systems are not fully SNOMED CT compliant should still submit this data to MHSDS by undertaking manual mapping of data to SNOMED CT terms. For more guidance on the use of SNOMED CT in MHSDS, including additional links to national SNOMED guidance, please see the MHSDS User Guidance at the above link.

A CTR is different from a Care Programme Approach (CPA) review which is recorded in Table MHS702. In practice, CTRs inform the CPA review but CTRs should be recorded separately in Table MHS202 (Care Activity).

Reporting of CTR data is included in the NHS Digital monthly Learning Disability Services Statistics and will develop over time as reporting improves:

<https://digital.nhs.uk/data-and-information/publications/statistical/learning-disability-services-statistics>

Current reporting by NHS Digital includes which providers have submitted CTR data to MHSDS and the number and type of CTRs reported in the month for each.

² SNOMED indicates Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®)

15. Hospital Discharge Good Practice Standards

The CTR policy outlines good practice in relation to discharge planning as follows. More detailed steps are contained in the CTR policy appendix: www.england.nhs.uk/publication/care-and-treatment-reviews-policy-and-guidance

Good Practice Standard	How will it be measured?
<p>1. I have a named discharge facilitator in hospital, who is a member of my multidisciplinary team (MDT). This person will help me with my discharge planning - with me and the people I choose.</p>	<p>This person is named on my admission document</p>
<p>2. I have a named CPA community care coordinator from the community team. This person makes sure all my health and social care needs are met after I leave hospital and works closely with me and others to plan my discharge, and have an important role in carrying out actions agreed as part of my CPA and C(E)TR meetings.</p>	<p>Named on my admission and discharge documents</p>
<p>3. I have a named social worker who will support my discharge into the community. (This person may also be my CPA Care Coordinator)</p>	<p>Named on my discharge plan</p>
<p>4. I am supported to be involved in my discharge planning and in making plans for my future with the people who are involved in and important to my care and support. I will have a copy of a discharge plan that is easy to understand, that shows the stages in my discharge plan, who is responsible for what, and by when. An easy read Leaving Hospital Planner and an Independence Pack³.</p>	<p>'Me and my family' will give feedback about how people responsible for my care involve us in discharge planning. There will be a questionnaire for us to fill in from the provider. My discharge plan will show how involved I am too.</p>
<p>5. Keeping in touch with friends and family: While I am in hospital I will have support to maintain my relationships with the family and friends I choose to. This will help me when I leave hospital.</p>	<p>There will be a questionnaire for us to fill in from the provider, written in a way we can understand.</p>
<p>6. I will have a named advocate who is independent of the people who provide my care. This person knows me well and helps me speak up or speaks up for me.</p>	<p>This person is named on my discharge plan and on my admission document.</p>

³ www.changepeople.org/blog/february-2016/independence-pack

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<p>7. While I am in hospital and before I am discharged, I will have full and regular reviews of my medication to make sure I am not taking medicines that I don't need and to find other ways of helping me.</p>	<p>Medication reviews will be shown on my discharge documents, letters to or from my GP, responsible clinician and community team.</p>
<p>8. Meetings held to plan for my future will include my hopes and wishes and will include the people I want to be there. Meetings will be easy to understand so I can take part. Information will be provided in a way I can understand. Future plans will also support any needs I have that are caused by my experiences before or in hospital (e.g. trauma). Plans will include what extra support needs I have because of this while supporting me to be as independent as possible.</p>	<p>I will give feedback about how this goes. There will be a questionnaire for me to fill in from the provider, written in a way I can understand.</p>
<p>9. The Responsible Clinician (RC) will support my discharge, offering advice and guidance to the discharge facilitator and both inpatient and community multidisciplinary teams (MDT) during my admission. The RC will be active in dealing with the Ministry of Justice if this applies to me. The RC will work closely with me and my family to support my future community package. The RC will make sure actions from Care and Treatment Reviews are carried out. The RC will also work with the community team doctor who will provide my future health care.</p>	<p>'Me and my family' will be able to ask the RC how all these things are going.</p>
<p>10. Planning for my future life outside of hospital while I am in hospital. Plans put in place to support me in hospital will also support me to make a good move into the community. This could include being supported to take more risks as I grow in confidence, skills and independence.</p>	<p>Care plans will show how I am gaining in confidence, skills and independence for leaving hospital.</p>

For more information

Please visit www.england.nhs.uk/ctr

Information about other work of the NHS England Learning Disability Programme can be found at www.england.nhs.uk/learningdisabilities

This includes:

Transforming Care – ensuring that people with a learning disability, autism or both receive the support they need in the community to reduce the number of people needing care and treatment in specialist learning disability hospitals

www.england.nhs.uk/learningdisabilities/care

STOMP – stopping the over medication of people with a learning disability, autism or both with psychotropic medicines www.england.nhs.uk/stomp

Ask Listen Do – making it easier for people with a learning disability, autism or both and families to give feedback, raise a concern or make a complaint in health, social care or education www.england.nhs.uk/asklistendo

Annual Health Checks and other GP initiatives – for people with a learning disability www.england.nhs.uk/annual-health-checks

NHS RightCare Pathways – joint work with NHS RightCare Pathways to improve health outcomes and make it easier for people with a learning disability to receive the care they need for diabetes, dysphagia, epilepsy, heart disease and other conditions

www.england.nhs.uk/rightcare2

Mortality Review – also known as the LeDeR Programme, a local process for reviewing the deaths of people with a learning disability

www.england.nhs.uk/mortality-review

Mental Health Services Data Set - Full guidance on data requirements and how to submit can be found at: <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/how-do-i-submit-data-to-the-mental-health-services-data-set>