Dynamic Support Registers and Commissioning Duties

This is a write-up of discussions held during the Challenging Behaviour – National Strategy Group national meeting on May 1st. These discussions were facilitated by Dave Williams, Head of Learning Disabilities at Northern Care Alliance NHS Foundation Trust.

Participants in these discussions included family carers, support providers, housing providers, commissioners, learning disability nurses, psychologists, psychiatrists, legal professionals, researchers, VCSE representatives, and representatives from both adults and children's learning disability and autism services from local government/ICBs. Attendees had experience of DSRs from both personal and professional perspectives.

Key Findings

- Contrary to the initial aims of Dynamic Support Registers (DSRs), they are too often a reactive crisis response as opposed to a proactive way of providing support to avoid this
- There needs to be clearer communication to individuals, their families, and professionals setting out what DSRs are and what the benefits of inclusion are, to tackle a) reluctance of individuals/families to consent to inclusion, and b) a lack of knowledge by professionals
- Examples of inclusion on the DSR being used inappropriately as a trigger for eligibility for particular services were shared – Manchester's use of an integrated health and care budget was shown as an example of how this can be tackled
- Attendees identified a gap in the new duty to have regard to DSRs that is included in the Mental Health Bill, which is that as the local authority duty only applies to market functions (a duty under the Care Act 2014) and not commissioning functions, the duty does not cover children and young people

Barriers – what factors prevent Dynamic Support Registers from working effectively

> *"Basically, the DSR is only as good as the services that are in place."* - VCSE representative

Reactive rather than proactive

A major topic of conversation was that Dynamic Support Registers, which were designed to be proactive in preventing admission and allowing access to support, are in practice in many cases being used as a reactive measure. Members of the group who had been involved in developing DSRs as a model when they were first conceived stated that the original conceived purpose of DSRs – to fast-track people with complex needs to additional support – was not in practice occurring.

> *"My main concern is you have to show such deterioration to get onto the register, which is not what it was originally designed for"* - Family carer

Family carers shared experiences of their relatives only being able to access support when they reach 'red'[1] on the Dynamic Support Register. This was attributed to a lack of resources; without sufficient resources to meet all needs, local areas are waiting until someone reaches crisis to intervene. Alongside a general lack of resources, the reactive nature was also attributed to recent cuts to specialist services for people with a learning disability and autistic people, which included both clinical support and services such as housing and respite.

'Gatekeeping support'

[1] The four levels of a DSR are:
Green – there are some risks that could lead to someone being (re)admitted to a mental health hospital, but these are being effectively managed
Amber – there will be an immediate risk that the person will be admitted to a mental health hospital without urgent intervention, and there may be a significantly increased risk of the person becoming mentally unwell and/or placement/family breakdown
Red – there is an immediate risk that the person will be admitted to a mental health hospital, the person/their family are experiencing a crisis and the risk(s) of admission are not being/cannot be managed in the community
Blue – individual is currently in an inpatient service
https://www.england.nhs.uk/wp-content/uploads/2023/01/Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide.pdf

Linked with the above, both families and professionals were concerned that DSRs operate as a form of gatekeeping of support, where children, young people and adults with a learning disability and/or who are autistic cannot access support or specific services unless they are on the DSR. Attendees felt that this had turned DSRs from a preventative/supportive measure (as they were initially conceived) to being another barrier to accessing support. This was exacerbated by difficulties with getting on the DSR; several families stated that they had found it difficult to get their relative on the DSR which was a barrier to them being able to access support prior to experiencing crisis.

An example was shared by one attendee, who had been in contact with a family experiencing crisis who wanted their relative to be included on the DSR but were having difficulty in achieving this. Having researched eligibility for services in their area, the family found that being on the DSR in that area was a potential trigger for specific funding; the family believed that the reason they had been unable to get their relative included on the register was because the local area did not want to be responsible for providing this particular funding.

Related to this, attendees highlighted that due to services having difficulty meeting demand, being on a DSR does not necessarily result in the individual being able to access additional support until they reach crisis.

> *"Mental health services, at this point in time, are really struggling to cope with the rising demand. And actually, if we're putting young people on a register, are we just creating another waiting list when there's so many difficulties in accessing support?"*
> - VCSE representative

<u>Issues identifying people who should be on the DSR</u>

Attendees highlighted multiple examples where people have been missed from the DSR. This was particularly the case for people who had not been diagnosed as autistic/as having a learning disability, or were on a waiting list for diagnosis. Linked with the problem of DSRs being reactive as opposed to proactive, people are not being identified as needing to be on the DSR until they are already admitted to hospital. Attendees were keen for work/research to explore how people who may need to be on the DSR could be identified earlier, and what mechanisms could be used to trigger consideration of whether an individual should be on the DSR – e.g., if someone is on a waiting list for diagnosis, should this be a trigger?

<u>Individual/family reluctance to consent to inclusion</u>

While some families shared experiences of not being able to get their relative included on the DSR, other families expressed reluctance for their relative to be included. This was supported by various professionals who had worked with families. This reluctance was attributed to:

- Inclusion being seen as 'tacit acceptance' that the person could be (re)admitted
- DSRs perceived as another (waiting) list
- Benefits/impacts of inclusion not being effectively conveyed to the individual/their family

> *"There needs to be more widespread communication about what the DSR is and how they can help, because if people are refusing it before they're even put on, you're not going to get the help that you could maybe get before it escalates to inpatient admission."* - Family carer

As well as the need to better communicate what DSRs are and the benefits of being included to individuals who are autistic/have a learning disability and their families, attendees highlighted gaps in professional knowledge which also need addressing. Social workers were identified as a profession where increasing knowledge of the DSR could be particularly beneficial as they are often the main, or a major, point of contact between the individual/their family and the services that support them.

<u>Separation between DSRs and other parts of the system</u>

Attendees working within the system stated from experience that DSRs are isolated from other parts of the system such as complex care responses.

> *"It feels like it's a process on its own, rather than feeding into the wider system"* - Local authority representative

Conversely, in areas where the DSR is integrated effectively with other community infrastructure, attendees have found it to be much more effective as a gateway to elements of support that help prevent crisis and admissions.

Ways to maximise benefits of DSRs being put on a statutory footing

<u>Using DSRs as a mechanism to identify whether there is strong community support in place</u>

As changes to detention criteria will not be enacted until there is strong community support in place, attendees highlighted that as well as being a mechanism for ensuring community support (e.g., through the new commissioning duties), DSRs could be used to facilitate capturing information that would enable judgements on whether strong community support is in place to be made. Attendees recommended exploring whether metrics could be tied to the DSR, and/or whether the DSR could be used to identify if there are particular gaps in services in a particular area.

Clearer linking of duties to different levels of the DSR

Attendees recommended making it clearer what level of support should be provided at each DSR level. This could involve coproducing guidance with people with lived experience and family carers that sets out:

- What constitutes a 'green', 'amber' or 'red' risk of hospital admission
- Factors to look out for that could indicate whether someone was at risk of moving up a level

A related recommendation was that inclusion on a DSR could unlock a pot of preventative funding, similar to the Independent Living Fund, which would enable people with particularly complex needs who are at risk of admission to access preventative funding to avoid this.[2] This was highlighted as particularly necessary given that people with a learning disability/autistic people who do not have a mental health condition will no longer be eligible for section 117 funding (which is viewed as a key mechanism for getting suitable community support, such as housing) once the changes to detention criteria come into force.

However, attendees recognised that producing clearer guidance/duties setting out what support should be provided at each level could further disincentivise local areas from adding people to the DSR (as they would then be required to put in place this support), and could also create an additional barrier to those who are not on the DSR being able to access the support they need. A suggestion of how to overcome this was to integrate health and social care budgets, so that financial responsibilities/burdens are shared.

This has been implemented successfully in Manchester. Alongside integrated health and social care budgets, Manchester also uses a broader definition of who should be included on their DSR – for example, they include people whose family carer has a health issue, as if

[2] A proposal for what this could look like is in development and can be shared.

this health issue were to deteriorate and they were no longer able to provide care, the individual could be at risk of admission.

Extending local authority duties to cover children and young people

The Mental Health Bill will place a duty on local authorities to "have regard" to their local DSR when carrying out their "market duties". These are duties imposed by the Care Act 2014, and therefore do not apply to services for children and young people, who are also required by law to be included on the DSR. Extending the duty on local authorities to also cover children and young people's services would increase the effectiveness of the DSR as a mechanism to prevent crisis/admission.