North East London CCGs

Guidance for the operation of local Dynamic Risk Registers and Care (Education) and Treatment Reviews during the COVID-19 pandemic

1.   Introduction

1.1   This guidance has been developed in response to the COVID-19 pandemic, and sets out a temporary structure for the operation of Dynamic Risk Registers (DRRs) and Care (Education) and Treatment Reviews (CTRs) by the North East London CCGs.

1.2   It is expected that as far as possible, NEL CCGs will continue to operate their DRR systems as per business as usual; however there will be factors relating to the current pandemic that will require temporary adjustments to some local policy.

1.3   This guidance is designed to be read in conjunction with local C(E)TR policy and should be used to support and supplement decision making during the pandemic.

2.   Operation of local Dynamic Risk Registers

2.1   Criteria for being added to the DRR

2.1.1   Each borough will have a list of indicative criteria to determine when someone with a learning disability and/or autism should be added to the local DRR. This criteria is not exhaustive and it is expected that clinical judgement should be used to assess whether an individual is in need of enhanced support.

2.1.2   During the pandemic it is expected that the following factors are also considered when exploring whether a case should be added to the local DRR:

- Has the person undergone a significant change to their routine and/or access to usual support avenues?
- Is the person at risk of their placement or home environment destabilising (for example, if there is an outbreak at a service or if their carer has fallen ill)?
- Is the person particularly anxious or stressed by the current situation?
- Is the person seeing an increase in the frequency or intensity of episodes of challenging behaviour as a result of current pressures?
- Has the person experienced distress as the result of illness or death of someone close to them?

2.1.3   As circumstances are changing rapidly it is recommended that at this time the holders of the DRR consider a lower threshold for adding someone to the register than they usually would. This is to ensure that those managing the register are familiar with cases who may experience stress or breakdown, and will therefore be able to intervene quickly if required.

2.2   Obtaining consent

2.2.1   It remains necessary for consent to be obtained from the patient (or, if they do not have capacity, consent from the person with legal power to act on their behalf). Explaining the concept of the DRR in order for the patient to give informed consent

usually falls to the professional who works most closely with them, such as their social worker.

2.2.2 As face to face visits may be limited at this time, professionals are strongly encouraged to send information (in easy read format where appropriate) to the patient for them to review at home so they are able to make an informed decision, and supplement this with conversations via telephone or video link if needed.

2.3 DRR review

2.3.1 Where this has not taken place already, each borough is asked to review their caseloads and consider if there are any individuals who should be referred to the DRR due to changes in their situation or stresses caused by the current pandemic. It should also be considered if cases currently on the DRR require a change in RAG rating due to changes in risk.

2.3.2 This is particularly relevant to children and young people who have been unable to attend school. Government guidance states that all children and young people with learning disabilities and/or autism who are not attending school need to be appropriately monitored; it is also recognised that those returning to school in September may find this experience more stressful than in previous years. Those holding CYP DRRs should therefore work with education colleagues to ensure that cases are referred to the DRR if enhanced support is required.

2.3.2 Each borough is asked to review the governance processes around their DRRs for both adults and children, and ensure that assurance meetings are taking place on a regular basis.

2.4 Levels of risk

2.4.1 Each borough will have their own levels of risk stratification used in the management of the DRR. It is not proposed that these be changed at this time, however when RAG rating cases professionals are asked to consider the factors outlined in section 2.1 and whether this may have an impact on the level of risk.

2.5 When to trigger a community C(E)TR

2.5.1 Local policy will outline when a community C(E)TR needs to be triggered. This is usually when a person is rated red on the DRR, or in some cases when they are amber but professionals agree that they need intervention to prevent the risk from escalating.

2.5.2 At this time, professionals are asked to consider the impact of the pandemic as one of the factors when deciding whether to convene a C(E)TR. Some of the questions that may need to be considered include:

- Is the person able to access their network of support as they usually would?
- Are there difficulties in the person accessing assessments or services they may need (for example, are they struggling with telephone or video appointments)?
- Is the person unable or unwilling to comply with the rules of lockdown, and is there police involvement because of this?
- Has there been a significant change in the person's behaviour, and do their family or support workers have the necessary strategies to manage this?

2.5.3   It should also be recognised that the lack of access to routine and usual types of support may mean that situations can escalate quickly. As such professionals are asked to considering having a lower threshold for calling a C(E)TR if they feel that intervention from an independent panel would be beneficial.

3.   Care (Education) and Treatment Reviews

3.1   Changes to Care (Education) and Treatment Reviews (C(E)TRs) during the COVID-19 pandemic

3.1.1   All C(E)TRs will be held virtually until further notice. If possible video conferencing is preferable, however teleconferencing is also an option. The format of the C(E)TR will be directed by the commissioner, dependent on patient preference and the technology available.

3.2   Patient involvement

3.2.1   Wherever possible and in line with the person's wishes, patients and their family should be invited to join the C(E)TR.

3.2.2   It is recognised that this is not possible for everyone, particularly patients who may not be comfortable with technology. In these cases the commissioner is encouraged to work with people who know the patient well to think about ways they can be involved. This could include:

- The commissioner or expert by experience arranging a time for a one to one call with the patient;
- A family member, advocate or support worker meeting with the patient before the C(E)TR to capture their views, and sharing this prior to the meeting; or
- Encouraging the patient to fill in the entire CTR planner, to be shared with the chair prior to the C(E)TR.

3.2.3   Where time allows, the chair or administrator should send the patient material to help prepare for their C(E)TR. This should include the CTR planner, and easy read information about the virtual C(E)TR and who will be on the call.

3.2.4   If possible, the patient should be given space to take part in the C(E)TR (or one to one conversation) without supervision so that they can raise any concerns they may not wish to discuss in front of family or support staff. It is recognised that this will not be able to happen in all circumstances (e.g. if the patient is on 1:1), but the provider should be asked to facilitate this wherever possible.

4.   Cover and contingency arrangements

4.1   It is recognised that over the next few weeks there may be an impact on staff availability to deliver C(E)TRs, both chairing and administrative support.

4.2   Where only one commissioner is available in a CCG to chair C(E)TRs, a second should be named. This may be a colleague, a manager, or a C(E)TR co-ordinator with the skills to step up. If there are any training needs required to support these individuals, the programme team will facilitate this.

4.3   ONEL boroughs (Barking & Dagenham, Havering and Redbridge) have two TCP project officers available to support C(E)TR co-ordination. INEL boroughs are

supported by one C(E)TR co-ordinator currently hosted by Waltham Forest CCG; any requests to access this resource should go through the lead commissioner.

4.4   The programme team will be available to chair or administrate C(E)TRs as necessary if local capacity is not available; any requests for this should go to nel.lda@nhs.net

5.   Quality monitoring and 6-8 week visits

5.1   6-8 week visits may not be able to take place in their usual formats at this time. Commissioners will need to consider the best way to undertake quality visits and include telephone and virtual contact, reviews of paperwork and feedback from patients and families. All 6-8 week contacts should be recorded on the Care Room spreadsheet.

5.2   The host commissioner model has now been implemented nationally. Where commissioners have identified concerns as part of the 6-8 visits, C(E)TRs or other avenues, they must follow the host commissioner guidance and escalate as required.

6.   Governance and review

6.1   This guidance will be reviewed on a monthly basis, or more frequently if needed, in response to rapidly changing service demand.

Last reviewed: 08/09/2020