DEPARTMENT FOR HEALTH AND SOCIAL CARE WINTER GUIDANCE, ISSUES FOR LOCAL AUTHORITIES

Siân Davies

Adult Social Care: Covid-19 Winter Plan 2020 – 2021[1]

This note provides an overview of the Department of Health and Social Care (non-statutory) guidance issued on 18 September 2020. It applies to England only.[2]

The Guidance is aimed at Local Authorities ("LAs"), NHS organisations, care providers and the CQC. For LAs it should be read alongside the Adult Social Care Action Plan (April 2020),[3] updated Visiting Guidance (21 September 2020)[4] and ADASS guidance.[5]

Contents

1 https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021/adult-social-care-our-covid-19-winter-plan-2020-to-2021

2 Health and Social Care are devolved: Wales has published its own Winter Protection Plan for Health and Social Care 2020 to 2021 https://gov.wales/winter-protection-plan-health-and-social-care-2020-2021

3 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879639/covid-19-adult-social-care-action-plan.pdf

4 https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus/update-on-policies-for-visiting-arrangements-in-care-homes

5 https://www.adass.org.uk/cohorting-zoning-and-isolation-practice-commissioning-for-resilient-care-home-provision-sept-2020

The Government's three overarching priorities for adult social care are described as:

- ensuring everyone who needs care or support can get high-quality, timely and safe care throughout the autumn and winter period.
- protecting people who need care, support or safeguards, the social care workforce, and carers from infections including Covid-19.
- making sure that people who need care, support or safeguards remain connected to essential services and their loved ones whilst protecting individuals from infections including Covid-19.

Interplay with the well-being principles of the Care Act 2014

The key issue for local authorities is the need to manage a potential conflict in terms of the wellbeing of both care home residents and those in the community with care and support needs as regards prevention of C-19, and the detrimental impact that prolonged periods without community access and visits from family and friends may have on their mental health.

The Winter Guidance addresses actions to LAs, care providers and the NHS as regards the former (pre-discharge testing, infection control measures in care homes, limiting staff movement between settings and PPE). On the latter, the DHSC states that it will distribute tablet devices to care homes that are in greatest need, so that care home staff can access remote health consultations for the people in their care. This will also support care home residents to stay connected with their families and loved ones. Technical and user support will be provided to set up the devices for use by care providers.

Social Prescribing (a bridge between health and social care) is addressed as a means of supporting those who are shielding, or who are in receipt of social care services, to maintain their independence by:

- conducting welfare telephone and/or video calls
- coordinating medication delivery or pick up with pharmacists.
- facilitating community support (such as food and shopping).
- connecting people to support social and emotional needs, including through use of digital platforms.
- supporting voluntary organisations and community groups to develop their virtual support.

The reliance on digital support is understandable in current circumstances but fails to engage with the needs of those for whom remote contact, either with professionals or family members, is inaccessible or insufficient to meet identified needs.

On the issue of visits to those in care homes, the Winter Guidance refers to the (now updated) Visiting Guidance which requires a risk-assessment based approach to family members attending care homes to visit residents. Overall, the Winter Guidance is clear that the "first priority remains to prevent infections in care homes and protect staff and residents".

The Guidance does not engage with the effect of this on the duty of a LA, in exercising functions under the Care Act 2014, to promote the well-being of an individual.

Well-being includes physical and mental health and emotional well-being, control by the individual over day-to-day life, participation in work, education, training or recreation, domestic, family and personal relationships and the individual's contribution to society [s.1(2)]. Under s.1(3), In exercising a function under this Part in the case of an individual, a local authority must have regard to the matters which include:

a) the importance of beginning with the assumption that the individual is best-placed to judge the individual's well-being,

b) the individual's views, wishes, feelings and beliefs,

c) the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist,

d) the need to ensure that decisions about the individual are made having regard to all the individual's circumstances,

e) the importance of achieving a balance between the individual's well-being and that of any friends or relatives who are involved in caring for the individual, and

f) the need to ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary for achieving the purpose for which the function is being exercised.

Many of these well-being factors are "in play" where an individual is in a care home or community setting and is restricted from access to friends, family, community resources and leisure/ recreation activities. It is not difficult to see how those restrictions are capable of exacerbating existing mental and physical ill health.

The Winter Guidance makes clear that the Care Act easements under the Coronavirus Act 2020 are to be exercised only when absolutely necessary.

What is not addressed is the apparent inconsistency of prioritising infection control over potentially conflicting well-being factors under s.1 Care Act 2014.

WINTER PLAN – IMPLICATIONS FOR THE RIGHT TO RESPECT FOR FAMILY AND PRIVATE LIFE

Steve Broach

Throughout the Covid-19 pandemic, as set out above, there has been a significant tension between the imperative to protect the health of social care users (and the social care workforce) and the need to respect the family life and private life rights of those who might be subject to protective restrictions. At certain points in the pandemic, some local areas and institutions have implemented 'blanket bans' on visiting in a way which is likely to be disproportionate and therefore contrary to Article 8 of the European Convention on Human Rights. Where these measures are adopted or supported by public authorities, this will in turn breach section 6 of the Human Rights Act 1998, which requires public bodies to act in accordance with ECHR rights.

The Winter Plan continues the English government's approach of treating decisions relating to restrictions on family and private life rights as a matter of local discretion. For instance, the 'key actions' section of the Plan includes the following: *'local authority directors of public health should give a regular assessment of whether visiting care homes is likely to be appropriate within their local authority, or within local wards, taking into account the wider risk environment and immediately move to stop visiting if an area becomes an 'area of intervention', except in exceptional circumstances such as end of life.'*

Importantly, the Plan states that *'local authorities and NHS organizations should continue to put co-production at the heart of decision-making, involving people who receive health and care services, their families, and carers.'* This involvement should extend to the production of the winter plan which is required for each local area; the Plan states *'local authorities must put in place their own winter plans, building on existing planning, including local outbreak plans, in the*

context of planning for the end of the transition period, and write to DHSC to confirm they have done this by 31 October 2020.'

As such, it appears that it is a matter for local areas whether care home visits can continue generally through the winter of 2020-21, unless an area becomes an 'area of intervention' when visits should only be permitted at end of life or in other exceptional circumstances (the Plan later clarifies that end of life visits should be permitted *'In all cases'*). The Plan is silent as to what the approach should be to visits in other settings, most obviously supported living settings. However, it can reasonably be assumed that the government expects a similar approach to be adopted to that in care homes.

The Plan goes on to state that *'care home providers should develop a policy for limited visits (if appropriate), in line with up-to-date guidance from their relevant Director of Public Health and based on dynamic risk assessments which consider the vulnerability of residents. This should include both whether their residents' needs make them particularly clinically vulnerable to COVID-19 and whether their residents' needs make visits particularly important.'* Again, significant discretion is given to individual providers, who will need to ensure that any restrictions on visiting placed on their residents and family members are proportionate. Providers are informed that *'Social workers can assist with individual risk assessments, for visits, and can advise on decision-making where the person in question lacks capacity to make the decision themselves.'* However this may prove to be a rather optimistic statement, given the limited capacity of many local authority adult social care teams.

There is a discrete section of the Plan, headed *'Visiting guidance'*. This section reiterates *'for avoidance of doubt'* that *'any area listed by Public Health England's surveillance report as an 'area of intervention' should immediately move to stop visiting, except in exceptional circumstances'* which would presumably include end of life visits as referred to above. However outside areas of intervention, the Plan is more permissive, stating *'we continue to encourage providers to find innovative ways of allowing safe contact between residents and their family members'*.

The Plan cross refers to separate visiting guidance for care homes: https://www.gov.uk/government/publications/visiting-care-homes-during-coronavirus/update-on-policies-for-visiting-arrangements-in-care-homes

and supported living: https://www.gov.uk/government/publications/supported-living-services-during-coronavirus-covid-19/covid-19-guidance-for-supported-living

Care home providers are also given the following specific guidance on visiting in the Plan:

> *'ensure the appropriate PPE is always worn and used correctly – which in this situation is an appropriate form of protective face covering (this may include a surgical face mask where specific care needs align to close contact care) and good hand hygiene for all visitors*
>
> *limit visitors to a single constant visitor wherever possible, with an absolute maximum of two constant visitors per resident to limit risk of disease transmission*
>
> *supervise visitors at all times to ensure that social distancing and infection prevention and control measures are adhered to*
>
> *wherever possible visits should take place outside, or in a well-ventilated room, for example with windows and doors open where safe to do so*
>
> *immediately cease visiting if advised by their respective director of public health that it is unsafe'*

It would perhaps have been helpful if the Plan acknowledged the human rights implications of restrictions on visiting for service users and their family members, and the need for such measures to be proportionate to the risks they are addressing in order to avoid a human rights breach. However it is undoubtedly welcome that

the Plan does not provide any support for blanket bans on visiting in care homes, outside 'areas of intervention'. Still less is there any support in the Plan for local areas or providers imposing restrictions on service users leaving their care setting, otherwise than in accordance with the regulations on guidance on self-isolation as applies to the general population. It remains unclear though why a national Plan like this is focused solely on care homes, ignoring the reality that many social care service users (particularly younger people) will be living in supported living arrangements.

Finally, the private life rights of many disabled people (including their 'psychological integrity' or well-being) have also been negatively affected by the closure of many services. As such it is welcome that the Plan states (twice!) that *'local authorities should work with social care services to re-open safely, in particular, day services or respite services. Where people who use those services can no longer access them in a way that meets their needs, local authorities should work with them to identify alternative arrangements.*'

WINTER PLAN: IMPACT ON THE DEPRIVATION OF LIBERTY SAFEGUARDS

Neil Allen

The Plan requires Directors of Adult Social Services and Principal Social Workers to ensure their social work teams and partner organisations are applying, *inter alia,* the Mental Capacity Act framework, to review any systemic safeguarding concerns to date and ensure actions are in place to respond, and to support adult social care to apply statutory safeguarding guidance with a focus on person-led and outcome-focused practice.

Of particular relevance to DoLS is that all those discharged from hospital or interim care facilities to care homes, and all new residents admitted from the community, should generally be isolated in their own rooms for 14 days. This is required regardless of whether they have symptoms, and whether they have tested positive. The purpose is to minimise the risk to care home residents during periods of sustained community transmission of Covid-19 and accords with other updated guidance. Everyone should be tested before being discharged from hospital to a care home and such discharge should not take place without the involvement of the local authority.

A similar 14-day isolation expectation is in place for hospital discharge to supported living settings or their own home. Care home visits are considered elsewhere but we note that constant visitors should be supervised at all times to ensure social distancing and should, wherever possible, take place outside or in a well-ventilated room.

The guidance recognises that "people with dementia or a learning disability, autistic people, and people experiencing serious mental ill health are likely to experience particular difficulties during the pandemic. This could include difficulty in understanding and following advice on social distancing, and increased anxiety. They may need additional support to recognise and respond to

symptoms quickly, and in some cases may be at greater risk of developing serious illness from Covid-19." We anticipate that such "additional support" may require measures to ensure they remain in their bedrooms.

In addition to this guidance, the Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020 requires those testing positive, or a notified close contact of the same, must self-isolate for 10-14 days depending on the circumstances. Failing to do so without reasonable excuse is an offence, with the Regulations making no provision for those with impaired decision-making capacity.

In these circumstances, does 14-days isolation constitute a deprivation of liberty for Article 5 ECHR purposes? Those with capacity will not be deprived of their liberty if they consent to their self-isolation. Those with capacity who refuse to self-isolate could, with reasonable force, be returned to their homes or another suitable place. As such, they are not 'free to leave' but – like guardianship – there is an absence of continuous supervision and control. The matter could, of course, be different if there was such supervision and control.

For those who lack the relevant capacity, and whose needs require continuous supervision and control, 14-day bedroom isolation seems to be more than a negligible period and accordingly would constitute a deprivation of liberty. It seems, therefore, that those lacking such capacity who are admitted to care homes – whether from hospital or the community – and are required to self-isolate for that period, with additional support required as a result of mental disorder to enable them to do so, ought to be subject to DoLS. Unless discharged from residential care, such safeguards are likely to be required in most cases beyond the 14-day period in any event. There has been a significant drop in liberty safeguards during the pandemic which must be addressed as we go through this Winter of increasing confinement.

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