Reference Guide

Care Act easements:

Proposed operating model and procedure for adult social care

 No: 0 - (April 2020)

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| **1.0 Introduction** |

The Coronavirus Bill became law on 25th March 2020, now known as the Coronavirus Act 2020. It has implications for adult social care because the measures it contains will enable authorities to prioritise resources, if necessary, should they be unable to meet their statutory duties in full if demand spikes and staffing resources shrink significantly as the Covid-19 pandemic reaches its peak. These are time limited measures and are to be used as narrowly as possible.

This document aims to provide a summary of the operating model for adult social care if the Local Authority decides to operate all of some of the measures set out by the Coronavirus Act 2020. The Act can be viewed by this link:[**http://www.legislation.gov.uk/ukpga/2020/7/pdfs/ukpga\_20200007\_en.pdf**](http://www.legislation.gov.uk/ukpga/2020/7/pdfs/ukpga_20200007_en.pdf)

This policy is based on the Care Act easements guidance for Local Authorities:

[**https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities**](https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities)

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| **2.0 Purpose of the easements** |

The easements took legal effect on 31st March 2020 but should only be implemented by Local Authorities where essential to do so. The purpose is to ensure the best possible provision of care to people in these exceptional circumstances. Local Authorities should comply with the pre-amendment Care Act provisions and related Care and Support statutory guidance for as long and as far as possible.

**Key duties which remain in place:**

* Care Act duties:
	+ to promote wellbeing
	+ relating to prevention and provision of information and advice
	+ involve the person and carers in any decisions about revising / changing their care and support plans
	+ relating to safeguarding adults. Further guidance on safeguarding is detailed here (*link to guidance)*
* Duties in the Mental Capacity Act 2005 relating to Deprivation of Liberty Safeguards (DoLS) remain in place.
* Duties imposed under the Equality Act 2010 also remain, including duties to make reasonable adjustments, the Public Sector Equality Duty and duties towards people with protected characteristics. These should underpin any decisions made about the care and support someone receives during this period

The principles set out in the [Responding to COVID-19: the ethical framework for adult social care](https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care/responding-to-covid-19-the-ethical-framework-for-adult-social-care)  should guide and underpin our decision making during this time:

* Respect
* Reasonableness
* Minimising Harm
* Inclusiveness
* Accountability
* Flexibility
* Proportionality
* Community

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| **3.0 Main changes** |

The changes fall into four key categories, each applicable for the period the powers are in force:

1. Local Authorities will not have to carry out detailed assessments of people’s care and support needs in compliance with pre-amendment Care Act requirements. However, they will still be expected to respond as soon as possible (within a timeframe that would not jeopardise an individual’s human rights) to requests for care and support, consider the needs and wishes of people needing care and their family and carers, and determine what care needs to be provided.
2. Local Authorities will not have to carry out financial assessments in compliance with pre-amendment Care Act requirements. They will have powers to charge people retrospectively for the care and support they receive during this period, subject to giving reasonable information in advance about this, and a later financial assessment.
3. Local Authorities will not have to prepare or review care and support plans in line with the pre-amendment Care Act provisions. They will however still be expected to carry out proportionate, person-centred care planning which provides sufficient information to all concerned. Where they choose to revise plans, they must also continue to involve users and carers in any such revision.
4. The duties on Local Authorities to meet eligible care and support needs, or the support needs of a carer, are replaced with a power to meet needs. Local authorities will still be expected to take all reasonable steps to continue to meet needs as now. In the event that they are unable to do so, the powers will enable them to prioritise the most pressing needs.

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| **4.0 People and carer needs/conversations**  |

The Local Authority will continue to consider people’s and carer’s needs and the easements will only apply if it is no longer possible to carry out the pre-amendment Care Act duties in full.

There is a duty to meet needs where failure to do so would breach an individual’s human rights under the European Convention on Human Rights.

The Coronavirus Act enables Local Authorities to be able to reduce the extent to which they would ordinarily do a needs or carers conversation, check people are eligible or conduct a financial assessment. This also applies to those young people transitioning to adult social care under sections 58 and 59 of the Care Act. All conversations and Keeping in touch conversations (including carer conversations) which are delayed or not completed will be followed up and completed in full once the easements are terminated.

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| **5.0 Governance and implementation of Care Act easements** |

During this period local authorities may need to take difficult decisions that impact on the way they respond to their responsibilities for care and support and their statutory functions.

National guidance recommends that there should therefore be clear professional oversight and, where relevant, professional sign-off for such decisions as well as evidence that due consideration has been given to the possible consequences.

Recording any decisions is crucial to ensure accountability and provide evidence for the thought process behind the decision making.

Any decision to implement a Care Act easement would need to be agreed through consultation with the Principal Social Worker and the Director of Adult Services (DASS). In addition to the national guidance the DASS has, in recognising the potential or perceived potential, power imbalance between himself and the Principal Social Worker, requested and agreed in principle that the Monitoring Officer for the Council would review any decision in order to provide an additional level of assurance that there is evidence to justify that all steps have been taken to mitigate a move into the next stage and that there is a sound legal basis to move to that position.

Oversight and governance arrangements at each stage of implementing Care Act easements are detailed in the relevant sections of this procedure

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| **6.0 Decision making tables and proposed operating models** |

The associated guidance published 31st March 2020 defines the steps local authorities should take before exercising the Care Act easements including that these should only be exercised when the workforce is **significantly depleted**, or **demand increased** to an extent that it is no longer reasonably practicable to comply with Care Act duties and where to continue to try and do so is likely to result in urgent or acute needs not being met, potentially risking life.

Local Authorities should have a record of the decision with evidence that was taken into account. The record should include the following:

* The nature of the changes to demand or the workforce;
* The steps that have been taken to mitigate against the need for this to happen;
* The expected impact of the measures taken;
* How the changes will help to avoid breaches of people’s human rights at a population level;
* The individuals involved in the decision-making process; and
* The points at which this decision will be reviewed.

**Operating models for likely scenarios at each stage**

These stages are not sequential. They can be enacted together or separately over a long period of time.

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| **Stage one**  | **Business As Usual:** continue in this stage for as long as possible. Except more use of digital processes where possible.  |
| **Stage two** | **Affecting individual services (includes providers):** Services may need to prioritise short term allocation of care and support using flexibility under Care Act (easements don’t apply at this stage). Service types may need to be flexible, adapt processes, be delayed or cancelled short term within that service type (e.g. day services, home care / supported living etc) due to COVID related absence.Fundamentally we are still deliveringCare Act except through social distancing requirements or very short-term changes to services due to short term delivery issues. |
| **Stage three**  | **Streamlining**: operating under new easements – moving to a position of ceasing formal Care Act assessments, application of eligibility criteria and reviews to ease pressure. However, the expectation is that local authorities would do everything they can to continue to meet need as originally intended in the Care Act. |
| **Stage four** | **Prioritisation under Care Act Easements:** Whole system prioritising care and support. This could involve making decisions about changing support for people in light of capacity difficulties. |

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| **7.0 Stage one – Business as usual**  |

Local authorities should continue to operate at this stage for as long as possible.

**General operating model** - business as usual, but with additional considerations and actions including:

* Shielding [***Advice on shielding extremely vulnerable people***](https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19)
* Infection control / use of PPE if required
* Social distancing [***Advice on social distancing and vulnerable groups***](https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults#summary-of-advice)
* Explore other means (WhatsApp video calling, skype etc) rather than face to face visits where possible (Appendix 1)
* Flex provision to increase D2A and step down to support acute / health
* The Carers Support team to contact all carers known to them offering advice and support as well as confirming contingency arrangements if they become unable to provide care and support.
* Anyone known to any of the inhouse provider service teams to be contacted and checked on regularly to minimise the risk of situations going into crisis (frequency to be determined on an individual basis depending on circumstances / risk)
* Where appropriate a check in call for those who are in at-risk groups, are isolated or any situation where people or families may struggle if they or their carer become unwell or need to self-isolate / be hospitalised. This will be decided and agreed locally within teams.
* Teams to access the Staysafebekind helpline for people they support
* Social work teams continue to adhere to Care Act statutory duties, whilst following all relevant government guidelines at all times to keep themselves and others safe. Practitioners will adopt a creative yet proportionate approach but continue to have good quality conversations and work together with people, connecting them to support and advice that will help, and arranging support when needed.
* Financial Assessments will be carried out as usual except with more use of digital processes where possible

**Hospital discharges – stage one**

* A Discharge to Assess (D2A) model introduced to other sites such as West Park Hospital.
* Additional capacity has been commissioned to support an increase in hospital discharges to support the Covid-19 crisis.
* All community teams should prioritise hospital discharges (across all Hospitals including out of area) during this period due to the immense pressure on the health system.
* The NHS's COVID 19 hospital discharge service requirements (19 March) can be found here: <https://www.england.nhs.uk/coronavirus/publication/covid-19-hospital-discharge-service-requirements/>

**Safeguarding – stage one**

* If possible, the person who has experienced abuse or neglect, or their representative, should be contacted by phone or email to determine their perspective on the situation and to find out their desired outcomes. Good practice suggests we should visit people to gain assurance they are safe and well but given the current government guidance you will need to consider alternative options to visiting.
* It is therefore important to consider whether there is another professional visiting the person who might be able to offer you the information you need.
* Consider using video calling if the person has a suitable application on their phone, to have a more personal face to face discussion (via WhatsApp/FaceTime/Skype).
* Before contacting the adult or their representative, you must also consider, whether by doing so you would be increasing the risks to the adult/others.

Safeguarding meetings:

* Where possible, safeguarding planning, outcomes and review meetings should be arranged on a virtual basis. Safeguarding meetings will be conducted in the usual way and chaired by the SWUM in the relevant team and minutes will be captured in a light touch way virtually.
* Particular importance should be given to the recording of the justification for decisions being made.
* Multi-Agency Safeguarding Meetings (in respect of care providers) will be chaired and minuted by the MASH and be held virtually.

Safeguarding safety planning:

* The following framework [Responding to COVID-19: the Ethical Framework for Adult Social Care](https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care/responding-to-covid-19-the-ethical-framework-for-adult-social-care) intends to serve as a guide for the difficult decisions that will have to be made when planning adult social care responses. The principles in this framework should underpin decision making in relation to safeguarding.
* You will need to give particular consideration as to whether proposed plans are safe and sustainable, given the current restrictions on social contact between individuals. As with any safeguarding safety planning, explicit consideration should be given to the person’s capacity to make or be involved in specific decisions.

Appendix 6 offers guidance for professionals to understand and respond to some of the specific risks increased by Covid-19.

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| **8.0 Stage two – Flexing under the Care Act** |

At stage two COVID related absence may mean some service types (e.g. supported living, day care, home care etc) need to be changed, delayed or cancelled short term within that service type. Decisions may need to be made for individual services to prioritise short term allocation of care and support using current flexibilities within the Care Act. At this stage other services may well continue to deliver their services as business as usual.

**Possible scenarios:**

* Day service closure
* Reduction / closure in respite care
* Staff shortage identified on sitrep
* D2A Demand for flow out of acute increases
* Demand to step up to prevent hospital admission
* Provider contingency planning reached stage 2
* Staffing levels may start to be impacted in MASH (less than 50% down) and / or number of safeguarding concerns significantly increase
* Providers / partners may start to struggle to contribute / undertake safeguarding enquiries if capacity becomes an issue
* Some financial assessment staff shortages / start to see an increase in number of people needing a new financial assessment

**Proposed operating model:**

Working under the Care Act but with flexibilities which include:

* Redeployment of staff across the sector
* Mobilising the home care contract early
* Volunteering with relatives
* Degree of restrictions – agile working
* Reviewing contingency planning – staffing pressures evident
* Staffing pressures – bringing in agency workers to fill backfill
* Involvement of OT - Single handed care approach
* DBS checks and volunteering best practice
* People who use services and support which have closed / ceased to operate due to the Coronavirus (e.g. day services) will be contacted by Service Information Officers (SIOs) to identify what support / advice / information they need, and further conversations will take place with the appropriate social work teams if they require any additional care and support during this period. Check in calls may take place at regular intervals depending on need / risks.

**Financial assessments**:

Business as usual but also:

* + Prioritise workloads
	+ Process Financial Assessments under verbal consent.

**Safeguarding**:

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| **Staffing levels may start to be impacted in MASH (less than 50% down) and / or number of safeguarding concerns significantly increase** Actions to address this;* Virtual visits – less face to face
* Allocate to other Service Managers to see if safeguarding enquiries can be shared across the teams.
* For situations involving self-neglect/ hoarding – after MASH checks would close and connect person to relevant support and services
* Non-statutory enquiries to cease where appropriate - signpost/refer onto other agencies/connect person
* Apply Section 42 criteria – be stringent with the application of this.
* Consider agency / recruiting temporary social workers (retired / students on third year etc) and any social workers on other roles in the council
* If Duty contact workers are understaffed there are 2 x SIO’s to undertake duty contact worker role)
 | **Providers / partners may start to struggle to contribute / undertake enquiries if capacity becomes an issue** Actions to be taken to address this:* Asking providers to agree timescales dependent on level of risk/staffing levels within the homes.
* In light of the immense pressures and challenges upon care homes due to Covid-19, the Care Act s42 criteria will be applied stringently to determine what are poor practice/care quality issues in care homes and what is abuse/neglect, so we do not put extra strain on care homes disproportionately.
* Where the criteria is not met, consideration will be given to whether the concerns can be addressed via other means e.g. provider addressing the concerns themselves via supervision, training or other mechanisms to improve practice, by carrying out a Keeping in Touch or a request that the home makes a referral to another professional, for example Tissue Viability/SALT.
* Timescales to be negotiable to take into consideration the challenges the homes are currently facing whilst carefully balancing the level of risk to the adult; nature of the concerns; any wider concerns, risk to others etc.
* See Appendix 2 for changes to the role of the Quality Nurse Advisor Team due to Covid-19
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**Process for moving to stage two:**

Where the relevant manager, or provider, feel that Care Act flexibilities need to be utilised then they should escalate this to the relevant Head of Service in the local authority. External providers should escalate this to their designated local authority lead who will then escalate further.

The Head of Service should complete the appropriate request form (appendix 7) and send it to the Principal Social Worker (PSW) and Director of Adult Services (DASS).

Where the PSW is satisfied that all other alternatives have been exhausted they will propose the recommendation to the Director of Adult Services (or the designated deputy) for a final decision about moving into stage two.

The completed form will be saved in the adult social care decision tracker.

The decision will be communicated to all partners, people and stakeholders.

**Governance arrangements:**

There will be a daily review of the situation by the Adult Leadership Team (ALT), including the PSW and DASS.

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| **9.0 Stage three – Streamlining**  |

This is the stage where the Care Act easements allow local authorities to cease formal Care Act assessments, application of eligibility and reviews if there is justification to do so.

The expectation is that local authorities will do everything they can to continue to meet need as was originally set out in the Care Act. However, where the impact of the pandemic is making this unachievable or untenable local authorities may need to move to a position of more proportionate assessment and planning.

However local authorities will remain under a duty to meet needs where failure to do so would breach an individual’s human rights under the European Convention of Human Rights.

**What should have been explored before reaching this stage?**

* Redeployment of staff across teams where demand is highest
* Explored potential to utilise staff with social work or other relevant qualification in other teams across adult social care
* Considered cancellation of all non-essential annual leave and non-essential meetings / work commitments.
* Consideration of using volunteers (offering appropriate training)
* Consideration of recruiting recently left or retired social workers
* Explored use of agency staff / other ways to recruit temporary social work qualified staff, including third year students likely to pass in the Summer
* Explored all other ways to carry out statutory tasks that would reduce time / resources e.g. virtual visits rather than face to face etc
* Business continuity plans will potentially have been activated.

**Possible scenarios**

There is insufficient capacity to maintain usual Care Act conversations and reviews due to:

* Staff absence –1/3 of staff absence or beyond business continuity plans (this trigger can be invoked earlier or later if professional judgement indicates) and all resources to maintain staffing levels have been explored
* Surge in demand (based on professional judgement and governance via PSW/Director of Adult Services/David Patterson)
* A requirement to support the COVID-19 hospital discharge pathway avoid hospital admission
* The need to prioritise statutory safeguarding functions as social work levels are impacted across ASC, reducing capacity to pick up safeguarding work

**Proposed operating model – stage three:**

**Applying Care Act eligibility criteria**

Eligibility criteria under the Care Act may not be recorded or applied during this stage, but it should be clearly explained to people that this will be considered at a future point. Practitioners should make clear to people with care and support needs and carers that at a future point their needs may be assessed or reassessed at the earliest opportunity. This could mean that the local authority may no longer believe it is necessary to meet those needs if they are not eligible and alternative arrangements may need to be agreed.

It should be explained that the current context is extremely unusual, and arrangements may be temporary and subject to change when the crisis ends.

**Financial assessments**

Financial assessment and charging will continue for as long as possible and only be impacted by staffing / demand issues and other care planning easement decisions.

Where this easement is enacted it is possible to meet people’s care and support needs without a financial assessment. However, practitioners must ensure they inform people of the following facts and record on Care First that they have done so:

* Explain what care and support they will be receiving and from what date
* A financial assessment will be carried out at a later date and any charges will apply retrospectively (from the date care and support started)

They should provide a leaflet with information about this if possible to do so (to be provided to practitioners by the financial assessment team).

**Proportionate recording of need**

Where the local authority has to reduce the extent to which it would ordinarily do a needs or carers assessment we would still continue to make a written record. The revised, streamlined process would therefore involve completion of a Conversation 2 record, which would capture just enough information to make a decision about whether an individual needs care and the most appropriate way to do this.

The “Sticking like glue” principle would not apply at this time unless it is appropriate to do so. This will avoid introducing delays into the hospital discharge pathway and allow best use to be made of social work capacity within the community.

Conversations may not be able to be carried out face to face due to staffing reduction and considerations about minimising harm, however CWC will consider other appropriate means, taking into account people’s cognitive and communication needs, such as:

* Use of a third party/allied professional to carry out as trusted assessors or using reports / other information gathered by others / previous conversations
* Use of technology such as video calls, if available, if people are comfortable with this, and if they can be made available at the location where people are living

Carers conversations will continue to be recorded proportionately on a Carers Conversation record.

There may need to be a review of current working arrangements in terms of 3 Conversations if pressures become apparent within the hospital to ensure system flow in and out.

If local authorities do not comply with their duty to carry out a relevant assessment / conversation within a reasonable period once the crisis is over, court action can be taken.

**Care Planning**

Should be person-led, person-centred and proportionate. Bureaucracy should be kept to a minimum whilst ensuring adequate records are kept.

The easements relieve CWC of the duty to prepare pre-amendment Care Act compliant care and support plans. However, there should be sufficient information for potential or existing providers to make an informed decision whether they can meet needs. The support plan on Conversation 2 should be completed with details proportionate to the situation.

Individuals who need support would be referred to the Personalised Support Team (PST) in the usual way, along with a brief care and support plan that would include sufficient information for providers to understand the care required. A Care Act compliant conversation and support plan and Care First activity to trigger a financial assessment would be completed at the first opportunity following the conclusion of the COVID-19 epidemic. The capacity tracker should be recorded and kept up to date on a daily basis at all stages of the pandemic.

**Keeping in Touch Conversations (reviews)**

Routine Care Act reviews would be suspended, whilst urgent reviews, in the event that individuals who are receiving council funded care services require immediate and significant changes to their care, would be maintained. Wellbeing checks will be put in place where appropriate.

**Huddles**

Decision making about personal budgets and care plans should be kept as close to the front line as possible with minimum restraints on flexibility and innovation in how needs can be met. Restrictive administrative practice and bureaucracy should be avoided as much as possible. Huddles will continue twice a week with recourse to emergency huddles as and when required.

There may need to be consideration of how huddles are organised where staffing is low. Separate sites in one service area may need to come together as one huddle at such times. Minimum numbers required for a huddle is detailed in separate huddle guidance.

Any spend in relation to Covid-19 must be recorded on the huddle spreadsheet.

**Safeguarding**

Duties in the Care Act relating to safeguarding adults at risk will continue. Safeguarding activity will be prioritised to ensure that concerns are investigated and resolved in a timely way proportionate to the severity of the concern. To achieve this, safeguarding enquiries may have to be allocated across all teams.

**Process for implementing stage three easements:**

The relevant senior managers will discuss the situation with their Heads of Service who will together agree whether the criteria for moving into stage three has been met. They will complete the request form (appendix 7) and send to the DASS and PSW. The form will be saved to the adult social care decision tracker.

Where the PSW and DASS is satisfied that all alternatives have been exhausted this will be discussed at the daily Care Act easement meeting with members of Adult Leadership team (ALT). The Monitoring Officer will be included in these discussions or consulted as soon as possible that same day. Key health partners will also be consulted and engaged in this decision making.

Once agreed, the Director of Adult Services (DASS) will brief the lead member.

The decision will also be reported by the DASS to the Department of Health and Social Care via email: CareActEasements@dhsc.gov.uk

Partners, people, carers and stakeholders will be informed about the decision and provided with any other relevant information.

**Governance arrangements:**

There will be a daily review by ALT, including the PSW and DASS, to agree whether easements at this stage need to continue.

A formalised review of Care Act easement status for the previous week would be documented on the first working day of the following week and recorded in the adult social care decision tracker.

Any decision to implement easements under stage three or stage four of the care act easements would be notified to Strategic Executive Board and reflected in the SEB decision tracker.

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| **10.0 Stage four – Prioritisation of care and support**  |

This is the point at which City of Wolverhampton Council (CWC) would need to start making decisions about changing support for people and looking at capacity across the whole of Adult Social Care.

This stage would be enacted as a last resort, where CWC consider, having followed the steps set out in the governance process***,*** that they need to prioritise and redistribute care and support to ensure those most in need and at highest risk receive this support as a priority.

Communication with stakeholders / the market will need to be maintained and decisions made accordingly based on need.

**What should have been explored before reaching this stage?**

* Agency pool exhausted
* Provider exhausted stage one and two of contingency plans
* Exhausted formal and informal support networks
* Redeployment of staff across the sector
* Capacity of in-house provision maximised

**Possible Scenarios:**

* Demand increased for new packages of care / increased support for existing packages of care (indicated by an increase in DTOC / PST not being able to find suitable provision) and / or care home resources exceeds capacity (external providers) – particular risk in terms of the COVID-19 hospital discharge pathway and those needing urgent support in the community. This would delay acute hospital discharges and critical needs would not be met which could result in significant harm / injury / neglect / hospitalisation etc.
* Staff shortage beyond business continuity plans
* Risk of Provider Failure across a number of providers
* Alternative care delivery models have been exhausted

**Proposed operating model:**

* Identifying the highest risk from the already identified vulnerable group
* Generate additional capacity by prioritising need by using relevant prioritisation tools (Appendix 3). Consideration of ethical framework at all times (Appendix 4)
* The flow chart in Appendix 5 should also be followed
* However, throughout all stages must try to meet care act statutory duties if we can / as soon as we can
* Food hub distribution – key stakeholders
* Provision of wellbeing checks
* CWC would request prioritisation list from providers – social workers / OTs to review prioritisation lists

**Wellbeing Checks:**

* A system of wellbeing checks will be put in place for individuals for whom any care has been deferred or suspended or is deemed at low risk and would benefit from this. These might include occasional care visits, voluntary and community sector support, and / or telephone contacts. These checks will be overseen and lead by the Community Support Team, with support from others such as SIOs, volunteers etc.
* Each team will keep a record of all people who have not received care or care has been reduced because of prioritisation and ensure that as soon as easements are lifted conversations take place and care plans reviewed as soon as possible.

**Safeguarding:**

Where there are significant capacity issues in the provider market they may struggle to undertake delegated safeguarding enquiries. Timescales will be negotiable in order to take into consideration the challenges the homes are currently facing whilst carefully balancing the level of risk to the adult; nature of the concerns; any wider concerns, risk to others etc. Other actions may include:

* Continue to triage all referrals, focussing on reds/ambers after rag rating as a priority but all safeguarding concerns / enquiries where criteria is met has to continue
* Prioritise those at greatest risk of harm, including acts of ill treatment and wilful neglect, whilst acknowledging that all duties regarding safeguarding continues
* Due to capacity issues providers may struggle to undertake delegated enquiries – this will be discussed with each provider on a case by case basis
* Consider if asking for information from partners is required / essential

**Process for implementing stage four easements:**

The relevant managers, or providers, should escalate any concerns to their relevant Heads of Service in the local authority. External providers should escalate to their designated local authority lead who will then inform senior managers and ALT.

When evidence indicates that stage four easements should be implemented a Head of Service will complete the request form (appendix 7) and share with the PSW and DASS. The form will be saved to the adult social care decision tracker.

Where the PSW and DASS is satisfied that all other options and alternatives have been exhausted and there is no other option but to enact the Care Act easement at this stage the PSW will arrange an emergency decision meeting with the Director of Adult Services and Monitoring Officer. A decision about whether, and how, to prioritise care and support across ASC will be made.

Once formally agreed, the Director of Adult Services (DASS) will brief the lead member.

The decision will also be reported by the DASS to the Department of Health and Social Care. This should be communicated to CareActEasements@dhsc.gov.uk

Partners, people, carers and stakeholders will be informed about the decision and provided with any other relevant information.

**Governance arrangements:**

Adult Leadership Team will review the situation daily, including the PSW, to agree whether easements need to continue.

A formalised review of Care Act Easement status for the previous week would also be documented on the first working day of the following week and recorded in the adult social care decision tracker.

Any decision to implement easements under stage three or stage four of the Care Act easements would be notified to Strategic Executive Board and reflected in the SEB decision tracker.

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| **11.0 Mental Capacity Conversations / DoLS / Advocacy**  |

The Mental Capacity Act 2005 has not changed and nothing in the Coronavirus Act will change the obligations under it. However, the Mental Capacity Act (MCA) needs to be applied in a different context, which requires us to think creatively and proportionately about carrying out these conversations.

**DoLS**

DoLS are not covered by the Coronavirus Act 2020, but the government has issued emergency guidance on DoLS and MCA which can be accessed [here.](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878910/Emergency_MCA_DoLS_Guidance_COVID19.pdf) We continue to have a responsibility to continue to safeguard adults through the DoLS process and to act proportionately.

**Advocacy**

Advocacy will continue to be accessible for people with care and support needs. However, the advocacy provider would consider the following when working with people:

a. They do not place the adult at risk of harm

b. Alternative ways are explored that could be used to gather relevant information i.e. technology (skype, phone, email), third parties (family members, other essential visiting professionals) – who are independent

Where access is restricted or prevented POhWER will continue to support people using a remote rights-based model and alternative working models depending on the type of advocacy required.

Health and social care professionals’ legal duties to connect eligible people to advocacy still apply. There is nothing in the Coronavirus Act that could suspend people’s rights to advocacy under the Mental Health Act 1983, Mental Capacity Act 2005 or the Care Act 2014. It is possible for a member of the family or friend to take on this role and this will always be explored and clearly recorded if someone is unable to be part of the process.

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| **12.0 Complaints Process**  |

People and carers must have a clear and transparent way of raising concerns quickly if they believe the decision about their care and support or the support they are receiving is a breach of their human rights under the European Convention of Human Rights. Every attempt will be made to address these locally within the relevant team / service on an informal basis in a timely way and / or formally via the complaints, appeals and representations procedure and mediation process.

There is no requirement for a separate Human Rights Complaint Procedure under the Care Act Easements. All complaints will be dealt with via the [Adult Services Complaints, Appeals and Representations Procedure](file:///L%3A%5CCYP%5CShared%20Information%20%28Read%20Only%29%5CChildren%20and%20Families%5CC%26F%20-%20Policies%2C%20Procedures%20and%20Protocols%5CINDEXNEW_files%5CDO%20NOT%20USE%5CAdult%20Social%20Care%5CDO%20Not%20Use%20-%20Docs%5CC%5CComplaints%20Appeals%20Representations%20Adult%20Services%20FINAL%20ASLT%2017.12.20%20EA%2012.3.20.pdf) .

**Timescale**

During the pandemic, the normal timescales for dealing with complaints will be followed as far as possible. An acknowledgement of the complaint will be provided to the complainant or their representative within three working days by the complaints team.

The complaints team will forward the details to the relevant Head of Service/Director of Adult Services for investigation and they will involve the council’s legal team where appropriate.

Resolution to the issue should be within 10 working days of receipt of the complaint. Where this is not possible, for example, because the complaint is complex, or because of delays in appointing an advocate, the complaints manager may, with the agreement of the complainant, extend the time period for consideration of the complaint.

**Any complaint that comes in which states that any change to support has placed someone at risk must be acted upon immediately.**

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| **13.0 Consultation/Involvement of partners and stakeholders** |

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| **Power / Interest**  | **Key players** **(high/high)** | **Keep involved** **(low/high)** | **Keep Satisfied** **(high/low)** | **Keep Aware** **(low/low)** |
| **Stakeholder**  | People CarersProvidersALTSEBOpposition membersWolverhampton Safeguarding Together ASC Staff  | Wider internal staff group UnionsAdvocacy groups/community organisationsHousing providersInsight and performanceCCG / health partners | External Agencies (DWP/CAB/CoP)Advice Providers- IMHA/IMCA/DOLS | Wolverhampton ResidentsMediaSpecialist media |
| **Desired Behaviour / Purpose** | To ensure they are aware and agree with the changes, why they are occurring and the impact of them. | To design and implement the changes safely.Reduce and mitigate risks Advise customers and carers | To enable signposting if requiredTo work in partnership where requiredProvide advice if needed | To share key messages of where to seek support – particularly if Care Act Easement is applied |
| **Stage 1 – Key Themes**BAU | Routine briefings and meetingsSharing guidance and our approach to the 4 stages | Routine briefings and meetings | Routine briefings and meetingsSharing guidance and our approach to the 4 stages |  |
| **Stage 2 – Key Themes**Applying flexibilities under the pre-amendment Care Act - Decision for Individual service type to prioritise short term allocation of care and support using current flexibilities within the Care Act | Briefings to Cabinet Members outlining any specific measures taken in line with the guidance: e.g. closing day centresLetters to all providers setting out Council approach, outlining operating models and any proposed prioritisation tools.Update public facing council website (comms team) – use social media to communicate decision | Letters to all partners setting out Council approach, outlining operating models.Notify CCG’S and partners of any changes to services / closures |  |  |
| **Stage 3 – Key Themes**Streamlining services under Care Act easements - Decision to operate under Care Act easements as laid out by the Coronavirus Act | Update cabinet that easements have been appliedUpdate public facing council website (comms team) – use social media to communicate decisionInternal comms to teams – briefing for senior social work managers.Update letter to providers. | Update letter to partners. | Notify of easements and potential increase of volunteer services and referrals for advice | Raise awareness of additional support available in the community |
| **Stage 4 – Key Themes**Prioritisation under Care Act easements - Whole system prioritising care and support | Confirming to Cabinet who is being supported, what measures are being used to signpost people and carers etc.Update council website (comms team) and use social media to communicate decisionSpecific comms to providers and social work teams with guidance about use of prioritisation tool and support to be provided. | Updated letter to all partners | As above | As above |

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| **Appendix 1 - Guidance about face to face visits for social care teams**  |

* Face to face interaction / physical visits should only take place where is it deemed essential. Alternative ways of gathering any relevant information should always be explored and used first, i.e. technology (skype, phone, email, WhatsApp video calling), third parties (family members, other essential visiting professionals), previous reports / assessments.
* Practitioners should be as creative as possible in their approaches to reduce harm to adults with care and support needs, particularly those in care home / group settings and those in the at-risk groups and those being shielded.
* Where visits are deemed essential the practitioner should always discuss this with their manager.

**Preparing for essential visits / face-to-face interaction**

* Before any visit is made the practitioner will contact the person / carer by telephone to make enquiries regarding their heath and that of their family to establish whether anyone has symptoms or is self-isolating in the household. Practitioners should follow this checklist:

1. Are you well? (if no, go to question 2 if yes, go straight to question 3)

2. Do you have symptoms and if so, when did they start?

3. Does anyone else in your family have symptoms and if so, when did they start?

4. Is anyone in the home shielding or in one of the at-risk groups?

* Where any members of the household have symptoms of Coronavirus the infographic below should be used to consider when it may be safer to visit, if a visit is deemed absolutely necessary / essential to carry out statutory duties, assuming that the visit can be delayed (in some cases it may not be possible to delay). This would need to be agreed with a manager only after all other alternative ways of gathering the information / speaking to the person using technology / phone has been explored and having weighed up the benefit of a visit and the possible consequence.
* Where it is identified that the person or family are in an at-risk group further reflection should take place about whether this could be delayed, weighing up the impact if this doesn’t take place with the possible consequences of infection.
* A discussion should take place with the manager about how visits could be carried out to safely minimise the risk to all involved and reduce the likelihood of spreading infection to at risk and highly vulnerable groups. A plan should be agreed identifying the measures needed to be put in place / be followed to protect the practitioner and the people they are visiting.
* BASW (The British Association of Social Workers) have produced some guidance on home visits during COVID-19 which may be useful and can be accessed via this link: <https://www.basw.co.uk/professional-practice-guidance-home-visits-during-covid-19-pandemic>). However please note that adult social work teams in the city will consider each visit on a priority basis with a manager, rather than keep a list of “essential” visits as described in BASW’s guidance.
* Staff should keep 2 metres away and follow Public Health England (PHE) Social Distancing Guidance. See also PPE section below.
* Where visits do not take place for any reason an observation on Care First should be written by the practitioner explaining the rationale for this.



**PPE**

* There is some guidance on the use of PPE and when / what PPE is required: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/884165/Domiciliary\_guidance\_England.pdf
* A video on putting on (donning) and removing (doffing) PPE can be found here: <https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-care-homes>
* PPE is only effective when combined with:
	+ hand hygiene (cleaning your hands regularly and appropriately); respiratory hygiene <https://coronavirusresources.phe.gov.uk/hand-hygiene>, avoiding touching your face with your hands, and
	+ following standard infection prevention and control precautions <https://www.nice.org.uk/guidance/cg139>
* There may be situations where a visit / face to face interaction is necessary due to the requirement to carry out statutory duties, and / or the seriousness of the situation and / or there are, or would be, significant risks to the person or others and there is no one else who can carry out the intervention and no other means (such as telephone / video calling etc) are appropriate. This may apply for instance in the case of Mental Health Act assessments and safeguarding situations, but there will be more examples. Appropriate Personal Protective Equipment (PPE) will be made available to workers with the agreement of the manager, where it is deemed it is required depending on the circumstances, and a risk assessment discussed. There should be consideration about whether it will be possible to follow social distancing guidelines and factor this into the risk plan.
* Alongside the guidance above this chart produced locally by public health may help teams decide what type of PPE is required when face to face visits are necessary:



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| **Appendix 2 - Changes to the role of the Quality Nurse Advisor Team due to Covid-19** |

The Quality Nurse Advisors (QNAs), as well as other clinically trained staff within the Clinical Commissioning Group, are being redeployed imminently,

with many moving into acute NHS settings.

This means that during this crisis, the QNAs will no longer be able to support City of Wolverhampton Council with undertaking s.42 safeguarding

enquiries i.e. where there are clinical concerns in nursing homes.

MASH will continue with ‘business as usual’ i.e. to triage and RAG rate any new safeguarding referrals and request intel from the relevant partners.

**In response to the temporary changes in the role of the QNA:**

**New safeguarding referrals where there are clinical concerns in nursing homes:**

* Where the criteria for a s42 safeguarding enquiry is met, the MASH/allocated team, as part of the strategy discussion, will contact the home and where appropriate, ask that the care home carries out an internal investigation/compete a report within an agreed timescale.
* In exceptional circumstances (during Covid-19), it may be appropriate for a social worker to visit the care home to take action to safeguard the adult/make independent enquiries (as well as asking the home to investigate.
* Upon triaging the referral, as agreed with the Quality Nurse Team Leader at the Clinical Commissioning Group, the MASH will continue to send any relevant safeguarding referrals to the CCG for their information.
* The MASH will also continue to send the weekly safeguarding spreadsheet to the CCG which lists all safeguarding concerns and inappropriate safeguarding referrals on care providers.
* The CCG will aim to review the referrals/safeguarding spreadsheet on a monthly basis for any emerging patterns/themes in care homes (with nursing) and, if necessary, will make an assurance call to the care home to discuss/request action is taken.
* The MASH will continue to send any relevant safeguarding referrals and the safeguarding spreadsheet (whether concerns are progressed or not) to the Quality Assurance and Compliance Team and the Care Quality Commission.

**Outstanding safeguarding enquiries (where reports are either outstanding from the care home or from the CCG)**

* Where the report has been sent by the care home to the CCG for validation, the CCG will not be contacting the care home for further information.
* The CCG will review the report/information already submitted by the care home and draw a conclusion based on the information received.  The conclusion will be fed back to the care home along with any lessons learned/actions required.  The CCG will also feedback the conclusion/send their report to the MASH/allocated social work team.
* MASH will forward any reports received from the CCG to the social work team that the SA3/safeguarding enquiry is allocated to
* Where the safeguarding enquiry/report has not yet been sent by the care home to the CCG, the MASH/allocated social work team to liaise with the care home to agree a date for completion of the enquiry. Where the QNA has been involved in the strategy discussion, the report and outcomes to be sent to the Quality Nurse Advisor Team for their information.

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| **Appendix 3 - Prioritisation tool**  |

This tool will be used when a decision to implement easements has been made and prioritisation needs to take place to ensure that those with the most pressing needs that cannot be supported in other ways or by volunteers and are highest risk are prioritised.

* The person completing this tool will need to take steps to ensure up to date information is being used to make any prioritisation decisions
* This process would apply to any new people and people who have existing packages of care
* The tool utilises the outcomes of the Care Act[[1]](#footnote-1) and should be used to consider whether any tasks within those outcomes can be undertaken by anyone else e.g. volunteers, family, friends etc or in different ways.
* Each individual and their situation is wholly unique and as such the complexity, risk and level of need should always be considered and we should apply this in a personalised way, engaging with people and carers throughout
* Each outcome can be considered individually but there should also be consideration of the cumulative effect of needs and risks and overall wellbeing.
* There should be consideration of each situation on its own merits, use of professional judgement and weighing up of the likely effect / impact on the person if any one of their needs is not met, not met in the same way (for example shorter calls / less frequent) or met by other means.
* Any risks should be considered as part of the prioritising decision making.
* Discussion within huddles are encouraged for advice and guidance when prioritisation is taking place
* Anyone completing this should consider the eight principles of the [Responding to COVID-19: the Ethical Framework for Adult Social Care](https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care/responding-to-covid-19-the-ethical-framework-for-adult-social-care) and explore whether any change to the person’s care and support would result in a breach of their **human rights** (please follow the flowchart in appendix 5)
* When prioritising, it is important to consider that situations may rapidly change so services and teams should be flexible and prepared to revisit and reprioritise. There should be consideration about how often situations should be reviewed and encourage people and carers to make contact if circumstances change.
* This tool should be shared, discussed and agreed with the local authority if being completed externally
* A copy should be saved on the person’s local authority Care First record.

Any situation where there are active safeguarding concerns should be discussed with a manager and may need to be considered as a high need / risk due to the continuation of safeguarding duties.

**Prioritisation tool:**

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| **Summary of the individual:** | *Provide brief information on the current situation, presenting needs and wishes of the person, including what matters most to the individual* |
| **Outcomes***Consider the outcomes below and whether they can be met through the following resources:**For information on what each outcome means follow this* [*link*](https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/outcomes-care-support-needs.asp) | **Can personal strengths / assets meet this outcome?***Provide a brief summary of the evidence used to reach this decision. Include if existing aids are required* **Yes / No** | **Can technology be used?** *Consider everyday tech such as mobile apps, phones as well as aids, sensors and alarms* **Yes / No***.* | **Can friends & family support?***Consider who can visit, and who can phone and record information on reliability of support* **Yes / No** | **Can community support meet this outcome?***Consider both existing community assets (church / clubs etc) and COVID19 volunteer services. Consider reliability* **Yes / No** |  **If outcomes cannot be met by any resources mentioned what support is now required?** **(please complete this where “no” has been selected in all columns)** |
| Managing toilet needs |  |  |  |  |  |
| Maintaining personal hygiene and being appropriately clothed |  |  |  |  |  |
| Managing and maintaining nutrition/ hydration |  |  |  |  |  |
| Managing / maintaining medication  |  |  |  |  |  |
| Carrying out caring responsibilities for a child. |  |  |  |  |  |
| Being able to make use of thehome safely  |  |  |  |  |  |
| Being able to maintain ahabitable home environment |  |  |  |  |  |
| Developing and maintaining family or other personal relationships |  |  |  |  |  |
| Making use of necessary services / facilities in the local community\*\* |  |  |  |  |  |
| Other (if appropriate) |  |  |  |  |  |
| Comments:*Workers should take into account any other considerations including:** *Living arrangements and where any informal carer cannot sustain caring arrangements and if there will be significant impact if the situation continues*
* The person and any informal carer’s mental health and emotional needs, wellbeing and all risks
* *The person’s capacity to request additional support if their needs change*
* *Fluctuation of need / risk*
* *Any other relevant information*

***If any need will not be met explain the reason for this and any assessment of risk/impact***\*\* This outcome needs to be considered in light of the government guidance on social distancing and staying at home with access to community only for limited purposes and essential tasks, exercise etc <https://www.gov.uk/government/publications/coronavirus-outbreak-faqs-what-you-can-and-cant-do/coronavirus-outbreak-faqs-what-you-can-and-cant-do> |

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|  **Appendix 4 - Analysis of recommendations for prioritisation of needs against the COVID-19 Ethical Framework for Adult Social Care** |

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|  | COVID-19 assessment process | Prioritising needs |
| Respect  | * The conversation process will continue to provide people with the opportunity to express their views and preferences, however the ability for the Council to continue to meet this choice may be restricted.
* Where a person may lack capacity the COVID-19 assessment process will continue to ensure that a person’s best interests and support needs are considered by those who are responsible or have relevant legal authority to decide on their behalf
* The Council will communicate that the situation will be reviewed daily throughout the prioritisation period and where wishes can be met the Council will do so. However, re-assessments will be available at the end of the crisis.
 | * The ability to meet all of a person’s wishes in terms of how their needs are met and preferred providers / placements may be restricted due to the available resource. Following the end of the coronavirus COVID-19 epidemic all assessments will be reviewed.
 |
| Reasonableness | * It would not be reasonable to continue to operate the normal Care Act assessment as the Council would have insufficient resource to deliver this function and people would be required to wait long periods of time for an assessment.
 | * It would not be reasonable for people at low risk to continue to receive support whilst new people at high and medium risk were left without any support. Also this would delay hospital discharges.
 |
| Minimising harm | * At all of the stages teams will follow the government guidance and carry out statutory duties / functions for as long as possible whilst minimising risks to their and other’s safety. This includes following social distancing rules (2M) where face to visits are necessary or using PPE. Alternative to face to face visits however should be explored first (e.g. virtual meeting, WhatsApp video calling etc).
 | * The prioritisation of needs will minimise the risk of harm to people at high and medium risk due to insufficient resources to meet their needs.
 |
| Inclusiveness | * The COVID-19 easements will apply to everyone and will ensure people, their carers and families / friends continue to be involved in the process
* Will continue to observe duties under the Equality Act 2010(which are unchanged) including duties to make reasonable adjustments and duties towards people with protected characteristics. These should underpin any decisions made about their care and support
 | * Individuals and families will be involved in all discussions about their care and support and notified individually of the changes to their care and given an opportunity to raise any concerns.
 |
| Accountability | * SEB and partners will have been consulted on this decision.
* Guidance has been completed for staff to enable them to work as BAU in the current pandemic and will receive guidance about arrangements at each stage if enacted.
 | * SEB and partners will be consulted at all stages
 |
| Flexibility | * Once stage 4 prioritisation is enacted the arrangements will be monitored daily and will continue to evolve to respond to the changing circumstances.
 | * Available resources will be monitored daily to ensure that we can meet the needs of people at high and medium risk.
 |
| Proportionality | * The COVID-19 easements enable the Council to assist people with care and support needs within the resource available.
 | * The prioritisation of needs enables the Council to assist people with care and support needs within the resource available.
 |
| Community | * The COVID-19 easement process utilises the role of voluntary and community sector (for example referring people for the delivery of food parcels).
 | * Individuals who can manage without formal care or with reduced support for a short period may be connected for support from the voluntary and community sector.
* A system of wellbeing checks will be put in place for individuals for whom any care has been affected or not started. These might include occasional care visits, voluntary and community sector support, and / or telephone contacts.
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| **Appendix 5 - flowchart – steps to consider as part of prioritisation** |

**Before, during and after applying any prioritisation of needs the following steps should be taken:**

Have you identified all elements of a person’s life that may impact on their needs and circumstances (e.g. Domestic violence, finances, sustainability of informal support?)

Have you identified what strengths, assets and support networks they have or could have available to them to meet needs and manage risks which will reduce or cancel out the need for formal support? Have you provided advice and information? Do they still need support?

Would not meeting any identified needs breach the person’s Human Rights, such as the right to life (Article 2), right to respect for private / family life, home and correspondence (Article 8) and / or the right to freedom from torture, inhumane and degrading treatment (Article 3)?

Duty to meet those needs

Yes

No

Apply prioritisation tool and check if any decision would result in a breach of Human Rights.

* Record any relevant information and all decision making (proportionately) - explaining the reasoning for any decision about prioritisation and how this has been arrived at.
* Decision making should consider and make reference to the ethical framework and Human Rights law. It should include consideration of the impact on the person’s wellbeing.

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| **Appendix 6 Covid-19 Safeguarding Risks** |

**Guidance for professionals**

During the COVID-19 crisis, safeguarding adults remains ‘everyone’s business’ and now more than ever, it is important that professionals are vigilant towards the signs and indicators of abuse and neglect.

Due to the impact of COVID-19, adults with care and support needs could be at increased risk of exploitation, abuse or neglect because of their vulnerabilities e.g. age, disability, mental or physical health needs.

* Fewer visitors to the household or care home e.g. by other family members and/or professionals may mean abuse or neglect goes unnoticed.
* Adults who are experiencing abuse may be less likely to ask for help during this period knowing that emergency services and health services for example are already stretched and facing challenging and unprecedented times.

**Who do our s42 safeguarding duties apply to?**

* Adults with care and support needs who are;
* Experiencing or at risk of abuse and/or neglect and are;
* Unable to protect themselves because of their care and support needs.

NB. There are no easements on safeguarding duties under the Coronavirus Act 2020.

**Points to consider:**

**Financial Abuse/Financial exploitation**

* Reduced or no income and financial hardship in families which may lead to financial abuse of vulnerable adults, in particular those adults whose money is being managed by a family member or a third party via Appointeeship or Lasting Power of Attorney and/or the adult lacks mental capacity to manage their finances themselves.
* Scammers and fraudsters - the emergence of people/community groups/’good citizens’ offering to support vulnerable adults but for financial gain who may overcharge for care and support services e.g. shopping, or sell necessities/items that are in demand at a premium.
* Increase in adults being online due to social distancing or self-isolating which could increase their risk from scammers; people entering ‘prize draws’ etc. with their personal details being added to the ‘suckers list’ and being sold on.
* Increase in take up of high interest loans from loan sharks.
* Bogus healthcare workers selling fake coronavirus testing, anti-virus kits etc.

**Domestic Abuse/Sexual Abuse:**

* Potential increase in domestic abuse incidents as a result of the lockdown (i.e. social distancing/self-isolation and the adult spending more time with the source(s) of risk within a closed environment.
* Potential increase in domestic abuse incidents due to other ‘stressors’ because of the impact of COVID-19 e.g. reduced income/loss of employment
* Enforced isolation may increase abusive behavior.
* Less opportunities for the adult to access and/or seek advice, help and support.
* Those with symptoms of COVID-19 not being able to seek support
* Fewer/zero visitors e.g. family/professionals to the household may mean domestic abuse goes unnoticed

**Emotional/Physical Abuse:**

* Potential increase in emotional abuse due to the number of stressors arising from COVID-19.
* Adults with care and support needs/adults with underlying conditions who may ordinarily access services such as day care are at home for longer periods possibly with informal carers who are not having a break/respite. This could lead to the adult with care and support needs being ‘blamed’ for their current situation.
* Risk to informal carers from the adult they care for due to significant changes to the adult’s routine.
* Possible increase in the mistreatment of adults who are diagnosed with COVID-19.

**Self-neglect:**

* Social isolation and the impact of COIVD-19 may be affecting the adult’s mental health and their ability to care for themselves.
* Not knowing how to access support and/or the adult’s usual informal arrangements may have stopped due to social isolation for example.
* Individuals not being able to access food or not going out for food for fear of catching the virus
* Those who can’t or won’t go out neglecting their personal hygiene
* Deterioration of physical ability due to prolonged periods at home leading to an inability to care for themselves
* Not attending medical appointments/treatment at hospital for fear of catching the virus
* Increased risk to people sleeping rough or homeless (especially sofa surfers); lack of awareness/reliable information about the risks, symptoms and actions to take including lack of access to hand washing facilities etc.

**Neglect/Acts of Omission:**

* A decision not to provide care to someone due to real or perceived COVID-19 risks (formal or informal carers)
* The need for an informal carer to self-isolate, or they become ill and require hospital treatment, but have sole responsibility for an adult with care and support needs
* Increased pressures on care providers due to the impact of COVID-19 e.g. reduced staffing and the possibility of missed domiciliary calls
* Organisational abuse - increased poor practice or shortfalls in the standards of care and treatment in care homes possibly due to less monitoring/visits by professionals
* Increased reports of advanced care plans with Do Not Attempt Resuscitation forms being completed for whole groups or settings

**Modern Slavery**:

* Risk of domestic servitude going unnoticed for longer due to the current restrictions in place.
* Victims of modern slavery who have care and support needs may have symptoms of the virus but may not be aware of how to seek healthcare or may not wish to for fear of being arrested etc.
* Possible increased risk of enslavement due to reduced access to safe and reliable employment
* Travel restrictions and border closures may mean some adults cannot/do not know how to safeguard themselves
* Closure of clubs etc. could result in sex work being pushed underground and/or more vulnerable adults being targeted to provide such a service
* Possible increase of using adults with care and support needs e.g. adults with a learning disability for criminal exploitation as individuals/gangs may not wish to place themselves at risk

**This is not an exhaustive list. Please consider what particular risks could arise for the adults you support and how your organisation will effectively manage these alongside the pressures of responding to Covid-19.**

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| **Appendix 7: Easement request and record of decision making:** |

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| What easement(s) is being requested |  |
| Who requires the easement and why |  |
| What other alternatives have been considered and steps taken to mitigate against the need for this to happen? |  |
| What is the expected impact of the measures taken? (include the impact on people who use the service, carers and families) |  |
| How will changes help to avoid breaches in human rights at a population level? |  |
| Who has been involved in the decision-making process? |  |
| Review date |  |
| PSW to complete:Signed by:Date: |  |
| DASS to complete:Signed by:Date: |  |
| Monitoring Officer to complete:Signed by:Date: |  |

1. The Care Act outcome “accessing and engaging in work, education and volunteering” has not been included specifically due to government advice on self-isolation / shielding for vulnerable groups which this will likely apply to, however if relevant and appropriate this can be considered in the “other” section [↑](#footnote-ref-1)