Care In The Time Of Covid

Autumn 2021 update on the effect of Covid 19 on care home residents, issues of vaccination and Court of Protection practice

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Presenters

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Care in the time of Covid

Age has no reality except in the physical world. The essence of a human being is resistant to the passage of time. Our inner lives are eternal, which is to say that our spirits remain as youthful and vigorous as when we were in full bloom.

Gabriel García Márquez, Love in the Time of Cholera

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Vaccinations to date

- The number of residents of **older adult care homes** reported to have been vaccinated with at least one dose was 301,679 at 29th August (97.0% of eligible residents). The number of residents of older adult care homes reported to have been vaccinated with a **second dose** was 295,431 at 29th August (**95.0% of eligible residents**).
- The number of residents of **younger adult care homes** reported to have been vaccinated with at least one dose at 29th August was 33,089 (92.8% of all residents8), and 31,685 were reported to have been vaccinated with a **second dose** (**88.9%** of all residents9).

Microsoft Word - COVID-19 weekly announced vaccinations 2 September 2021.docx (england.nhs.uk)

- … **third dose** should be offered to people over 12 who were **severely immunosuppressed** at the time of their first or second dose, including those with leukaemia, advanced HIV and recent organ transplants. These people may not mount a full response to vaccination and therefore may be less protected than the wider population.
- This offer is separate to any potential **booster** programme. The Joint Committee on Vaccination and Immunisation (JCVI) is **still deliberating** the potential benefits of booster vaccines for the rest of the population and is awaiting further evidence to inform this decision

JCVI issues advice on third dose vaccination for severely immunosuppressed - GOV.UK (www.gov.uk)

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Vaccinations: capacity to consent

Section 2: People who lack capacity

For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is **unable to make a decision** for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Section 3: Inability to make decisions

- (1)For the purposes of section 2, a person is unable to make a decision for himself if he is unable—
- (a)to understand the **information relevant to the decision**,
- (b)to retain that information,
- (c)to use or weigh that information as part of the process of making the decision, or
- (d)to communicate his decision (whether by talking, using sign language or any other means).

Section 1: The principles

- (1)The following principles apply for the purposes of this Act.
- (2)A person must be assumed to have capacity unless it is established that he lacks capacity.
- (3)A person is not to be treated as unable to make a decision unless **all practicable steps to help him to do so have been taken without success**.
- (4)A person is not to be treated as unable to make a decision merely because he makes an **unwise decision**.
- (5)An act done, or decision made, under this Act for or on behalf of a person who lacks capacity **must be done, or made, in his best interests**.
- (6)Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

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Best interests

- **Section (5)**: An act done, or decision made, under this Act for or on behalf of a person who lacks capacity **must be done, or made, in his best interests**

- Requires a determination – taking into account factors set out in section 4, including **section 4(6)**:
  - past and present **wishes and feelings**;
  - **beliefs and values** that would be likely to influence their decision if they had capacity;
  - **other factors** they would be likely to consider if able to do so.

- Will require gathering of information from family and, if relevant, friends: **section 4(7)**:
  - **must take into account**, if it is practicable and appropriate to consult them, the views of—
  - (a)anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
  - (b)anyone engaged in caring for the person or interested in his welfare,
  - (c)any donee of a lasting power of attorney granted by the person, and
  - (d)any deputy appointed for the person by the court

Public Health England **consent forms and letter**: COVID-19 vaccination: consent forms and letters for care home residents - GOV.UK (www.gov.uk)

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E (Vaccine) [2021] EWCOP 7

- **Capacity to consent**: *11. Acknowledging the informality of the assessment of Mrs E's capacity to decide whether to receive the vaccine, I am nonetheless satisfied that, it is sufficiently rigorous to comply with* ***section 2 and section 3 of the MCA 2005*** *. Mrs E is* ***unable to understand*** *information concerning the existence of the Covid-19 virus and the potential danger it poses to her health. I am also satisfied that she is* ***unable to weigh*** *information relating to any advantages or disadvantages of receiving the vaccine. It is also clear that she* ***cannot retain*** *information long enough to use it to make a decision. This is because of her dementia. I find that Mrs E lacks the capacity to decide for herself whether to receive the Covid-19 vaccine.* ***Evaluating capacity on this single and entirely fact specific issue is unlikely to be a complex or overly sophisticated process when undertaken, for example, by experienced GPs and with the assistance of family members or care staff who know P well.***
- **Wishes**: *13…. Mrs E had, prior to her diagnosis of dementia, willingly received the influenza vaccine and is also recorded as receiving a vaccination for swine flu in 2009. I consider the fact that, when she had capacity, Mrs E chose to be vaccinated in line with public health advice, to be relevant to my assessment of what she would choose in relation to receiving the Covid-19 vaccine today. 14. … Moreover, while Mrs E lacks the capacity to consent to receiving the vaccine, she has articulated a degree of trust in the views of the health professionals who care for her by saying to Dr Wade that she wanted "whatever is best for me" . Although this is not a capacitous statement, it is in my view important to emphasise it, particularly as it has been repeated.* ***This is to respect Mrs E's autonomy, which is not eclipsed by her dementia****. Moreover, her straightforward and uncomplicated approach resonates with the trust that she has placed in the medical profession in the course of her life, illustrated by her earlier reaction to vaccination.*

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E (Vaccine) [2021] EWCOP 7

- **Views of family**: *15. Her son does not share this trust or confidence. He is deeply sceptical about the efficacy of the vaccine, the speed at which it was authorised, whether it has been adequately tested on the cohort to which his mother belongs, and, importantly, whether his mother's true wishes and feelings have been canvassed. He also queries whether the tests have properly incorporated issues relating to ethnicity.* ***I respect W's right to his own views. However, they strike me as a facet of his own temperament and personality and not reflective of his mother's*** *more placid and sociable character.* ***It is Mrs E's approach to life that I am considering here and not her son's****. Mrs E remains, as she must do, securely in the centre of this process. …*

- **Risk:** *17 … For the avoidance of doubt and though no epidemiological evidence has been presented, I take* ***judicial note*** *of the particularly high risk of serious illness and death to the elderly living in care homes.* ***In stark terms the balance Mrs E, aged 80, must confront is between a real risk to her life and the unidentified possibility of an adverse reaction to the virus****.*

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SD v Royal Borough of Kensington And Chelsea/V, Re [2021] EWCOP 14

- *14. … When an issue arises as to whether a care home resident should receive the vaccination, **the matter should be brought before the court expeditiously**, if it is not capable of speedy resolution by agreement. This is not only a question of risk assessment, it is an obligation to protect P's autonomy.*
- *26. … In circumstances where an individual is not capacitous and cannot take medical decisions for themselves, the court is required, in the absence of agreement, to identify best interests for itself, surveying the entire canvas of the available evidence. **Strongly held views by well-meaning and concerned family members should be taken into account but never permitted to prevail nor allowed to create avoidable delay**. To do so would be to expose the vulnerable to the levels of risk I have identified, in the face of what remains an insidious and highly dangerous pandemic virus.*
- *33. In the circumstances and for all the above reasons, I find that the **risk to V's life and health, if she were not to have the vaccine, would be unacceptably high** and that it is in her best interests to receive it. In cases such as this, there is **a strong draw towards vaccination** as likely to be in the best interests of a protected party (P). However, **this will not always be the case, nor even presumptively so**. What it is important to emphasise here, as in so many areas of the work of the Court of Protection, is that respect for and promotion of P's autonomy and an objective evaluation of P's best interests will most effectively inform the ultimate decision. **It is P's voice that requires to be heard and which should never be conflated or confused with the voices of others**, including family members however unimpeachable their motivations or however eloquently their own objections are advanced.*

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SS (by her Accredited Legal Representative) v London Borough of Richmond upon Thames, South West London Clinical Commissioning Group [2021] EWCOP 31

- *22. Apart from her cousin, TB, who has, in the past, visited approximately 3 or 4 times per year and during the period of social restriction spoken to her occasionally by telephone, SS receives no visitors at all. She is **reserved and private** in her approach to life and temperamentally inclined to keep her distance from others. She is **at very low risk** of infection from the other residents, all but one of whom has been vaccinated.*

- *32. … This involves feeding into a delusional belief system. Whilst that may occasionally have been necessary in negotiating routine day to day challenges, it risks, in this context, compromising all involved. It **requires there to be a collusion to trick SS** into complying with a vaccination which, on balance, it seems unlikely she would have wanted whilst capacitous and certainly does not want at this point. It is **an artifice of a different magnitude and complexion** to those earlier more mundane negotiations. It becomes disrespectful to her, not merely as the woman she once was but to the one she is now. Though undoubtedly a well-intentioned suggestion, it **risks compromising her dignity and suborning her autonomy. It cannot, in my judgement, be in her best interests**.*

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"[39] Applying these provisions in Aintree University Hospital NHS Trust v James [2013] UKSC 67 Baroness Hale stated:

[39]

SS (by her Accredited Legal Representative) v London Borough of Richmond upon Thames, South West London Clinical Commissioning Group [2021] EWCOP 31

- *36. It was submitted on behalf of the CCG that the Court should conclude that vaccination is in SS's best interests. For all the reasons Dr Prabhakaran says I have no doubt that is correct, were I to confine the issue solely to the health-related states, events and data he identifies. **A determination of "best interests" in this context however is, for all the reasons discussed above, not to be confined to the epidemiological**; it requires evaluating welfare in the broader sense. As Baroness Hale said, it requires us to put ourselves in the place of the individual concerned. (Aintree University Hospital NHS Trust v James [2013] UKSC 67 Baroness Hale at [39])*

- *37. I was told that there was no question of SS being supine or passive if she recognised that the vaccination was being given against her will. One of the carers noted that those involved in attempting any "gentle restraint" had better be "kung fu experts", as she put it. The plan which involves both sedation and restraint contemplated the carers' involvement. Ms Fisher did not think that was appropriate. She told me that she thought that SS would look to her carers for help. They would not be able to intervene; that would be **distressing for both parties**. Moreover, in Ms Fisher's analysis it would most likely **dismantle the tentative trust that had been established over the months and in consequence of sensitive and determined professional effort**. I find this reasoning to be measured and persuasive. The Local Authority and the Accredited Legal Representative on SS's behalf both submitted that when evaluating welfare in the broader sense, it could not be said to be in SS's best interests. I agree.*

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Re G (TJ) [2010] EWHC 3005 (COP) :

"The word "interest" in the best interests test does not confine the court to considering the self-interest of P. The actual wi

Other cases

- ***NHS Tameside & Glossop CCG v CR (by his litigation friend CW) v SR* [2021] EWCOP 19**
  - *3.4 As I have determined that it is not possible to reasonably* ascertain his wishes, it seems to me that the position is akin to that proposed by the Law Commission and also referred to by Baroness Hale in *Aintree University Hospitals NHS Trust v James [2013] UKSC 67 at [24]* *' but the best interests test should also contain* ***'a strong element of substituted judgment*** *(para 3.25) taking into account both the past and present wishes and feelings of patient as an individual and also* ***the factors which he would consider if able to do so*** *(para 3.28)'*

- ***Re G (TJ)* [2010] EWHC 3005 (COP)**
  - *54. The word "interest" in the best interests test* ***does not confine the court to considering the self-interest of P****. The actual wishes of P, which are altruistic and not in any way, directly or indirectly self-interested, can be a relevant factor.*

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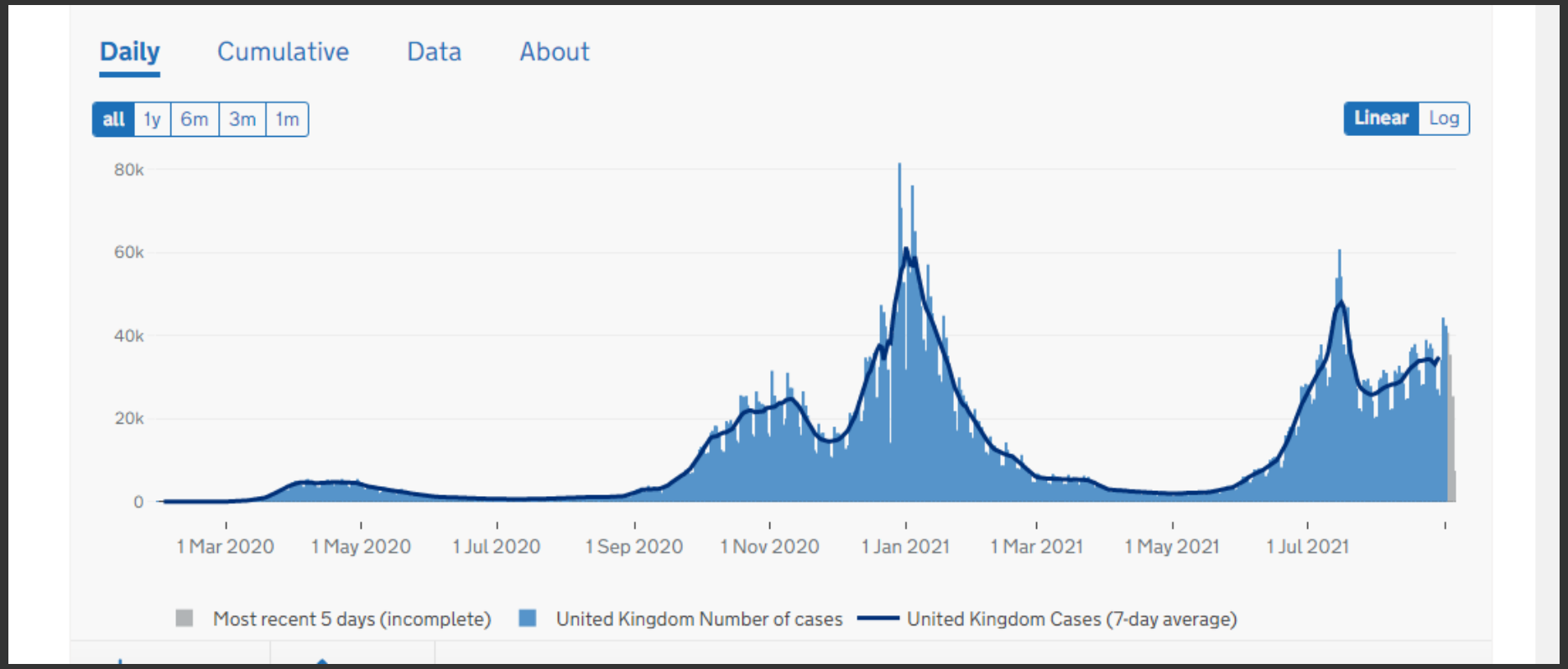
Best interests decision making during Covid

- The journey since March 2020:
- Cases of Covid



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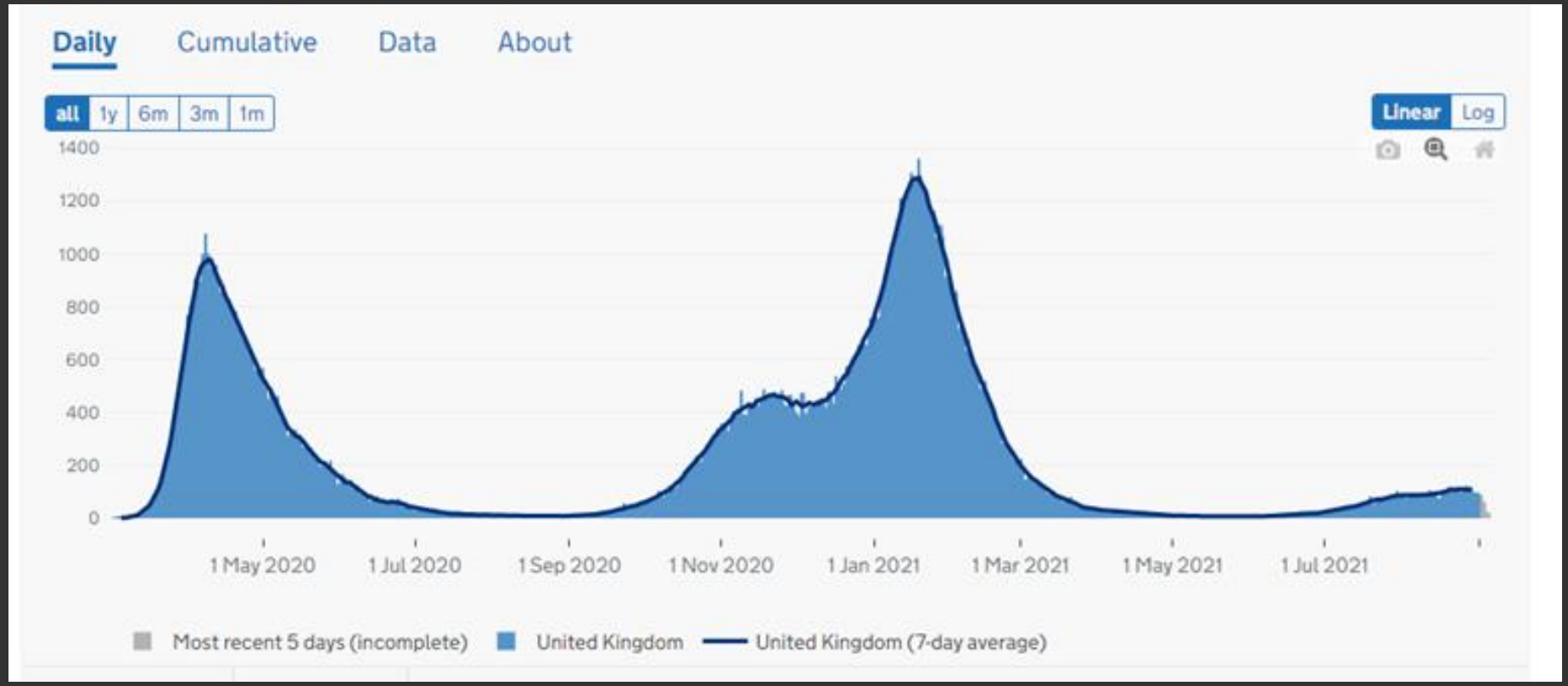
Best interests decision making during Covid

Deaths with Covid



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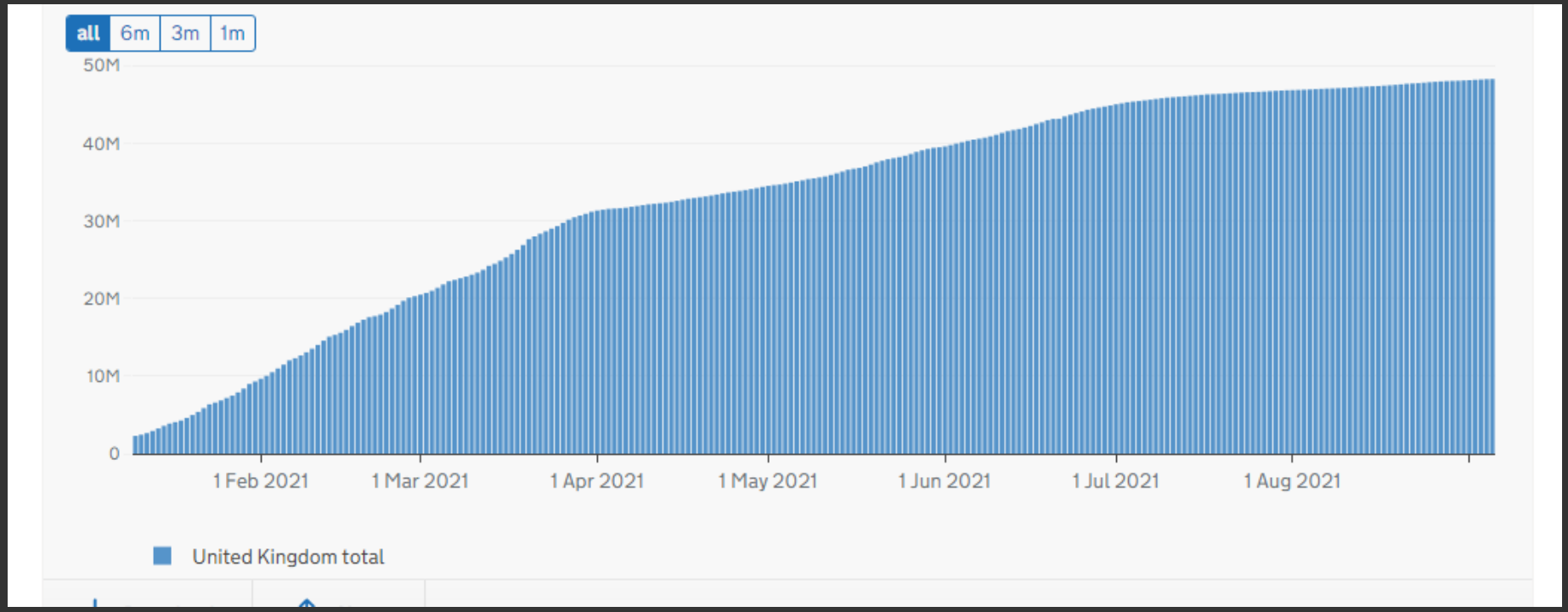
Best interests decision making during Covid

- First vaccinations



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Best interests decision making during Covid

- How will things pan out going forwards:

- Vulnerable groups still at heightened risk and community based activities remain limited
- Winter coming
- Future strains?
- Government commitment to re-vaccination?
- Appropriate to hold lessons learned from last 18 months firmly in mind

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- The Mental Capacity Act (2005) (MCA) and deprivation of liberty safeguards (DoLS) during the coronavirus (COVID-19) pandemic.
- Last updated 27.4.21 but withdrawn on 10.8.21:

- “During the pandemic, it may be necessary to change a person’s usual care and treatment arrangements to, for example:
- provide treatment to prevent deterioration when they have or are suspected to have contracted COVID-19
- move them to a new hospital or care home to better utilise resources, including beds, for those infected or affected by COVID-19, and
- protect them from becoming infected with COVID-19, including support for them to self-isolate or to be isolated for their own protection
- New arrangements may be more restrictive than they were, for the person, before the pandemic. It is important that any decision made under the MCA is made in relation to that individual; MCA decisions cannot be made in relation to groups of people.”

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Restrictions on visits and access to the community

- BP v Surrey County Council & Anor [2020] EWCOP 17 (Hayden J, VP) (25 March 2020)

- s.21A MCA 2005 challenge to a standard authorisation
- 83 year old resident with Alzheimer's disease
- Care home decision on 20.3.20 to suspend all visits
- Application made that care home should facilitate a visit by a capacity assessor , and resume family visits
- Failing which, Court invited to declare that qualifying requirements for the standard authorisation were not met, and to order discharge home with a package of care
- New visiting regime said to interfere with ECHR Articles 5 (right to liberty and security) and 8 (private and family life) of P

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Restrictions on visits and access to the community

- “27 It strikes me as redundant of any contrary argument that we are facing "a public emergency" which is "threatening the life of the nation", to use the phraseology of Article 15. That is not a sentence that I or any other judge of my generation would ever have anticipated writing. The striking enormity of it has caused me to reflect, at considerable length, before committing it to print.”

- In the facts, the Judge found that BP’s care requirements could not be met by his daughter alone, 24 hours a day, and it would nto be in BP’s best interests to be discharged home

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Restrictions on visits and access to the community

- “37 Over the last few weeks I have had cause to issue a number of guidance documents to address a rapidly changing landscape. On 19th March 2020 I recognised the reality that capacity assessments would, of necessity, for the time being require to be undertaken remotely. There is simply no alternative to this, though its general undesirability is manifest. Assessments in these circumstances will require vigilant scrutiny. This said, with careful and sensitive expertise, it should be possible to provide sufficient information. In response to an identified question, answered with the benefit of consultation with the profession I was able, in the guidance document, to state the following:‘

  Can capacity assessments be undertaken by video when it is established that P is happy to do so and can be "seen" alone?

  Suggested solution: In principle, yes. The assessor will need to make clear exactly what the basis of the assessment is (i.e. video access, review of records, interviews with others, etc.) Whether such evidence is sufficient will then be determined on a case by case basis. It is noted that GPs are rapidly gaining expertise in conducting consultations by video and may readily adopt similar practices for assessments. Careful consideration will need to be given to P being adequately supported, for example by being accompanied by a "trusted person." These considerations could and should be addressed when the video arrangements are settled. It should always be borne in mind that the arrangements made should be those which, having regard to the circumstances, are most likely to assist P in achieving capacity.”

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Restrictions on visits and access to the community

- Foot note:
- BP v Surrey County Council [2020] EWCOP 22 (29 April 2020)
- Agreement between parties that BP could return home with a package of care
- Psychiatrist Dr Babalola had not able to carry out capacity assessment remotely, and declined to attend the care home for fear of bringing Covid in. Heyden J opined that if BP were not now planned to return home, a different assessor would need to be identified.

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Effect of pandemic on decisions in end of life care:

- Sandwell And West Birmingham Hospitals NHS Trust v TW & Anor [2021] EWCOP 13

- TW suffered catastrophic brain injury, arising from a stroke. The court had been asked to declare whether it would be in TW's best interests to continue to receive life sustaining treatment, ventilation and blood pressure medication or alternatively, whether it would be lawful to withdraw it.

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Effect of pandemic on decisions in end of life care:

- “34. TW's daughters and his second wife, who is not the children's mother, live in Canada. In consequence of the restrictions presently placed on international travel it was thought impossible to be able to arrange a visit in under three weeks. TW's situation is such that he will likely require invasive intervention in this period. In particular, further cardiac arrest is foreseeable. Cardiopulmonary Resuscitation (CPR) to a patient in TW's circumstances has now become inappropriate, in the sense that it serves only to compromise his dignity whilst achieving nothing by way of treatment. I am ultimately satisfied that any plan artificially to sustain TW's situation to enable his daughters or wife to come over from Canada would be inimical to his best interests at the end of his life. Although I have been deeply moved by the evidence of these three impressive young women, I am ultimately unable to yield to their request, whilst fulfilling my obligations to their father. The medical evidence indicates that he would not know of their presence beside him.”

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Effect of pandemic on decisions in end of life care:

- VE v AO & Ors [2020] EWCOP 23
- Best interests issue – terminally ill woman leaving a care home to live with her daughter
- Not deemed by the Judge to be a case which raised public issues per se, but potentially relevant to the question of Article 8 for terminally ill patients:

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Effect of pandemic on decisions in end of life care:

- “28.The principal factual difference from AO’s case to that of BP is that AO has been diagnosed as having terminal cancer and is likely to have something between a few weeks and 3-6 months to live. This case concerns, as BP did not, questions as to whether it is in AO’s best interests to be allowed to live with her family in the last period of her life. The ability to die with one’s family and loved ones seems to me to be one of the most fundamental parts of any right to private or family life. That how a person dies can fall within the ambit of article 8 is now well established, see as but one example Pretty v UK [2346/02] at [65]. I have not been able to find any case law on the degree to which an inability to die with one’s family engages article 8, but it would seem to me self-evident that such a decision by the state that prevents someone with a terminal disease from living with their family, must require a particularly high degree of justification under article 8(2). Wider public health considerations, such as the protection of the community by restricting visits to a care home were considered in BP, but are not the issue in the present case. It was not argued that there was any public health reason to prevent AO leaving TO to live with her family.”

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Effect of pandemic on decisions in end of life care:

- Further issue: Heath Protection regulations – “reasonable excuse”?

- “44. It was necessary to consider the Health Protection (Coronavirus Restriction) Regulations 2020 (SI 2020/350) in order to ensure that in allowing VE or a family member to collect AO from the care home I was not inadvertently allowing a breach of the Regulations. Regulation 6(1) prohibits any person from leaving home without a reasonable excuse. Regulation 6(2) lists, apparently non-exhaustively, matters that would amount to a “reasonable excuse”. At regulation 6(2)(d) these include providing care or assistance to a vulnerable person. For a family member to collect AO from TO is to provide assistance to a vulnerable person and thus falls within that sub-regulation. It would in any event also accord with the order of the court.”

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Further on “reasonable excuse”

- NG (By His Litigation Friend, the Official Solicitor) v Hertfordshire County Council & Ors [2021] EWCOP 2 (11 January 2021)
- Young man with moderate to severe autism and mild learning difficulty.
- Lived independently but with a paid 24 hour package of care
- HG was a court appointed deputy for health, welfare, property and affairs
- In March 2020,. HG suspended contact with parents due to the suggestion that parents will be committing a criminal offence under Reg 6(2)(d) of the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 the paid carers had threatened to withdraw their service if NG continued to have contact with his parents.

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Further on “reasonable excuse”

Reg 6:

- "6.— Restrictions on movement

(1) During the emergency period, no person may leave the place where they are living without reasonable excuse.

(2) For the purposes of paragraph (1), a reasonable excuse includes the need—

(d) to provide care or assistance, including relevant personal care within the meaning of paragraph 7(3B) of Schedule 4 to the Safeguarding of Vulnerable Groups Act 2006, to a vulnerable person, or to provide emergency assistance; ... ”

Challenge to CoP: First instance - HHJ Vavrecka held that where there were paid carers:

> “The Deputy quite properly in my view come to the conclusion that the parents did not need to 'provide care and assistance' given the care package (with adjustments) would ensure all of NG's care needs were met.”

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Further on “reasonable excuse”

- On appeal to Mrs Justice Lieven in the High Court:

- Notwithstanding that the package of care received by NG was not commissioned as a ‘shared care’ package, by paid professionals, and NG’s parents:

- “The factual position is that NG's parents have been providing him with a significant part of his care throughout his life, and in particular since he became an adult. There is, so far as I am aware, no magic in the words "shared care", it is merely a reflection of the reality of the care that is being provided.”

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Further on “reasonable excuse”

- and

“45 ... On the second ground, the starting point when interpreting the regulation is to consider its words. Neither the opening words of regulation 6, nor the words in regulation 6(2)(d), provide for the care to be "essential".

46 ...There must be a "need", and not simply a subjective "desire", to undertake the activity in each limb or the restrictions in the first restrictions Regulations would become impossible to enforce. ..

...

48 If one considers the need for the care from NG's perspective then, in my view, it is clear that he needs parental care as well as paid care. His physical needs can be met by 24/7 paid care, but his emotional needs and best interests are met by having a mix of family and paid care. It is wrong in my view to focus simply on the fact that his physical needs can be met by paid care. As NDG and the OS submitted, NG's best interests must be relevant to meeting his needs and those best interests include being cared for, at times, by his parents.”

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Further on “reasonable excuse”

- The appeal was allowed, and is to be resumed that the other objection raised by the deputy, i.e. that paid carers would withdraw their services if NG was to have contact with his parents, had been abandoned.

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Further on “reasonable excuse”

- UR, Re (Rev 1) [2021] EWCOP 10 (28 January 2021)

- Polish resident of a care home in the United Kingdom
- Although lacking capacity to make the decision, her expressed wish was to return to live in Poland

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Further on “reasonable excuse”

- “One further issue (is ...) whether UR could leave this country to travel to Poland under the present regulations (Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020/1374). I have carefully considered schedule 3A(1) of the January 2021 Regulations. I have come to the clear and, I believe, uncontroversial conclusion that this move from the care home to her family in Poland, is not only incorporated within the identified 'exceptions' specified in paragraph 2(2)(f)(iv) of the Regulations (see paras 30,31 and 33 above), but reflects both the spirt and objectives of the Regulations as a whole and in particular paragraph (5)(c) and (e), paragraph (7) and/or paragraph 13 of schedule 3A(1). ...

- Additionally, and for the avoidance of doubt, I consider that UR's carers have a 'reasonable excuse' to accompany her and are therefore validly 'exempt' from the regulations. In assisting UR to move to Poland her carers are operating 'in a work capacity' and are providing physical assistance to her as contemplated by paragraph 5(c). The care home manager and a nurse have indicated that they are prepared to travel with UR and to accompany her all the way home. They are also content to self-isolate or perhaps quarantine, if required, on their return. Their selfless and dedicated professionalism is profoundly impressive.”

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Current guidance for visits and access to community

- “Guidance on care home visiting” Updated 23.8.21

- Key message:

- Visiting must be supported and enabled wherever and whenever it is possible and safe to do so – and a wide range of professionals have a role in supporting this, including care home managers, DPH and DASS.

- As the default position, all care homes should seek to enable the different types of visits described in this section.

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Current guidance for visits and access to community

- All care homes, except in the event of an active outbreak, should seek to enable:

- Indoor visiting by '**named visitors**' for each resident. These visitors should comply with the arrangements for testing, PPE and limiting close contact set out in within the guidance

  - These visitors should be tested using rapid lateral flow tests on the day of every visit and produce a negative COVID test prior to their visit. (2.1)

  - The visitor should also wear appropriate PPE and follow all other infection prevention and control measures. (See separate guidance - hand hygiene and respiratory hygiene, and the wearing of a face covering (if tolerated) along with social distancing must be encouraged and maintained. Therefore visitors require no additional PPE.)

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Current guidance for visits and access to community

- Keep physical contact to a minimum … Physical contact like handholding acceptable if hand washing protocols are followed. Close personal contact such as hugging presents higher risks but will be safer if it is between people who are fully vaccinated, without face-to-face contact, and there is brief contact only.

- Where resident lacks the capacity to make this decision, care home to discuss situation with resident's family, friends and others who may usually have visited the resident or are identified in the care plan. In this situation, a person can only be nominated if this has been determined to be in the resident's best interests in accordance with MHA 2005 … Where necessary, social workers can be approached by the care home, resident or family to support these conversations – in particular to help resolve any issues or concerns, and to ensure professional support and/or oversight where required.

- Visits should take place in a well-ventilated room, for example with windows and doors open where it is safe to do so. Consider use of designated visiting rooms, only used by one resident and their visitors at a time and are subject to regular enhanced cleaning and ventilation between visits. Any areas used by visitors should be decontaminated several times throughout the day and providers should avoid clutter to aid cleaning.

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Current guidance for visits and access to community

- “Essential care giver”

- Care home residents can choose to nominate an essential care giver who may visit the home to attend to essential care needs. The essential care giver should be enabled to visit in all circumstances, including if the care home is in outbreak.
- ECG role - intended as a way of supporting residents to benefit from companionship and additional care and support being provided by someone with a unique personal relationship with the resident, perhaps formed over many years. Essential care givers should be allowed to continue to visit during periods of isolation or where there is an outbreak.
- ECG’s: to follow the same testing arrangements, PPE and infection control arrangements, as care home staff.
- The assumption is that there will only be one essential care giver for one resident – although exceptions may be agreed subject to this assessment of individual circumstances
- Weekly PCR test and 2 LFT per week

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Current guidance for visits and access to community

- Also – should be other opportunities for residents to see more people than just their named visitors, by enabling outdoor visiting and ‘screened’ visits.

- visits in exceptional circumstances including end of life should always be enabled.

- All visitors – vaccination recommended – if an essential caregiver is not fully vaccinated, and is notified of close contact of someone who has tested positive for Covid 19, they should not visit until negative PCR tests

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Current guidance for visits and access to community

- Further Guidance: “Visits out of care homes” - Updated 23.8.21

- Opportunities for care home residents to make visits out of the home are an important part of care home life.

- Certain types of activity where the risks are inherently higher and the advice is that in these cases the resident should self-isolate for 14 days on their return to the care home. ... These activities are:
  - overnight stays in hospital that are **unplanned** (an emergency admission to hospital is considered higher risk than an elective procedure)
  - visits assessed to be high-risk following an individual risk assessment (below)
  - travel to an amber list country

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Current guidance for visits and access to community

- For **planned** hospital overnight stays (such as elective admissions), residents do not need to isolate upon return provided they meet the following criteria. Residents should:
  - be fully vaccinated
  - receive a negative PCR test following their return to the care home (and isolate until the result is received)
  - complete daily lateral flow tests for 10 days following their return
  - avoid contact with other highly vulnerable residents in the care home

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Current guidance for visits and access to community

- Otherwise - perform an “individual risk assessment”:
- Individual risk assessments should take into account:
  - the vaccination status of residents, visitors and staff, including the extent of second vaccinations
  - any testing of those accompanying the resident or who they intend to meet on their visit out
  - levels of infection in the community
  - variants of concern in the community
  - where the resident is going on a visit and what activities they will take part in while on the visit
  - the mode of transport that residents intend to use”

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- Court of Protection practice and procedure in the light of the pandemic

- Remote access to the Court of protection guidance 31 March 2020
- https://www.judiciary.uk/wp-content/uploads/2020/04/20200331-Court-of-Protection-Remote-Hearings.pdf

- “6 Remote hearings are the default position until further direction.”

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- Nuffield Family Justice Observatory research, 14-28.4.20, 10-30.9.20 and 10-27.6.21
- Latest survey results: “Remote hearings in the family court post-pandemic”, July 2021:
- The consultation applied to hearings undertaken in both public and private familylaw cases, and to all types of hearings including hearings in the Court of Protection
- * The majority of professional respondents saw a continuing role for certain types of remote hearing, although many felt that the decision should be made on a case-by-case basis. The main considerations respondents identified as relevant to such a decision were the vulnerability of lay parties and their wishes and views, the complexity of the case, and whether there was access to suitable technology for all those taking part. There were particular concerns about the use of remote hearings where intermediaries were required. There were many concerns about the challenges of managing remote hearings where interpreters were required and many concerns about the challenges facing litigants in personnt

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- • Overall, there was support for remote ‘administrative’ hearings (subject to certain caveats) such as case management hearings (CMH), first hearing dispute resolution appointments (FHDRA) and also for initial and/or ex parte applications for non-molestation/occupation orders. There was much less support for remote fact-finding hearings, hearings involving contested applications for interim care or contact orders, or final hearings.

- • Many barristers, solicitors, local authority lawyers, social workers, Cafcass and Cafcass Cymru advisers and guardians highlighted the positive impact of remote hearings on their time and working patterns.

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- 880 professionals responded to the question could Court of Protection hearings continue to be held remotely

- 50% answered 'yes'- although many of the comments attached to 'yes' responses contained caveats similar to the points raised by those who said 'it depends' (38% of responses}.
- Only a minority (12%} felt that it would not be appropriate for remote hearings to continue to be used by the Court of Protection

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- Continuing Court of Protection hearings remotely

- Those who were in favour of continuing with remote hearings suggested that it was easier for medical and other professional witnesses to attend, that it was more efficient with less waiting around, there was less time travelling(particularly in rural areas}, and some suggested that it was easier for the protected person(P) to take part.

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- Not continuing Court of Protection hearings remotely

- Some of those who answered ‘no’ to this question also added that remote hearings could be used for straightforward directions hearings but were concerned that any remote hearings for a person lacking capacity were fundamentally unfair. “Profound decisions are taken in the COP [Court of Protection]. Often, they involve strong family emotions and the suspicion that the ‘system’ is against them. They need the transparency that can only be achieved by attended hearings” (Barrister).

- “I think heavily contested trials should be held face to face otherwise parties don't always feel heard” (Circuit judge).

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- “Subject to the caveat that short directions hearings involving lawyers only can be dealt with remotely. Remote hearings for people with impaired capacity are fundamentally unfair. The person may already have problems of orientation in relation to time, person and space and building rapport and engagement, and therefore meaningful participation, requires face-to-face contact. The problems are amplified where the person is unrepresented or their solicitor is not with them during a remote hearing. Subject to the above caveat, it is essential that we return to attended hearings as soon as practicable.” (District judge).

- See also continuing research by Open Justice
- https://openjusticecourtofprotection.org/about/

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Thanks for watching!

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