

**COVID-19 SAFEGUARDING DOCUMENT**

**THE MID AND WEST WALES SAFEGUARDING BOARD INTERIM GUIDANCE FOR SAFEGUARDING SERVICES**

**May 2020**

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Introduction

The Mid & West Wales Safeguarding Board is a multi-agency strategic partnership of statutory agencies who work together collectively for a common purpose to prevent and protect children and adults who may be at risk from experiencing harm abuse and neglect. Its statutory duties are clearly outlined under Part 7 of the Social Services and Well-Being Act (Wales) 2014. The Mid and West Wales Board serves the communities of Pembrokeshire, Carmarthenshire, Ceredigion and Powys. In accordance with its statutory responsibilities the Board endeavours to raise awareness of safeguarding issues with members of the public and provide support, advice and guidance to professionals who deliver a range of statutory safeguarding services. This includes professionals such as nurses, health visitors, teachers, police officers, Social Workers and probation officers.

In accordance with Safeguarding Board structures, The Mid and West Wales Safeguarding Board has an active regional Policies and Procedures group that has developed a number of multi-agency safeguarding policies and protocols that provide professional guidance to staff working across all agencies. All these policies are available on the Board‘s website at <http://www.cysur.wales/>

The COVID-19 pandemic has presented agencies with significant and unexpected challenges on how to continue to meet their statutory obligations under current government social distancing guidance and travel restrictions. As a result, it has been necessary for all statutory partners of the Mid and West Wales Safeguarding Board to promptly review how they deliver key services to ensure children and adults who may be at risk receive an appropriate response and service where necessary.

The following regional guidance and policies have been developed and endeavour to ensure a “business as usual approach” is adopted to key prioritised Safeguarding Services for children and adults across the region, albeit in adapted and different format. The policies and protocols also aim to establish consistent practice and responses for key services across the four local authorities across the region wherever practical and possible.

Safeguarding Board Arrangements During the COVID-19 Pandemic

The Mid and West Wales Safeguarding Board is continuing to operate in accordance with its statutory obligations during the current national emergency and pandemic. Although some non-essential Board work has been stood down temporarily, all the Board’s mandatory sub-groups i.e. Training, Policies and Procedures and Practice Review Sub Groups are continuing to meet and function. The completion and development of ongoing regional policies, procedures and strategies as well as ongoing Child and Adult Practice Reviews are being prioritised. Any new work and reviews not yet started are being considered on a case by case basis.

Executive Board meetings are continuing to take place at regular intervals, and an interim COVID-19 Regional Operational Group has been set up to oversee, monitor and respond to any identified areas of increased risk that have emerged as a result of the pandemic. This multi-agency group consists of heads of service and senior service managers from across the region and their equivalent from agency partner organisations. This group currently meets fortnightly.

In addition to this, multi-agency safeguarding leads meetings for children and adult services with representatives from the four local authorities, regional health boards and Dyfed Powys Police are taking place weekly. The focus of these meetings is to lead the development of interim COVID-19 regional policies, establish consistent professional practice across the region where appropriate and to share ideas and offer peer support. The Regional Safeguarding Board Manager and Business Unit Staff’s roles have been realigned to prioritise supporting these new regional groups, and any actions that emerge, as well as continuing to progress the Board’s key sub groups as outlined above.

***Safeguarding Children in Mid and West Wales***

Duty desks and teams continue to answer and receive calls, assess and triage information in the usual way. Where deemed necessary, strategy meetings and discussions are continuing to be held and Section 47 investigations conducted. Statutory child protection visits continue to be carried out and all child protection conferences and Looked after Children Reviews are continuing to take place. A process for the management of child protection medicals has been jointly developed for both Health Boards. All cases are being prioritised and risk assessed using screening tools. A variety of methods are being used to fulfil these obligations depending on the outcome of any assessment, including the use of virtual meetings and both remote and direct contact. No child assessed to be in need of protection will be left without a service by any statutory agency. The following protocols provide more information on how these services will be delivered which include wider services for children who may be subject to Care and Support Plans or those in the Criminal Justice system.

Regional Section 47 and Statutory Visits Interim Process

Child Protection practices during COVID-19

*19/04/2020*

This briefing is designed to support child protection practices, particularly defensible decision making, in the context of COVID-19. It covers s47 planning, child protection visits, core group and care and support protection plans.

Balancing risk and wellbeing

During the COVID-19 pandemic, there is a need to consider the potential for increased risk to children and young people. This involves either drastically reduced or no contact with professionals, family members and peers and a change to support networks. Children and families are now spending most of their time indoors together, which may lead to increased pressures on the family unit. However, child protection practices, which involve direct contact with the child and family, increase the risk of COVID-19 spreading. We need to assess the risks of all direct contact against the risks of potentially leaving children in an unsafe environment. Therefore, the following key principles must always be considered:

1. Social Services have a duty to safeguard and promote the safety and wellbeing of children. Any assessment of risk should now include the impact of self-isolation and shielding on a child’s wellbeing and safety, which may increase risk and the likelihood of harm.
2. Social Services have a responsibility to reduce day-to-day contact between people to help manage the spread of COVID-19 and to promote health and wellbeing by ensuring proportionate responses in the current context. This responsibility includes children and families as well as the workforce and must be considered through Local Authorities COVID-19 risk assessments.

All child protection practice and decision-making must consider these key principles and clearly record decision making which incorporates this. Any deviation from standard procedures must be agreed with a manager and explained on the child’s record.

Child protection in the context of COVID-19

Whilst there is no current evidence base on increased likelihood of child abuse during COVID-19, organisations and specialists are discussing the heightening of risks due to self-isolation. Child protection practitioners and managers should consider the likely effects of self-isolation, which could include the following:

* Education plays a significant role in child protection with teachers normally having contact with the child 5 days a week. School closures and the restrictions on movement will dramatically change the child’s routine and reduce opportunities to identify abuse. In addition, having to facilitate their child’s continuing education at home may place further stress on the parent and on the relationships within the family.
* Additional stressors will be placed on parents who may experience additional caring responsibilities for vulnerable or sick family members and a loss of contact with wider family networks, friendships and support services. Families may also experience additional distress through bereavement.
* Children and adults who live with domestic abuse will be isolated in the household with the perpetrator for a prolonged period. They will have difficulties in speaking out about worries or incidents and feel unable to speak with staff if the perpetrator is in the household when visits occur.
* Children and young people who are experiencing sexual, physical or emotional abuse within the household e.g. from a parent, stepparent or sibling will have no respite from the perpetrator.
* Children and young people who experience neglect may not be having their basic needs met and their wellbeing may not be being monitored by education and health staff who would normally have contact with the child and family.
* Heightened levels of anxiety and depression amongst family members may occur. Families may feel increased tension at the lack of space and ability to take a break from each other.

The strategy discussion/meeting

When a report is received which gives reasonable cause to suspect a child is at risk of significant harm, a strategy discussion or virtual strategy meeting should be initiated to determine whether s47 enquiries should be initiated and how this should occur in the context of COVID-19.

The planning of **s47 enquiries** and attendance at critical situations will need to consider these additional factors:

* Does the risk require direct contact, or can a discussion occur remotely?
  + *Example: The risk may relate to extra-familial harm and the suspected perpetrator may not live in the family home.*
* How can the child be spoken to alone?
  + *Points to consider: Are there private areas in the family home? Can the child be spoken to privately in the family’s garden? Is there a nearby green space which is safe to access and can afford privacy?*
* If required, is it possible for the Social Worker to speak to a suspected child victim without the knowledge of a parent or caregiver?
  + *E.g., is the child attending a childcare hub? And if so, can they be seen there? Is the child supported through a Care and Support Protection Plan and therefore already has regular contact with a Social Worker alone?*
  + *If this has been compromised, the Social Worker may need to inform the parents that a referral has been received which requires the child to be spoken to alone. This could be done by making an unannounced visit to the family home and requesting to speak to the child alone. The Social Worker must consider any consequences the child may experience when returning home and ensure that parents are spoken to about appropriate responses towards the child. In these circumstances, the impact of this on the child’s safety must be considered by a manager and recorded.*
* What is the child and family’s health status?
* *If the child is reported to be sick by the parent, the manager will need to consider the referral content and the urgency of seeing the child.*
* *If it is felt that s47 should be delayed, to allow the child time to recover, please seek manager approval and record this decision. Considerations of immediate safety must be considered.*
* *If it is felt that the child may require immediate protection, police, health and Social Services must hold a further strategy meeting immediately to identify how the child can be protected. Senior managers will need to be notified. Children may need to be removed from their family home whilst unwell and placed in an emergency placement.*
* *Any intentional coughing towards staff should be reported through Health and Safety procedures and to the police.*

**All social care practitioners having contact with children and families must undertake a Risk Assessment and save this to the child’s record. PPE guidance issued by Local Authorities must be followed.**

Child Protection visits

The Wales Safeguarding Procedures (2019) state that the child **must be seen by the Social Worker every 10 working days**. This timescale will remain in place during the pandemic; however, the methods of contact may need to adapt and there may be circumstances when a Children’s Services practitioner is unable to see the child at home.

Having direct contact with a child may impact on their health due to the increased risk of infection. In turn, this will compromise the wellbeing of all other household members and increase the strain on family functioning potentially leading to the child being at greater risk. If any household members are in high-risk categories, the Social Worker must speak with their manager and agree / record how to proceed. This discussion should consider the wishes and feelings of the family.

In certain circumstances, CP visits could include:

* Having a telephone call/video chat with the child (if age appropriate) and family and seeing/speaking with the children and parents through the household window (whilst on the phone if that is easier) or in the doorway.
* Spending time with the child alone in a private part of the family home, garden or whilst walking through a local green space whilst ensuring that social distancing techniques are adopted.

Ultimately, all decision making must continue to be defensible, agreed with a manager and clearly recorded on the child’s record.

**Core groups:**

The initial core group will continue to be held 10 working days after the ICPC and must occur every 6 weeks or more frequently if required. These can occur remotely and could occur over a series of calls. Core group members should remain in regular contact and seek creative ways to support and safeguard the child.

**The Care and Support Protection Plan**:

These should continue to be reviewed and updated by core group members. It is important to update the plan to reflect any changes to support and the impact of this as well as any changes to risks due to COVID-19. There is potential for children to feel increased stress during this period, which should be taken into consideration when assessing a child’s welfare. Children may become more hypervigilant and feel worried about the wellbeing of their family members. They may be exposed to the news or others speaking about the pandemic and experience anxiety and stress. Parents can be supported with how to communicate with their child about COVID-19 if required. Additional consideration should be given to children aged 0-3 years who are reliant on their parents for care. All professionals working with the child and family will need to make efforts to maintain relationships. Local arrangements in place for health and education should be considered in the plan. Families can be supported to access childcare hubs if required, which can be included in the plan.

Regional Child Protection Conference Interim Process

Purpose of this Document

This briefing paper has been prepared to support staff across the region in the delivery of services to children and families during the COVID-19 pandemic. It is anticipated that normal service delivery will remain disrupted for several months. During this period, it is vital that children at risk of abuse receive protection and support. Therefore, as of the 30th March 2020 the following will be in place until further notice;

* Initial Child Protection Conferences will remain business critical and will continue to be held, albeit remotely in Ceredigion, Pembrokeshire and Powys. *Exception; Carmarthenshire will be retaining face to face conferencing for families, Social Workers and conference Chairs*
* Review Child Protection Conferences will become less critical and will continue to be held, albeit remotely OR will be undertaken by the conference Chair as a desktop audit.

Whilst it is important that child protection conferences continue, the way they are undertaken will need to adapt based on anticipated changes to service capacity, the health of children and families and the impact of self-isolation. During this period, every effort should be made by professionals to engage children and families and to ensure that their voice is heard.

The position in relation to child protection conferences will remain under constant review and any changes communicated via the Mid and West Wales Safeguarding Board.

Initial Child Protection Conferences (ICPCs)

ICPCs will continue to be held within timescales. Each Local Authority will set out and communicate a process for running the conference remotely (see appendices). This will vary on resources available and may include using email, Skype, telephone and other group chat platforms.

Conferences will still require agency reports 2 working days prior to the conference date, and all these reports should be shared with the family 24 hrs before the conference. Agencies will need to use remote methods to share the reports.

The pre-conference discussions with children and family members could occur through a telephone/Skype call and the report could be emailed or posted to the family. All reports sent by electronic means should be protected by password or encryption.

The Chair must be satisfied that sufficient information is likely to be available to ensure an informed judgement about continuing risk of harm can be made e.g. in the case of an unborn baby, it is essential that midwifery and health visitor services can contribute.

Review Child Protection Conferences (RCPCs)

RCPCs will continue to be held within timescales. Each Local Authority will set out and communicate a process for running the conference remotely OR a desktop audit to be completed by the conference Chair (see appendices).

Conferences or audits will still require agency reports 2 working days prior to the conference/audit date, and all these reports should be shared with the family 24 hrs before the conference/audit date. Agencies will need to use remote methods to do this. Agencies should include their views on registration and reasons in their report.

The pre-conference discussions with children and family members can occur through a telephone call, and the report can be emailed or posted to the family. All reports sent by electronic means should be protected by password or encryption.

The Chair must be satisfied that sufficient information is available to ensure an informed judgement about continuing risk of harm, and using the reports and/or discussions will make a decision on further registration based on the agency recommendations.

The conference Chair will then communicate this decision to families and partner agencies.

Quoracy

Wales Safeguarding Procedures (2019) require a minimum of three agencies or practitioner groupings that have direct contact with the child to be present for the conference to proceed. Situations of two agencies can occur in certain circumstances at the Chair’s discretion. The Chair must be satisfied that the key agencies’ input has been gained. If the Chair is of the view that the appropriate partners have shared enough information e.g. from conference reports and recent contact with the Chair, the Chair has the discretion to convene the conference.

Timescales

The conference can be delayed in exceptional circumstances e.g. if the child and family members are unwell and therefore unable to participate. A delay in coming to conference must not prevent any immediate action being taken to safeguard the child. If a delay occurs, the Chair must be satisfied that the child is protected. In such circumstances, this discussion must be recorded on the child’s record. This delay should not exceed 1 week. If there are circumstances arising, which could delay the conference further, the child’s and family’s wishes should be ascertained and shared with the Chair and the conference should go ahead.

Missing Information

If the Chair feels not all the required information is in place, they should make a professional judgement, given the information that is available, as to the level of risk to the child or children. A decision can be made to continue with the conference, but acknowledging the missing information. If a child or children are registered then a RCPC should be scheduled within 14 days to consider the missing information.

**Recording of conferences**: A record of the conference will be made, and the minutes will detail the methods used to come to the conference decision.

*Please see Appendix 2 at the end of the document for each Local Authority’s individual process.*

Regional LAC Review Interim Process

This briefing paper has been prepared to support staff across the region in the delivery of services to children and families during the COVID-19 pandemic. It is anticipated that normal service delivery will remain disrupted for several months. During this period, it is essential we continue to review and monitor the wellbeing and safety of all children in our care and continue to deliver the reviewing service.

Therefore, as of the 30th March 2020 the following will be in place until further notice;

* All Initial and Subsequent Care Plan reviews will remain business critical and will continue to be held, albeit remotely in Carmarthenshire, Ceredigion, Pembrokeshire and Powys.

Whilst it is important that IROs continue to review Care & Support, Pathway and Adoption Plans, the way they are undertaken will need to adapt based on anticipated changes to service capacity, the health of children and families and the impact of self-isolation. During this period, every effort should be made by professionals to engage children and families and to ensure that their voice is heard. Every effort will continue to be made to communicate with parents.

The positon in relation to Looked after children’s reviews will remain under constant review and any changes communicated via the Mid and West Wales Safeguarding Board.

It should be noted all local escalation and issue resolution protocols remain in place and should continue to be utilised where appropriate and necessary during this period.

TGP continue to offer a regional advocacy service remotely and children and young people should continue to be encouraged to access this service as required on an active offer principle and basis.

Initial Reviews – s76; ICO; Adoption

Initial reviews will continue to be held within timescales. Each Local Authority will set out and communicate a process for running the conference remotely; (see appendices) this will vary on resources available and may include using, email, Skype, telephone and other group chat platforms.

IROs will still require agency reports 2 working days prior to the review date. These can be emailed in the same way as previously.

The pre-review discussions with the Social Worker will occur through a telephone/Skype call.

The consultation visit to the child/young person will occur remotely using Skype/telephone or other available social media platforms.

Subsequent Reviews

Subsequent reviews will continue to be held within timescales. Each Local Authority will set out and communicate a process for running the review remotely (see appendices).

Reviews will still require agency reports 2 working days prior to the review date and all these reports should be shared with the IRO and Social Worker before the review date, agencies will need to use remote methods to do this.

The pre-review discussions with the Social Worker will occur through a telephone/Skype call.

The consultation visit to the child/young person will occur remotely using Skype/Telephone or other available platforms.

All reports sent by electronic means should be protected by password or encryption.

**Timescales**: The review can be delayed in exceptional circumstances e.g. if the child and family members are unwell and therefore unable to participate. If a delay occurs, the IRO must be satisfied that the child is safely cared for. In such circumstances, this discussion must be recorded on the child’s record. This delay should not exceed 20 working days. If there are circumstances arising, which could delay the review further, the child’s and family’s wishes should be ascertained and shared with the IRO and the review should go ahead.

**Recording of reviews**: A record of the review will be made and the minutes will detail the methods used to come to the conference decision.

Regional Briefing for IRO Service, reviewing statutory care plans for Looked after and Accommodated children @ 13th April 2020

*Please see Appendix 3 at the end of the document for each Local Authority’s individual process.*

Regional Child Protection Medical Risk Considerations

Child Protection (CP) Medicals

Telephone contact arrangements for child protection medicals will remain in place as usual in HDUHB and PTHB. The Consultant Paediatrician will risk assess the need for a CP medical with the aim of safeguarding children appropriately and reducing the risk of viral spread.

The impact of COVID-19 pandemic for vulnerable children’s well-being is significant. There are many reasons why they may be at increased risk of physical abuse during the pandemic, particularly as time goes on. These include self- isolation, increased risk of domestic abuse, parental substance misuse, illness, poor mental health, additional employment or financial worries, poverty, lack of safe adults/school/ childcare.

All referrals for child protection medicals should be considered on a case-by-case basis. The following is guidance to assist with decision-making based on a medical risk assessment for the type of medical to be considered e.g. virtual, telephone, face-to-face.

The following principles can be applied in most cases to reduce the risk of viral spread.

* Maximise the amount of history taken over the telephone in advance to minimise the duration of the appointment
* Ensure minimum numbers present - likely to be 4 with consultant, child, one parent and a chaperone or Social Worker
* Use the largest available clinical room to ensure social distancing
* Use of appropriate PPE bearing in mind the need to protect any vulnerable people present for the medical
* Consideration of the need for sibling child protection medicals based on risk assessment including age, history from siblings, findings in index case.

Guidance for Medical Risk Assessment

The following indicators must not be considered in isolation and a holistic assessment must be carried out in each case.

***1. Indicators of lower risk cases***

* These could involve older and cognitively competent secondary school age children who are able to give a clear verbal account.
* Historically no or minimal previous involvement with Social Services.
* Cases where families are known to Social Services and are already having support (that may need to be reviewed)
* Cases where safeguarding risk factors already known and managed (e.g. poor parental mental health, drug or alcohol dependency, history of domestic violence etc.)
* ‘One off’ or a relatively minor incident and/or minor injury or with a manageable level of concern expressed by Social Services and Police
* Some safeguarding measures available or in place (such as another adult carer)
* Documented no concern about hidden injuries

In the context of this pandemic, these cases could potentially be managed without face-to-face consultation following a full and thorough strategy discussion with Social Services and the police.

**2*. Indicators of Higher risk – very likely to need a face-to-face medical***

* Younger preschool child.
* Child with a disability.
* Child who is non-verbal or has any other communication or learning difficulties.
* Direct disclosure of a physical assault.
* Evidence of a physical injury.
* Multiple injuries or bruises
* Evidence of poor general care or neglect
* Higher concern expressed by safeguarding partners
* Concern about hidden skin, skeletal or head injuries
* Family history of involvement with Social Services or the police

***3. Indicators of HIGHEST RISK – should have a face-to-face medical***

* All potential physical abuse cases that involve non-mobile infants and any potential non-accidental head injures will need a physical medical assessment and investigation as before.
* Non-mobile infants with minor injuries and a potential explanation will still require physical assessment.

COVID-19 Screening questions and Social Distancing

Should the Consultant agree to conduct a CP medical, the Social Worker must respond to the following screening questions.

* Has the child or those who care for them had a temperature over 37.8°C?
* Has the child or those who care for them got a continuous cough/shortness of breath?
* Have any of the household or contacts been in isolation due to coronavirus symptoms in the last 7 to 14 days?

NB: The Social Worker must ensure that only one family member attends the CP medical with the Social Worker, preferably with parental responsibility.

The decision as to whether the Social Worker and/or Police wear PPE when transporting a child, should be consistent with current PPE guidance.

**If a child does attend a health facility for a CP medical, the relevant Health Board must ensure provision of a room of sufficient size to accommodate social distancing.**

Professional Differences

In the event of disagreement regarding the outcome of the strategy discussion as to how the medical will be conducted, the Consultant to whom the request for a CP medical has been made with should consult with the Health Board’s Named Doctor or peer without delay. Should the disagreement remain unresolved, the Regional Professional Differences Procedure must be implemented without delay.

Appropriate Adults – Social Workers/ YOT Staff Attending Custody



Home Office guidance states that Appropriate Adults must be present for most functions within the Custody process relating to vulnerable detainees, including during Police interviews.

Some of the measures currently implemented to safeguard the health of persons attending custody in an official capacity include:

* Offer of PPE
* Ensuring the 2 metre rule is adhered to
* Regular enhanced cleaning of Custody Units
* Deep cleaning following a contamination
* Unbolting furniture in interview rooms to allow 2 metre spacing
* Completing all relevant processes whilst Appropriate Adult is present, reducing need for re-attendance

There is a facility for Appropriate Adults to participate remotely in teleconference calls where this is deemed suitable and appropriate, ***but this does not include interview****.*

***Remote participation will be acceptable in very limited circumstances and will usually require the subsequent attendance of the Appropriate Adult.***

It is strongly recommended that Social Workers/YOT staff acting as Appropriate Adults contact the Custody Sergeant to discuss what control measures can be facilitated to maintain their safety prior to attendance.

*Please see Appendix 4 at the end of the document for the Home Office Guide for Appropriate Adults.*

Looked after Children in Care Placements in Breach of Restrictions



Looked After Children (LAC) are children or young persons who have been placed in the care of a Local Authority. These children may be accommodated in a variety of locations including residential care homes and foster care placements, sometimes away from their home Local Authority area.

During the current COVID-19 situation, the government has provided Police with powers to enforce restrictions on the movements of the public, including children and young persons.

* **If a Constable believes anyone is outside of their premises without reasonable excuse - including a child (someone under 18 years of age) - they can:**
* direct that person to return to the place where they are living
* remove that person to the place where they are living
* give the person concerned any reasonable instructions you consider to be necessary
* use reasonable force in the exercise of the power
* **The powers also apply to an individual over 18 accompanying the child, if applicable.**
* **The powers extend to direct anyone who has responsibility for the child - even if temporary - to secure compliance with the regulations.**
* **If you are dealing with a parent or guardian who is not preventing their child going outdoors and all other avenues to engage - explain - encourage have been exhausted, you can enforce by issuing them the fine.**

The emphasis is on Engage, Explain and Encourage. It is **not desirable** to issue fines to Local Authorities or other professional carers providing the role of parent. Nor is it desirable to **unnecessarily criminalise** Looked After Children. To ensure a proportionate response, the following guidance will apply.

A Looked After Child does not have to be reported missing to be in breach of the regulations. Where a LAC child/young person is found breaching restrictions, engage them and make a record of:

* Full name and DOB
* Address
* Time and location of offence
* Brief account of incident & offence code
* Details of any other persons present
* Where possible, record incident on Body Worn Video including a warning that breaches could lead to prosecution

Voluntary compliance should be encouraged with the child/young person. This could be through asking them whether they have heard about the restrictions and the need to comply with them. This should be done by stressing the risks to their own health, public health and the NHS. Then:

* Direct the child/young person back to their placement; or
* Remove the child/young person to their placement. Update staff within the placement, and obtain the name of the staff member spoken to; and
* Give the young person any reasonable instructions you consider to be necessary;
* Use reasonable force in the exercise of the power, if necessary;
* Submit an Intelligence Report including the Missing Person Coordinator (MPC)

The MPC will monitor these breaches and will contact the child’s Social Worker to highlight the issue. If a child/young person breaches more than twice in one week or six times in a month the MPC will contact the Social Worker and Care Home/Placement outlining the restrictions in place and possible outcomes for failing to adhere, including referral to youth justice services and potential escalation to Care Inspectorate Wales. The MPC will also submit a MARF to trigger a multi-agency meeting with relevant partners involved with the child/young person to safeguard the child and to record concerns and actions taken by all agencies.

The PRUDiC Process in Mid and West Wales will follow guidelines consistent with advice issued from Public Health Wales.

Advice for Health Professionals regarding PRUDiC in view of the COVID-19 Outbreak.



*06.04.2020*

*This advice is in response to queries from NHS staff regarding PRUDiC during the COVID-19 outbreak and reflects the situation at present although this is changing daily and NHS staff are urged to keep up to date with current advice from PHW and the UK Government.*

<https://www.gov.uk/coronavirus>

[https://COVID19-phwstatement.nhs.wales/](https://covid19-phwstatement.nhs.wales/)

<https://gov.wales/coronavirus>

PRUDiC

PRUDiC is the process of multiagency communication, collaborative action and information sharing following the unexpected death of a child. Its aim is to ensure that the response is safe, consistent and sensitive to those concerned, and that there is uniformity across Wales in the multi-agency response to unexpected child deaths. The purpose of the PRUDiC is

* to coordinate support for the parents, siblings and the peer group of the child who has died
* to share and collate relevant multiagency information, including with the coroner, pathologist and to inform any police investigation
* and to consider the potential risk to other children and the need for child protection procedures.

The process is well established in the NHS across Wales and is supported and monitored through the Regional Safeguarding Boards. Professionals should adhere to this good practice despite the current COVID-19 outbreak. If any variance is necessary, this should be recorded, along with the rationale for digressing from the PRUDiC process.

PRUDiC:

<http://www.wales.nhs.uk/sitesplus/documents/888/PRUDiC%202018%20Final.pdf>

COVID-19 Outbreak

As of Monday 6 April, there have been 3499 people in Wales who have tested positive for COVID-19 during the current outbreak, although the true number of cases are likely to be higher.

Any child who dies during this outbreak, from whatever cause, must be considered to be a potential infection risk and all professionals should take appropriate infection control measures to protect themselves by wearing personal protection equipment (PPE). The current guidance on PPE can be found at the following link: <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control> .

In particular, please see Table 1 PPE recommendations for health and social care workers by context for both NHS and independent sectors in secondary care inpatient clinical settings:

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877728/T1_Recommended_PPE_for_healthcare_workers_by_secondary_care_clinical_context_poster.pdf>

And Table 3 Recommended PPE for ambulance, paramedics, first responders and pharmacists:

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877602/T3_Recommended_PPE_for_ambulance_staff_paramedics_first_responders_and_pharmacists_poster.pdf>

Transmission of infection

The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. During aerosol generating procedures (AGPs) there is an increased risk of aerosol spread of infection and airborne precautions must be implemented when performing AGPs such as cardiopulmonary resuscitation (CPR). In the context of PRUDiC, professionals should use their judgement and, whilst making every attempt to preserve life, should avoid performing CPR when it would be futile.

Mementoes of the child, such as handprints and locks of hair, should be collected and put into memory boxes in line with normal practice. They will not pose an additional significant infection risk to a parent who has been living with and caring for the deceased child.

Safeguarding considerations

During the current COVID-19 outbreak, families are following government advice to stay at home, maintaining social distance and in some cases socially isolating or even shielding. Schools are closed and children are having little if any contact with friends, neighbours, teachers and extended family members. We know isolation can put some children at greater risk of abuse and makes it more difficult for children to seek help. Professionals need to be aware of this possibility when examining the deceased child, and when considering the safeguarding of other children especially in families where bereavement will be an additional stressor.

Safeguarding Adults who may be at Risk in Mid and West Wales

Duty desks and teams continue to answer and receive calls, assess and triage information in the usual way. Where deemed necessary strategy meetings and discussions and professional concerns meetings are continuing to be held. All cases are being prioritised and risk assessed using screening tools. Where considered necessary visits will be undertaken. A variety of methods are being used to fulfil these obligations depending on the outcome of any assessment including the use virtual meetings, remote and direct contact where deemed necessary. A Regional Pathway for victims of domestic abuse has been developed as well as a comprehensive regional process for the management of Deprivation of Liberty Safeguards (DoLS). A process to support the robust oversight of care homes in the region via an escalation process has been developed with providers and commissioning services. This will enable any concerns or challenges to be escalated promptly. Regional generic communication for care providers has been developed which has been widely distributed to remind service providers of their duty to report. No adult assessed to be in need of protection will be left without a service by any statutory agency in Mid and West Wales.

*The following protocols provide more information on how these services will be delivered:*

Regional DoLS Guidance Process

Introduction

As a result of the recent COVID-19 outbreak and the clear restrictions on visiting residential and nursing care homes at this time, the Mid and West Wales Safeguarding Board Region has agreed the following approach to managing Deprivation of Liberty Safeguards applications and authorisations.

Due to the risks associated with the outbreak, there has been a collective agreement that face-to-face visits for the purpose of Deprivation of Liberty Safeguards assessments are not deemed necessary at this time unless there are safeguarding concerns i.e. allegations of abuse and/or neglect. The Honourable Mr Justice Hayden (Vice President of the Court of Protection) has been **‘unambiguous in advising that visits to care homes are to be strongly discouraged.’**

This guidance applies to Local Authorities and Health Boards as Supervisory Bodies who will apply their usual mechanisms for prioritising assessments. This guidance may change in light of any further guidance from Welsh Government.

Applications in Health Boards

The management of DoLS referrals in the Health Board will substantially follow the process below.

* References to care homes and case management teams can be read as referring to hospital wards and multidisciplinary teams (MDTs)
* Ward-based doctors will be asked to provide evidence of a mental disorder as an equivalent assessment of Mental Health.
* Authorisation periods in hospitals are usually substantially shorter than those in care homes and this will be reflected in the timescale for any Authorisations given under these temporary arrangements

This approach applies to:

* New standard applications
* New Urgent (with standard) applications
* Further standard applications – Previous authorisation for 12 months
* Further standard applications – Previous authorisation less than 12 months
* Applications currently in the Court of Protection process

New Standard Applications (no previous DoLS authorisation)

1. Gather information from all other sources as per the Code of Practice, including records of any other previous assessments (including capacity assessments for same or similar decision)
2. Liaise with care management teams and the care home to provide as much information as possible about the person and the circumstances of admission.
3. Have discussions with family members and other interested parties as per usual process for DoLS assessments.
4. Attempt to use any other means available for speaking with “P”. E.g. Telephone/Skype etc.
5. Consider as a matter of professional judgement whether this information permits us to reach a decision to authorise. To include evidence that P’s condition is degenerative and not likely to improve.
6. If sufficient information is available, we will authorise restrictions to the minimum extent considered necessary to protect, and **in any event up to a maximum of 6 months.** If the authorisation is given for a 6-month period, then a review **must** be undertaken in month 3. If the restrictions on visiting care homes are lifted prior to the 3- or 6-month stage, we must progress with the assessments as usual as a matter of urgency.
7. If there is still uncertainty as to whether on the balance of probabilities a person lacks mental capacity and/or it is in their best interest to be deprived of their liberty, an application will be made to the Court of Protection if appropriate.

New Urgent (with Standard) applications

1. Consider the circumstances of the urgent application, paying particular attention to any significant restrictions and P’s objections.
2. Accept that the Care home will have provided themselves with urgent authorisation for 7 days in the usual way.
3. Gather information from all other sources as per the Code of Practice, including records of any other previous assessments (including capacity assessments for same or similar decisions)
4. Liaise with Care management teams and the care home to provide as much information as possible about the person and the circumstances of admission.
5. Have discussions with family members and other interested parties as per usual process for DoLS assessments.
6. Attempt to use any other means available for speaking with P E.g. Telephone/Skype etc.
7. Consider as a matter of professional judgement whether this information permits us to reach a decision to authorise. To include evidence that P’s condition is degenerative and not likely to improve.
8. If sufficient information is available, we will authorise restrictions to the minimum extent considered necessary to protect, **and in event** **up to a maximum of 6 months.** If the authorisation is given for a 6-month period, then a review **must** be undertaken in month 3. If the restrictions on visiting care homes are lifted prior to the 3- or 6-month stage, then we must progress with the assessments as usual as a matter of urgency.
9. If there is still uncertainty as to whether on the balance of probabilities a person lacks mental capacity and/or it is in their best interest to be deprived of their liberty, an application will be made to the Court of Protection if appropriate.

Further standard applications – (Previous authorisation for 12 months)

1. Gather information from all other sources as per the Code of Practice, including records of any other previous assessments (including capacity assessments for same or similar decisions).
2. Confirm with previous s12 doctor (where possible) that existing assessments are still valid – See Regional Interim Form 4
3. Confirm with the care home and the RPR that there is no change in P’s presentation or circumstances. Expired assessments could be used by the BIA, repeating the information in the DoLS forms and recording that they had confirmed by telephone with an identified individual at the placement that nothing has changed.
4. Have discussions with family members and other interested parties as per usual process for DoLS assessments.
5. If sufficient information is available, we will authorise restrictions to the minimum extent considered necessary to protect, and **in any event up to a maximum of 6 months**. If the authorisation is given for a 6-month period, then a review **must** be undertaken in month 3. If the restrictions on visiting care homes are lifted prior to the 3- or 6-month stage, then we must progress with the assessments as usual as a matter of urgency.
6. Attempt to use any other means available for speaking with P. E.g. Telephone/Skype etc.
7. **If sufficient information is available, SB will authorise restrictions to the minimum extent considered necessary to protect (up to a maximum of 12 months).**
8. Where there have been significant changes (such as an increase in dependency or restrictions) the BIAs could still complete renewal assessments by telephone, recording any significant new information in a Form 3 (Combined Best Interests Assessment) and identifying the circumstances which have prevented a visit
9. Consider as a matter of professional judgment whether this information permits SB to reach a decision to authorise. To include evidence that “P’s” condition is degenerative and not likely to improve.
10. If P is now objecting, or objecting more strongly, then BIAs should highlight the strength of objection and consider advising on an application to the Court of Protection at the earliest opportunity
11. If there is still uncertainty as to whether on the balance of probabilities a person lacks mental capacity and/or it is in their best interest to be deprived of their liberty an application will be made to the Court of Protection if appropriate.

Further standard applications (Previous authorisation less than 12 months)

1. Gather information from all other sources as per the Code of Practice, including records of any other previous assessments (including capacity assessments for same or similar decisions).
2. Confirm with previous s12 doctor (where possible) that existing assessments are still valid- see Regional Interim Form 4
3. Confirm with the care home and the RPR that there is no change in P’s presentation or circumstances. Expired assessments could be used by the BIA, repeating the information in the DoLS forms and recording that they had confirmed by telephone with an identified individual at the placement that nothing has changed.
4. Have discussions with family members and other interested parties as per usual process for DoLS assessments.
5. Attempt to use any other means available for speaking with P. E.g. telephone/Skype etc.
6. Where there have been significant changes (such as an increase in dependency or restrictions) the BIAs could still complete renewal assessments by telephone, recording any significant new information in a Form 3 (Combined Best Interests Assessment) and identifying the circumstances which have prevented a visit
7. Consider as a matter of professional judgement whether this information permits us to reach a decision to authorise. To include evidence that P’s condition is degenerative and not likely to improve.
8. If sufficient information is available, the SB will authorise restrictions for **up to a maximum of 12 months from the date of the previous Form 4 assessment.**
9. If P is now objecting, or objecting more strongly, then BIAs should highlight the strength of objection and consider advising on an application to the Court of Protection at the earliest opportunity
10. If there is still uncertainty as to whether on the balance of probabilities a person lacks mental capacity and/or it is in their best interest to be deprived of their liberty an application will be made to the Court of Protection if appropriate.

Cases currently in the Court of Protection Process

1. Seek guidance from the Court of Protection; request extension until further order.
2. Where case exceeds the 12-month period, we will follow the regional guidance set out above unless directed otherwise by the Judge.

*…as ever, it is essential not to “dress-up” resource-based decisions in relation to deprivation of liberty – even in a time when resources may be stretched to the limit – as best interests decisions. This is only likely to generate s.21A challenges, which will be a further pressure on resources.*

*Where it is necessary to deviate from normal practices or procedures (as set out in the practical procedures above), it is essential to have clear systems in place for explaining why those deviations took place, how they might have impacted on the assessments and what steps were taken to mitigate those impacts* .*The suggested wording for BIAs and Supervisory Body signatories below is a good example of this*.  [[**THE COVID-19 PANDEMIC, THE CORONAVIRUS BILL AND THE MENTAL CAPACITY ACT 2005**](https://www.39essex.com/the-covid-19-pandemic-the-coronavirus-bill-and-the-mental-capacity-act-2005/)**:** published 25th March 2020]

BIA report: (Form 3)

*“This assessment occurred at a time when public health measures had been put in place by HM Government to contain the spread of the COVID-19 virus. Professionals were being advised only to carry out essential visits to care homes.*

*When completing this assessment, I had to balance the need to protect X’s Article 5 rights against the need to protect him/her from transmission of the virus. COVID-19 infection would have posed a grave risk to X in view of his/her underlying health conditions.*

*In view of these concerns, I therefore decided to base my assessment on existing documents and on the views of X’s carers and family/friends rather than visiting him/her in person.”*

Supervisory Body Authorisation document: (Form 5)

“*I note that the BIA decided not to assess X face to face in view of the risk of COVID-19 transmission. I agree that this is the best way of promoting X’s Article 5 rights whilst protecting him from serious illness. This authorisation will be reviewed when public health restrictions are lifted*.”

The wording above has been agreed by the Mid and West Wales Regional Safeguarding Board - DoLS Partnership.

*Please see Appendix 5 at the end of the document.*

**VAWDASV Regional Pathway to Support for Victims of Domestic Abuse**

This Regional Pathway to Support has been designed in partnership with the VAWDASV Specialist Providers across the region, to assist in assuring consistency and continuation of service availability and accessibility for citizens of the Mid and West Wales region.

This Pathway firstly acknowledges the disruption to service delivery relating to COVID-19, also known as the Coronavirus outbreak. It is intended that this document will set out the clear pathway to VAWDASV support and advice for citizens and professionals living and working within the region.

It is important to acknowledge that all Specialist Service Providers are continuing to operate, albeit with reduced and/or limited resources. The majority of services are being delivered via remote working; however, all agencies will respond to referrals via their normal referral routes.

Access to Support

In terms of access to support we maintain a consistent route to services via the **Live Fear Free Helpline on 0808 8010800 –** This helpline isopen to women, men and young people experiencing any form of Domestic Abuse or Sexual violence (DA/SV).

The **Live Fear Free** **Helpline** will provide immediate advice and guidance before signposting to a local Specialist Support Provider.

Specialist Service Providers in Mid and West Wales:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Local Authority** | **Provider(s)** | **Specialism** | **Contact number** | **Covered by Live Fear Free Helpline** |
| Regional Service | IDVA Service- Hafan Cymru and Pobl | High Risk Domestic Abuse | Carmarthenshire and Powys- 01267 221194 Pembrokeshire and Ceredigion- 01646 698820. | Yes |
| Regional Service | New Pathways | Sexual Violence | Ceredigion: 01970 610124  Carmarthenshire:  01267 235464  Powys:  01267 226166  SARC Out of Hours (All areas)  07423 437020 | Yes |
| National Service | BAWSO | VAWDASV BAME | 0800 731 8147 (24 hr helpline) |  |
| Powys | Montgomery Family Crisis Centre | Domestic Abuse | 01686 629114 | Yes |
| Calan DVS | Domestic Abuse | 01874 625146 | Yes |
| Ceredigion | West Wales Domestic Abuse Service | Domestic Abuse | 01970 625585  And/or  01239 615385 | Yes |
| Carmarthenshire | Carmarthen DAS | Domestic Abuse | 01267238410/234725 | Yes |
| Threshold DAS | Domestic Abuse | 01554 752422 | Yes |
| Calan DVS | Domestic Abuse | 01269 597474 | Yes |
| Dewis Choice | Domestic Abuse for people aged 60+ | Referral via statutory agency e.g. safeguarding, police, health | No |
| Pembrokeshire | Pobl | Domestic Abuse | 01646 698820 | Yes |
| Hafan Cymru | Domestic Abuse- Refuge Only | 0808 80 10 800 | Yes |

Refuge

Refuge provision and the availability of refuge accommodation will vary depending on the individual circumstances at each refuge at the time and the circumstances of the individual seeking refuge. As in normal circumstances, each request will be considered on a case-by-case basis, taking into consideration matters such as: current availability, facilities required, personal circumstances and safety of the person(s) seeking accommodation and the circumstances and safety of existing residents and/or their children.

Each Local Authority has specific measures and plans in place, regarding emergency accommodation stock to support the demand for refuge accommodation during this time.

MARAC and Daily Discussions

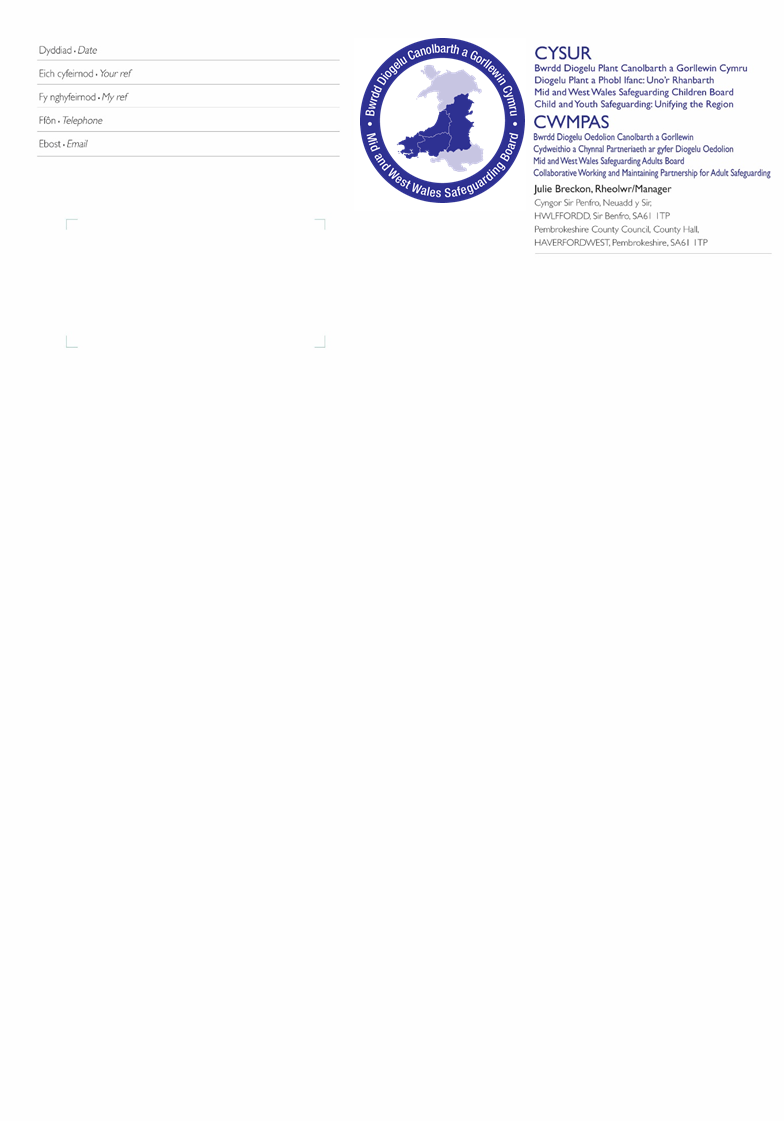
Where staff have been trained (including staff outside specialist services), they must use the DASH Risk Identification Checklist and MARAC referral form where appropriate as per the usual process.

Dyfed Powys Police (DPP) are revising the daily discussion process in response to decreasing staff capacity within all agencies. Further information on these arrangements will follow shortly.

Personal Safety Alarm Provision

Dyfed Powys Police have a supply of personal alarms and Skyguard alarms available to access. DPP and the Specialist Services have agreed a process for managing these alarms and promptly distributing to individuals who have been identified as requiring them.

The multi-agency safeguarding leads group for adults has contacted providers reminding them of their duty to report under the Social Services and Well-being Act (Wales) 2014 where there are concerns an adult may be at risk. The following regional communication has been developed and sent to all care and nursing home providers in the region to ensure a consistent message is being delivered across the Mid and West Wales area.

**CWMPAS Letter to adult Service Providers**

\*\*/\*\*/2020

Contact no

LA email address

ADDRESS

Dear Service Provider,

We are aware that you are currently working hard to keep your service running safely and efficiently and that the current pressures are new territory. We also know that the vulnerable adults in INSERT LOCAL AREA are at higher risk during the COVID-19 outbreak due to a number of factors such as staff shortages and an increase in crimes being committed towards them.

In recent days, we have seen a significant decrease in Safeguarding referrals being submitted to the Local Authority, and this is concerning. All providers have a statutory duty to report, as always, in line with the Social Services and Wellbeing Act 2014. Adult Safeguarding, the Police, Health, Out of Hours Social Care and our colleagues in Commissioning are all still operating. Whilst we understand that you are focusing your resources on providing care for the residents of INSERT AREA at this time, we urge you not to forget to keep Safeguarding at the forefront of your work.

We are aware present circumstances create opportunities for members of our communities to be susceptible to and become potential victims of scams and crimes, as a high number of unofficial groups offering support to vulnerable adults have emerged in recent weeks. Whilst we recognise many of these offers of help and support may be genuine with good intent, present circumstances also create increased opportunities for vulnerable members of our community to be exploited. We would therefore be grateful if you could encourage service users to utilise any support from official LA approved sources and hubs. Should you become aware of any such groups or individuals who cause you concern, please report this in the usual way.

We have set out below some key information in relation to practice during the COVID-19 pandemic, which demonstrates the regional dedication to uphold all statutory duties wherever possible, using risk assessments and alternative communication methods to reduce the risks to staff and service users.

* **Duty to report** remains
* **Normal referral routes** and telephone numbers apply
* **Strategy discussions** will continue as normal
* **Strategy meetings** will continue via Skype/telephone conferencing and any other means of remote discussion. Professionals are still expected to prioritise their attendance/contribution at strategy meetings
* **Collaboration with other agencies** will continue as normal e.g. Section 126 enquiries
* **Urgent and necessary visits** to a person’s home will be risk assessed, an intervention plan agreed between agencies and individual professionals involved with the person
* **Personal Protective Equipment (PPE)** will be used as and when needed

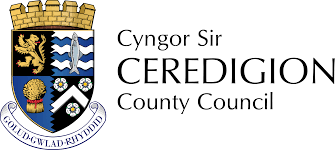
If you have any questions or if you are unsure of when you should refer to us, our duty Social Worker is available Monday – Friday between 9am-5pm on PHONE NUMBER.

Yours sincerely,

Nursing & Residential Care Homes Risk and Escalation Management Policy

**** A picture containing drawing

Description automatically generated

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Strategic Intent

Within the context of an infectious outbreak (such as COVID-19), the purpose of this Risk Management and Escalation Policy is:

**1** To ensure that there are robust contingency plans in place:

* To mitigate the risks of harm to care home residents and/or care home failure;
* To prevent avoidable deaths;
* To ensure timely, appropriate interventions to support recovery from an escalation in their Risk status
* To minimise the impact of care home failure on the whole health and social care system

**2** To provide additionality to the existing Regional West Wales Escalating Concerns Policy for provider performance and support analysis of further risk escalation related to COVID-19 and implementation of escalation protocols and processes to mitigate

**3** To provide a process that allows us to assess the level of risk for every care home contracted by Health Board or the Local Authority and provide a daily overview of that risk

4. To provide a process that allows organisations to analyse the level of risk and implement appropriate and necessary escalation processes to mitigate the risk and timely de-escalation.

Context

The ability of care homes to be able to continue to care for their residents safely and appropriately during any infection prevention outbreak is important in relation to improving outcomes for individuals, other residents and the home itself. London School of Economic identified 42-57% of all deaths linked to the virus were among care home residents. Studies included Spain, Italy, Ireland, Belgium and France. Further, the stability of care homes, particularly care homes for older people, is critical to the stability of the whole health and care system. Indeed, local and national evidence, focused primarily on older peoples care homes, has demonstrated the significant impact that care home compromise has already had with care homes being rendered unable to provide ongoing care to its residents. The latter has been mainly due to workforce constraints; historically recruitment and retention is challenging in the sector and has run on an average vacancy factor of around 8 to 9%[[1]](#footnote-1). COVID-19 has exacerbated this problem and quite simply there is no other resource available to fill this void. Financial viability of the home is also challenged with a care home’s reluctance to accept new residents when affected by an outbreak of the virus, associated with the potentially significant risks to other residents contracting COVID19, their duty of care to residents, and the associated reputational and financial risks.

Needless to say, prolonged periods in this position considerably challenges the financial viability of the home at a time when the health and care system simply would not tolerate it. It is also pertinent to acknowledge that the impact of COVID-19 on care home viability and sustainability is also highly likely to continue to have an effect on the market way beyond the current pandemic.

The usual measures that local authorities / health boards would implement in the event of the potential failure of a care home, such as moving residents to another care home; the local authority taking over the running of the care home; take over by another care home provider; or the health board taking over the running of a nursing care home are severely restricted in the context of the current Corona Virus pandemic, due to the risk of transference of COVID-19 and the health and social care system as a whole being under pressure due to reductions in staffing levels.

It is therefore of paramount importance that additional timely interventions are implemented to support the care home’s recovery from escalated risk and ultimately to ensure the continuity of care of the residents.

Scope

The scope of this policy includes:

* Care homes for adults with personal care (residential)
* Care homes for adults with nursing
* Care homes for learning disability
* Care homes for mental health

Risk Management

**Risks include:**

* Failure to continue to provide the required standard of care
* Compromised safety and wellbeing of residents
* Compromised safeguarding practices
* More significant Deprivations of Liberty
* Failure in infection control creating a public health risk
* Destabilisation and closure of the home
* Failure to prevent avoidable deaths
* Increased demand on unscheduled care in acute hospitals
* Increased demand on community nursing and community hospitals
* Increased demand on alternative forms of social care
* Reputational and regulatory risks

In assessing risks associated with infectious outbreaks in nursing and residential care homes need to consider the unique challenges of each home which may impact on its resilience in these circumstances. There are two primary types of risk factors to be considered; however others include reputational, political, regulatory and service users’ families.

Risk Assessment

Each care home should be able to rate their level of risk in terms of their resilience to infectious outbreaks based on the challenges outlined above.

**Organisational**

**Financial Viability –** Nursing and residential care homes vary widely in their legal structures, business ownership and financial arrangements from a privately-owned single home, to not-for-profit organisations, and from local authority-run care homes to large companies operating many care homes across the UK.

The continued financial viability of the company or organisation which owns the care home(s) within the county is critical to its sustainability. In the event that cash flow failure or the home is unable to meet its financial obligations then a care home can rapidly collapse as a functioning entity, with the responsibility for the care and protection of the residents falling to health and social care, under the local authority’s legal duties as well as the contractual obligations of the contracting organisation.

**Leadership –** Each care home will have key personnel which include the registered manager; deputy manager; registered nurse (if required); senior care workers / shift leaders.

Effective, responsive and cooperative leadership from the Responsible Individual and their key personnel is critical to mitigating the risks.

Small homes rely on a small number of key staff- the absence of these, even temporarily can cause rapid decline in the functioning and viability of the home. Many homes have entered this period with key weaknesses in this area.

**Workforce –** Typically the care sector’s workforce is fragile compromised by recruitment and retention pressures. The workforce may consist of younger inexperienced staff and in contrast older workers close to retirement. Both these groups present their own challenges.

The availability and competence of the nursing and residential care home’s workforce, together with any contingency staffing, to be able to deliver the required standard of care is essential to maintaining the health and well-being of the residents.

Homes which are reliant on temporary, bank or agency staff, or where morale is already low, are at particular risk.

**Environment –** The building layout and space in some nursing and residential care homes may not lend themselves easily to be able to effectively implement strategies to contain the spread of infection presenting increased risk of infection to other residents. In these situations, the guidance recommends isolation in ‘a single room, with a separate bathroom where possible’.

**Health & Wellbeing**

**Individual Residents** - Each resident is an individual and their complexity / acuity will vary. Individual assessments will need to be considered to provide cumulative risk assessment in relation to the level of need / complexity / acuity of the entire nursing / residential care home population. This may regularly change given the ‘turnover’ of residents and their vulnerable disposition.

Assessments and interventions must distinguish between the different needs and wishes of each individual within a setting and avoid any generic approach to health needs of a setting. The needs of residents in care settings vary enormously from the well and active, people with the additional challenges of cognitive impairment or dementias, to people at the end of life. Interventions should reflect this range of needs within the setting.

**Safety & Well-being of all Residents of the Nursing / Residential Care Home** – Before agreeing to provide a service to an individual, the Registered Manager must consider any risks to the individual or to other residents, including preventing safeguarding concerns and avoidable deaths.

**Safety & Well-being of the Staff** – Before agreeing to provide a service to an individual, the Registered Manager must consider any risks to staff.

**Risk Mitigation**

**Mitigating actions** on the level of risk can be considered against the four key areas that nursing and residential care home standards are assessed upon:

* Wellbeing
* Care & Support
* Environment
* Leadership & Management

The mitigating actions are based on evidenced based best practice guidance in relation to managing outbreaks.

**Wellbeing**

* The average level of acuity / complexity is well managed and proportion of residents that are stable are greater than those who are not
* Nursing and residential care homes should have in place standard operating procedures for individual residents with suspected and confirmed infection, including appropriate infection control precautions to protect staff and residents.
* Nursing and residential care home staff should be trained to check the temperature of residents displaying possible signs of infection, using a tympanic thermometer (inserted into the ear). HDUHB has offered training via its Skills to Care programme.
* Where possible, nursing and residential care home staff should be trained to measure other vital signs, at the request of the physician, including blood pressure, heart rate, pulse, oximetry and respiratory rate. This will enable external healthcare practitioners to triage and prioritise support of residents according to need. HDUHB has offered training via its Skills to Care programme.
* All staff working with care home residents should recognise that COVID-19 may present atypically in this group. It may be necessary to use barrier precautions for residents with atypical symptoms following discussion with General Practitioners or other primary healthcare professionals.
* Where possible, primary care clinicians should share information on the level of frailty of residents (mild, moderate, severe frailty) with nursing and residential care homes, and use the Clinical Frailty Scale to help inform urgent triage decisions.
* Plans and protocols are available and implemented effectively to maintain wellbeing of residents (consider levels of escalation, CIW reports / inspections etc.)
* Practices within the home should continue to ensure individuals are properly safeguarded from abuse and/ or neglect. Any actual or risk of abuse or neglect must be reported to the local authority as usual.
* Any deprivations of liberty should continue to be the least restrictive options and must be necessary and proportionate to the perceived risks. New or renewal applications for deprivation of liberty safeguards should continue as usual.

**Care & Support**

* All residents have the opportunity to have an Advanced Care Plans in place, if they have the capacity to do so.

[advance-care-planning-quick-guide](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwj-qubOwvToAhUZGsAKHTxkDw8QFjAAegQIARAB&url=https%3A%2F%2Fwww.nice.org.uk%2FMedia%2FDefault%2FAbout%2FNICE-Communities%2FSocial-care%2Fquick-guides%2Fadvance-care-planning-quick-guide.pdf&usg=AOvVaw01G8D3thWr_nfAudtqejIy)

* Care Homes should be supported to remain open to new admissions and to receive existing residents back from hospital during an infectious outbreak, following government guidance [COVID-19-admission-and-care-of-people-in-care-homes](https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes). This decision will ultimately remain with the Responsible Individual and Registered Manager and should only occur when it is safe to do so.
* When symptoms of infection present there is daily access to General Practitioners or other primary healthcare professionals.
* Remote monitoring available within the home to identify early signs of potential infection and access to intermediate care response within 2 hours
* Nursing and residential care homes should have standard operating procedures for isolating residents with a cognitive impairment who ‘walk with purpose’ (often referred to as ‘wandering’). Behavioural interventions may be employed but physical restraint should not be used. If the person already has a DoLS authorisation, **in many cases changes to the person’s arrangements for their care and treatment will not constitute a new deprivation of liberty and the current authorisation will cover the new arrangements**, but it may be appropriate to carry out a review.
* Nursing and residential care homes should consider whether it is feasible to manage residents entirely within their rooms or in identified ‘zones’ during a possible or actual outbreak. This will have implications for safe staffing, which should be considered before adopting such a policy. Advice from the Infection Prevention team will be provided for the individual circumstances of each home reporting a possible outbreak.
* Nursing and residential care homes should work with GPs and local pharmacists to ensure that they anticipate palliative care requirements and order anticipatory medications early in the illness trajectory.
* Workforce stability – reporting of deficits and recruitment challenges

**Environment**

* Social distancing measures have been adopted, particularly in communal lounges and dining areas
* Personal Protective Equipment is being worn and used correctly.
* Staff are following the correct hand washing procedure
* Cleaning schedules have been increased and focus on “high traffic” areas such as door handles, toilet flushes, and other frequently touched surfaces
* Government infection control guidance is being followed: [coronavirus-infection-prevention-and-control](https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control)

**Leadership & Management**

* Clear evidence of support from GPs and the community multidisciplinary teams
* Nursing and residential care homes should work with General Practitioners, community healthcare staff and community geriatricians to review Advance Care Plans with care home residents. This should include discussions about how COVID-19 may cause residents to become critically unwell, and a clear decision about whether hospital admission would be considered in this circumstance.
* Advance Care Plans must be recorded in a way that is useful for healthcare professionals called in an emergency situation. A paper copy should be filed in the care home records and, where the facility already exists, an electronic version used which can be shared with relevant services.
* Nursing and residential care homes should be aware that escalation decisions to hospital will be taken in discussion with paramedics, general practitioners and other healthcare support staff and in consideration of the individual’s Advanced Care Plan.
* A jointly agreed algorithm for **Care Home Assessment of a Suspected Case of COVID-19** is known and available for care homes to follow, see **Care Home Assessment and Management of Suspected COVID (pending approval)**
* They should be aware that transfer to hospital may not be offered if it is not likely to benefit the resident and if palliative or conservative care within the home is deemed more appropriate. Support will be provided to Care Homes by Clinical Nurse Specialists for Palliative Care. Care Homes should work with healthcare providers to support families and residents through this.

**Escalation Levels and Monitoring Processes**

**Overview**

The County should have in place a Community **Daily Operational Command** (DOC) system, which acts as the central point for care home data gathering, monitoring and analysis to inform a risk escalation level and appropriate reporting lines.

The **Daily Operational Command** will:

* Gather and monitoring processes to determine the level of risk within the service area
* Identify different level of risk escalation including the triggers for action
* Manage risk escalation levels 1 & 2 through monitoring processes and coordinated collaboration through use of a series of ‘Action Checklists’ – ensuring that actions are communicated and reported back through appropriate levels of command.
* Produce a daily Situation Report (SitRep) with key data.

Alert key partners through the SitRep of any Level 3 issues that will need to be immediately escalated.

**County Escalation Levels**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Colour Coding** | **Level of Pressure** | **Monitoring** | **Level of Support** | **Action** |
| **LEVEL 1** | Moderate/ manageable pressure | Monitoring officer works with staff and reports into daily DOC | Standard operating processes are **functioning as efficiently as possible** and not significantly compromising the system. | **Tolerate** |
| **LEVEL 2** | Significant Pressure | Senior Manager / Head of Service (HoS) | **Enhanced support required** with senior managers and HoSworking together across the whole care system to provide appropriate support. | **Collaborate** |
| **LEVEL 3** | Extreme Pressure | Head of Service / Director | Requires **crisis intervention from** **external support** to continue service provision. | **Intervene** |
| **BUSINESS CONTINUITY** | Failure | Director of Social Services / Director of Long Term Care | Nursing / residential care home ceases to be in a position to continue to provide care **and requires extreme contingency** such as transfer of residents to alternative setting and / or external ‘take over’. | **Contingency** |

Care Home Risk Assessment

Every nursing and residential care home is contractually required to have a Business Continuity Plan which complies with the County’s guidance document. This includes advice to keep their Business Continuity Plan under constant review, as official advice changes. The nursing / residential care home’s risk rating is assessed using the West Wales Escalating Concerns Policy’s risk assessment matrix:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Likelihood** | **Impact** | | | |
|  | **1. Insignificant** | **2. Minor** | **3. Moderate** | **4. Major** |
| **4. Almost certain** | **4** | **8** | **12** | **16** |
| **3. Likely** | **3** | **6** | **9** | **12** |
| **2. Possible** | **2** | **4** | **6** | **8** |
| **1.Unlikely** | **1** | **2** | **3** | **4** |

Residential and nursing care homes are advised that their staffing levels will determine their risk level, as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| Staff Availability | 0-10% Reduction | 10-20% Reduction | 20-30% Reduction |
| Risk Level |  |  |  |

Residential and nursing care homes are advised that the number of residents who are suspected COVID-infectious will determine their risk level, as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| Staff Availability | 0-1 resident | 2 – 4 residents | 5 or more residents |
| Risk Level |  |  |  |

The County’s guidance to residential and nursing care homes sets out what is expected of providers during a COVID-19 incident or outbreak.

**Operational Management of Escalation**

* Baseline risk assessment should have been undertaken between care home providers and the County’s Commissioning team for each care home (core provider performance practice)
* Nursing and residential care home managers will contact the County’s Commissioning team to update their risk assessment when there is a change (i.e. 2 or more residents presenting with COVID-19 symptoms; more than 10% reduction in staff availability).
* Nursing and residential care home business owners will contact the County’s Commissioning team to update their risk assessment if there are concerns about the financial viability of their business.
* The West Wales Escalating Concern Procedure will be used where the risk level of a nursing / residential care home is elevated to amber or red.

**Actions to be taken at each level of Escalation**

The menu of actions below provides an overview of the actions expected to be undertaken at each level.

|  |  |  |
| --- | --- | --- |
| **Colour Coding** | **Level of Pressure** | **Actions Expected** |
| **Green: Level 1** | | |
| TOLERATE | Moderate/ manageable pressure | Business as usual to ensure compliance with regulations / health and care standards  Care Settings should have in place standard operating procedures for individual residents  Appropriate infection control precautions to protect staff and residents.  Home is provided with contact details for additional advice and support e.g. Infection Prevention & Control, district nursing visits, ‘just checking’ calls from senior management. |
| **Amber: LEVEL 2** | | |
| COLLABORATE | Severe Pressure | Implement any guidance and protocols associated with risk (e.g. *Managing outbreaks in care settings with multiple occupants*)  Maintain good communication links with all relevant Authorities and Professionals.  Communication to families and any other parties will need to be done in agreement with the Local Authority and or Local Health Board  Daily reviews of residents’ symptoms by appropriate professionals  Engage with primary care GP, in reach from community nurse daily, virtual vital signs monitoring, routine IP&C / Environmental Health Officer assessments, monitoring spread of infection, implementation of protocols to zone  Access to secondary care physician for advice re Advanced Care Planning and Palliative care planning as appropriate. |
| **Red: Level 3** | | |
| INTERVENE | Extreme Pressure | Care provision replaced by either Local Authority and / or Health Board personnel.  Transfer of infected residents into another facility to protect those not infected.  In consultation with Director of Operations and Medical Director, admit those residents who are infected to hospital to protect those remaining residents. |
| **BLACK: BUSINESS CONTINGENCY** | | |
| CONTINGENCY | Failure | In the event of business continuity failure, transfer of all residents to another facility which is able to meet their needs.  Re-provision of the nursing / residential care home into a RED nursing / residential care home site and admit other infected residents from other facilities. ‘  Take over’ by other organisation to stabilise the home on temporary and / or permanent basis. |

**De-Escalation Process**

Head of Service confirms de-escalation to Level 3 or below and notifies Directors.

**Operational Management and Responsibility**

See **Daily Operational Command – Standard Operating Procedure (draft)**

**Clinical Management and Monitoring of Affected Residents**

* Those residents affected by COVID-19 (suspected and confirmed) will be identified by the Daily Operational Command
* DOC notifies the relevant Locality Leadership (GP, Locality Manager and their teams)
* Daily consultation by GPs with their Care Home registered patients daily
* GPs will be responsible for reviewing those residents daily and where affected by COVID-19 ensure that close monitoring of their condition is in place by themselves and their multidisciplinary (MDT) professional colleagues
* Communication with family members undertaken by the appropriate individual determined by the GP and the MDT
* GP will refer to secondary physicians (medical and / or specialist palliative care) for specialist advice and / or when Outbreak of 10+ residents in the home
* Infection Prevention and Control / Environmental Health Officers daily support

**Management to Support Provider Performance and Home Sustainability**

* Those care homes affected by COVID-19 (suspected and confirmed) will be identified by the DOC
* DOC notifies the appropriate Head of Service (Local Authority and / or Health Board)
* DOC notifies the relevant Locality Manager who will work with the Head of Service to support provider performance and implement appropriate mitigating actions

Powys Integrated Monitoring, Assurance & Escalation of Nursing & Residential Care Homes during the COVID-19 Pandemic



|  |  |  |
| --- | --- | --- |
| **Document Reference No:** | Integrated Monitoring, Assurance & Escalation of Nursing & Residential Care Homes during the COVID19 Pandemic | |
| **Version No:** | 1.5 | |
| **Issue Date:** | April 2020 | |
| **Review Date:** | October 2020 | |
| **Author:** | Director of Nursing & Midwifery PTHB  Assistant Director Quality & Safety, PTHB  Section 33 Pooled Funds Manager PCC | |
| **Document Owner:** | Assistant Director Quality & Safety, PTHB  Section 33 Pooled Funds Manager PCC | |
| **Accountable Executive:** | Director of Nursing & Midwifery PTHB  Director of Social Services PCC | |
| **Approved By:** | Gold Command PTHB | |
| **Approval Date:** | April 2020 | |
| **Document Type:** | Policy | Non-clinical |
| **Scope:** | The policy applies to staff within PTHB and PCC who provide services to care homes. | |

The latest approved version of this document is online.

If the review date has passed, please contact the Author for advice.

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board.

Version Control

|  |  |  |
| --- | --- | --- |
| **Version** | **Summary of Changes/Amendments** | **Issue date** |
| 1 | Original policy published | 30 April 2020 |
| 1.1 | Inclusion of feedback from PTHB and PCC colleagues | 28 April 2020 |
| 1.2 | Review and feedback on version 1.1 | 29 April 2020 |
| 1.3 | Additional comments from DoN | 29 April 2020 |
| 1.4 | Addition of draft SITREP | 29 April 2020 |
| 1.5 | Approved documents added to Appendices  Optimal & Consistent Primary Medical Care in Care Homes May 2020 added to evidence base | 20 May 2020 |

Engagement & Consultation

**Key Individuals/Groups Involved in Developing this Document**

|  |
| --- |
| **Role / Designation** |
| Director of Nursing & Midwifery PTHB |
| Director of Planning and Performance PTHB |
| Director of Social Services PCC |
| Assistant Director Quality & Safety PTHB |
| Section 33 Pooled Funds Manager PCC |
| Board Secretary PTHB |
| Director of Finance PTHB |
| Director of Therapies and Health Sciences PTHB |
| Medical Director PTHB |
| Director of Public Health PTHB |
| Head of Commissioning Social Services PCC |
| Assistant Director of Nursing PTHB |
| Senior Nurse Lead CHC PTHB |
| Consultant Public Health Medicine |
| Assistant Director Innovation & Improvement PTHB |

Circulated to the following for Consultation

|  |  |
| --- | --- |
| **Date** | **Role / Designation** |
| 28.4 2020 | PTHB Executive Director and Director of Social Services |
| 29.0.2020 | Director of Nursing & Midwifery PTHB |
| 29.4.2020 | PTHB GOLD |
| 20.5.2020 | All members of MDT and Care Homes Oversight Group |

Evidence Base

This policy and Standard Operating Procedure is based on the application of Welsh Government’s policies and guidance and identified best practice.

**Legislation which determines the Council's dealings with care homes**

This includes:

* Social Services and Wellbeing (Wales) Act 2014
* Part 9 of the Social Services and Well-being (Wales) Act 2014 reference to primary care responsibilities
* Regulation and Inspection of Social Care (Wales) Act 2016 (RISCA)
* Deprivation of Liberty Safeguards, as an amendment to the Mental Capacity Act 2005

**Guidance documentation**

This includes:

* Infection control guidance

<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>

* British Geriatric Society COVID-19: Managing the COVID-19 pandemic in care homes for older people. <https://www.bgs.org.uk/sites/default/files/content/attachment/2020-04-14/BGS%20Managing%20the%20COVID-19%20pandemic%20in%20care%20homes%20V2.pdf>
* Public Health Wales guidance

[https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-COVID-19/information-for-healthcare-workers-in-wales/](https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-healthcare-workers-in-wales/)

**Primary Care**

**Optimal & Consistent Primary Medical Care in Care Homes May 2020**

The COVID-19 pandemic is an unprecedented event in our lifetimes. Local Health Boards, Clusters and General Practices listened to the advice offered and took action to prepare for a massive wave of patients infected with coronavirus. General practices in particular have taken extraordinary steps to rapidly change its operating model and adopt new ways of working. However, not only has that single massive wave not appeared, but the service changes have exposed risk and potential harm. Health Service leaders need to adjust focus of the COVID-19 campaign, and make changes to service delivery to minimise that risk of harm and provide high value, safe care in the community.

A Task and Finish group was set up, and tasked with focusing on 3 main standards;

1. To be assured that every care home resident has had an appropriate and recently opportunity to develop or review an advance or future care plan (ACP) in place
2. To be assured that a call by a health professional working in a care home to any GP practice/primary care provider in Wales during Monday to Friday 0800-1830 will result in a timely and appropriate response
3. To be assured that care homes are effectively communicating the situation about which they are asking for professional advice through the use of an appropriate approach

The group was chaired by Dr Andrew Havers, Senior Medical Officer, Welsh Government.

Impact Assessments

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Equality Impact Assessment Summary** | | | | | |
|  | **No impact** | **Adverse** | **Differential** | **Positive** | **Statement**  Please remember policy documents are published to both the **intranet** and **internet.**  The version on the internet must be translated to Welsh. |
| **Age** |  |  |  | √ |
| **Disability** |  |  |  | √ |
| **Gender reassignment** | √ |  |  |  |
| **Pregnancy and maternity** | √ |  |  |  |
| **Race** | √ |  |  |  |
| **Religion/Belief** | √ |  |  |  |
| **Sex** | √ |  |  |  |
| **Sexual Orientation** | √ |  |  |  |
| **Marriage and civil partnership** | √ |  |  |  |
| **Welsh Language** | √ |  |  |  |
| **Human Rights** | √ |  |  |  |
| **Risk Assessment Summary** | | | | | |
| **Have you identified any risks arising from the implementation of this policy / procedure / written control document?**  No risks identified | | | | | |
| **Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?**  No issues identified | | | | | |
| **Have you identified any training and / or resource implications as a result of implementing this?**  None | | | | | |

Policy Statement

Powys Teaching Health Board (PTHB) and Powys County Council (PCC) are committed to improving the quality, efficiency and effectiveness of services for people residing in residential care homes, nursing care homes or dual registered care homes in Powys.

The COVID-19 pandemic raises particular challenges for care home residents, their families and the staff that look after them. To maximise the opportunity to protect health and prevent ill-health for residents and staff, as well as secure sustainability of the sector, it is essential that PTHB and PCC build on existing good practice, predicated on quality, assurance and improvement. The availability and accessibility of robust local data and intelligence is fundamental to identifying the need for added support, intervention, assurance and improvement.

This policy applies to older adults residing in care homes. It sets out the way in which Powys Teaching Health Board (PTHB) and Powys County Council (PCC) will monitor, seek assurance & respond to escalated issues in these homes during the COVID19 pandemic, within the context of the statutory responsibilities of both organisations including safeguarding. **This can be found at Appendix 8.**

The pressures faced by Powys’ care homes are acknowledged and the measures taken in respect of this policy need to be proportionate to the capability of those settings to engage with and deliver.

Aim and Objectives

The aim of this policy is to save lives in the light of the COVID-19 pandemic, by strengthening the opportunity for system leadership in Powys. To achieve this we will:

* 1. Work in partnership to ensure avoidable harm to residents, staff and more broadly across the system including the potential for increased spread by staff employed in more than one setting.
  2. Ensure that there are robust contingency plans in place.
  3. Provide a framework for provider performance and analysis of further risk elevation related to COVID-19.
  4. Provide a process that allow us to assess the level of risk for every home and provide a daily overview of that risk.
  5. Provide a process that allows PTHB and PCC to analyse the level of risk and implement appropriate escalations processes to mitigate that risk.
  6. Implementation of escalation protocols and processes to mitigate identified risks in a timely way.
  7. Support the current and future sustainability of the care and home sector.
  8. Share learning in all arenas where this can influence policy and support improvement.

It is recognised that there are a number of Powys funded residents in settings out of county which is outside the direct scope of this policy, and managed through existing processes.

Recognising that some of the established mechanisms that currently form part of the supportive and commissioning element to this sector are less accessible during the pandemic; this policy will enable PCC and PTHB, as joint commissioners, to fulfil their statutory duties and maximise the opportunity to protect, prevent and control the spread of COVID-19 within care homes.

Integrated Focus

The COVID-19 pandemic introduces a new, highly challenging environment in which people are living, working and providing a service. PTHB and PCC recognise that much of the care home provision within Powys in independently provided and therefore requires a collaborative approach.

The experience in Powys mirrors that in the rest of Wales and the UK and learning generated from these sources is being used to shape the response locally. An enhanced integrated monitoring and assurance approach expressed in a Standard Operating Procedure (see Appendix) is required to enable identification, management and mitigation of risk, plus to share learning more widely, supported by:

* Robust integrated SITREP reporting, focusing on access, flow, staffing and impact of testing on supply and demand of both. Details of the SITREP can be found at Appendix 8.
* Standardised, regular nursing review in care homes, focusing on quality, safety, infection prevention and control, safeguarding, the experience, skillset, training, competency, and wellbeing of care home staff. Details of the nursing and quality review in care homes can be found at Appendix 8.
* Working collaboratively with Public Health Wales Closed Setting Cell
* The availability of personal protective equipment (PPE), its appropriate use, the training and competency of staff
* Cognisance of each resident’s preference in relation to care and treatment including advanced care planning, status in relation to commencement of cardio-pulmonary resuscitation and the role of Primary Care
* The existence and effectiveness of application of standard operating procedures that specifically support the health and wellbeing of residents
* The accessibility and appropriate use of other services to support resident’s health and wellbeing including general practice, safeguarding and Care Inspectorate Wales
* The environment in which the care home operates, e.g. the layout of the building, the ability to prevent and manage the spread of infection
* Existing local assurance processes
* Soft intelligence from other stakeholders
* The leadership and management response of care and residential home providers and the factors affecting it e.g. financial sustainability
* Care Inspectorate Wales reports
* Recommendations from national research and guidance
* Professional judgement based on all of the above, subsequently assessed against the escalation metrics. Details of the Care Homes Response Escalation Matrix can be found at Appendix 8.

Oversight, reporting and accountability

Joint integrated monitoring and assurance will be realised through a multidisciplinary team approach. The MDT Lead will report and contribute to the Executive Oversight Group, scheduled to meet twice weekly, who will scrutinise the work of the MDT in conjunction with taking a system wide view of the objectives listed under section 2 above. The Terms of Reference of the MDT Group can be found atAppendix 8.

The Executive Oversight Group will report directly into both PCC and PTHB Gold Command Groups initially. The arrangements for both groups will be reviewed regularly to ensure they maintain fit for purpose to deliver on the contents of this policy. The terms of reference of the Executive Oversite Group can be found at Appendix 8.

Post COVID-19

This policy identifies the challenges faced in relation to maximising the health and wellbeing of both residents and staff in the care sector, including whole system change to effectively and efficiently respond. The lessons learned as a result of implementing this policy should be reflected upon formally, ensuring that the future integration of health and social care services is maximised. The existing Section 33 Residential and Nursing Home Operational Group will be used as the principle vehicle for taking this work forward.

Further information regarding this document and its appendices please contact Powys Teaching Health Board Safeguarding Team via the generic email address;

[PowysTHB.Safeguarding@wales.nhs.uk](mailto:PowysTHB.Safeguarding@wales.nhs.uk)

Generic Specialist Services for Victims of Sexual Assault

An interim process for victims of sexual assault in need of a forensic service has been developed by Dyfed Powys Police in collaboration health partners as outlined below.

Dyfed Powys Police guidance for SARC attendance During the COVID-19 Pandemic

This document has been produced to provide guidance for SARC attendance during the COVID-19 pandemic. This document should be read in conjunction with the information contained within the FFLM (link below). The guidance is being regularly updated so please ensure you refer to the most up to date guidance. (Version 3 is current as of 20th March 2020).

[https://fflm.ac.uk/publications/template-for-step-by-step-guidance-for-sarc-fmes-via-telephone-or-videoconferencing-during-COVID-19-pandemic/](https://fflm.ac.uk/publications/template-for-step-by-step-guidance-for-sarc-fmes-via-telephone-or-videoconferencing-during-covid-19-pandemic/)

Why is there a new process?

The guidance introduces a new process in which medical staff (Force Medical Examiners) assess the health of the victim. This will allow the FME’s to triage the case and make a decision whether it’s appropriate for the victim to undergo a forensic examination or whether other methods of evidence recovery should be followed.

By adhering to this guidance, we will reduce the exposure of DPP and partner agency staff to COVID 19, whilst ensuring the victim is medically assessed, supported and where possible forensic samples obtained. The needs of the victim’s and the opportunity for the recovery of evidence will be assessed against the availability of resources and facilities.

It is vital Police work together with the FME’s, SARC staff and the Health Authority to provide a service to our victims.

When does the guidance apply?

The guidance should be followed where there is a report of a Rape or Sexual offence and the report is made within the forensic window.

Early Considerations

Police investigators should consider prioritising lines of enquiry, which may negate the need for a forensic examination. For example, an early suspect interview may lead to a defence of consensual sex. This could reduce the demand on the service and the risk of spreading coronavirus.

The guidance advises that where attendance at the SARC for an examination is not deemed suitable, the victim may obtain swabs themselves.

It is imperative to note that some of the measures suggested in this guidance may impact on the integrity of the forensic evidence. **Therefore, this should be considered as part of the multi-agency discussion, and documented by the senior investigating officer as a policy decision.**

SARC Resilience

New Pathways have resilience, however in the event no crisis workers are available, police will be provided instructions so they can access the building through their ‘on call’ facility.

New Pathways are reviewing their equipment to ensure they have the swabs, early evidence kits, medication and paperwork available in line with the protocol.

DPP will also make efforts to ensure additional swabs are available at key stations.

New Pathways are in the process of receiving PPE equipment which will enable them to assist victims diagnosed/ suspected of having COVID-19.

New Pathways only supply the morning after pill to victims, with all other medication provided by local arrangements. We are liaising with Health, CRG and New Pathways to provide an interim solution. In the Dyfed Powys Police area, local health authorities will continue to run sexual health clinics across the counties albeit in a reduced capacity.

SARC suites currently uses cleaning products, which will destroy COVID-19.

SARC units have implemented their own procedures to assess and identify any risk to staff from visitors to the suite.

Initial Response

The initial investigative response will be conducted as per the force guidance, with the exception of our initial contact with the victim.

A SOTO must be allocated where available, and they should implement the process outlined in this guidance. The response will be coordinated in conjunction with the Senior CID supervisory Officer (DS/DI).

The Sexual Offences Trained Officer should then proceed with the following instructions- ensuring the senior CID supervisor is briefed at each stage of the process, in order for them to make informed decisions.

If a SOTO is not available then the most appropriate resource to support the victim and gather evidence should be identified.

Process

1. A COVID-19 Telephone Screening and Triage tool should be used for any request for an FME (see appendix).

2. Use Flowcharts 1 and 2 (below) to assist with the management of cases.

Please note: Unless the Victim attended the station to make the report, please do not bring the victim to the station to utilise the video conferencing facilities. If video conferencing is not available at the victim’s location, the assessment can be conducted by telephone. Victims may use FaceTime, Skype or WhatsApp if these are available to both the FME and the Victim.

3. In cases where the client has reported straight to SARC, (whilst maintaining safe and caring practice), limit face to face contact, as some may be infectious whilst symptomless, initiate contact over the phone to obtain their history.

4. It is essential that your written records reflect the process you have undertaken.

Outcome of the Health Assessment

The FME assessment will provide information to the investigative team. The information (contained in the flowcharts) will assist you to respond appropriately in each situation.

Cases where self-swabbing is advised by the FME

Where the FME advises that the victim should self-swab there are two scenarios. Either the Victims will have attended SARC to self-swab or the police will collect the relevant medication, swabs and paperwork from the SARC and take them to the victim.

The Sexual Offences Trained Officer /Officers will be expected to lead on the collection of evidence from early evidence kits, clothing and when appropriate self-swabbing.

There are leaflets to explain the self-swabbing process to victims and these should be provided on every occasion. You can find these in the appendix below.

Consent

As per the current force policy a victim’s consent is required for the forensic examination to take place, this should be documented. In addition please ensure the assessment process is explained, please make it clear the FME will be asking health related questions.

Confidentiality

Where feasible the victim should be left alone when discussing the health assessment with the doctor. If disclosures are made in the presence of officers these must be treated confidentially.

Protection for officers/CSIs responding to complaints of Rape and Sexual Offences

Officers must defer to the most recent force guidance on the use of PPE in circumstances where the victim discloses they have symptoms of, or where they have been diagnosed with COVID-19.

Where Victims have been diagnosed or have symptoms of COVID-19, officers should encourage victims to utilise their own equipment to facilitate contact with the Dr. Please bear in mind that some electronic devices may contain evidence, and if the phone is used to facilitate a call, the SOTO should record details of this.

Where officers utilise their force allocated laptops or hand held devices to facilitate communication then care should be taken to clean the devices after use to prevent the spread of COVID-19.

Transporting the victim to SARC suites

Where possible ask the victim to convey himself or herself to the SARC suite, if this is not feasible the officer assisting the Victim should ensure that the police vehicle, which has been utilised to transport the victim of COVID-19 is flagged up as per the force procedure in order that the appropriate measures can be undertaken to clean the car.

During the car journey, the victim should be asked to wear a facemask and to continue to wear this upon entry to SARC where they have symptoms of or have been diagnosed with COVID-19. The FME can provide guidance on this following the health assessment.

Victims should be asked to attend alone or with only one supporter.

Attendance at the SARC suite

Officers, Victims and any supporters attending the SARC will be asked screening questions as per their current protocol. Anyone entering SARC will be asked to wash their hands, and practice social distancing. SARC staff will direct you to limit your movement within the building to specific areas and we ask you respect their request.

Support for the victim

Attendance at the SARC guarantees a referral is made to the ISVA service provided by New Pathways. It is vital at a time when victims are less likely to attend, that referrals are made in every case where the victims consent. At a time of imposed isolation and ill health, the ISVA support is more important. New Pathways will aim to contact all new clients within 72 hours.

Regional response

A regional response may be required if there are significant resource, facility and equipment challenges. If a SARC or partner involved in the process have concerns about capacity, they should request a meeting between police, health, New Pathways, CRG in order that it can be escalated.

*Please see Appendix 6 at the end of the document.*

Data Protection Guidance

Due to the increase in the numbers of staff, working from home and working remotely the following regional guidance and advice for staff has been put together, to ensure compliance with GDPR legislation (Data Protection Act 2018) and help reduce the risk of any unintentional data breaches.

Purpose of this Document

This document has been created to remind staff of best practice when working from home, in light of the measures being taken to contain COVID-19 through more flexible working arrangements.

This guidance is for advisory purposes only, and the responsibility for information governance and compliance with GDPR requirements and legislation remains with each agency in the partnership. Staff should read this document alongside their own agency’s guidance and Data Protection Procedures.

Work Area

Be mindful of where you are working and discussions being undertaken. Consider anyone else in your household in terms of where you set up your workspace. No one else should be able to see your screen or paperwork, or overhear confidential discussions. It may not be possible to prevent this completely; but every effort should be taken to minimise risk of others in your household hearing/seeing confidential information.

You should also bear in mind windows and whether anyone outside can hear phone calls/see your screen. Lock your computer screens when away from the desk/location, however briefly you are leaving the workspace.

Be mindful of paper records and keep them secure at all times. Avoid leaving them out and visible to others in the household; if you can, lock or store them away in a drawer.

Methods of Communication

Communication with colleagues which involve personal data should be through usual work channels only, e.g. phones/Skype/work email etc. Avoid use of other channels such as Facebook messenger as these rarely use encryption services to protect data in transmit, unless agreed by your organisation. **NB: it is the responsibility of organisations to ensure any approved communication platforms are secure and encrypted.**

Skype / Microsoft Teams Meetings

Consider who is invited to calls discussing confidential information and keep this to a minimum; avoid bolting-on confidential discussions to team/group meetings unless everyone on the call is a necessary recipient of that information. Check at the start of the call who is taking part and take care when setting up calls to ensure the correct individuals are invited.

Recordings should only be made when necessary to do so and all parties are in agreement.

Email

As we rely more heavily on email, keep practice as robust as possible in terms of checking that the email addresses of recipients is correct. One of the most common data breaches occur as a result of selecting the wrong name in a contact list, or self-populated suggestions e.g. clicking David John instead of David Jones. Auto-Populate of recipients can be turned off and should be considered as a means of reducing the risk of this.

If you need to send any confidential information via email, keep the body of the email free of anything which identifies a customer, and instead contain all of the personal information in an attachment which you then password protect. If the information you are sending is sensitive, best practice would be to password protect this data to reduce the risk of someone else accessing it.

If you are sending anything with a password, do not include the password in the email. Ideally, give the recipient the password via other means, e.g. asking them to call you for it wherever practicable.

If you are sure of and have checked the recipient, then organisational email encryption can be employed, such as Microsoft Encrypt or TLS.

**NB: encryption systems on email servers protect against external interception of messages, but do not protect against unintended recipients within agencies from accessing the data.**

Auto forwarding organisational emails to personal email accounts is not acceptable, and avoid using personal email accounts wherever possible; these do not have the same encryption or protection as work accounts. If this is not possible in the current COVID-19 context, use the most secure method of protection available.

Personal Devices

If you have no option but to use a personal laptop, ensure you have anti-virus software. If this device is shared with others in your household/family, keep all confidential information password-protected under your own user account or area. Do not select “remember me” options for work-related login details on a shared computer or account, and make sure that you log off after each session in any work-related programmes or sites so that they cannot be accessed by any other users of the computer.

Where in place, the organisation’s Bring Your Own Device policy must be followed.

School staff can and should make use of the storage area available on Hwb, which enables secure and password-protected storage of data.

Save all documents to servers instead of desktops, to ensure the data is backed-up and secure.

Other Considerations

* Keep your passwords secure and confidential and change them frequently.
* Avoid use of memory sticks to save files, but where these are employed ensure they are encrypted.
* If visiting customers, be mindful about what paperwork you take and restrict this to the paperwork required for the visit(s) being undertaken only.
* When in transit equipment or paperwork should not be left in sight in unattended vehicles.
* If you think that there has been a breach of personal data, you should report this following your agency’s Data Breach Procedure.

Appendix 1 - Partner Agencies of the Mid and West Wales Safeguarding Board

|  |  |
| --- | --- |
| **Carmarthenshire County Council** | C:\Users\hickss\Pictures\Annual Report Logo's\1. Carmarthenshire CC.jpg |
| **Ceredigion County Council** | C:\Users\hickss\Pictures\Annual Report Logo's\4. Ceredigion CC.jpg |
| **Pembrokeshire County Council** | C:\Users\hickss\Pictures\Annual Report Logo's\2. Pembrokeshire CC.jpg |
| **Powys County Council** | C:\Users\hickss\Pictures\Annual Report Logo's\3. Powys CC.jpg |
| **Dyfed Powys Police** | C:\Users\hickss\Pictures\Annual Report Logo's\6. Dyfed Powys Police.jpg |
| **Hywel Dda Health Board** | C:\Users\hickss\Pictures\Annual Report Logo's\10. Hywel Dda.jpg |
| **Powys Teaching Health Board** | C:\Users\hickss\Pictures\Annual Report Logo's\8. PTHB.jpg |
| **National Probation Service** | C:\Users\hickss\Pictures\Annual Report Logo's\5. National Probation Service.jpg |
| **Public Health Wales** | C:\Users\hickss\Pictures\Annual Report Logo's\9. Public Health Wales.jpg |
| **Welsh Ambulance Service NHS Trust** | C:\Users\hickss\Pictures\Annual Report Logo's\37. Welsh Ambulance Trust.jpg |
| **Ceredigion Association of Voluntary Organisations (CAVO)** | [CAVO - Ceredigion Association of Voluntary Organisations ...](https://www.google.com/url?sa=i&url=https://ceredigion.volunteering-wales.net/&psig=AOvVaw22aMLsMRJEynE2gS9BrQiQ&ust=1588771870552000&source=images&cd=vfe&ved=0CAIQjRxqFwoTCODtm8vqnOkCFQAAAAAdAAAAABAD) |

Appendix 2 - Regional CP Conference Interim Process

Appendix 2a – Carmarthenshire

**ICPCC Conference**

**Prior to conference;**

* Invitations will be sent out by email with a conference date & time for conference to take place.
* Agency reports to be submitted to the conferencing support team 48 hrs in advance of the conference.
* Agencies to share their reports with the family by phone 24 hrs in advance of the conference.
* On the day of the Conference and where possible, the parents will be invited into the relevant office to meet with the conference Chair and Social Worker to participate in the conference with other agencies who will be available through Skype.
* Alternatively, when it is not possible for the parents to meet at the offices or through Skype, the conference Chair will contact the family to ensure they have received all of the reports, seek their views/responses, and read out any reports not sent to them (usually GP and Police reports). They will ask the family’s views on registration. The Chair will share with agency partners in the conference via Skype.

**Conference**

* Agency Partners are expected to be available on Skype at the time and date of conference.
* Conference support team will e-mail the agency partners all reports 30 minutes prior to the start of the conference. Partners will be given 30 minutes to read the reports.
* After 30 minutes, agency partners will be expected to participate in the Conference meeting through Skype.
* Following a SoS analysis at the Conference, the Chair will then review the responses and request a decision from the agencies regards registration and the reasons. Family will also be consulted on views.
* If the family are unable to attend the Conference or join through Skype, the Chair will ring the family and explain the decision of the meeting. This will be followed up the same day by the Social Worker to inform the family of any Care and Support Protection Plan and how visits etc. will proceed.

**RCPCC – Remote Review Conference (Skype/Telephone)**

**Prior to conference;**

* Invitations will be sent out by email with a conference date & time for RCPCC to take place.
* Agency reports to be submitted to the conferencing support team 48 hrs in advance of the meeting.
* Agencies to share their reports with a family by phone (preferably) 24 hrs in advance of the conference.
* Prior to the conference, Chair will contact the family though Skype/telephone to ensure they have received all of the reports and read out any reports not sent to them (usually GP and Police reports).

**Conference**

* Following the Chair’s Skype/telephone call to family prior to conference, Chair will continue with Skype/telephone call to family and commence conference.
* Agency Partners are expected to be available on Skype at the time and date of conference.
* Conference support team will e-mail the agency partners all of the reports 30 minutes prior to the start of the conference. Partners will be given 30 minutes to read the reports.
* After 30 minutes, agency partners will be expected to participate in the Conference meeting through Skype at the time arranged for the start of conference.
* Following a SoS analysis at the Conference, the Chair will review responses and request a decision from the agencies regards registration and the reasons. Family will also be consulted.
* If the family are unable to join through Skype or via telephone, the Chair will ring the family and explain the decision of the meeting. This will be followed up the same day by the Social Worker to inform the family of any Care and Support Protection Plan and
* How visits etc. will proceed.

Appendix 2b – Ceredigion

**ICPCs**

**Prior to conference;**

* Invitations to agencies and family will be sent out by email with a conference date & time from the QA admin.
* Agency reports are to be submitted to the QA admin team 48 hrs in advance of the conference.
* QA admin will establish with each agency how they will they take part in the conference. The Social Worker will contact the family to establish how they take part.
* Agencies are to share their reports with the family by phone (preferably) or email 24 hrs in advance of the conference. If email is used, the report must be password protected.
* On the day of the conference, the Conference Chair will contact the family to ensure they have received all of the reports, seek their views/responses and share any reports not sent to them. They will ask the family’s views on registration if the family is unable to take part in the call/Skype meeting.
* QA admin will be on the call/Skype and in receipt of the emails, and will produce concise minutes as a record of the meeting and decision and agreed actions in the plan.

**Conference Process**

* Agency Partners are expected to be available via conference call or Skype meeting or email at the time and date of the conference for roughly 1 ½ hrs.
* QA admin will email agency partners all reports (password protected with the date of conference) 24 hours before the conference. Agencies will be expected to accept the read receipt so that QA admin are aware they have been received.
* Agency partners will be expected to provide their views on registration during the call/Skype meeting or to email them and their reasons for this at the time of the conference. Emails received will be saved under the child’s name on the QA folder and this information will be included in the minutes.
* The Chair will then review all the responses made in the call or via email and will confirm the conference decision in an email directly after the conference to all conference members.
* The Chair will ring the family and explain the decision of the meeting if they have not been able to take part in the call/Skype meeting. This will be followed up the same day by the Social Worker to discuss with the family the Care and Support Protection Plan and how visits etc. will proceed.
* The Plan will be emailed by QA admin to the Core Group Members in advance of the Core Group meeting. The minutes of the meeting will be completed by QA admin within the required timescale and sent out via email.

**RCPCs**

**Prior to conference;**

* Invitations to agencies and family will be sent out by email with a conference date & time from the QA admin.
* Agency reports are to be submitted to the QA admin team 48 hrs in advance of the conference
* QA admin will establish with each agency how they will they take part in the conference. The Social Worker will contact the family to establish how they take part.
* Agencies are to share their reports with the family by phone (preferably) or email 24 hrs in advance of the conference. If email is used the report must be password protected.
* On the day of the conference, the Conference Chair will contact the family to ensure they have received all of the reports, seek their views/responses and share any reports not sent to them. They will ask the family’s views on registration if the family is unable to take part in the call/Skype meeting.
* QA admin will be on the call/Skype and in receipt of the emails, and will produce concise minutes as a record of the meeting and decision and agreed actions in the plan.

**Conference Process**

* Agency partners are expected to be available via conference call or Skype meeting or email at the time and date of the conference for roughly 1 ½ hrs.
* QA admin will email agency partners all reports (password protected with the date of conference) 24 hours before the conference. Agencies will be expected to accept the read receipt so that QA admin are aware they have been received.
* Agency partners will be expected to provide their views on registration during the call/Skype meeting or to email them and their reasons for this at the time of the conference. Emails received will all be saved under the child’s name on the QA folder and this information will be included in the minutes.
* The Chair will then review all the responses made in the call or via email and will confirm the conference decision in an email directly after the conference to all conference members.
* The Chair will ring the family and explain the decision of the meeting if they have not been able to take part in the call/Skype meeting. This will be followed up the same day by the Social Worker to discuss with the family the Care and Support Protection Plan and how visits etc. will proceed.
* The Plan will be emailed by QA admin to the Core Group Members in advance of the Core Group meeting. The minutes of the meeting will be completed by QA admin within the required timescale and sent out via email.

Appendix 2c – Pembrokeshire

The following processes will be adopted in Pembrokeshire; ICPC and RCPC will run as a virtual desktop conference with immediate effect.

**ICPC and RCPC – Desktop Conference**

**Prior to conference;**

* Invitations to professionals will be sent out by email with a conference date & time for a desktop conference to take place.
* Parents will receive paper invites and be advised over the phone by the Social Worker.
* Agency reports to be submitted to the conferencing support team 48 hrs in advance of the desktop conference (as per Wales Safeguarding Procedures).
* Agencies to share their reports with a family by phone (preferably) or email 24 hrs in advance of the desktop conference (as per Wales Safeguarding Procedures).
* One hour before the official start time on the day of the conference, the Conference Chair will contact the family to ensure they have received all of the reports and seek their views/responses. They will also share any reports which have not been received by the family (usually GP and Police reports). Should the family have not received the reports and the family feel they have not had sufficient time to ensure that family members are aware of the contents of the report, to draw attention to any inaccuracies and make sense of the report contents (Wales Safeguarding Procedures 2019) then the conference will be postponed. The Chair will ask the family’s views on progress against the plan (RCPC) and registration. The Chair will write this up to share with agency partners (Chair form to complete with Parents).

**Desktop Conference**

* Agency Partners are expected to be available on email/ phone at the time and date of conference for roughly 1 ½ hrs.
* Conference support team will e-mail the agency partners all of the reports, as well as a summary of the parent’s views at the start of the allocated time. Partners will be given 1 hr to read the reports and parent’s views.
* After 1 hr agency partners will be expected to email the Chair their analysis sheets (What is working well/What are we worried about/What do we need to see) and views on registration and their reasons for this.
* The Chair will then review the responses and confirm the decision in an email, this will be followed up by a decision letter
* The Chair will ring the family and explain the decision of the meeting, this will then be followed up the same day by the Social Worker to inform the family of any Care and Support Protection Plan and how visits etc. will proceed.
* Chair will be available by Skype/phone should any family/agency partner need to speak with them.

Appendix 2d – Powys

**ICPC and RCPC – virtual conferences**

* Invitations will be sent to children and families by post or secure access email.
* Professionals will receive invitations electronically. Generic emails for partner agencies will also be sent invites. The Safeguarding Unit will email the agenda, confidentiality statement and information in relation to requirements of registration and categories of abuse alongside the invite to conference.
* Professionals are required to send reports to the Safeguarding unit 2 working days prior to conference. The Safeguarding unit will email these reports to professional attendees and Chair of conference. Police reports will not be shared.
* Professionals are required to share the content of their report with children and families 2 days prior to conference.
* Chairs will contact the family 30 minutes prior to conference starting to discuss the conference process and to seek their views on registration.
* Professionals are required to join the virtual conference promptly.
* The conference will occur virtually. Children and families can either join by invite through Skype or can be dialled into the conference.
* Minutes will be sent to professionals via email and posted to parents or sent via secure access email if necessary.
* The Chair will be available to speak with the child and family members after the virtual conference if this is wanted.

Appendix 3 – Regional LAC Review Interim Process

Appendix 3a – Carmarthenshire

* The IRO Service is currently operating a Skype for business service, which enables external partners, including foster carers, children and young people and their parents to access the meeting as a guest.
* The business support team will continue to email Invites for reviews. Clear guidance will be included in those emails on how to access the meeting, this will require the Skype for Business App to be installed on a smart phone/tablet; Laptop/PC beforehand. The guidance explains how to do this.
* In partnership with the Family Placement Team, it is expected that foster carers will allow children to use their devices to ensure children are able to attend their meeting for those children who do not currently have access to a smart device or computer. The same principle applies for video consultations to take place with their Independent Reviewing Officer.
* For parents who do not attend their child’s review meeting, the IRO will make direct contact to arrange the most appropriate way to ensure your views are heard and included in the reviewing process for your child/ren.

Appendix 3b – Ceredigion

* The IRO Service is currently operating a Conference Call or Skype for business service which enables external partners, including foster carers, children and young people and their parents to be on the phone or access the meeting as a guest.
* The IRO business support team will continue to email Invites for reviews. Clear guidance will be included in those emails on how to access the meeting, this will require the Skype for Business App to be installed on a smart phone/tablet; Laptop/PC beforehand. There is guidance that explains how to do this or if the meeting will be held via conference call.
* In partnership with the Family Placement Team, it is expected that foster carers will allow children to use their devices to ensure children are able to attend their meeting for those children who do not currently have access to a smart device or computer. The same principle applies for video or phone consultations to take place with their Independent Reviewing Officer.
* For parents who do not attend their child’s review meeting, the IRO will make direct contact to arrange the most appropriate way to ensure your views are heard and included in the reviewing process for your child/ren
* In the event that skype for business or conference call is not possible for participants then email will be used to share information and gain views.

Appendix 3c – Pembrokeshire

* The IRO Service is currently operating a Skype for business service, which enables external partners, including foster carers, children and young people and their parents to access the meeting as a guest.
* The business support team will continue to email Invites for reviews. Clear guidance will be included in those emails on how to access the meeting, this will require the Skype for Business App to be installed on a smart phone/tablet; Laptop/PC beforehand. The guidance explains how to do this.
* In partnership with the Family Placement Team, it is expected that foster carers will allow children to use their devices to ensure children are able to attend their meeting for those children who do not currently have access to a smart device or computer. The same principle applies for video consultations to take place with their Independent Reviewing Officer.
* For parents who do not attend their child’s review meeting, the IRO will make direct contact to arrange the most appropriate way to ensure your views are heard and included in the reviewing process for your child/ren.

Appendix 3d – Powys

* Invitations will be sent to children and families by post or secure access email
* Professionals will receive invitations electronically. Generic emails for partner agencies will also be sent invites.
* Children will receive electronic consultation booklets to return and complete via foster carers secure email if appropriate or verbal feedback via telephone can be gained.
* Social Workers will continue to have pre-review contact with children to ascertain the wishes and feelings of the child.
* IROs will continue to have pre-review contact with the child by either video link or a telephone call. This should be undertaken in a private space wherever possible.
* Children may join the review via skype alongside their foster carers or be dialled in by the IRO.
* All CLA reviews will be held virtually. If required, this may occur as a part 1 and part 2 if circumstances require this.
* Minutes will be sent to professionals via email and posted to parents or sent via secure access email if necessary. Children will either be sent a copy via their foster carers secure email address or by post.

Appendix 4 - Appropriate Adults

Your role as an appropriate adult

Appropriate adults are called to the police station as an important safeguard, providing independent support to detainees who are:

* aged under 17, or
* maybe mentally disordered or mentally vulnerable

You are not simply an observer. Your role is to assist the detainee to ensure that they understand what is happening at the police station during the interview and investigative stages. In particular you should:

* support, advise and assist the detainee
* ensure that the police act fairly and respect the rights of the detainee
* help communication between the detainee, the police and others

You are not there to provide the detainee with legal advice.

Key information

The way in which police investigate offences is governed by the Police and Criminal Evidence Act 1984 (PACE).

The **PACE Codes of Practice** set out the powers, responsibilities and procedures of the police in more detail. Copies are available at the police station.

The **Custody Officer** is responsible for the care and welfare of the detainee and must ensure that the investigation is conducted quickly and fairly.

Rights of the detainee

The Custody Officer must tell the detainee, in your presence, that they have the following rights:

* The right to have someone informed of their arrest.
* The right to independent legal advice free of charge.
* The right to consult the PACE Codes of Practice.

These rights can be exercised at any time while the detainee is in custody. In exceptional circumstances some or all of these rights may be delayed.

The custody officer must give the detainee a written notice of these rights and other entitlements which explain how the detainee should be looked after.

The detainee (if under 17 or mentally vulnerable) must be advised of the duties of the appropriate adult and told that they may speak to the appropriate adult in private at any time.

Your rights as an appropriate adult

You must be present when:

* the custody officer informs the detainee of their rights and entitlements. *If this is carried out before you arrive it must be repeated in your presence.*
* when the detainee is cautioned. *If the* *caution is given before you arrive it must be repeated in your presence.*

In your role you also have a right to:

* be told why the detainee is being held.
* inspect the written record of the detainee’s period in detention (the custody record) at any time, and have a copy of that record.
* see a copy of the Notice of Rights and Entitlements.
* see a copy of the PACE Codes of Practice.

Interviews

You must be present when the police interview the detainee. You should:

* ensure that the detainee understands the caution that is given by the police at the start of the interview.
* intervene if you feel it is necessary to help the detainee communicate effectively with the police, or if you feel that the police questioning is confusing, repetitive or oppressive.
* ask for a break in the interview if you feel the detainee needs to rest or if you feel that they need legal advice or you want to talk to them in private.
* be present when the detainee is asked to agree and/or sign any documentation.

If you have any queries or complaints about the conduct of an interview you should speak to the Custody Officer immediately.

Other procedures

You are also required to be present for the following procedures:

* Subject to strictly limited exceptions, during any search of the detainee involving the removal of more than outer clothing or intimate searches.
* During any form of identification procedure, involving the participation of the suspect including the taking of DNA samples.
* During any process involving the fingerprinting, photographing of the detainee or when a sample or footwear impression is taken from them.

If you are available at the time you are also entitled to be present:

* when the police review whether there is a need to keep a person in detention.
* when a decision to authorise extended detention to 36 hours is made by a senior police officer.
* when the detainee is formally charged.

Legal Advice

Even if the detainee refuses legal advice you have the right to request that a solicitor be called. The Custody Officer must call the solicitor but the detainee cannot be forced to see them when they arrive.

You are not entitled to be present during private legal consultations between the detainee and their legal representative.

You may assist the communication between the detainee and their legal representative if they request your support. However you should make sure that the detainee understands that you are not covered by ‘legal privilege’. This means that, in exceptional circumstances, you could be questioned as a witness by the police, or in court, about what was discussed.

Legal advice for certain (usually minor) offences is normally only provided over the telephone. However, if the detainee is eligible for assistance from an appropriate adult, the legal advisor should attend the police station in person.

Further Information

This leaflet was produced by the Home Office in consultation with the National Appropriate Adult Network (NAAN).

It is designed for parents, carers, relatives or friends who might be called to act as an appropriate adult for someone they know. It aims to give you a quick overview of your role and responsibilities.

It is strongly advisable that people acting as an appropriate adult in a professional capacity, whether as a volunteer or paid worker, should be trained. Further information about this and about all aspects of the appropriate adult role can be obtained from the National Appropriate Adult Network [www.appropriateadult.org.uk](http://www.appropriateadult.org.uk/)

*February 2011*

Appendix 5 –Regional DoLS Guidance Process

Appendix 5a – Regional Contact for Managing Authorities

**Please use your individual organisation Logo on each letter also**

**Important Information update for Managing Authorities in relation to Deprivation of Liberty Safeguards during COVID-19 Outbreak**

During the COVID-19 pandemic; as supervisory body we wanted to make contact with you to update you on our priorities as it stands on 2nd April 2020. We are awaiting further guidance from government, we will update you further once this has been received.

It is important the principles of the Mental Capacity Act and DoLS continue to be adhered to, we need to look at solutions creatively to reduce the risk of greater restrictions imposed than required. We need to ensure P remains centre of our decisions, maintaining the principles of the Mental Capacity Act remains important when completing the work we do.

Normal face to face assessments are to be restricted during this period; assessments will only be allocated for completion for those cases where it is deemed necessary and proportionate to assess. High priority cases are where the resident is actively objecting to the arrangements amounting to the deprivation. For example, a resident is expressing their wish to leave; significant physical restraint is being used or safeguarding concerns. All applications to the team must contain all restrictions in detail to use when triaging.

Due to the circumstances, authorisation periods will be a maximum of 6 months during this period with a view to review once government restrictions are lifted.

As managing authority, you must weigh up any visit requirements; it is strongly encouraged for technology to be used to keep in touch with P’s support network i.e. phone and video calls to be used. All mental capacity assessments, best interest decisions and risk assessments must be completed where required; principles of the Mental Capacity Act 2005 have not been displaced and remain be adhered to.

With DoLS legislation still being applied; the way in which we will be assessing is changing. We will require your assistance in gathering information on the resident and their support networks as well as diagnosis information available. Wherever possible evidence will be requested to be sent digitally to support assessments.

We understand work pressures are increasing and there will be situations where staff numbers are depleted, we appreciate all that you are doing.

Please note that there remains a duty to report any safeguarding concerns as per normal routes.

The DoLS team will remain the first point of contact for advice for all issues relating to new and existing DoLS authorisations. Please do not hesitate to contact us on local DoLS Number or email address.

Appendix 5b – COVID-19 Interim Form 3a and 4 doctor

 Please insert your organisation also

COVID-19

Mid and West Wales Region

Interim DoLS Form 3a/4

**For completion by S12 Doctor (Please complete part A or B)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Person/ Case ID Number: | | | | | |
| **DEPRIVATION OF LIBERTY SAFEGUARDS INTERIM FORM 3a/4**  **MENTAL CAPACITY, MENTAL HEALTH, and ELIGIBILITY ASSESSMENTS** | | | | | |
| **This form is being completed in relation to the current COVID-19 situation and the embargoed visits to care homes/hospital wards**   |  |  |  |  | | --- | --- | --- | --- | | Full name of the person being assessed |  | | | | Date of birth |  | Est. Age |  | | Name of the care home or hospital where the person is, or may become, deprived of liberty |  | | | | | | | | |
| 1. **PLEASE INDICATE BELOW THAT YOU HAVE REVIEWED THE EXISTING ASSESSMENTS BELOW AND CONFIRM THERE ARE NO CHANGES IN THE PERSENS CIRCUMSTANCES.** | | | | | |
| Mental Capacity |  | Mental Health |  | Eligibility |  |
| NAME OF DOCTOR: DATE OF ORIGINAL ASSESSMENTS | | | | |  |
| DOCTOR COMMENTS ON REVIEW: | | | | |  |
| DATE OF REVIEW: | | | | |  |

|  |  |  |
| --- | --- | --- |
| I CONFIRM THAT ON REVIEW I RECOMMEND FURTHER AUTHORISATION UP TO A 6 MONTH PERIOD | YES | NO |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **B. PLEASE INDICATE BELOW THAT YOU HAVE REVIEWED THE EXISTING ASSESSMENTS BELOW AND CONFIRM THERE ARE CHANGES IN THE PERSENS CIRCUMSTANCES WHICH ARE REFLECTED IN THE COMMENTS BELOW.** | | | | | |
| Mental Capacity**\*** |  | Mental Health |  | Eligibility |  |
| NAME OF DOCTOR DATE OF ORININAL ASSESSMENTS | | | | |  |
| DOCTORS COMMENTS ON REVIEW: | | | | |  |

|  |  |  |
| --- | --- | --- |
| I CONFIRM THAT ON REVIEW I RECOMMEND FURTHER AUTHORISATION UP TO A 6 MONTH PERIOD | YES | NO |

Each Supervisory Body signatory will need to decide on whether to authorise the deprivation based on the information above and any other information gathered as part of the interim arrangements. This will be detailed in the DoLS Form 5.

*April 3rd 2020*

Appendix 5c – Regional Contact to Paid RPRs

 **Please use your individual organisation Logo on each letter also**

**Important Information update for Paid RPRs**

**in relation to**

**Deprivation of Liberty Safeguards during COVID-19 Outbreak**

During the COVID-19 pandemic; as supervisory body we wanted to make contact with you to update you on our priorities as it stands on 2nd April 2020. We are awaiting further guidance from government, we will update you further once this has been received.

It is important the principles of the Mental Capacity Act and DoLS continue to be adhered to, we need to look at solutions creatively to reduce the risk of greater restrictions imposed than required. We need to ensure P remains centre of our decisions, maintaining the principles of the Mental Capacity Act remains important when completing the work we do.

Normal face to face assessments are to be limited during this period; assessments will only be allocated for completion for those cases where it is deemed necessary and proportionate to assess. High priority cases are where the resident is actively objecting to the arrangements amounting to the deprivation. For example, a resident is expressing their wish to leave; significant physical restraint is being used or safeguarding concerns.

Relevant persons’ representatives must weigh up any visit requirements; it would be encouraged for phone and video calls to be used for monitoring duties. High-risk residents may need greater attention; it is important that any s21A challenges are not postponed during this period but are referred as per legislative process to maintain P’s human rights.

Please note that there remains a duty to report any safeguarding concerns as per normal routes.

The DoLS team will remain the first point of contact for advice for all issues relating to new and existing DoLS authorisations. Please do not hesitate to contact us on local DoLS Number or email address.

Appendix 5d – Regional Contact to Unpaid RPRs

 **Please use your individual organisation Logo on each letter also**

**Important Information update for Unpaid RPRs**

**in relation to**

**Deprivation of Liberty Safeguards during COVID-19 Outbreak**

During the COVID-19 pandemic; as supervisory body we wanted to make contact with you to update you on our priorities as it stands on 2nd April 2020. We are awaiting further guidance from government; we will update you further once this has been received.

We need to ensure that **NAME** remains centre of our decisions, maintaining the principles of the Mental Capacity Act remains important when completing the work we do.

Understandably, face to face visits to **NAME** will be limited, as relevant persons’ representative you must weigh up any visit requirements; it would be encouraged for phone and video calls to be used for monitoring duties. It is important that any *section* 21A challenges are not postponed during this period but are referred as per legislative process to maintain **NAME** human rights. Please contact the team if you believe that a challenge to the DoLS is needed and you want the support of an Independent Mental Capacity Advocate to take this forward.

The DoLS team will remain the first point of contact for advice for all issues relating to new and existing DoLS authorisations. Please do not hesitate to contact us on local DoLS Number or email address should you wish to discuss anything.

Appendix 6 – Dyfed Powys Police guidance for SARC attendance During the COVID-19 Pandemic

COVID-19 screening tool

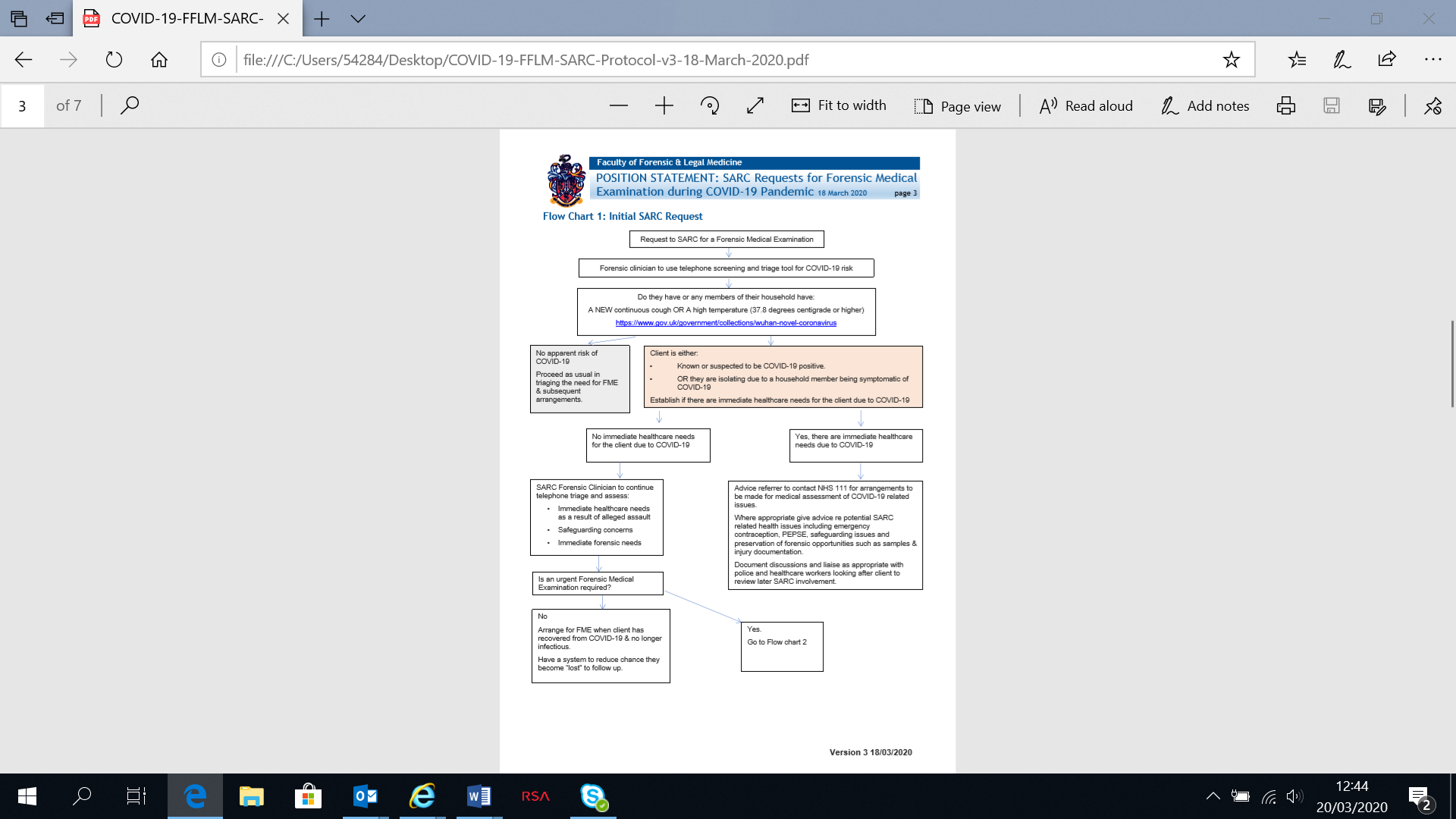
The screening tool to be utilised is below. The Sexual Offences trained Officer /officer should complete the first page of the COVID-19 screening tool prior to meeting the victim in person. This must be shared with SARC staff and health professionals.

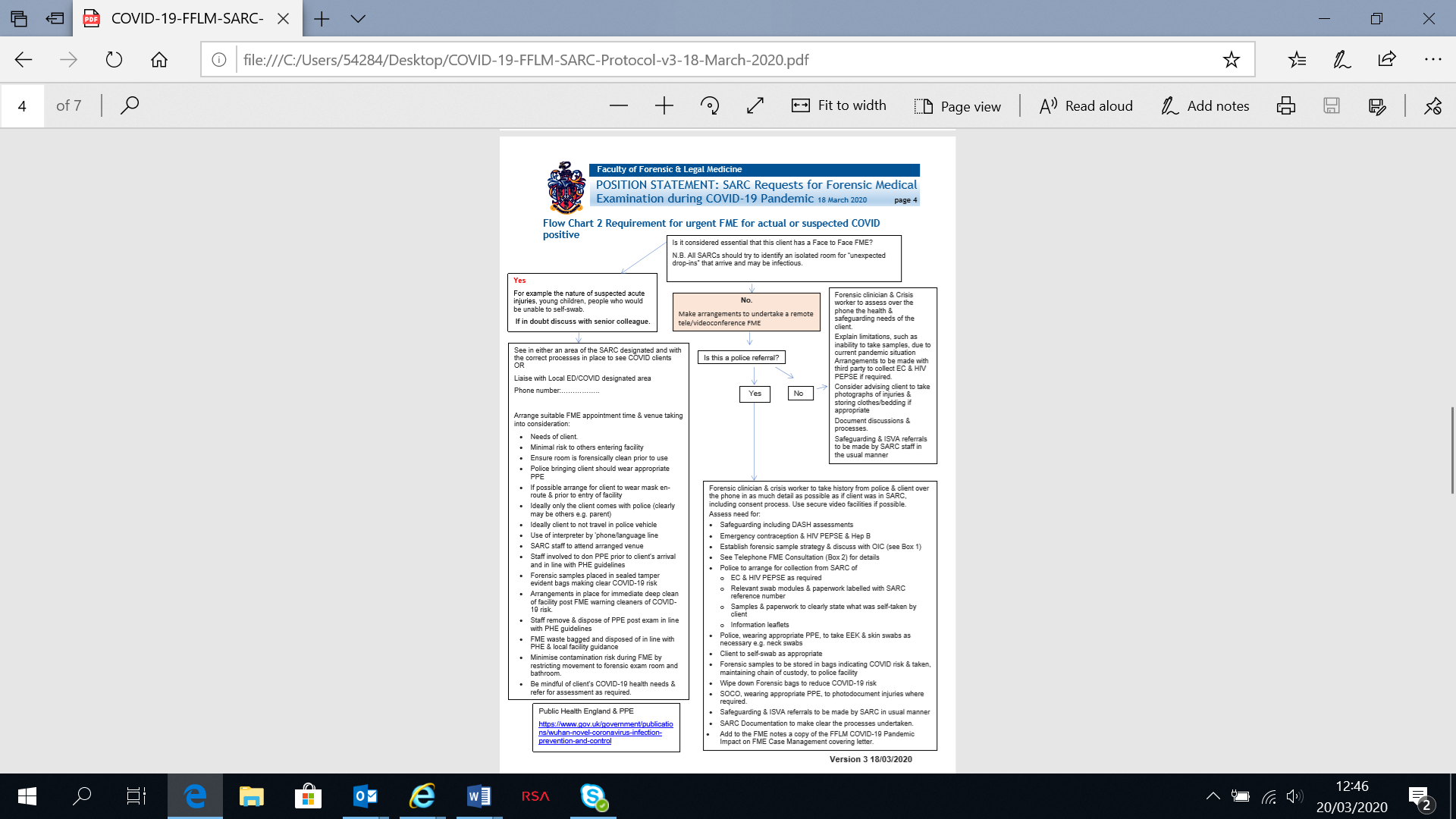
Appendix 6a





Appendix 6b





Appendix 7 – Local Authority Checklists for Escalation Mitigation

Appendix 7a – Carmarthenshire

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| **Risk Escalation level** | **Carmarthenshire Actions** |
| 1 | * Care Settings should have in place standard operating procedures for individual residents with suspected and confirmed COVID-19 infection, including appropriate infection control precautions to protect staff and residents. * An ‘***incident***’ of COVID-19 refers to a situation where there may only be one suspected case of coronavirus present. Where this is the case, it is still essential to assess the risk of infection to other Service Users and staff and monitor appropriately. * Care Settings should have a high level infection prevention and control plan which provides initial guidance for the home to implement should an ‘incident’ or an ‘outbreak’ occur. This information (and any further information relating to expert infection prevention and control advice) should be available and accessible to the multi professional team supporting the care setting to manage the situation. * Care settings should be aware of the existence of Advanced Care Plans for residents and how these are accessed. * An incident of COVID-19 will still require immediate action so that the individual is isolated and that precautions can be put in place to prevent the spread of the virus. * For any suspected incident of coronavirus, the responsible Individual / Manager **MUST** inform that nominated representative from the Local Authority and/or Health Board. * When COVID-19 is suspected, staff should immediately follow the PPE guidance and infection control procedures. A deep clean should be carried out in the home and attention should be given to communal areas and surfaces such as handrails and door handles, this will help to reduce the risk of spread to others living in the setting. * The Provider Manager will need to establish good communication links with all relevant Authorities and Professionals. Communication to families and any other parties will need to be done in agreement with the Local Authority and or Local Health Board. * GP practices to contact the care home twice weekly to review current position * Inform the Health Protection Team 0300 00 30032 and request that a COVID-19 test is carried out. [COVIDenquires.hdd@wales.nhs.uk](mailto:covidenquires.hdd@wales.nhs.uk) * Create a separate area for non-affected Service Users and or where possible, reduce communal gatherings. * Care Home Staff made aware of Psychological and Wellbeing Services availability for self-referral |
| 2 | * Implement the Carmarthenshire Outbreak Procedure for Care Homes * Consider closing the home to new admissions * Care settings should notify GPs are informed of the situation and appropriate advice is sought for each individual. This may include discussing / reviewing palliative care arrangements. * ‘Named’ nurse allocated to support the affected home and is responsible for escalating concerns to the district nursing team who will implement appropriate intermediate care / palliative care pathways as per routine practice * GP to refer to secondary care physicians where and when required and request face to face specialist consultation should GP deem necessary * Care Setting and / or district nurse will consult with GP and request face to face assessments on a day to day basis * Where care worker depletion; Deploy peripatetic crisis care workforce (Simply Safe) * Consider appropriate transfer of affected residents to ‘Red Care Home’ and / or acute hospital (where appropriate and necessary) * Advise Infection Prevention & Control and request review and appropriate daily support * Arrange for staff to work in separate teams: one team caring for affected residents and the other caring for unaffected residents. * If appropriate, use signage to inform residents and staff of areas / zones not to be entered. * Ensure laundry of affected individuals are either placed in alginate bags or washed separately at the recommended temperature (infection control). * The responsibility of managing the outbreak lies with the Responsible Individual / Manager. * The Local Authority / Health Board will have a nominated lead person who will work closely with the Manager. In the case of the setting being both Residential and Nursing Care, the Local Health Board will also have a nominated lead person. * In the context of an outbreak, that settings of this type have the capability to take a Service User’s temperature. * Where clinically indicated and requested (by GP and / or WAST) settings will have the capability to take and report peripheral oxygen saturations (Oxymetry). This will help clinicians to remotely assess the resident’s clinical status. * Community nursing service will provide the Care Setting with training to support staff in End of Life care including recognising early signs of distress; contact number for Clinical Nurse Specialists (including Out of Hours) to be provided. * The Provider Manager will need to establish good communication links with all relevant Authorities and Professionals. Communication to families and any other parties will need to be done in agreement with the Local Authority and or Local Health Board. * The Local Authority’s/Health Boards lead officer will arrange a COVID-19 meeting within 48 hrs – to include RI, Manager and Senior Managers (LA/ LHB) * Monitor the situation closely by carrying out regular monitoring of all Service Users – checking for elevated temperatures and other respiratory symptoms * Inform the hospital and paramedics in advance if an individual requires admission to hospital during the outbreak. * The Local Authority and or Local Health Board’s lead officers will coordinate a guided response to families. This will involve Social Work /Nurse Assessors. * Provide staff with opportunity to talk about their feelings; Refer to psychological and wellbeing services |
| 3 | * All guidance as above should be followed * Where confirmed cases in the Care Setting are > 10 residents, GP to request secondary care support as per local agreements * Transfer of infected residents into nominated RED care home facility * Care provision replaced by either Local Authority and / or Health Board personnel as according to CIW and Legal recommendations in such extreme circumstances * In consultation with Director of Operations and Medical Director – consider need to admit those residents who are infected to hospital to protect those remaining residents |
| 4 | * In the event of business continuity failure, consider:   1. Re-provision of the nursing/residential care home into a RED nursing/residential care homme site and admit other infected residents from other facilities.   2. ‘Take over’ by other organisation to stabilise the home on temporary and/or permanent basis. |
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Appendix 7b – Ceredigion

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| **Risk Escalation level** | **Ceredigion Action Checklist** |
| 1 | * Care Settings should have in place standard operating procedures for individual residents with suspected and confirmed COVID-19 infection, including appropriate infection control precautions to protect staff and residents. * An ‘***incident***’ of COVID-19 refers to a situation where there may only be one suspected case of coronavirus present. Where this is the case, it is still essential to assess the risk of infection to other Service Users and staff and monitor appropriately. * Care Settings should have a high level infection prevention and control plan which provides initial guidance for the home to implement should an ‘incident’ or an ‘outbreak’ occur. This information (and any further information relating to expert infection prevention and control advice) should be available and accessible to the multi professional team supporting the care setting to manage the situation. * Care settings should be aware of the existence of Advanced Care Plans for residents and how these are accessed. * An incident of COVID-19 will still require immediate action so that the individual is isolated and that precautions can be put in place to prevent the spread of the virus. * For any suspected incident of coronavirus, the responsible Individual / Manager **MUST** inform that nominated representative from the Local Authority and/or Health Board. * When COVID-19 is suspected, staff should immediately follow the PPE guidance and infection control procedures. A deep clean should be carried out in the home and attention should be given to communal areas and surfaces such as handrails and door handles, this will help to reduce the risk of spread to others living in the setting. * The Provider Manager will need to establish good communication links with all relevant Authorities and Professionals. Communication to families and any other parties will need to be done in agreement with the Local Authority and or Local Health Board. * The Provider Manager must inform the Local Authority and/or the Health Board regarding any issues affecting quality of care or safe working practices or any Safeguarding issues. * GP practices to contact the care home twice weekly to review current position * Inform the Health Protection Team 0300 00 30032 and request that a COVID-19 test is carried out. [COVIDenquires.hdd@wales.nhs.uk](mailto:covidenquires.hdd@wales.nhs.uk) * Create a separate area for non-affected Service Users and or where possible, reduce communal gatherings. * Care Home Staff made aware of Psychological and Wellbeing Services availability for self-referral |
| 2 | * Implement the Ceredigion Outbreak Procedure for Care Homes * Consider closing the home to new admissions * Care settings should notify GPs are informed of the situation and appropriate advice is sought for each individual. This may include discussing / reviewing palliative care arrangements. * ‘Named’ nurse allocated to support the affected home and is responsible for escalating concerns to the district nursing team who will implement appropriate intermediate care / palliative care pathways as per routine practice * GP to refer to secondary care physicians where and when required and request face to face specialist consultation should GP deem necessary * Care Setting and / or district nurse will consult with GP and request face to face assessments on a day to day basis * Where care worker depletion; Deploy peripatetic crisis care workforce (Simply Safe) * Consider appropriate transfer of affected residents to ‘Red Care Home’ (if such facility is available) and / or acute hospital (where appropriate and necessary) * Advise Infection Prevention & Control and request review and appropriate daily support * Arrange for staff to work in separate teams: one team caring for affected residents and the other caring for unaffected residents. * If appropriate, use signage to inform residents and staff of areas / zones not to be entered. * Ensure laundry of affected individuals are either placed in alginate bags or washed separately at the recommended temperature (infection control). * The responsibility of managing the outbreak lies with the Responsible Individual / Manager. * The Local Authority / Health Board will nominate a lead person who will work closely with the Manager. In the case of the setting being both Residential and Nursing Care, the Local Health Board will also have a nominated lead person. The nominations will be recorded via the Daily Operational Command process. * In the context of an outbreak, that settings of this type have the capability to take a Service User’s temperature. * Where clinically indicated and requested (by GP and / or WAST) settings will have the capability to take and report peripheral oxygen saturations (Oximetry). This will help clinicians to remotely assess the resident’s clinical status. * Community nursing service will provide the Care Setting with training to support staff in End of Life care including recognising early signs of distress; contact number for Clinical Nurse Specialists (including Out of Hours) to be provided. * The Provider Manager will need to establish good communication links with all relevant Authorities and Professionals. Communication to families and any other parties will need to be done in agreement with the Local Authority and or Local Health Board. * The Local Authority’s/Health Boards lead officer will arrange a COVID-19 meeting within 48 hrs – to include RI, Manager and Senior Managers (LA/ LHB) * Monitor the situation closely by carrying out regular monitoring of all Service Users – checking for elevated temperatures and other respiratory symptoms * Inform the hospital and paramedics in advance if an individual requires admission to hospital during the outbreak. * The Local Authority and or Local Health Board’s lead officers will coordinate a guided response to families. This will involve Social Work /Nurse Assessors. * Provide staff with opportunity to talk about their feelings; Refer to psychological and wellbeing services |
| 3 | * All guidance as above should be followed * Where confirmed cases in the Care Setting are greater than 10 residents, GP to request secondary care support as per local agreements * Transfer of infected residents into nominated ‘Red Care Home’ facility (if such facility is available) and / or acute hospital (where appropriate and necessary) * Care provision replaced by either Local Authority and / or Health Board personnel as according to CIW and Legal recommendations in such extreme circumstances * In consultation with Director of Operations and Medical Director – consider need to admit those residents who are infected to hospital to protect those remaining residents |
| 4 | * In the event of business continuity failure, consider: * Re-provision of the nursing / residential care home into a RED nursing / residential care home site and admit other infected residents from other facilities. * ‘Take over’ by other organisation to stabilise the care home on a temporary and/or permanent basis. |
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1. # Skills for Care: The state of the adult social care sector and workforce in England (Oct 2019) reported that “In England, the average vacancy rate was 7.8%”.

   # Social Care Wales Workforce Development Programme (SCWWDP) – workforce data collection 2017: Commissioned Care Provider Services Care reported that “Providers commissioned by Carmarthenshire and Swansea had the highest percentage of reported vacancies (9%) in Wales”.

   [↑](#footnote-ref-1)