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MENTAL CAPACITY DEPARTMENT NEWSLETTER – WINTER 2020

We can't quite believe that Christmas is nearly upon us. The spectre of Covid-19 has had far reaching consequences for care homes and for P this year but fortunately there has also been a number of positive developments in relation to Mental Capacity practice and procedure.

In this newsletter we touch upon just a few topics that we hope will be useful for you over the festive period and into the New Year. As always, if you have any queries on the below information or wish to speak to us in relation to one of your clients, please do not hesitate to get in touch.

PROTECTION v QUALITY OF LIFE

Whilst 2020 has been hard for us all, the greater impact of the pandemic on the vulnerable has re-enforced our desire to protect them from harm. However for those living in care homes, the restrictions have meant some of the most significant interferences in their human rights. Many residents have been denied regular access to their private and family life and for some, more broadly they have been denied the ability to engage in the community and the world around them.

However, for almost all residents, access to loved ones and the freedom to make day to day choices regarding their movements, is crucial to their well-being and quality of life.

In November 2020, this question was raised again in the courts with a case brought by Mr Davies, a gentleman seeking reassurance from the Court of Protection (COP) that he will be able to continue to have face to face contact with his 58 year old wife who currently resides in a residential care home.

Mr Davies was concerned that his wife has not been treated as an individual, and has asked the Court to ensure that she receives visits tailored to her needs during the pandemic.

The matter is being heard by Mr Justice Hayden, Vice President of the COP. Whilst the Judge has not yet reached a final decision, he has highlighted the need for care homes to be flexible in their approach and not just to consider what is 'presently available' but also to

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consider what may be possible in the future, particularly with the potential for Covid-19 vaccines to be imminently available.

Mr Justice Hayden carefully highlighted the need for any contact to be subject to **'frequent and vigilant review'** by care homes.

> *"THE TIME HAS COME FOR CARE HOMES TO POSITION THEMSELVES IN THE VANGUARD OF THE DEVELOPING OPPORTUNITIES. IN OTHER WORDS, THEY SHOULD MOVE TO THE FRONT LINE AND BE CAREFUL NOT TO LAG BEHIND WHEN IDENTIFYING THE EMERGING OPTIONS."*
>
> Mr Justice Hayden

With the Government due to distribute 11,000 iPad tablets to thousands of care homes across the UK and with rapid testing and vaccines being rolled out, contact and access to care homes is on everybody's minds.

1. VISITS TO CARE HOMES

On the same day that the nation went into a second lockdown, the Government published revised guidance on visits to care homes. Unlike previous, neutral guidance, the update made it clear that care homes should be focussing on facilitating visits *'wherever possible'*. However, we are still encountering cases where care homes have blanket bans on any visits.

On 2 December 2020, The Department of Health and Social Care (DHSC) published further guidance on visiting care homes during Covid-19. This guidance acknowledges the crucial role that visits from loved ones play in care home residents' lives and states that *'visiting should be supported and enabled wherever it is possible to do so safely'.*

The guidance provides that safe visits should be encouraged **when the visitor can provide a negative Covid-19 test result**. The Government has confirmed that they will provide sufficient rapid tests for each resident to receive visits from two people up to twice a week (with a suggestion that it should be the same two people visiting each time). However not all homes, especially smaller ones, have received their tests yet and some care homes have stopped using them over concerns as to their accuracy. The guidance sets out how visits can take place indoors and outdoors if testing is not available including the suggestions that care homes use an outdoor 'pod' or conservatory that is well ventilated, screened and has a single access point for residents and a separate access point for the visitor.

The guidance emphasises the need to find *'the right balance between the benefits of visiting on wellbeing and quality of life, and the risk of transmission of Covid-19 to social care staff and the clinically vulnerable residents…'*

In acknowledging that exposure to 'the community' will bring with it the risk of infection it helpfully sets out how care homes can mitigate the risks with proportionate steps that include the preparation of 'visiting policies' and assessments in order to weigh these risks. Of course care home managers are not medical experts and so assessing the balance of these risks will be difficult.

Notably the guidance asks providers prepare risk assessments in relation to each individual resident. Whilst acknowledging that providers will need to consider the well-being of other residents when preparing their visiting policies, **there is a clear emphasis on individual risk assessment being carried out for each resident:**

> **"WHEN DEVELOPING THEIR VISITING POLICIES, PROVIDERS SHOULD UNDERTAKE INDIVIDUAL RISK ASSESSMENTS WHERE NECESSARY, TO ASSESS THE RIGHTS AND NEEDS OF INDIVIDUAL RESIDENTS, AS WELL AS ANY SPECIFIC VULNERABILITIES WHICH ARE OUTLINED IN THE RESIDENT'S CARE PLAN, AND TO CONSIDER THE ROLE THAT VISITING CAN PLAY IN THIS."**

Social workers are also encouraged to get involved in these assessments and attention is drawn to the well-being duty in section 1 of the Care Act 2014 which requires that a local authority promote an individual's well-being including their control over their day to day life and domestic, family and personal relationships.

SUMMARY

When testing is available

Inside and outside visits:

- a negative test result
- wearing PPE
- following all infection control measures

If testing is not available

Indoor visits:

- may be possible **in tier 1 areas**
- limited to two people
- Wearing PPE
- social distancing, no physical contact

Outdoor/ Visiting Pod visits:

- used by one visitor at a time
- visitor enters from the outside if possible
- substantial screen between resident and visitor
- good ventilation
- wearing PPE
- maintaining social distancing and good hand hygiene.

As set out above, decisions on visiting policies will depend on risk assessments

If a resident lacks the relevant capacity to consent to a care homes visiting policy, then their Deputies/Power of Attorney or advocate should be consulted and a best interest decision may need to be considered. Best Interest assessments should include consideration of all

relevant circumstances including the person's wishes and feelings, past views and the views of any people interested in their care.

When visiting homes, family members are asked to take appropriate precautions including wearing PPE, observing social distancing and acting in accordance with 'robust infection prevention and control measures'.

In the event of an outbreak of positive Covid-19 cases all face to face visits should immediately stop **except** end of life visits and other exceptional circumstances and the care home should continue to provide alternative ways of communicating.

2. VISITS OUT OF THE CARE HOME

Many of our clients previously enjoyed visits out of their care home and for some, visits to loved ones homes was an essential part of their well-being. The Government has recognised the need to provide care homes with guidance on such visits.

The rules on these visits may vary from area to area as local guidance has been devised by the local Director of Public Health and Director of Adult Services. However, again, they have been encouraged not to take a local authority wide approach, and to consider the particular circumstances of communities and care homes.

THE GOVERNMENT GUIDANCE MAKES A NUMBER OF RECOMMENDATIONS FOR HOW 'OUTWARD VISITS' SHOULD TAKE PLACE:

- Visits out should only be considered for care home residents of 'working age';
- Visits can take place across all tiers so long as all involved adhere to the local rules;
- Loved ones are asked to consider whether visits out are 'the best thing to do' and whether a visit to P in the care home may be safer;
- The number of people a resident has contact with should be kept to a minimum including minimising the number of locations visited.

The crucial element of this 'person centred' guidance is that any outward visit should be considered on an **individual basis** having regard to residents 'personal needs and circumstances.'

It is also acknowledged in the guidance that care homes will need to consider the varying needs of *all* of their residents as a whole and care homes are encouraged to develop a policy for how these outward visits should take place. It is suggested that each provider should devise '***individual and whole home risk assessments.***'

"The care home should balance this against a consideration of the risks to others in the home, in the event that the resident becomes infected on their visit, and the ability of the home to isolate the resident on their return." Ahead of any visit out of the care home, a plan should be developed and discussed with the resident themselves and their loved ones.

THE GOVERNMENT SUGGESTS THE FOLLOWING ITEMS BE CONSIDERED WITHIN THE PLAN

- The nature of the planned visit, including where the resident will stay and what activities will take place;
- The support needs that resident may have during the visit and how those needs will be met, i.e. by staff, a carer, a loved one;
- How the resident will be supported to follow social distancing, hand hygiene, face coverings etc;
- Transport and how this can minimise exposure to those outside the household/bubble.

If the resident lacks the relevant capacity to agree to the plan, then a best interests assessment should take place.

After the visit the resident *will need to* isolate for 14 days, if they do not present with symptoms after this time, then they *may* return to communal areas. If the resident lacks capacity to make the decision regarding the visit, the impact of isolation on that resident will need to be considered when deciding whether the visit is in their best interests. As with all of the guidance in relation to visits of any kind, an outbreak of positive test results in the care home is likely to result in all visits being stopped.

If you are aware that any of your clients hope to spend Christmas with a loved one outside of the care home, then they should be advised to arrange this as early as possible with the provider.

Should you have any concerns as to the best interest decisions that have been made for your clients, or their capacity to agree to individual risk assessments, please do not hesitate to get in touch.

23 TO 27 DECEMBER 2020

THE DHSC HAS ALSO LAID OUT A NUMBER OF RULES/GUIDELINES FOR THOSE WANTING THEIR LOVED ONES TO RETURN HOME FOR CHRISTMAS:

- A resident from a care home *should* only mix with people from **one** household (or one household bubble). A resident *should not* become part of a three household bubble;
- The members of that household or bubble *should consider* taking steps to limit the number of people they see in the two weeks prior to the visit;
- All members of the household *should* have a negative result from a Covid -19 test taken immediately preceding the visit;
- The resident *should* be tested immediately before the visit out of the care home;
- It is *advised* that during the visits, households maintain social distancing, wash hands, let plenty of fresh air into rooms and consider wearing a face covering.

3. VISITS FROM PROFESSIONALS

The DHSC updated their guidance on The Mental Capacity Act 2005 and deprivation of liberty safeguards during the coronavirus pandemic on 11 November 2020.

As you will all be aware, the Government confirmed in summer 2020 that advocates and solicitors acting in matters involving deprivation of liberty are key workers, as opposed to 'visitors'. The updating guidance confirms that if you are an IMCA or a RPR you should continue to represent the person who is or may be subject to the DoLS authorisation during the pandemic and the importance of face to face visits by professionals has been recognised.

The guidance recommends that remote techniques should be considered such as telephone or video calls. However, face to face visits can take place if needed to *'meet the person's specific communication needs, in urgent cases or if there are concerns about the person's human rights'.*

During local restrictions, visits from professionals can continue to take place, however, decisions around visiting are an 'operational decision'. Professionals are asked to understand

and respect local visiting policies and work with care homes and hospitals to decide if a face to face visit is appropriate.

The guidance also points professionals to the practical guidance on how to facilitate safe visits summarised above which it suggests may be *useful* for DoLS professionals.

Again, risk assessments should be carried out on an individual basis. For many of our clients telephone or video calls are very difficult making remote visits impossible or simply not sufficient to be able to ascertain a residents wishes and feelings. In such cases, a face to face visit may be the only option and if they can be carried safely then they should go ahead, with the support of care home staff. If you are being prevented from accessing your clients and have concerns about this, please do not hesitate to get in touch.

We continue to advise clients and advocates in relation to the lawfulness of testing and vaccinating an individual who lacks the relevant mental capacity without their consent, so if you have any concerns in this area, please do not hesitate to get in touch.

4. SUMMARY

Exposure to 'the community' of any kind will, inevitably, increase the risk of exposure to Covid-19, however the need to protect an individual will not always outweigh the benefit to their quality of life.

Each individual is different in the same way that each care home is different. The vulnerabilities and needs of an individual must be weighed against the benefit of a specific visit to that person within the context of the limitations and opportunities of each individual care home. This is not an easy balance and some cases may need more careful consideration than others.

If you are concerned that any of your clients are not having visits that may be in their best interests or that a care home has instigated a blanket ban on certain types of visit, then please do not hesitate to get in touch.

DP V LB HILLINGDON [2020] EWCOP 45 – A GUIDE FOR RPRS

In the matter of DP and Hillingdon, Mr Justice Hayden gave a judgment dealing with the situation where there is insufficient evidence before the court regarding the 'capacity' requirement for a DOLS authorisation.

As RPRs and legal practitioners, we will have all likely seen cases where the DOLS form 4 (the form which contains an assessment of P's capacity to make decisions about where he or she should be accommodated), is, at best, substandard. Traditionally, this has been addressed by

the court making an 'interim' declaration that P lacks capacity whilst further evidence around P's capacity is gathered – often by way of a s49 or independent expert report.

In the case of DP, the interim declaration that DP lacked capacity to make decisions as to his care and residence was successfully appealed. The court found that the capacity evidence of the Local Authority – the DOLS form 4 – was insufficient and did not overcome the presumption that P had capacity. In particular, it was noted by the court that the assessing psychiatrist had not explained to P the purpose of his visit, thus 'gravely undermining' the reliability of the psychiatrist's conclusions. It was also not clear what information had been put to P by the psychiatrist, or the qualifications, expertise and experience of the psychiatrist. It is important that a detailed record of the information given to P is kept.

It is a well-tested principle that P is presumed to have capacity, and this presumption applies at all stages of the MCA. In DP, as in many cases, the evidence had failed to rebut this presumption. Therefore, it was not correct for the court to make interim declarations that P lacked capacity when there was no evidence of this.

In order to remedy this apparent conflict, where P is presumed to have capacity and yet a DOLS is in force, the court addressed the specific nature of a s21A application. Namely, that it is the task of the court to evaluate the relevant qualifying requirements for a DOLS authorisation and to come to a view, on the available evidence, as to whether those requirements continue to be met. Ultimately, the court will decide whether the authorisation is lawful and should remain in force.

> *Whilst the extant authorisation remains in force' there is no need for any positive decision by the court. The court does not become responsible for authorising P's deprivation of liberty upon the issuing of a s21A application. The court's only function is to provide the review of the authorisation which is in force.*

The duty of the court was to investigate speedily whether the requirements for a DOLS authorisation were met. Until the court determines this, usually at a final hearing, the authorisation remains in force whilst further evidence is gathered, meaning no interim declarations were needed. The case therefore emphasises the need for s21A matters to be dealt with speedily in order to ensure the court can address whether the qualifying requirements are met as quickly as possible in order to safeguard P's convention rights.

The court identified that, when ascertaining whether the capacity requirement was met, it could permit questions to be put to the psychiatrist who had conducted the capacity assessment and/or, if necessary, to arrange for them to give evidence or revisit their assessment. It is important therefore that practitioners thoroughly scrutinise the DOLS form 4 (and indeed, all capacity evidence) and consider whether any gaps or uncertainties in the capacity evidence could be addressed by the clinician who conducted the assessment. It is yet to be seen whether this approach will result in a reduction of the volume of s49 reports ordered by the court.

The DP case will hopefully serve as a reminder to those assessing capacity that the DOLS form 4 is not merely a 'tickbox exercise' but a crucial safeguard to P, the presumption always being that P has capacity. Further, it is a reminder to all practitioners to progress cases as swiftly as possible to ensure P's rights are protected and maintained. RPR's should ensure that capacity assessments contain enough detail to demonstrate that the requirements of the MCA have been met and the presumption of capacity has been rebutted. If you have concerns regarding capacity assessments that are in place or require assistance with a s21A challenge, then please do not hesitate to get in touch.

THE GOVERNMENT'S U-TURN ON THE ROLE OF CARE HOME MANAGERS UNDER THE LIBERTY PROTECTION SAFEGUARDS

WHAT ARE THE CONTROVERSIAL CHANGES?

The introduction of the Liberty Protection Safeguards (LPS) is now on hold until 2022. Its implementation continues to create controversy and spark debate. Introduced in the Mental Capacity (Amendment) Act 2019, the LPS are scheduled to replace the DoLS system in April 2022. The aim is to improve the effectiveness of the existing system by implementing changes to the process, structure and requirements of depriving someone of their liberty, whilst providing additional protections for the vulnerable people who should be at the core of any measures put in place. In short, the LPS was designed to be the *solution* to the issues that we face with the current DoLS scheme.

Proposed key changes had included giving local authorities the power to transfer existing responsibilities currently held by themselves or mental health/best interests assessors, onto care home managers instead.

The LPS had originally intended to provide care home managers with responsibilities such as deciding:

- Whether P is deprived of their liberty;
- If the P's deprivation of liberty should be authorised under the Mental Health Act 1983 rather than the LPS;
- Whether an approved mental capacity professional (AMCP) needs to be instructed by the responsible body;
- Whether to appoint an independent mental capacity advocate (IMCA);
- Who should be P's representative;
- Objections to the proposed care plan.

Other responsibilities also included arranging:

- Assessments regarding whether P lacks capacity in relation to their care and whether they have a mental disorder;
- An appropriate assessor to carry out the 'necessary and proportionate' assessment;
- An appropriate person to decide if the assessments correspond with the care plan;
- Consultation with P's family members or friends to gain their views (including consulting with attorneys, deputies and advocates).

Care home managers would have had to ensure that a pre-authorisation review is arranged by the responsible body and also draft an authorisation for P's deprivation of liberty to be approved by the local authority. These new responsibilities, to be placed upon the managers, proved to be highly controversial. Whilst the benefit to local authorities and CCGs was clear in terms of a reduction in workload, there were concerns that the proposal would place increased burden instead on a system that is already fragile.

CONCERNS WITH THE NEW ROLE FOR CARE HOME MANAGERS?

Increased workload and responsibility

Care home managers expressed concerns as to the increasing amount of duties that would fall under their remit. Concerns included that they would have little say in changes that were to be implemented, they would be forced to rapidly digest and apply the revised legal framework, whilst also absorbing the administrative burden not withstanding their existing duties.

Training and costs

Placing the onus on care home managers to have legal knowledge of the LPS practice and procedure raised concern amongst many. There were unanswered questions about how care home managers would be provided with the level of training that would be required and how this would be funded. Although one of the rationales for the LPS system was to reduce costs, there seems to have been an under-estimation *(in the 'impact assessment')* of the potential costs that would be involved for care homes instead. In worst case scenarios, this could have resulted in a domino-like effect which could have seen an increase in care home fees and could have potentially led to the closure of smaller care homes, whilst also discouraging others from setting up care homes.

Potential conflict of interest

It has been speculated that it may be in a care home managers' financial interest to provide services to P. Concerns have appropriately been raised as to the potential for a conflict of interest. Although, the responsible body should ensure that people connected to the home do not carry out the LPS assessments, this did not sufficiently mitigate the risk. Furthermore, care home managers might wish to avoid scrutiny of provision. Concerns remain as whether

P's best interests would always be prioritised and whether the least restrictive alternatives would be considered fairly.

WHAT NEXT?

The LPS Steering Group meeting took place on 13 October 2020. The minutes of the meeting revealed the turnaround regarding the role of care home managers under the LPS. This part of the Mental Capacity (Amendment) Act 2019, shall not be implemented for now (if at all). The minutes of this meeting suggest that the Government intends to keep this role under review.

The proposed transfer of responsibility was motivated by the premise that the care home manager knew P and was best placed to take the lead in the LPS procedure thereby reducing the pressure on local authorities. However, the Government has since recognised that this approach is not the correct one, as although those who care for P play a key role, impartiality in decision making is essential.

FACTORS THAT LED TO THE GOVERNMENT'S U-TURN

The Government's turnaround in regards to the role of care home managers has been well received. A public consultation on the draft regulations and Code of Practice is planned for Spring 2021.

The minutes of the LPS Steering Group set out what the draft regulations will cover, including:

- The role of IMCA's;
- The role of the Approved Mental Capacity Professional (AMCP) a replacement of the Best Interests Assessor;
- The legal framework for LPS and DoLS to run alongside each other for the first year of implementation;
- A set of assessments regulations will set out who is able to carry out assessments and determinations under LPS;
- A set of consequential regulations will amend other pieces of legislation that will need updating as a result of the MC(A)A 2019

It is anticipated that the Government will be taking into consideration the outcome of that consultation before any decisions are concluded about the LPS and its design.

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TALK TO US:

New website

Our newsletters can be found in the 'News' section of our new website www.abbotstonelaw.com.

Talk to us:

Medical advances and the promise of comprehensive testing offer a glimmer of hope in 2021. Should this newsletter have highlighted any issues that you wish to discuss further then please do feel free to talk to us on 020 3735 1999 or e-mail our experienced solicitors directly.

HEAD OF DEPARTMENT

FRANCESCA GABBITAS francescag@abbotstonelaw.com

LAWYERS

LYRA NIGHTINGALE lyran@abbotstonelaw.com
ANGELA SMITH angelas@abbotstonelaw.com
RHIANNON JONES rhiannonj@abbotstonelaw.com
FRANCES RATTRAY francesr@abbotstonelaw.com
KATE LUSCOMBE katel@abbotstonelaw.com
ANDREA SPYROU andreas@abbotstonelaw.com
LARA PATRICK larap@abbotstonelaw.com