A Report identifying the Regulatory and Process easements that DASSs require to manage the reprioritisation of needs and delivery of services in a future Pandemic Flu response.

April 2018

The most up to date source of Government guidance documentation is the Gov.UK Pandemic Flu Webpage.

https://www.gov.uk/guidance/pandemic-flu

The Government flu pandemic website was updated in November 2017. Although links are provided in this report to national guidance documents for ease of reference, readers should use the website to check they are reading the most up-to-date version.

The recommendations in this report are directed to government and regulators, through The Department of Health and Social Care (DHSC).

Appropriate easements, agreed by all relevant parties, will support DASSs to maintain essential services and protect the health and wellbeing of service users and the wider population in the event of a flu pandemic. Their use, accompanied by effective, ethical, recorded decision making, will maximise capacity and flexibility of response in a managed way as the pandemic progresses. Clearly documented agreements on easement, if absolutely necessary, will protect the wider population needing care and support and both commissioners and providers in the face of complaints from clients not receiving their usual standard and/or pattern of service.

The overview on the *Gov.UK Pandemic Flu guidance website*[1] makes clear that local planners should plan for a mild, moderate and severe impact of flu on the population. Current health and social care escalation plans and local adaptation of processes used in winter will probably be sufficient for a mild to moderate impact, depending on the age groups most affected.

Most of the easements described in this report could be necessary in the extreme circumstances of a pandemic with a severe impact.

1. Legislation, Regulations and Guidance impacting on a social care response to a severe impact flu pandemic.

The purpose of including relevant legislation and regulations is to demonstrate that the core duties in each validates easements of normal practices and processes in the interest of the health and wellbeing of the population.

[1] https://www.gov.uk/guidance/pandemic-flu

The *Civil Contingencies Act 2004 (CCA)*[2] and associated Regulations, place a duty on councils and others to plan for, and respond, to major emergencies. This includes having business continuity plans in place to enable the continuation of essential functions in the face of a range of emergencies.

In extreme circumstances, the Government may initiate emergency powers under Part 2 of the Civil Contingencies Act to ensure the required response and agency capability. Government may be very reluctant to do this in a flu pandemic, especially if the pandemic moves through the country in phases, rather than the whole country being affected at once.

The *Local Government Act 1972 (Section 138)*[3] provides limited powers to councils to incur expenditure connected with any imminent major incident or the likelihood of such, if they consider it necessary to avert, alleviate or eradicate the effects or potential effects of the emergency on their inhabitants.

The Health and Social Care Act 2012[4] gives local authorities responsibilities to improve the health of their populations. Section 18 of the Act gives the Secretary of State '*the power to make regulations as to the exercise by Local Authorities of certain public health functions… (to) require local authorities to carry out aspects of his (Secretary of State) health protection functions by taking certain prescribed steps).*

The Care Act 2014[5] signified a shift from existing duties on local authorities to provide particular services, to the concept of 'meeting needs' (sections 8 and 18 – 20 of the Act). This is the core legal entitlement to care and support for adults. It establishes a single, clear and consistent set of duties and powers for all people who need care and support.

Recommendation 1: DHSC should consult the Local Government Association (LGA) on supporting Local Authorities to understand and prepare for the breadth of responsibilities of their various departments and the importance of working together to safeguard their citizens during a flu pandemic.

[2] http://www.legislation.gov.uk/ukpga/2004/36/contents

[3] www.legislation.gov.uk/ukpga/1972/70/section/138

[4] www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[5] www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The Bellwin Scheme [6]: The Department of Communities and Local Government (MHCLG) Guidance on The Bellwin Scheme of Emergency Financial Assistance to Local Authorities 2017-18 Sections 1 – 4, does not explicitly refer to a flu pandemic, but states:

"A Bellwin Scheme may be activated where an emergency or disaster involving destruction of or danger to life or property occurs and, as a result, one or more local authorities incur expenditure on, or in connection with, the taking of immediate action to safeguard life or property, or to prevent suffering or severe inconvenience, in their area or among its inhabitants… Ministers are empowered… to decide whether or not to activate a scheme after considering the circumstances of each individual case… for the most part actions not taken within one month would be unlikely to be considered immediately. Annex A of the guidance states that additional staffing costs can be claimed if they meet the required financial threshold when:

"Additional employees or contractors, to work on the emergency or replace permanent employees diverted from normal work; special overtime for employees, either during the emergency for overtime worked on the emergency itself, or afterwards to catch up on work from which they were diverted by the incident."

As the guidance on the Bellwin Scheme does not explicitly include pandemic flu it is not clear if it applies in this case. At least one city council flu pandemic plan, updated in 2016, includes a clear expectation in the event of a Flu Pandemic, that Bellwin may apply and therefore that Council requires its officers to record expenditure related to the emergency in a specific database designed for a Bellwin claim.

Recommendation 2: DHSC consults with Ministry of Housing, Communities and Local Government (MHCLG) about whether the Bellwin Scheme might ever apply to a flu pandemic in England, and if so under what circumstances, MHCLG to advise local authorities accordingly.

a.) DHSC and MHCLG should recommend to Local Authorities that they make a record of additional expenditure under specific budget codes, incurred due to the flu pandemic, using a consistent and accurate methodology. This will create a record across England of the local expenditure, regardless of the source of funding of those costs.

b.) DHSC should consider how government flu pandemic guidance and agreements with regulators can enable easements in regulations and processes without the need for Government to invoke emergency powers to permit easements.

[6] www.gov.uk/government/uploads/system/uploads/attachment_data/file/653402/Bellwin_Scheme_Guidance_Notes_2017-18.pdf

2. Care Quality Commission

During the peaks of a pandemic, CQC should support commissioners and providers in implementing the least worst options and decisions. CQC will wish to ensure that standards of care and regulated practice do not fall without good reason, that there are floors below which they should never fall and that they are raised again by providers as soon as their staffing and care dependency levels reasonably allow.

DASS and commissioner relationships with regional and local CQC inspectors and managers will be vital to manage any easements and monitor care quality in a controlled and measured way.

Support from CQC to make planned deviations from normal standards and practice will be vital for commissioners and providers to implement different ways of working.

Recommendation 3: DHSC and CQC should, as part of planning for a flu pandemic, consider the regulatory and standards easements identified in this document by DASSs and care providers and agree a process for consistent implementation, where relevant, within CQC, at national and local level.

3. Disclosure and Barring Service (DBS)

The Safeguarding Vulnerable Groups Act 2006[7] – describes the requirements for a vetting and barring scheme for people working with children and vulnerable adults. These responsibilities are overseen by the Disclosure and Barring Service. This scheme incorporates DBS checks to create a centralised and continuously updated system of pre-employment vetting and referral-based barring.

While DASSs and Care Providers would have no desire to avoid using DBS checks, in the event of a Flu Pandemic they would need to be able to recruit and utilise new staff very quickly, so easements may be required.

Recommendation 4: DHSC should involve the DBS in considering any operational changes to their processes that may be helpful during a flu pandemic.

4. Sharing confidential client/patient information

The *NHS Governance Toolkit - The Caldicott Principles 1997(Revised 2013)*[8] is about sharing of information in health and social care in line with the Data Protection Act 1998.

> *Information: To Share or Not to Share: Government Response to the Caldicott Review September 2013[9]. This document endorsed the revision of the Caldicott principals to include the 7th principal on the duty to share information, as follows:*

[7] http://www.legislation.gov.uk/ukpga/2006/47/pdfs/ukpga_20060047_en.pdf

[8] https://digital.nhs.uk/information-governance-alliance/resources/information-sharing-resources

[9] www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF

- *Justify the purposes*
- *Don't share confidential data unless it is necessary*
- *Use the minimum information necessary for the purpose*
- *Access to personal confidential data should be on a strict need-to-know basis*
- *Everyone with access to personal confidential data should be aware of their responsibilities*
- *Comply with the law*
- ***The duty to share information can be as important as the duty to protect patient confidentiality***

Attention to required retention periods and the deletion of personal data will be crucial activities during recovery periods between pandemic waves and at the end of the pandemic. Personal confidential information may have been shared with or by voluntary organisations or, in emergency situations, with or by informal volunteers such as neighbours, local parish councillors and faith based pastoral care teams. Attention to these issues will be essential.

The EU General Data Protection Regulation (GDPR) will apply from 25 May 2018 and is expected to continue to apply, post Brexit. A guidance document has been published by the Information Governance Alliance *CEO Briefing Note – Changes to Data Protection legislation: why this matters TO YOU' 2016*[10]. States:

> *"Although in general the principles of data protection remain similar, there is greater focus on evidence-based compliance… and considerably harsher penalties for non-compliance"*

Caldicott Guardians and Data Protection Officers in organisations are necessarily expert and powerful officers. They will require clear government guidance on information sharing during a pandemic to enable them to be of real expert assistance, rather than being perceived as a block to managing such information flows. Their importance means Councils should ensure there are deputising arrangements to cover sickness.

Whilst sharing confidential personal information does not require easements of Data Protection law, it does require data sharing protocols to be in place. In addition to managerial level protocols between partners, health and care operational services and voluntary organisations need clear, straight forward advice about how to apply the law and guidance in a severe impact flu pandemic phase.

Flexible working by care staff in the community could involve the use of telephone apps. For instance, reporting on client visits via a phone app, or sending their employer a photograph of, for instance, a pressure area or unhealthy skin on a leg, so that the office can request a health assessment. These actions would normally be completely unacceptable by a health or care worker, although a friend or relative

[10] https://digital.nhs.uk/media/31435/Changes-to-Data-Protection-legislation-why-this-matters-to-you/pdf/GDPR_CEO_Briefing_3-7-17

might readily do this in a situation where they can't get a GP or community nurse visit in the normal way due to overwhelming demand.

Smart Phones offer the potential for a GP or nurse to consult a patient face to face on camera through the smart phone of a care worker, relative or volunteer – this is a form of mobile telemedicine but using insecure channels and without protocols. This potentially valuable technology has major data protection issues to be understood and addressed.

Recommendation 5: DHSC should consult the UK Caldicott Guardian Council about what guidance it can give to facilitate information sharing during a pandemic and proper retrieval/deletion of information with reference to a severe impact in the community, when needs outstrip healthcare supply.

> **Doctors duty of confidentiality:** *The General Medical Council Guidance 2009: Pandemic Influenza, Good Medical Practice – the Responsibilities of doctors in a national pandemic*[11] sets out the regulators expectations of Doctors. Included in the 'musts' about the doctor-patient relationship, the doctor:
>
> *"Must as far as possible respect patients' privacy and right to confidentiality."*

In part of Section 37 on confidentiality, this guidance says:

> *"During a pandemic, staff working in health protection agencies will be part of the healthcare team and you should share information with them freely. In addition, you should provide the minimum necessary data for any additional public health monitoring or surveillance introduced during a pandemic."*

Sections 50 and 51 refer to the importance of sharing information when referring a patient to other healthcare professionals for safe and effective care, and that all relevant information should be shared.

Recommendation 6: DHSC should consult with the General Medical Council (GMC) about updating information sharing protocols, in particular on sharing confidential personal information with people beyond the definition of 'healthcare professional', during peaks of pandemic waves if healthcare staff cannot make urgent home visits requested by patients or by relatives, carers or volunteers on their behalf.

5. Easements suggested by DASSs:

Most of the suggested easements below are achievable at local level, so recommendations are to DHSC and MHCLG to ensure DASSs and Local Authority Chief Executives, are aware of the duties of the Local Authority in a flu pandemic and provide the necessary resources and permissions.

[11] www.gmc-uk.org/guidance/news_consultation/medical_pandemic.asp

5.1. Planned vs Ad Hoc local easements in processes: DASSs report that in an emergency or when Acute Trusts go in to 'Black'/OPEL 4 status, or when there are sudden, short-term emergencies such as a fire or flood and Care Home residents need help to move immediately, DASSs describe how everyone pulls together both across the NHS and the council, for example, staff working round the clock, and also in the voluntary and private sector, with care providers providing care first and talking about costs later. In such short-term emergency situations, ad hoc responses are often used, and the focus during the emergency is on results with less scrutiny on the process or longer-term outcomes for the people concerned.

During a flu pandemic, however, the local health and care system may be working at this level for weeks or months at a time, and it will not be possible for short-term ad hoc solutions to be used. In a pandemic, there may be one or more waves, with possibly 30% (or more) staff shortages due to flu and staff staying away from work to care for family who are ill, or because they are afraid of being infected themselves. Cooperation and heroic efforts that might be used on an ad hoc basis suitable during short-term emergencies are unreasonable to expect and less likely to work well during the lengthy period of a pandemic. Planned and rehearsed responses will be necessary. It is therefore essential to plan for any easements that would be used.

It should also be noted that ad hoc arrangements also increase financial risks to both commissioners and providers. At local level, normal spending control measures will need to be adapted and a different set of financial monitoring and control put in place.

5.2. The duties of the whole Council: DHSC and MHCLG should provide guidance to Local Authorities about the need for the wider Council to recognise the impact of a coming pandemic and create space for DASSs and the teams they need from across the Council to plan ahead and manage the demands.

5.3. Simple assessments undertaken by a much wider range of people
Designating a much wider range of people as assessors can provide quicker access to short-term care and enable a record of immediate needs for care, equipment or supplies. Paper-based short assessments will be of value to trained volunteers and to micro-providers taking on new clients without access to electronic record/reporting software.

There is some concern expressed by DASSs about short-term simple assessments undertaken by people authorised to assess during the pandemic but who may have less accountability or knowledge of Adult Social Care processes. In this situation, there may be an increased need for early reviews to confirm that the allocated resources are justified. This may in turn create a backlog of short-term reviews (occurring perhaps within 5 days), although it could be argued that the majority of frail/elderly/disabled people with flu requiring social care support in their home for a few days will not require reviews, as they will recover sufficiently for family and friends to give the support required.

Recommendation 7: DHSC should support the use of shortened, electronic (tablet or smart phone app) or paper-based assessments. People authorised to assess during the pandemic would need briefing on the requirements and Care Act eligibility for services and full needs assessments may need to be set aside in favour of brief assessments followed by reviews, as necessary.

5.4. **Procurement rules** could be loosened or set aside at local level for letting contracts/arranging care and other essential work to provide timely goods and services.

5.5. **Care Contracts:** Some DASSs describe contracts with providers of Care at Home that under normal conditions operate with terms that are intended to maintain a steady flow of income for the provider. In such contracts the funding is not removed immediately when a client is admitted to hospital, moves into a home or dies. For example, one DASS described their contracts: the funding continues for up to two weeks with the expectation that the provider will take on more clients very quickly. Their contract ensures that patients awaiting discharge with care at home packages wait no longer than 24 hours after being fit for discharge.

During a flu pandemic, however, the time between a person being fit for discharge and actual discharge will need to be no more than a few hours – as would a new care at home package to avoid a hospital admission.

During a pandemic, residential homes may find that several of their residents who are normally relatively mobile and self-caring, become highly dependent at the same time. High dependency from flu may last two weeks or longer given their frailty and risk of acquiring complications. This will have a real cost to providers in terms of staffing and equipment/disposable supplies.

There may be other issues, such as a need for emergency placements being used for fluctuating periods over several months which may skew provider finances. To maximise cooperation and avoid lengthy local negotiations preventing or delaying the provision of care during the pandemic, the triggering of national or regional rates would assist.

Recommendation 8: DHSC should consider the possible advantages and disadvantages of a national rate (with allowance for regional variations) for emergency placements and high dependency periods in residential homes. ADASS, NHS England and care provider representatives should be consulted and guidance would be required on local application of any emergency rates.

5.6. Rapid turnover of empty Care Home bedrooms: Commissioners will want Care Home Providers to reuse a room much quicker than usual after a death despite difficulties for grieving relatives. Many Care Homes have self-funder contracts requiring payment for a week or longer after a resident moves/dies, and funeral directors may have a backlog with delays in removing bodies.

5.7. Sheltered and Extra Care Housing: local areas could stop non-urgent allocations to free up capacity and require wardens and other staff to work differently to meet residents' needs.

5.8. **Unregistered premises**: At local level it would be useful to have permission, finance and insurance to commandeer premises, for example a Hotel and its staff. The easement would be permission to use even if they do not CQC or NHS environmental standards.

Recommendation 9: DHSC should consult CQC about the use of unregistered premises to provide extra care bed capacity in buildings such as hotels, and on the use of hotel staff for housekeeping, noting that sufficient care staff and/or trained volunteers such as from the Red Cross, would also be required.

6. Staffing Capacity:

6.1 Staff who are sick: clear public health and HR advice is required bout when to stay away from work and when to return to adapted or normal duties.

6.2 Staff who are unpaid carers of people with flu: clear HR advice is required about emergency carers' leave in the context of a flu pandemic.

6.3 Working Time Directive: Staff must be properly rested, but flexibility beyond the Directive limits may be required.

6.4 Rapid Recruitment Processes: will be required that enable new staff to start work pending full clearance, based on risk assessments

6.5 Use of volunteers: It is considered this will be above and beyond usual forms of volunteering.

6.6 Cross organisation staff supervision arrangements: potential process and 'norms' easements concerning Community Nurses may be useful, such as a nurse supervising a group of domiciliary care workers, so they can reach more people under a nurse's supervision. Selected, experienced care workers could each coordinate 10 volunteers who are making visits and undertaking tasks within a care worker's client list.

7. Logistics:

7.1. Sourcing hot meals: to be delivered to people at home who need them, decisions about suppliers could be informed by Environmental Health Rating. Small Care Homes with sickness amongst catering staff could be supported by supplying meals from larger Homes – managing the food hygiene aspects of this requires forethought.

7.2. Purchasing food and fuel cards for clients at home: where a socially isolated disabled or elderly frail adult living at home who has flu and is unable

to leave their home to obtain cash or buy food or electric meter keys/cards, visiting care agencies or voluntary agencies may use Food and Fuel cards to manage the process of buying necessary supplies/fuel and reclaiming the cost. Consideration could also be given to optimising supermarket deliveries to support those in this situation.

Recommendation 10: DHSC and MHCLG should provide guidance to Local Authorities and the local NHS about the need for the wider Council to recognise the potential impact of a coming pandemic and support DASSs, DCSs and the teams they need with local easements and capacity to manage the breadth of planning and potential demands during a pandemic. This should include the importance of the role of public health in clinical decision-making as part of risk assessments before bringing a care home back into use following closure due to flu.

8. Easements suggestions from the Care Provider Alliance and the UKHCA:

Providers have much the same suggestions for easements as DASSs. There is a real willingness to work flexibly and very differently in a flu pandemic, but require significant support to do so over a prolonged period when they may well have high sickness rates amongst their staff and current residents/clients.

The issues raised and recommendations arising from provider representatives are the same as those from DASSs.

8.1. Care Quality Commission: Provider representatives' overriding concern is the view that CQC might take if, by working differently to provide additional bed and workforce capacity, providers deviate from expected practice and environmental standards. For example:

- Care staff being asked by commissioners to act as Trusted Assessors during the pandemic with an abbreviated training for the role and without the formal qualifications or registrations normally expected of Trusted Assessors.

- Working with or supervising volunteers recruited/requested from Voluntary Organisations by the local authority or NHS.

- CQC support is essential for care providers in case they are challenged by service users/relatives that they are not receiving the level of service being paid for/commissioned.

8.2. Sharing Confidential Personal Information: Providers require clarity about information sharing protocols that provide them with a framework for sharing information and guidelines about how to do it and with whom. During a peak when there is overwhelming demand, information sharing may need to be outside of normal processes. Section 4 refers.

8.3. Staff absenteeism, accompanied by rising vacancy levels in social care: Provider representatives expressed caution about recruiting large numbers of new staff for the pandemic. They said it takes 13 weeks to recruit and train a care at home member of staff, so they can make visits alone. Recruitment and training is costly for providers. If the staff will not be required once the pandemic is over there is no incentive for providers to incur these costs and management time when they need to concentrate on providing care during the pandemic.

8.4. Disclosure and Barring Service (DBS) and Protection of Vulnerable Adult Checks: Providers asked for these to be faster to speed up recruitment and staff being able to work alone.

8.5. Financial instability amongst providers: Providers concerns include

- High levels of complications of flu causing higher dependency of clients and residents and higher costs.
- Higher than normal death rates, including among self-funders who pay more (and therefore the income reduces more on death).
- Higher number of clients being admitted to hospital or transferred to a different care category and commissioner fees being suspended/ stopped.
- Inability to acquire new self-funder business because all beds and care at home capacity is required for flu pandemic prioritised care provision.
- Requirement to accept new clients at very short notice but who are highly dependent due to flu, but payment for the work following slowly, leading to cash flow issues.
- Self-funders demanding rebates due to not receiving contracted level of service.
- See Sections 5.5, 5.6.

8.6. Delay in removing bodies of deceased residents from Care Homes by Funeral Directors – when commissioners want the room re-occupied that day or the next at the latest.

Recommendation 11: DHSC should consult with CQC to seek CQC assurance that local easements of regulated practice and processes can be agreed with local commissioners to increase capacity by, for instance, a less personalised service, and working to short-term essential user outcomes only.

Recommendation 12: DHSC should recommend to Local Authorities that where providers are required to make every effort to maximise capacity and service quality in prolonged difficult conditions, Commissioners and contract departments should reciprocate. This could be with appropriate easements, including ensuring that providers are paid promptly, perhaps through a different payment regime than normal to support provider cash flow.

9. Educational and child care establishment closures:

Closures are included here only because some DASSs and Care Provider representatives interviewed mentioned the health and care workforce implications if schools and nurseries close during periods of a pandemic.

Annex C of the LRF/Local Planners Flu Pandemic Guidance refers to Education and the implications of schools closing or remaining open on infection spread and on the workforce. There may be national or LRF decisions to close, taken by Public Health England. However, decisions to close a school due to concerns about the safety of children and staff due to staff shortages appear to lie entirely with the Head Teachers and school governors.

The Gov.UK pandemic flu guidance overview states that Education and Childcare guidance is currently under review. The literature research only found the following relevant national guidance, which was published in 2006, and does not advise on the role of Ofsted:

> *Planning for a Human Influenza Pandemic Guidance to schools and children's services, Department for Education (DfE) 2006*[12].

This report does not address the complexities of closing education and child care establishments. The DfE guidance indicates there are significant implications for the wellbeing and safety of particular types of establishment and children, requiring careful planning and management.

There would be similar and different issues with nurseries, many of which are run as small or medium sized businesses or franchises. The impact of staff shortages and closure on cash flow will influence their decisions.

The degree of control that Local Education Authorities (LEAs) have over schools, colleges and nurseries since the last pandemic is considerably reduced, with the emergence of academies. They have influence and expertise to provide support and advice to Head Teachers, Governing Bodies and nursery managers about how to adapt their school day and week, curriculum, staffing and use of trusted volunteers during a pandemic.

Recommendation 13: DHSC should, in consultation with DfE and Ofsted, encourage educational and child care establishments to work with the LRF to plan for both options of remaining open and closing, well ahead of a flu pandemic taking into account the impact of closures on the wider workforce, that is, parents of children who cannot attend due to closure.

a.) Relevant government departments should update advice to education and child care establishments about flu pandemic and the role of public health advice. Where closures are threatened due to staff shortages there should

[12] http://dera.ioe.ac.uk/6536/1/STERL-0706-WEB.pdf

be recommendations about cooperation between schools and adapting provision if possible, rather than closure, in the interest of the local community.

b.) Pandemic guidance to Directors of Children's Services and local planners should consider how school closures might be minimised.

10. Conclusion:

The existing legislation and guidance allows for easements in regulated or normal standards and business processes in the interest of the safety of individuals and the wider public during an emergency.

Easements suitable for a flu pandemic with a severe impact take adult social care well beyond normal escalation practice and experience of short-term emergencies. Proposed easements should be planned for at local level with partner organisations well in advance of a pandemic if they are to work safely and effectively.

Recommendations for Government/DHSC action:

Recommendation 1: DHSC should consult the Local Government Association (LGA) on supporting Local Authorities to understand and prepare for the breadth of responsibilities of their various departments and the importance of working together to safeguard their citizens during a flu pandemic.

Recommendation 2: DHSC consults with Ministry of Housing, Communities and Local Government (MHCLG) about whether the Bellwin Scheme might ever apply to a flu pandemic in England, and if so under what circumstances, MHCLG to advise local authorities accordingly.

a.) DHSC and MHCLG should recommend to Local Authorities that they make a record of additional expenditure under specific budget codes, incurred due to the flu pandemic, using a consistent and accurate methodology. This will create a record across England of the local expenditure, regardless of the source of funding of those costs.

b.) DHSC should consider how government flu pandemic guidance and agreements with regulators can enable easements in regulations and processes without the need for Government to invoke emergency powers to permit easements.

Recommendation 3: DHSC and CQC should, as part of planning for a flu pandemic, consider the regulatory and standards easements identified in this document by DASSs and care providers and agree a process for consistent implementation, where relevant, within CQC, at national and local level.

Recommendation 4: DHSC should involve the DBS in considering any operational changes to their processes that may be helpful during a flu pandemic.

Recommendation 5: DHSC should consult the UK Caldicott Guardian Council about what guidance it can give to facilitate information sharing during a pandemic and proper retrieval/deletion of information with reference to a severe impact in the community, when needs outstrip healthcare supply.

Recommendation 6: DHSC should consult with the General Medical Council (GMC) about updating information sharing protocols, in particular on sharing confidential personal information with people beyond the definition of 'healthcare professional', during peaks of pandemic waves if healthcare staff cannot make urgent home visits requested by patients or by relatives, carers or volunteers on their behalf.

Recommendation 7: DHSC should support the use of shortened, electronic (tablet or smart phone app) or paper-based assessments. People authorised to assess during the pandemic would need briefing on the requirements and Care Act eligibility for services and full needs assessments may need to be set aside in favour of brief assessments followed by reviews, as necessary.

Recommendation 8: DHSC should consider the possible advantages and disadvantages of a national rate (with allowance for regional variations) for emergency placements and high dependency periods in residential homes. ADASS, NHS England and care provider representatives should be consulted and guidance would be required on local application of any emergency rates.

Recommendation 9: DHSC should consult CQC about the use of unregistered premises to provide extra care bed capacity in buildings such as hotels, and on the use of hotel staff for housekeeping, noting that sufficient care staff and/or trained volunteers such as from the Red Cross, would also be required.

Recommendation 10: DHSC and MHCLG should provide guidance to Local Authorities and the local NHS about the need for the wider Council to recognise the potential impact of a coming pandemic and support DASSs, DCSs and the teams they need with local easements and capacity to manage the breadth of planning and potential demands during a pandemic. This should include the importance of the role of public health in clinical decision-making as part of risk assessments before bringing a care home back into use following closure due to flu.

Recommendation 11: DHSC should consult with CQC to seek CQC assurance that local easements of regulated practice and processes can be agreed with local commissioners to increase capacity by, for instance, a less personalised service, and working to short-term essential user outcomes only.

Recommendation 12: DHSC should recommend to Local Authorities that where providers are required to make every effort to maximise capacity and service quality in prolonged difficult conditions, Commissioners and contract departments should reciprocate. This could be with appropriate easements, including ensuring that providers are paid promptly, perhaps through a different payment regime than normal to support provider cash flow.

Recommendation 13: DHSC should, in consultation with DfE and Ofsted, encourage educational and child care establishments to work with the LRF to plan for both options of remaining open and closing, well ahead of a flu pandemic taking into account the impact of closures on the wider workforce, that is, parents of children who cannot attend due to closure.

a.) Relevant government departments should update advice to education and child care establishments about flu pandemic and the role of public health advice. Where closures are threatened due to staff shortages there should be recommendations about cooperation between schools and adapting provision if possible, rather than closure, in the interest of the local community.

b.) Pandemic guidance to Directors of Children's Services and local planners should consider how school closures might be minimised.