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Welcome to Landmark Chambers'

'Health and Social Care Law and COVID-19' webinar

The recording may be accessed here.

Your speakers today are…

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David Lock QC (Chair)

Topic:
Medical decision making when demand for respiratory services exceeds NHS capacity

Stephen Knafler QC

Topic:
Coronavirus & Adult Social Care

Leon Glenister

Topic:
Who is who in the COVID-19 crisis?

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Who is who in the COVID-19 crisis?

Leon Glenister

Relevant bodies

- Central government: Secretary of State, Public Health England, Chief Medical Officer.
- NHS bodies: NHS England, Clinical Commissioning Groups
- Local authorities
- Other interested groups: NICE, BMA.

Secretary of State

- Section 2A of the NHS Act 2006: SoS “must take such steps as the SoS considers appropriate for the purpose of protecting the public in England from disease or other dangers to health”.

- This can include:
  - “conduct of research”
  - “providing vaccination, immunisation or screening services”
  - “providing other services or facilities for the prevention, diagnosis or treatment of illness”
  - “providing information or advice”

Secretary of State

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- Also has powers under Public Health (Control of Disease) Act 1984 Part IIA, which was inserted by the Health and Social Care Act 2008 following SARS, so a pandemic was in mind.

- Section 45B: “The appropriate Minister may by regulations make provision for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination in England and Wales”

Secretary of State

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- It was based on this power that SoS made the Health Protection (Coronavirus) Regulations 2020.

- Questions over whether the Regulations are lawful. Act permits restrictions on where “groups of persons” go or have contact if they may be infected. Is the entire population a “group of persons”?

- Questions re guidance, e.g. the Government guidance states “one form of exercise a day” but the Regulations do not place any limit. Guidance amended following threatened legal challenge based on the potential need for disabled people to exercise more than once a day.

Public Health England

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Public Health England

- An executive agency of the Department of Health and Social Care.

- Website describes responsibilities as “preparing for and responding to public health emergencies”, and that it will “provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific expertise and support”.

- In legal terms it mainly discharges duties on Secretary of State in relation to public health

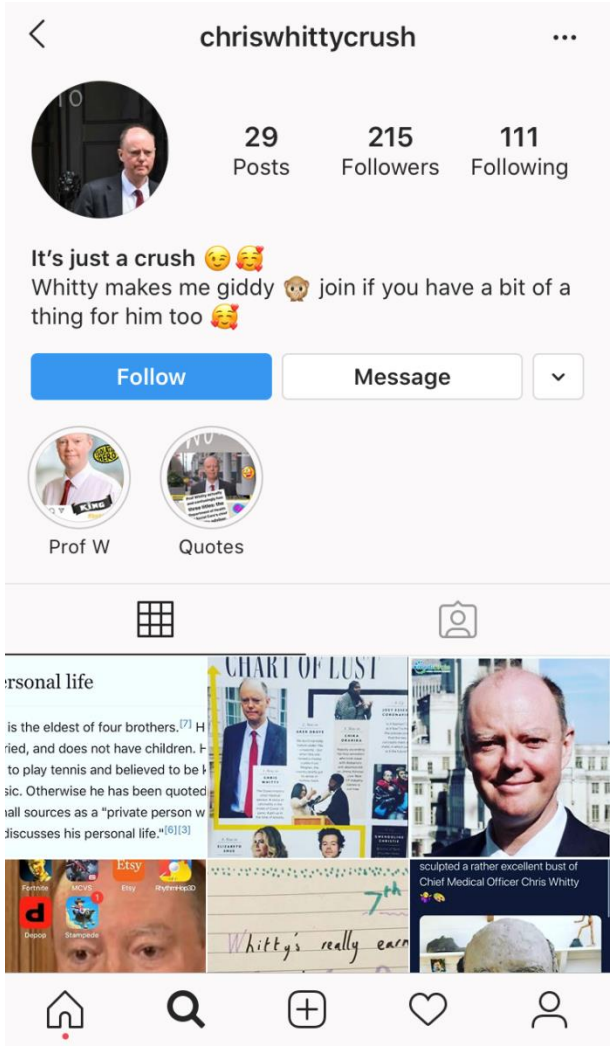
Public Health England

- In respect of COVID-19 so far it has:
  - Provided guidance e.g. on PPE, stay at home guidance
  - Monitoring the number of cases in the UK
  - Carrying out research into a vaccine
  - Provide emerging evidence, e.g. the greater impact on smokers

Chief Medical Officer

- A role within the Department of Health and Social Care.
- Described on the gov.uk: “acts as the UK government’s principal medical adviser, and the professional head of all directors of public health in local government and the medical profession in government.”
- Currently held by Professor Chris Whitty

Chief Medical Officer



NHS England

- Its duties are set out in the NHS Act 2006.

- Its general duties remain as set out in the NHS Act 2006: to promote a comprehensive health service, exercising functions in view of continuous improvement of services, reducing inequality, promoting research, etc.

- In relation to public health “Parliament did intend to exclude NHS England from any responsibility in the field of public health…” (R (National Aids Trust v NHS Commissioning Board [2017] 1 WLR 1477 per Underhill LJ).

Other NHS bodies

- CCGs:
  - CCGs are in charge of commissioning health services, and its duties are set out in Chapter A2 of the NHS Act 2006 (inserted by HSCA 2012).
  - It general duties remain (which mirror those of NHSE).
  - No direct role in public health pursuant to legislation.

- NHS Trusts
  - Sections 25-27 and Schedule 4 of the NHS Act 2006.
  - Provision of goods and services for the purpose of the health service.

Local authorities

- Section 2B of the NHS Act 2006 states “[e]ach local authority must take such steps as it considers appropriate for improving the health of the people in its area.”

- This can include:
  - “information and advice”
  - “providing services or facilities for the prevention, diagnosis or treatment of illness”
  - “providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment”
  - “making available the services of any person or any facilities”

Local authorities

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- Note a range of guidance from central government for local government, which even if non statutory, is both helpful and relevant to decisions (ranging from housing, education, rates, PPE, etc): https://www.gov.uk/guidance/coronavirus-covid-19-guidance-for-local-government

NICE

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NICE
National Institute for Health and Care Excellence

- National Institute for Health and Care Excellence
- Part 8 of the HSCA 2012, functions to carry out research.
- It has released “Guidelines” in relation to particular patients and departments. CCGs do not have an absolute duty to implement guidance, but had a duty to consider it and understand it in determining whether to implement it: *R (Fisher) v North Derbyshire HA* [1997] EWHC Admin 675

British Medical Association

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- The trade union and professional body for all doctors in the UK. It "represents, supports and negotiates on behalf of all UK doctors and medical students".

- A key body in campaigning for doctors in respect of PPE and testing.

- Has also released guidance on prioritising life saving treatment.

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Medical decision making when demand for respiratory services exceeds NHS capacity

David Lock QC

The nature of the problem.

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- How does the NHS take decisions about who gets access to critical care if the number of patients who need critical care support exceeds the NHS's capacity to provide that support;
- Can the NHS lawfully:
  - Ration who gets access to critical care treatment
  - Withdraw treatment from those not progressing in favour of others.

- Can NHS rationing be lawful in public law terms?
- Would it be unlawful discrimination?
- Would it lead to doctors being prosecuted for manslaughter or struck off the GMC register?
- If need for critical care exceeds supply, what else should doctors do?

Is this a problem now?

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But will it be a problem in future?

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- Answer is “nobody knows for sure”
- Everyone hopes enhanced critical care capacity will meet the need
- But no one knows for certain
- NHS areas are planning for all foreseeable eventualities – and this is clearly foreseeable
- So the questions need to be addressed.

BMA Guidance (1)

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"During this pandemic, it is possible that demand on health services may outstrip the ability of the NHS to deliver services to pre-pandemic standards. As we have seen in China, Italy and Spain, deaths frequently follow hospitalisation and critical care interventions. In Wuhan, 5% of those infected were admitted to ICU, and 2.5% required mechanical ventilation. It is possible therefore that restrictions in the availability of mechanical ventilation may for a period become severe.

Although not everyone will become ill at once, the initial wave of illness can be extremely rapid, over a few days to a few weeks. In these circumstances, if demand outstrips the ability to deliver to existing standards, more strictly utilitarian considerations will have to be applied, and decisions about how to meet individual need will give way to decisions about how to maximise overall benefit."

BMA Guidance (2)

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"Doctors would be obliged to implement decision-making policies which mean some patients may be denied intensive forms of treatment that they would have received outside a pandemic. Health professionals may be obliged to withdraw treatment from some patients to enable treatment of other patients with a higher survival probability. This may involve withdrawing treatment from an individual who is stable or even improving but whose objective assessment indicates a worse prognosis than another patient who requires the same resource ….

Although doctors would likely find these decisions difficult, if there is radically reduced capacity to meet all serious health needs, it is both lawful and ethical for a doctor, following appropriate prioritisation policies, to refuse someone potentially life-saving treatment where someone else has a higher priority for the available treatment"

BMA Guidance (3)

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Triage: Triage is a form of rationing or allocation of scarce resources under critical or emergency circumstances where decisions about who should receive treatment must be made immediately because more individuals have life-threatening conditions than can be treated at once ….

In these circumstances it is likely that priority will ordinarily be given to those whose conditions are the most urgent, the least complex, and who are likely to live the longest, thereby maximising overall benefit in terms of reduced mortality and morbidity. ”

BMA Guidance (4)

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- To maximise benefit from admission to intensive care, it will be necessary to adopt a threshold for admission to intensive care or use of scarce intensive treatments such as mechanical ventilation or extracorporeal membrane oxygenation. Relevant factors predicting survival include severity of acute illness, presence and severity of co-morbidity and, where clinically relevant, patient age.

- Those patients whose probability of dying, or of requiring a prolonged duration of intensive support, exceeds a threshold level would not be considered for intensive treatment, though of course they should still receive other forms of medical care”

Is NHS rationing lawful?

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- Yes – according to a long series of cases
- *R v Central Birmingham Health Authority ex parte Collier* [1988 WL 1608598]
- *R v Cambridge Health Authority ex parte B* [1995] 1 WLR 898
- *R (BA) v The Secretary of State for Health and Social Care* [2018] EWCA Civ 2696 where NHS rules made by the Secretary of State in Directions prioritising donated organs for those lawfully resident in the UK were unsuccessfully challenged.

University College v MB

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- Very recent decision from Chamberlain J

- *“In some circumstances, a hospital may have to decide which of two patients, A or B, has a better claim to a bed, or a better claim to a bed in a particular unit, even ceasing to provide in-patient care to one of them to leave will certainly cause extreme distress or will give rise to significant risks to that patient's health or even life. A hospital which in those circumstances determines rationally, and in accordance with a lawful policy, that A's clinical need is greater than B's, or that A would derive greater clinical benefit from the bed than B, is not precluded by Article 3 ECHR from declining to offer in-patient care to B”*

Human Rights complaints

- Questionable whether human rights are even engaged in NHS rationing decisions: see *R (Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910 [2012] PTSR 460

- Long series of ECtHR cases where the court has refused to engage with the problems of inadequate state funded health care services: *Sentges v Netherlands*, no 27677/02, 8 July 2003; *Pentiacova v Moldova*, no 14462/03, 4 January 2005; *Tysiac v Poland* (2007) 22 BHRC 155

- Only possible grounds are article 14 discrimination – but no cases.

- Hence ECHR grounds probably do not assist.

Will doctors be exposed to negligence claims?

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- How can doctors not act negligently if they make decisions which result in their patients having sub-optimal medical treatment?

- Answer is not straightforward, but in essence:

  – clinicians working in the NHS can be simultaneously make decisions as a doctor who owes a private law duty of care to a patient and as a public law decision maker who has to take decisions on the basis of rationing resources – and there cannot be different legal rules for each.

  – Hence doctors should not be able to be sued in negligence for making lawful public law decisions.

Standard of care is affected by available resources.

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- See academic text "*Who should we treat*" by Professor Chris Newdick (OUP: 2005) at page 187 in a chapter entitled "*Are negligence standards resource dependant?*" The answer to that question given by Professor Newdick is "Yes".

- *Knight v Home Office* [1990] 3 All ER 237

- *King v Sussex Ambulance Service NHS Trust* [2002] ICR 1413

- *Humphrey v Aegis Defence Services Ltd and another* [2017] 1 WLR 2937

Summary on negligence

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- A public law decision maker who takes a decision based on a rational policy which allocates treatment based on a fair allocation of medical resources as between different patients should not be liable in private law negligence for failing to provide a service with resources at a greater level than afforded by the public law decision.

- Reason is that a breach of public law duties does not, of itself give rise to any liability and it cannot be reasonable to expect a doctor or other clinical professional to provide additional medical resources to a patient over and above that which the public law allocation decision has determined.

Equality considerations

- It could be indirect discrimination but it would be a proportionate means of achieving a legitimate aim, namely maximising the number of lives to be saved

- Duty to make reasonable adjustments is engaged – but what adjustments can be reasonable where (a) there is no clear evidence base and (b) the standards will constantly shift depending on the need/resources equation

- Test on proportionality explained in *R (Steinfeld and Keidan) v Secretary of State for International Development (in substitution for the Home Secretary and the Education Secretary)* [2018] UKSC 32.

Criminal and regulatory considerations

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- Patients would die from their underlying conditions, not because of withdrawal of care: see *Airedale NHS Trust v Bland* [1993] AC 789

- Cannot be in the public interest to prosecute a doctor for the consequencecs of following a lawful Trust policy to prioritise case on those who can benefit most

- No breach of the GMC Code as no case to support unfitness

So in summary

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Assuming these circumstances arise, the dilemma for those in the NHS planning how to respond to the Covid-19 pandemic is thus not "*whether*" these terrible types of decisions will need to be made but:

- "*how*" these decisions should be made – i.e. by what criteria, and
- *whether* any proposed decision making system which is sufficiently clear it will be lawful.

What should NHS bodies in practice?

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- Work with their clinicians to ask and answer the difficult questions about how these decisions should be taken
- Develop draft policies and engage with the public (albeit briefly) to satisfy s14Z2 and 242 of NHS Act
- For Boards to consider and adopt policies to guide clinical decision making.
- Ensure that front line clinicians have accurate and up to date information about extent of patient need and extent of available critical care resources

What would be inexcusable?

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Coronavirus & Adult Social Care

Stephen Knafler QC

An outline of the new framework (1)

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- Section 15 and Schedule 12 to the Coronavirus Act 2020 (“the Act”), in force in England on the 31 March 2020. on the 1st April, in Wales.

- The statutory guidance, *Care Act easements: guidance for local authorities* (“the Guidance”).

- The non-statutory guidance, *Responding to COVID-19: the ethical framework for adult social care* (“the Ethical Framework”).

- The non-statutory guidance, *Covid-19: guidance on care home provision.*

An outline of the new framework (2)

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- The Act amends the Care Act 2014 by reducing the duties therein. These are referred to as “the easements”.

- Local authorities are no longer required to discharge their duties to assess the needs of adults or carers, make eligibility determinations, undertake financial assessments or prepare care and support plans.

- Local authorities continue to have the power, but are no longer under a duty, to meet needs except in the case of persons ordinarily resident or present and not settled elsewhere, so far as necessary to avoid a breach of Convention rights and subject to charging provisos.

An outline of the new framework (3)

- The Guidance advises local authorities to exercise their powers, e.g. to assess and meet needs, as if the Care Act 2014 remained in force, and for as long as reasonably possible.

- When that ceases to be reasonably possible, the Guidance advises that care and support needs should continue to be assessed and as far as possible met in a timeous, proportionate, evidence-based and person-centred manner, in accordance with the Ethical Framework.

What remains unchanged

- Safeguarding functions (and see Annex D of the Guidance).
- Duties to promote well-being, preventing duties and advice and information duties.
- Complaints procedures.
- The PSED and the reasonable adjustments duty under the Equality Act 2010.
- The LGSCO has suspended operations and the CQC is operating on a limited (largely remote) basis.
- DOLS – see *Coronavirus (Covid-19): looking after people who lack mental capacity.*

The first two lines of defence

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- The Guidance advises local authorities to exercise their new functions as if the Care Act 2014 remained fully in force, and for as long as possible and it advises that this can be done by (i) business as usual; and then (ii) by taking short-term measures and using flexibilities that always have been in the Care Act 2014. For example:

  – Para 6.3 of the Care and Support Statutory Guidance (proportionate assessments of different kinds);
  – Para 10.11 of the CSSG (flexibility as to how needs may be met)(may warrant changes to types of provision, delays or short-term cancellations – Annex B of the Guidance).

The third and fourth lines of defence (1)

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- The Guidance envisages local authorities applying the easements in two stages:
  - (i) ceasing formal assessments, eligibility decisions, assessment reviews and care and support plans, with some shifting of resources;
  - (ii) wholesale prioritisation of needs.
- First, the “tipping point” needs to be reached.
- Second, the right process needs to be undertaken.

The third and fourth lines of defence (2)

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- The “tipping point” is reached

  “*when the workforce is significantly depleted, or demand on social care increased, to an extent that it is no longer reasonably practicable for it to comply with its Care Act duties (as they stand prior to amendment by the Coronavirus Act) and where to continue to do so is likely to result in urgent or acute needs not being met, potentially risking life. Any change result from such a decision should be proportionate to the circumstances in a particular Local Authority”* (Guidance, page 5).

The third and fourth lines of defence (3)

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- A decision to operate the easements should (i) be taken by the Director of Adult Social Services in conjunction with the Principal Social Worker; (ii) having involved and briefed the lead member; (iii) having discussed the matter with the local CCG leadership; and (iii) carefully recorded. Decisions to reduce/prioritise needs should be reviewed every 2 weeks and reversed asap (Guidance, page 5 and 8-9).
- A decision to operate the easements should be (i) communicated to the HWB (Health and Well-being Board); (ii) communicated to all providers, service users and carers (taking into account any communication difficulties/needs); and (iii) reported to the DHSC (when a decision is made to start prioritising services, explaining why the decision has been made and providing brief details) (Guidance, page 5 and 8-9).

The third and fourth lines of defence (4)

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- The easements should be applied as narrowly as possible.

- The third line of defence is applying the easements so as to undertake streamlined assessments and reviews of need and care planning, re-allocating resources, meeting needs differently, and reducing levels of personal care (Guidance, pages 8-9).

- The fourth line of defence is moving into full scale prioritisation. Such decisions need to be made separately, to be reviewed every two weeks, to be communicated to the DHSC with reasons and to be revoked asap (Guidance, page 9).

Assessments, Reviews, Care Planning (1)

- Assessments, reviews and care planning should still mirror the approach and ethos under the Care Act 2014.
- Local authorities must still respond as soon as possible to requests for care and support, consider needs and wishes and make an assessment of what care needs to be provided (page 3).
- Assessment (and care planning) must still be proportionate and person-centred (pages 3, 4-5, 6).
- Assessments must demonstrate that decisions (i) are evidenced; (ii) based on professional judgment; (iii) apply the Ethical Framework (see below); and (iv) consider Convention rights (page 10).

Assessments, Reviews, Care Planning (2)

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- Assessments must take into account risks both current and future (page 7).
- Assessments need not be conducted face-to-face and a range of different methods may be adopted (page 10).
- People need to be informed that their needs may be assessed or re-assessed in the future and a different decision made (page 10).
- Local authorities must ensure there is a clear and transparent pathway for Convention issues to be raised (page 11).
- Escalation and complaints procedures remain unaffected (page 11).
- All assessments and reviews not completed must be followed up and completed in full once the easements are terminated (page 4).

Prioritisation (1)

- Surprisingly, given its central importance, the Guidance offers very little advice about prioritisation, stating that “The Department does not propose to advise local areas on how to prioritise as methods of prioritisation will be unique to each area. The Department also recognises that there will already be well established methods of prioritising in most areas” (page 14).

- One suggestion that the Guidance does make is that “Local Authorities may want to ‘RAG-rate’ their packages and have them split between High, Moderate and Low (or similar terminology). It is likely that many will have a mixed care package. They should note these but work on the most essential element of care for mapping purposes” (page 13).

Prioritisation (2)

- Does anyone else remember *Fair access to care services: prioritising eligibility for care and support*: https://www.scie.org.uk/publications/guides/guide33/files/guide33.pdf. .

- Could it be a useful starting point, to inform the identification of different levels of need, bearing in mind that the first level must be “Convention rights”?

Prioritisation (3)

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- **Critical** – when: • life is, or will be, threatened; and/or • significant health problems have developed or will develop; and/or • there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or • serious abuse or neglect has occurred or will occur; and/or • there is, or will be, an inability to carry out vital personal care or domestic routines; and/or • vital involvement in work, education or learning cannot or will not be sustained; and/or • vital social support systems and relationships cannot or will not be sustained; and/or • vital family and other social roles and responsibilities cannot or will not be undertaken.

Prioritisation (4)

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- **Substantial** – when: • there is, or will be, only partial choice and control over the immediate environment; and/or • abuse or neglect has occurred or will occur; and/or • there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or • involvement in many aspects of work, education or learning cannot or will not be sustained; and/or • the majority of social support systems and relationships cannot or will not be sustained; and/or • the majority of family and other social roles and responsibilities cannot or will not be undertaken

Convention rights

- *R (Bernard) v Enfield LBC* [2002] EWHC 2282 Admin, (2002) 5 CCLR 340.
- *R (Anufrijeva) v Southwark LBC* [2003] EWCA Civ 1406, [2004] QB 1124.
- *R (Limbuela) v SSHD* [2005] UKHL 66, (2006) 9 CCLR 30.
- *Pentiacova v Moldova* (2005) 40 EHRR SE23.

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Q&A

We will now answer as many questions as possible.

Please feel free to continue sending any questions you may have via the Q&A section which can be found along the top or bottom of your screen.

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Thank you for listening

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