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Coronavirus – its impact on Discharges, DNARs, DPs and DoLs

Catherine Rowlands, Peggy Etiebet, Lee Parkhill, Zoë Whittington and Tara O'Leary

What are we going to cover?

1. Introduction and welcome – Peggy Etiebet
2. Discharges – Zoë Whittington
3. DNAR – Lee Parkhill
4. Direct Payments – Tara O’Leary
5. DoLS – Catherine Rowlands
6. Questions and answers

Discharges

Zoë Whittington

Hospital Discharges

- *Covid-19 Hospital Discharge Service Requirements* ("the Guidance")

- Emphasis on:
  - discharging from hospital ASAP to free up beds
  - removing 'blocks' (e.g. funding, beds, choice)
  - reducing pressure on acute services

- Discharge to Assess ("D2A") model across England

Hospital Discharges

- Removing the blocks to enable rapid discharge by:
  - All support under the Guidance funded by NHS (incl. support to *prevent* hospital admission)
  - National community bed tracker system
  - Not allowing patient choice to delay discharge
    - Potential area for legal action, see *University College Hospitals v MB* [2020] EWHC 882 (QB)

Hospital Discharges

- MCA duties still apply including DoLS but guidance says should not delay discharge.
- Section 5 Guidance details specific role of LA's, with an emphasis on:
  - providing and expanding social care & provider capacity
  - collaborative working with NHS & providers

Hospital Discharges

- How is it working so far?

- Concerns about:
  - Social care staffing levels to meet all demands
  - Potentially rushed MCAs
  - Insufficient care home capacity or expertise and/or care homes unable/refusing to take persons who require isolating
  - Clarity over when the NHS Covid-19 funding applies

DNACPR

Lee Parkhill

DNACPR

- What is CPR?

‘CPR is an invasive and traumatic medical intervention and usually includes chest compressions, attempted defibrillation, injection of drugs and ventilation of the lungs.

Decisions relating to cardiopulmonary resuscitation, Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 3rd edition (‘the Guidance’)

DNACPR

- How effective?

  The proportion of people who survive cardiorespiratory arrest following CPR is relatively low. In hospital, the chance of surviving cardiorespiratory arrest to discharge varies considerably and depends on many factors, including comorbidities and the cause and circumstances of the arrest. In most hospitals the average survival to discharge is in the range of 15-20%

DNACPR

- Risks?

  There is also some risk that the person will be left with brain damage and resulting disability, especially if there is delay between cardiorespiratory arrest and the initiation of CPR. CPR attempts are unavoidably physical and potentially traumatic, as a result of which death may occur in a manner that neither the person affected nor people close to them would have wished.

DNACPR

- Decisions not to attempt CPR engage the patient's art. 8 rights, see ***R (Tracey) v Cambridge University Hospitals NHS Foundation Trust*** [2014] EWCA Civ 822
- Patients cannot compel clinicians to provide treatment which the clinicians think is inappropriate.
- Patient's art. 8 rights require procedural safeguards in connection with DNACPR decisions.

DNACPR

- Patient with capacity can refuse any treatment, including CPR.
  - After being advised of the risks, some patients, with capacity, might decline CPR.
- Clinicians cannot provide treatment if the patient, with capacity, has refused consent.
- Where patient has lost capacity - be aware of any advance decision to refuse life sustaining treatment.
- Sections 24 and 25 of the Mental Capacity Act provide for advance decisions. An advance decision will only apply to life sustaining treatment if it expressly refers to such treatment, and is signed and signed by a witness.

DNACPR – refusal

- Deputies cannot be given the power to refuse life sustaining treatment, see MCA, s. 20(5).
- Attorneys, under a health and welfare LPA, will only have the authority to refuse life sustaining treatment if
  - the patient lacks capacity to decide the issue, and
  - the LPA expressly confers that authority, see MCA, s. 11(7) and (8).

DNACPR – making the decision

- It is a clinical decision
- Ultimate responsibility for the decision to offer CPR rests with the most senior clinician responsible for the patient's care.
- The procedural safeguards, required by art. 8(2), generally, require that all patients are
  - consulted about DNACPR decisions, and
  - informed of the decision made, see ***Tracey***.

DNACPR – making the decision

- Clinicians should only refrain from consulting / notifying patients if they consider that doing so would cause physical or psychological harm.
  - Some degree of distress is almost always going to arise.
- A decision not to discuss the issue should be documented.
- A failure to consult / notify the patient will amount to a breach of art. 8 – unless justified by reference to the harm that consultation / notification would have caused.

DNACPR – where the patient lacks capacity

- Where the patient lacks capacity to decide - consultation requirement supplemented by s. 4(7) of the Mental Capacity Act 2005, see ***Winspear v City Hospitals Sunderland NHS Foundation Trust*** [2015] EWHC 3250 (QB).

- Section 4(7) requires that a best interests decision maker take account, if it is practicable and appropriate to consult them, the views of:
  - anyone named by the patient as person to be consulted;
  - anyone engaged in caring for the person / interested in his welfare;
  - any attorney under a LPA; and
  - any deputy

DNACPR – where the patient lacks capacity

- In ***Winspear***,
  - a failure to consult at a time when it was, perhaps, undesirable, but nonetheless practicable, to do so (the decision made in the early hours – P's mother could have been telephoned, but was not called).
  - No consultation in accordance with s. 4(7),
    - therefore DNACPR decision was not in accordance with law,
    - therefore in breach of art. 8.

DNACPR – resolving disputes

- If the patient, or family members, do not accept the clinical team's decision, generally they will be offered a second opinion.
- No art. 8 right to a second opinion
- One might not be offered if the patient has a multi-disciplinary team, and all members support the DNACPR decision.
- Second opinion - from a senior clinician with experience of the patient's condition but who is not directly involved in the patient's care, see the Guidance, at 14.

DNACPR – resolving disputes

- Ultimately, the court could be invited to adjudicate on any dispute. However, the court cannot compel clinicians to provide a particular treatment, see ***AVS v A NHS Foundation Trust & Anor*** [2011] EWCA Civ 7, per Ward LJ at [35]:

  'it is trite that the court will not order medical treatment to be carried out if the treating physician/surgeon is unwilling to offer that treatment for clinical reasons conscientiously held by that medical practitioner...'

Direct Payments

Tara O’Leary

Direct Payments: usual rules

- Mandatory duty, if conditions made out and no exemptions apply: ss.31-32 CA 14
  - Only if satisfied that DPs are "*appropriate way to meet the needs in question":* ss.31(7), 32(9), CSSG §12.19
  - Only if used to pay for arrangements to meet assessed eligible needs: s.33(3)
- Requests for DP can be made at **any time**, and should be swiftly processed "*in as timely a manner as possible":* CSSG §§12.10 and 12.22
- No power to "force" DPs: may only be provided if requested by or on behalf of P: ss.31(1)(b), 32(1)(c)

Direct Payments: family members

- DPs can be used to pay close relatives **only** if LA *"considers it necessary to do so"*:
  1. Spouse, civil partner or cohabiting partner
  2. Relatives including children, parents, grandparents and siblings (or their spouse/partner) **but only if** the relative is "*living in the same household as [P]"*

  Reg. 3 Care & Support (Direct Payments) Regs 2014/2871

- No "*unreasonable restriction*" should be imposed on payment of DP to relatives – low threshold: §12.35

- LGO has held "necessary" does not mean "exceptional"

Direct Payments under COVID-19

COVID-19: Guidance for people receiving direct payments
21.04.20

- Steps for local authorities and CCGs to support people who use DPs to purchase care and support
- Expressly contemplates family stepping in to replace cover from professional care providers
- LAs should "*adopt flexible approach*" to use of DPs during lockdown to ensure appropriate care is delivered
- LAs should "*consider requests to pay a close family member to provide care if deemed necessary*" – and respond "*as quickly as possible*"

Direct Payments under COVID-19

- Remember: normal Care Act duties should be followed "*for as long, and as far, as possible*" … easements should only be exercised if "*essential in order to maintain the highest possible level of services".*
- How else will the care be provided if DP is not permitted and/or LA does not permit payment to family to provide care? (NB - s.1 CA 2014 still applies)
- Do you have **cogent reasons** for (a) relying upon easements, (b) departing from CSSG and/or COVID-19 Guidance and/or local policy on DPs, (c) anticipating no breach of ECHR?

Local authorities and CCGs should consider requests to pay a close family member to provide care if deemed necessary

Deprivation of Liberty

Catherine Rowlands

Deprivation of Liberty Safeguards

- The Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) During the Coronavirus (COVID-19) Pandemic
- Main principle: nothing has changed
- Main issues:
  - Changes to usual arrangements
    - Helping people stay socially isolated
    - Practical arrangements for assessments
  - No blanket decisions

Deprivation of Liberty Safeguards

- *BP v Surrey CC* [2020] EWCOP 17, Hayden J, 25/3/20
- Emergency application for discharge from CH to family home
- Noted the emergency situation can mean derogation from article 5
- Capacity assessments by video permitted
- Creative plan for contact

Deprivation of Liberty Safeguards

- *BP v Surrey CC* [2020] EWCOP 22, Hayden J, 29/4/20
- Capacity assessment did not happen but that does not change Hayden's view that they can be done remotely
- BP had depression as a result of lack of contact and parties agreed he should return home when carers can be put in place

Deprivation of Liberty Safeguards

- Hearings in CoP going on remotely: see guidance https://www.judiciary.uk/you-and-the-judiciary/going-to-court/family-law-courts/court-of-protection-guidance-covid-19/
- Participation of P in the hearing – see CoA guidance in *Re A* [2020] EWCA Civ 583 and *Re B* [2020] EWCA (Civ) 584.
- Note template orders

Deprivation of Liberty Safeguards

- Can the Court extend a standard authorisation beyond 12 months?
  - Our view is that a Court does have the power to extend SA more than 12 months
  - Alternatively order could include recitals that if it were not for the limitation, would have authorised extension ie it’s technical breach only ie no damages
  - Combine the two

Questions and Answers

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Ask us more questions:

events@cornerstonebarristers.com

For instructions and enquiries:

elliotl@cornerstonebarristers.com

dang@cornerstonebarristers.com

samc@cornerstonebarristers.com