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BRIEFING PAPER

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Coronavirus Bill: health and social care measures

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1. Introduction

It is becoming increasingly likely that SARS-CoV-2 (coronavirus) and the associated disease, covid-19, will become a significant epidemic in the UK. The NHS and social care sector will have to manage increasing numbers of patients needing medical treatment. Health and care services will also face pressures from staff shortages due to sickness, imposed isolation and caring responsibilities.[1] The Government has identified that urgent legislative measures are needed to support the NHS and social care, and to increase the available health and social care workforce in particular.

This briefing paper is one of a collection of Commons Library briefings on the Coronavirus Bill (the Bill). It deals with the key health and social care provisions of the Bill:

- Section 2 covers the Bill's health and social care workforce measures, including provisions on emergency registration, indemnity cover, emergency volunteers and NHS pensions.
- Section 3 covers measures to reduce administrative requirements on health and social care staff.
- Section 4 covers changes to mental health and mental capacity legislation.
- Section 5 covers other public health measures.

Other Library briefing papers, dealing with other parts of the Bill and general background, are available on the Commons Library website (Coronavirus Bill: Overview).

The Bill includes measures to allow the emergency registration of certain health and care professionals and students, and would support recently retired staff to return to work without any negative repercussions to their pensions. Measures to support volunteers are also intended to ease pressure on frontline NHS and adult social care staff. The Bill would extend state-backed insurance to ensure new and existing NHS staff can care for patients if, for example, they are working outside of their normal areas. The Health Secretary has suggested that some NHS staff will need to be redeployed to support care of people

[1] NHS England estimates that in the event of a worst-case scenario the absenteeism rate could be as high as 30% for healthcare workers. As the Impact Assessment on the Coronavirus Bill notes, in this situation, many essential health and social care services may cease with detrimental impacts on those that need them most.

infected with covid-19: "We will be stopping some other activity, and asking doctors who normally do other things to retrain to be able to, for instance, use… ventilators."[2]

The Bill includes measures to help services continue to operate effectively during periods of significant staff shortage, by reducing the administrative burden on frontline staff and allowing tasks to be performed more quickly. To support this, the Bill enables the following changes to the way care is provided during an emergency period:

- enabling local authorities to prioritise care for people with the most pressing needs; and
- allowing NHS providers to delay undertaking NHS continuing healthcare assessments for individuals being discharged from hospital.

Given there are likely to be high rates of coronavirus related staff absence, organisations may find it very difficult to comply with the procedural requirements set out in Mental Health legislation. The Bill also makes temporary modifications to the procedural safeguards around the detention ("sectioning") of patients with severe mental illness for treatment or assessment in hospital.

The Bill also introduces new powers in Northern Ireland and Scotland around public health which are aimed at ensuring powers are equivalent across the UK.

Further information is available in the Explanatory Notes (Bill 122-EN) and Impact Assessment for the Coronavirus Bill, which were published on 19 March 2020.

See also:

- Department of Health and Social Care (DHSC) news story, Emergency bill to strengthen coronavirus (COVID-19) response plans, 17 March 2020
- DHSC briefing, Coronavirus bill: what it will do, 17 March 2020

The NHS and social care sectors are already taking a wide range of actions to prepare and respond to the coronavirus outbreak, for example, the NHS in England is suspending elective non-urgent surgery from 15 April at the latest, for at least three months. The Impact Assessment for the Bill sets out some of the plans the NHS has been developing and implementing to provide additional staffing capacity and flexibility.

> The National Pandemic Influenza Service will be initiated, and non-urgent operations and services will be cancelled or delayed. Both of these actions should release staff who can be deployed to other critical services. These form a core part of the UK Influenza Pandemic Strategy 2011. Similarly, the NMC already has the power to increase registrant's responsibilities in the event of emergency involving loss of human life or human illness – for example by enabling nurses (not already qualified to do so) to order drugs, medicines and appliances in a specified capacity with regards the emergency.[3]

Information and guidance on the coronavirus response for health and care professionals and organisations can be found on the Public Health England and Gov.uk websites.[4]

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2 BBC News, Coronavirus: Five ways hospitals will change to tackle the pandemic, 15 March 2020
3 Department for Health and Social Care (DHSC), Coronavirus Bill Summary of Impacts, 19 March 2020, para 2
4 On 17 March 2020 the Health and Social Care Select Committee took evidence from the Chief Scientific Advisor and the senior leadership of NHS England and NHS Improvement, on NHS preparedness for coronavirus.

2. Workforce measures

On 17 March 2020, the UK Government published a guidance document, What the coronavirus bill will do, which noted measures that would be included to increase the available health and social care workforce across the UK:

> Increasing the available health and social care workforce — by removing barriers to allow recently retired NHS staff and social workers to return to work (and in Scotland, in addition to retired people, allowing those who are on a career break or are social worker students to become temporary social workers).[5]

2.1 Emergency registration of health and care staff

Clauses 2-4 and Schedule 1 of the Bill provide for the emergency registration of health and care professionals across the UK by the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC). There are already existing powers for the General Medical Council (GMC) to register doctors in the UK in an emergency and the Bill intends to confer similar powers onto the NMC and the HCPC.

Clauses 5 and 6 and Schedule 4 and 5 of the Bill would also enable regulators in different parts of the UK to temporarily add social workers to their registers who may have recently left the profession, to ensure continuity of care for vulnerable children and adults.

On notification from the Secretary of State for Health and Social Care of an emergency, the Bill would allow the Registrars of the NMC and HCPC to temporarily register fit, proper and suitably experienced persons as regulated healthcare professionals (such as nurses, midwives or paramedics[6]). This might include recently retired professionals and students who are near the end of their training.

There are already existing emergency powers for the General Pharmaceutical Council to register pharmacists in Great Britain, but the Bill includes similar provisions for pharmacists in Northern Ireland.[7]

The Government has said that decisions on how to deploy new and returning staff who have been through the emergency registration process should be made on a local basis, to enable essential health and care services to function during the height of the epidemic.[8]

The Impact Assessment for the Bill states that it is currently unknown how many professionals registered under the powers in the Bill will be willing to provide services. The GMC has indicated that re-registering doctors who have left the register in the last three years would provide a potential pool of 15,500 additional doctors. The NMC have indicated a potential pool of 60,000 nurses, midwives and nursing associates, who have left the register in the last three years.[9]

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5 DHSC, What the coronavirus bill will do, 17 March 2020

6 The NMC registers nurses, midwives, and nursing associates, and the HCPC registers paramedics, biomedical scientists, clinical scientists, operating department practitioners and a number of other professions.

7 The Pharmaceutical Society of Northern Ireland is the regulatory body for the pharmacy profession in Northern Ireland. The Bill will allow temporary registration in Northern Ireland for pre-registration pharmacists or recently retired pharmacists. The Bill also provides for prescribing powers for pharmaceutical chemists in Northern Ireland. See paras 17 and 18 of the Explanatory Notes (Bill 122-EN, 19 March 2020).

8 DHSC, What the coronavirus bill will do, 17 March 2020

9 DHSC, Coronavirus Bill Summary of Impacts, 19 March 2020, para 6

On 20 March 2020 the BBC reported statements from the Chief Nursing Officer, Ruth May, and NHS England's National Medical Director, Professor Steve Powis, urging doctors and nurses who have left the NHS in the last three years to re-register with the NMC and GMC. The NMC is expected to write to 50,000 nurses whose registration has lapsed in the last three years; and the GMC will contact 15,500 doctors who have left since 2017. Those who return will be assessed to see how they can best help the NHS fight the pandemic. The BBC also note that final-year medical students and student nurses could also be given temporary roles.[10]

On 19 March 2020 the NMC, the four UK Chief Nursing Officers, and health unions and training bodies, issued a joint statement on expanding the nursing workforce in the covid-19 outbreak. This sets out four specific actions that are being put into place to expand the nursing workforce:

> 1. Once the UK Government has passed the legislation to enable the NMC to establish a Covid-19 temporary emergency register our first focus will be to invite those nurses who have left the register within the last three years to opt in should they wish to do so.
> 2. Encourage those nurses who are currently on the register but not working in clinical care to consider coming into clinical practice during this time.
> 3. Change the nature of the programme for undergraduate nursing students so that they can opt to undertake their final six months of their programme as a clinical placement.
> 4. The next stage of the Covid-19 temporary register would be to establish a specific student part to the emergency register for students in the final six months of their programme, which would have specific conditions of practice to ensure appropriate safeguards are in place.

To deliver these outcomes as quickly as possible, the NMC, the other signatories to the joint statement, together with the DHSC, have agreed and signed up to a number of joint working commitments:

> **The Nursing and Midwifery Council agrees to:**
>
> - Write out to those nurses who have left the register in the last three years inviting them to join the NMC Covid-19 temporary register. No fee will be applicable for registrants on the Covid-19 temporary register.
> - Introduce varied emergency education standards to enable the last six months in the final year of undergraduate nursing degrees to be spent in clinical placement.
> - To support this, the NMC understands that it will not be possible for students on clinical placement to be supernumerary in this emergency situation but will expect students to be supervised and work within an appropriate delegated framework.
> - Discuss with relevant stakeholders the conditions of practice for the student part of the Covid-19 temporary register for the NMC Council to agree.
> - Initially extend the revalidation period for current registered nurses by an additional three months and seek further flexibility from the UK Government for the future.
>
> **The Chief Nursing Officers for England, Scotland, Northern Ireland and Wales agree to:**
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> - Develop appropriate deployment guidance for employers, professionals and students that are bespoke for each of the four countries of the UK, working with stakeholders, including the terms and conditions and remuneration for those on the Covid-19 temporary register and the students whose final six

[10] BBC News, Coronavirus: Tens of thousands of retired medics asked to return to NHS, 20 March 2020

months are spent in clinical placement. Whatever choice they make, no student will be disadvantaged.

- Establish a point of contact (telephone helpline, website) for all health and social care employers in all four nations across the UK that can provide appropriate information for potential registrants and final year students.

Council of Deans of Health agrees to:

- Work with Approved Education Institutions (AEIs) and local employers to place student nurses in clinical placements appropriately in all four nations across the UK.
- Work with Approved Education Institutions to formally sign off each student as per normal processes, taking personal circumstances into consideration before putting them forward for the register (full). Depending upon individual circumstances, this may require additional supernumerary clinical practice or theoretical learning.

Royal Colleges and Trade Unions representing nurses and students agrees to:

- Provide expertise with and on behalf of their memberships to inform the development and implementation of guidance, ensuring individual choice is paramount within the context of emergency measures.
- Negotiate employment terms and conditions within emergency measures.
- Support their registered nurse members in non-clinical roles who may be willing to return to clinical practice during the emergency where appropriate.

UK Government Department of Health and Social Care is:

- Working with other stakeholders, government bodies and devolved administrations to clarify policies concerning pay, pensions, training and student loans.
- Supporting the NMC with emergency changes to its rules to allow it to take the actions set out above.
- Agreeing emergency changes to the rules to enable the action outlined above to be effective.[11]

The Chief Executives of the NMC, HCPC and the other statutory regulators of health and care professionals issued a joint statement on 3 March 2020, recognising that in dealing with the coronavirus outbreak professionals may need to depart from established procedures in order to care for patients and people using health and social care services:

> We hold the registers of health and care professionals in the UK. We support those professionals to deliver better, safer care by setting the standards they need to meet, to act in the best interests of patients and people who use health and social care services at all times.
>
> As registered professionals, the first concern of the individuals on our registers will be the care of their patients and people who use health and social care services. We encourage health and care professionals, working in partnership with each other and people using services, to use their professional judgement to assess risk to deliver safe care informed by any relevant guidance and the values and principles set out in their professional standards.
>
> We recognise that in highly challenging circumstances, professionals may need to depart from established procedures in order to care for patients and people using health and social care services. Our regulatory standards are designed to be flexible and to provide a framework for decision-making in a wide range of situations. They support professionals by highlighting the key principles which should be followed, including the need to work cooperatively with colleagues to keep people safe, to

[11] NMC, Joint statement on expanding the nursing workforce in the Covid-19 outbreak, 19 March 2020

> practise in line with the best available evidence, to recognise and work within the limits of their competence, and to have appropriate indemnity arrangements relevant to their practice.
>
> We recognise that the individuals on our registers may feel anxious about how context is taken into account when concerns are raised about their decisions and actions in very challenging circumstances. Where a concern is raised about a registered professional, it will always be considered on the specific facts of the case, taking into account the factors relevant to the environment in which the professional is working. We would also take account of any relevant information about resource, guidelines or protocols in place at the time.
>
> We may issue profession specific guidance to registrants to provide additional support where that is needed.[12]

On 19 March 2020 the NMC set out a statement on how it will continue to regulate nurses and midwives during the coronavirus pandemic.[13]

Information on the latest coronavirus guidance, news and information from the Royal College of Nursing (RCN) can be found on the RCN website.

Emergency registration of doctors

For Scotland only, the Bill makes provision to modify the *NHS (Primary Medical Services Performers Lists) (Scotland) Regulations 2004* to support the fast deployment of temporarily registered GPs, despite not being included in the primary medical services performers list of a Scottish Health Board.[14]

The BMA has called for answers to concerns raised about the UK Government's proposal to bring doctors out of retirement, specifically on issues such as GMC registration and indemnity, and how they will be protected against more serious illness should they contract covid-19.[15]

Plans are being put in place to allow healthcare students near the end of their training to work in the NHS (e.g. medical students registering with the GMC).[16] In a joint statement, UK training bodies and the GMC have said that there will be increased requirements for trainees and trainers to support the management of acutely unwell patients:

> This might result in disruption or cancellation of training activities and trainees being directed to alternative tasks and/or locations to support the covid-19 response," it said. "This could mean trainees in non-acute areas being asked to support urgent and unplanned care, such as medical admissions and the subsequent management of those patients, but may also in exceptional circumstances include providing support to clinical teams in other disciplines. [17]

Supporting the Covid-19 response: Guidance regarding medical education and training also includes guidance that "trainees must not be asked to undertake any activity beyond their level of competence and must be advised that they should seek senior workplace guidance if that arises." On the 11 March 2020 the UK Chief Medical Officers, the GMC

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12 HCPC, Joint statement on coronavirus from the Chief Executives of the statutory regulators of health and care professionals, 3 March 2020
13 NMC, How the NMC will continue to regulate during the coronavirus pandemic, 19 March 2020
14 Coronavirus Bill Explanatory Notes (Bill 122-EN, 19 March 2020) para 14
15 BMA proposes doctor COVID-19 safeguards, March 2020
16 NHS cuts corners to boost doctor numbers fighting coronavirus, the Times, 15 March 2020
17 Health Education England, NHS Education for Scotland, Health Education and Improvement Wales, Northern Ireland Medical and Dental Training Agency, GMC, Supporting the covid-19 response, 10 March 2020.

and other medical bodies also issued guidance for doctors in the event of a covid-19 epidemic.

The BMA has stated that final-year medical students should not be "conscripted" without their consent and that "They must have adequate supervision and be inducted into employment and paid as if first-year foundation doctors."[18] (See also Trainees and covid-19: your questions answered, BMJ, 13 March 2020).

2.2 Indemnity cover for healthcare staff

Clauses 10-12 of the Bill would provide indemnity cover for clinical negligence liabilities of healthcare staff arising from the response to the coronavirus outbreak (and where there is no existing indemnity arrangement in place[19]). This will ensure that those providing healthcare services across the UK are legally protected for the work they are required to undertake as part of dealing with cases of covid-19. The Explanatory Notes to the Bill provide the following summary

> The Bill includes powers to provide indemnity coverage for clinical negligence of health care workers and others carrying out NHS and Health and Social Care (HSC) activities connected to care, treatment or diagnostic services provided under the arrangements for responding to the covid-19 pandemic. This indemnity is intended to act as a 'safety net' where clinical negligence arising from the provision of such services is not already covered under a pre-existing indemnity arrangement, for example under state indemnity schemes, private medical defence organisation or commercial insurance policies or through membership of a professional body.[20]

The Impact Assessment for the Bill notes that while there may be a substantial cost associated with the indemnity provision, the exact number of health and care workers covered, and the potential cost of claims are hard to quantify (and will be dependent on the severity of the outbreak and the availability of healthcare professionals). However, the Impact Assessments states that the Government expect the "…the vast majority of persons carrying out activities in connection with the provision of NHS services as a consequence of a coronavirus outbreak to have sufficient clinical negligence indemnity cover in place under the pre-existing state-backed schemes, reducing any reliance on the 'safety net' provisions created by this clause."[21]

2.3 NHS pensions

Clauses 43 to 45 of the Bill make changes to NHS pensions to ensure that recently retired NHS workers do not have their pension reduced (or 'abated') if they return to NHS employment to help manage covid-19.

NHS Pension Scheme

The NHS Pension Scheme is a public service pension scheme. It is a Defined Benefit (DB) scheme, which pays pension benefits based on salary and length of service. There are separate schemes for different parts of the UK:

- NHS Pension Scheme in England and Wales;
- NHS Scotland Pension Scheme;

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18 BMA proposes doctor COVID-19 safeguards, March 2020

19 Existing indemnity arrangements in England include the Clinical Negligence Scheme for Trusts and the Clinical Negligence Scheme for General Practice.

20 Coronavirus Bill Explanatory Notes (Bill 122-EN, 19 March 2020), para 29

21 DHSC, Coronavirus Bill Summary of Impacts, 19 March 2020, para 85

- Health and Social Care Pension Scheme in Northern Ireland.

Because they have been reformed in recent years – in 2008 and 2015 - there are different schemes, depending on age and date of joining.[22] In each case, the rules are in regulations made by the relevant Minister in the 'responsible authority' (the UK Parliament, the Scottish Government or the Northern Ireland Assembly) within the framework of primary legislation.[23]

Pension reductions when returning to work

Someone who has started to receive their pension may have it reduced (or 'abated') if they return to NHS employment before pension age. These rules are common across the NHS Pension Schemes.[24] They also apply in other public service schemes.[25]

The purpose is to provide a safeguard against the "potential abuse of re-employment". It helps avoid the position where "a re-employed member could receive a higher income from public funds, taking account of pay and pension, than a colleague of the same rank, seniority and trade with whom he or she might work."[26]

The rules can apply where an individual took early retirement and had their pension enhanced by the scheme or employer (for example, where the early retirement was on ill-health grounds or 'in the interest of efficiency of the service').[27] They cease to apply at pension age.

Whether the pension is reduced will depend on: the level of earnings whilst re-employed; when they left the Scheme; when they claimed their pension benefits and the type of pension benefits claimed.[28] Changes to the rules in 2008 mitigated the impact of the policy, so that any reduction would only relate to the 'enhanced element' of the pension.[29]

Clauses 43 to 45

Clauses 43 to 45 of the Bill would suspend these rules. This would allow recently retired healthcare professionals to return to work or increase their hours without there being an impact on their pension, which the Government thought might act as a disincentive to re-enter the NHS. It said:

> It is important that restrictions on returning to work whilst in receipt of a pension do not act as a disincentive for healthcare professionals who wish to re-enter the workforce in order to assist the healthcare response to covid-19. The Bill will therefore suspend certain rules that apply in the NHS Pension Scheme in England and Wales so that healthcare professionals who have recently retired can return to work and those who have already returned can increase their hours without there being a negative impact on their pension entitlements.[30]

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22 For more on the background, see Library Briefing Papers Public Service Pensions – the 2015 reforms (CBP 5768, Feb 2020) and Public Service Pensions – facts and figures (CBP 8478, December 2019)

23 *Public Service Pensions Act 2013*, s2 and Sch 2; *Public Service Pensions (Northern Ireland) Act 2014*, s2 and Sch 2

24 The regulations that apply the rules are in each case are cited in clauses 43-5 of the current Bill

25 HC Deb, 29 April 2008, c253W; See, for example, Civil Service Pensions, What is abatement? A guide for members of classic, classic plus, nuvos and premium, (September 2014)

26 HC Deb, 26 April 2004, c724W

27 For an explanation of the different types of early retirement, see NHS Pensions Scheme 1995/2008 – Guide for members, p28

28 NHS Pensions, Returning to the NHS after retirement, May 2018 and Returning to work after ill-health retirement, August 2017; Scottish Public Pensions Agency, Working after retirement, 2013

29 Moving to the future: the NHS Pension Scheme Review: joint proposals from NHS Employers and the NHS trade unions. August 2006; Library Briefing Paper NHS Pension Scheme – background (CBP 1823)

30 Coronavirus Bill Explanatory Notes (Bill-122 EN), paras 80-1

Separately, **clause 21** of the *Finance Bill 2019-21* would increase the level of earnings at which the 'tapered annual allowance' applies.

The current rules have a negative financial impact on senior NHS clinicians taking on additional work to cover shifts - this is discussed in Library Briefing Paper Pension tax rules – impact on NHS consultants and GPs (CBP 8626, March 2020).

2.4 Emergency volunteering

Clauses 7 and 8 and **Schedule 6** of the Bill create a right to 'emergency volunteering leave' (EVL), a new type of leave created to enabled workers to volunteer in the health and social care sectors.

Overview

Clauses 7 and 8 and **Schedule 6** apply to the whole of the UK.[31] Unlike in Scotland and Wales, employment law is devolved in Northern Ireland. The Sewel Convention provides that the Westminster Parliament will *not normally* legislate in areas of devolved competence unless the devolved institution has passed a legislative consent motion.

Emergency volunteering leave

A worker is entitled to take a period of EVL if they have obtained an 'emergency volunteering certificate'.[32] This is a certificate issued by a relevant authority which states that the person has been approved as a volunteer in health or social care. It must specify the dates for which the worker will be a volunteer. A certificate can specify that a person will be a volunteer for two, three or four consecutive weeks. The worker must give their employer at least three days' notice before taking EVL.

The Bill lists a number of 'relevant authorities' who can issue certificates to workers. These include the Secretary of State for Health and Social Care, the NHS, councils and a Ministers in devolved administrations.[33] The Bill does not provide detailed guidance on the sort of work for which a certificate might be issued, beyond stating that it must relate to health and social care.

A worker can only take EVL once in each 'volunteering period'. The first volunteering period is 16 weeks from the date Schedule 6 comes into force. The Secretary of State, for Great Britain, and Department for the Economy in Northern Ireland can make regulations to create subsequent 16-week volunteering periods. Subsequent volunteering periods do not have to follow immediately from the end of a previous period.[34]

Who can take EVL?

For these purposes, 'worker' has the meaning given to it in section 230 of the *Employment Rights Act 1996*.[35] The right is also specifically applied to agency workers.[36]

Certain workers are excluded from this category. These include:

- Those who work for a business with fewer than 10 workers;
- Crown employees;

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31 Clause 85
32 Para. 1, Schedule 6.
33 Para. 4, Schedule 6.
34 Para 2, Schedule 6.
35 See Employment Status, Commons Library Briefing Paper, CBP-8045, 28 March 2018.
36 Para. 30, Schedule 6.

- Staff of the House of Commons and the House of Lords;
- Those who work for the Scottish Parliament, Welsh Assembly and Northern Irish Assembly; and
- Those employed under a contract of employment with the police service (most police officers are office holders, not workers).[37]

Rights of workers taking EVL

Schedule 6 of the Bill also provides a range of employment law protections to workers who take EVL.

A worker who takes EVL is entitled to return to their work in the same position as if they had not been absent.[38] A number of provisions are made to ensure that a workers pension rights are not adversely affected by taking EVL.[39]

Part 3 of Schedule 6 modifies the *Employment Rights Act 1996* . The 1996 Act shall be read as including a new section 47H, protecting workers who take or seek to take EVL from suffering any detriment. The Act will also be read as including a new section 104H, providing that if an employee is dismissed for taking or seeking to take EVL, the dismissal will be automatically unfair. As with other cases of automatic unfair dismissal, all employees qualify for protection, not only those who have two years' continuous service with their employer (as is the case in standard unfair dismissal claims). Claims relating to detriment or dismissal can be brought to the Employment Tribunal in the same way as other claims under the Act.[40]

Part 4 of Schedule 6 makes the same modifications to the *Employment Rights (Northern Ireland) Order 1996*.

Compensation for emergency volunteers

The Bill does not provide for EVL to be paid. However, **clause 8** provides that the Secretary of State must make arrangements to compensate emergency volunteers for loss of earnings, travel and subsistence costs. The Secretary of State can set out the conditions a volunteer must satisfy to be eligible for compensation and the way in which compensation should be claimed.

The Secretary of State must pay compensation out of money provided by Parliament.

The Secretary of State must lay a statement about the arrangements before Parliament as soon as is reasonably practicable after they are made.

2.5 Disclosure and vetting of health and care staff in Scotland and Wales

Wales

Regulations governing social care service providers and independent health care providers in Wales include requirements relating to vetting procedures for staff before they are permitted to start work. **Clause 31** the Bill would allow Welsh Ministers to issue a notice disapplying or varying these requirements, to provide increased flexibility for providers to address workforce issues. Notices issued in this way must contain a statement by the

37 Para. 3, Schedule 6.
38 Para 6, Schedule 6.
39 Para 7, Schedule 6.
40 Part 3, Schedule 6.

Welsh Ministers, explaining why the step is appropriate and proportionate. Notices will have effect for one month though Welsh Ministers may issue further notices as well as cancelling them.[41]

Scotland

In Scotland, **clauses 32 and 33** of the Bill will allow Scottish Ministers to relax certain requirements under the Protecting Vulnerable Groups legislation to allow the disclosure service to better cope in an emergency and continue to support recruitment in key sectors. To ensure that safeguarding is not compromised should its staff be seriously affected by illness, the Bill contains powers for the Scottish Ministers to reclassify certain types of disclosure application to allow faster processing. The Explanatory Notes to the Bill also provide the following:

> Disclosure Scotland (an Executive Agency of Scottish Government) is also working to ensure that disclosure checks are not a barrier to fast employment and deployment of emergency health and care workers. With this in mind, the Bill will permit the Scottish Ministers to suspend certain offences which would otherwise apply if an employer appointed a person who was barred from working with vulnerable groups to do regulated work. It will continue to be an offence for a barred individual to take on regulated work.[42]

3. Reducing administrative requirements on health and care staff

The UK Government guidance document, What the coronavirus bill will do (17 March 2020) noted measures to ease administrative burdens on staff to help services continue to operate effectively during periods of reduced staffing and increased demand:

> Easing the burden on frontline staff — by reducing the number of administrative tasks they have to perform, enabling local authorities to prioritise care for people with the most pressing needs, allowing key workers to perform more tasks remotely and with less paperwork, and taking the power to suspend individual port operations.

To support these efforts, the Bill would:

- enable local authorities to prioritise care for people with the most pressing needs; and
- allow NHS providers to delay undertaking the assessment process for NHS continuing healthcare for individuals being discharged from hospital until after the emergency period has ended.

3.1 Local authority care assessments

A lot of people who work in social care could be off sick or may need to care for loved ones as a result of coronavirus. The Government has stated that this could mean that local authorities (LAs), which are responsible for social care, may not be able to do all the things they are usually required to do.[43]

England and Wales

Under the *Care Act 2014*, local authorities in England have a range of duties relating to assessing and meeting the care and support needs of adults. This includes, for example, a

41 Coronavirus Bill Explanatory Notes (Bill 122-EN, 19 March 2020), para 66
42 Ibid., para 67
43 DHSC, What the coronavirus bill will do, 17 March 2020.

duty to carry out an assessment within a reasonable timescale where an adult appears to have needs for care and support.[44] Under section 18 of the Act, the authority then has a duty to meet those assessed needs that meet prescribed eligibility criteria (see box 1).[45] A local authority may charge for meeting a person's care and support needs, subject to a financial assessment.[46] Similar duties apply to local authorities in Wales under the *Social Services and Well-being (Wales) Act 2014.*[47]

Box 1: Eligibility criteria for adult with care and support needs

The eligibility threshold for adults with care and support needs is set out in the *Care and Support (Eligibility Criteria) Regulations 2015.* In considering whether an adult has eligible needs, local authorities must consider whether:

1. The adult's needs arise from or are related to a physical or mental impairment or illness
2. As a result of the adult's needs they are unable to achieve two or more of a number of specified outcomes (for example, being appropriately clothed and managing toilet needs).
3. As a consequence of being unable to achieve these outcomes there is, or there is likely to be a significant impact on the adult's wellbeing.

An adult's needs are only eligible where they meet all three of these conditions.

The eligibility criteria set a minimum threshold for adult care and support needs which local authorities must meet. Authorities can also decide to meet needs that are not deemed to be eligible if they chose to do so.[48]

Paragraphs 6.104 to 6.112 of the care and support statutory guidance provides more information on the eligibility criteria.

Clause 14 and Schedule 11 of the Bill provide for the relaxation of local authority duties in England and Wales around the provision of care and support needs. For example, under the Bill local authorities would not have to comply with the duty to conduct needs assessments. In addition, the duty to meet assessed needs would, in England, only apply where not to do so would breach a person's human rights. In Wales, the duty would only apply where it is necessary to meet a person's needs in order to protect them from abuse or neglect, or a risk of abuse or neglect. Local authorities would still have the power to meet other needs and the Bill's explanatory notes state that they will still be expected to do so "if they are able to and to prioritise provision as necessary."[49]

Where a local authority has not charged a person for their care during the pandemic, the Bill provides for the power to apply charges retrospectively, subject to a financial assessment.

The Bill provides for the Department of Health and Social Care (DHSC) for England and the Welsh Government for Wales to have the power to issue guidance to local authorities on they exercise their functions under the Bill. Respective ministers in England and Wales would have the power to direct local authorities to comply with the guidance.

Guidance on the Bill published by the DHSC states that the changes are aimed at enabling local authorities to prioritise the social care services they offer "in order to ensure the most urgent and serious care needs are met, even if this means not meeting everyone's assessed needs in full or delaying some assessments." It adds that the measures will

44 *Care Act 2014,* section 9.
45 *Care Act 2014,* section 18.
46 Further information on the financial assessment is available in Library Briefing 1911, Social care: paying for care home places and domiciliary care (England).
47 *Social Services and Well-being (Wales) Act 2014,* sections 19, 24, 35 & 40.
48 DHSC, Care and support statutory guidance, updated 2 March 2020, paras 6.104-112.
49 Coronavirus Bill Explanatory Notes (Bill 122-EN, 19 March 2020), paragraph 177.

"ensure that local authorities will continue to be able to deliver the best possible care services during the peak and to protect the lives of the most vulnerable members of society."

The powers would, the guidance states, "only be used if demand pressures and workforce illness during the pandemic meant that local authorities were at imminent risk of failing to fulfil their duties and only last during the duration of the emergency."[50]

Local authorities will, the guidance adds, still be expected to "to do as much as they can to comply with their duties to meet needs during this period and these amendments would not remove the duty of care they have towards an individual's risk of serious harm or neglect."[51]

Scotland

As in England and Wales, local authorities in Scotland have a range of duties relating to assessing and meeting the care and support needs of individuals. For example, under section 12A of the *Social Work (Scotland) Act 1968,* authorities have a duty to assess the needs of a person for community care services where it appears that they may require them. The authority must then decide whether the assessed needs call for the provision of any services.

In addition, under the *Carers (Scotland) Act 2016,* if a Scottish local authority identifies a person as an adult carer, they have a duty to offer them an adult carer support plan setting out their identified needs and any support to be provided by the local authority to meet those needs. A similar duty to prepare a young carer statement for a person identified as a young carer applies under section 12 of the Act.

Clause 15 of the Bill provides for a relaxation of the duty to conduct a needs assessment under the *Social Work (Scotland) Act 1968.* Local authorities will be able to dispense with the requirement if conducting an assessment would be impractical or cause unnecessary delay in providing community care services to any person.

Similarly, the Bill provides that a local authority need not comply with the duties to prepare an adult carer support plan or a young carer statement under the *Carers (Scotland) Act 2016* where it would not be practical to do so, or where doing so would cause unnecessary delay in providing support to any identified carer.

Clause 16 of the Bill makes further provision relating to clause 15, including (but not limited to):

- For the issuing of statutory guidance to local authorities by Scottish Ministers.
- Preventing a local authority from charging for community care services if, in relying on the provision made by clause 15, it did not comply with certain duties, including the duty to conduct an assessment under section 12A of the *Social Work (Scotland) Act 1968*.
- Protecting local authorities against legal action if there are delays in providing assessments when the normal system is switched back on again.

The guidance on the Bill states that the changes will enable local authorities "to prioritise people with the greatest needs."[52]

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50 DHSC, What the coronavirus bill will do, 17 March 2020.
51 Ibid.
52 Ibid.

Impact assessment

The UK Government's Impact Assessment for the Bill states that without the provisions relating to social care support, local authorities "would be constrained by existing assessments, which could result in them maintaining these at the expense of new, more urgent needs, or prevent them from allocating scarce support purely on the basis of severity of need." It adds that the clauses should not in themselves cause local authorities to reduce their adult social care offer because at the point they were triggered this would be a risk regardless. Given this, it states, the timing of the triggering of the clauses is key.[53]

Regarding the impact on individuals, the Impact Assessment for the Bill states:

> If triggered, these clauses could result in individuals not receiving support for some needs where LAs' judge that resources need to be focused on meeting the most acute and pressing needs. This could also have secondary impacts on the family members or carers of individuals with needs or the local community, to whom LAs might have to look to provide temporary support. It is worth noting, however, that in these extreme circumstances these impacts would transpire regardless of the introduction of these clauses and that the intent of these clauses is to allow LAs to mitigate the negative impacts of necessary prioritisation as far as possible.[54]

Ethical framework for adult social care

On 19 March 2020, the UK Government published Responding to COVID-19: the ethical framework for adult social care. The introduction to the framework explains that, while local authorities and the health and care workforce are faced with difficult decisions every day, "planning for and responding to COVID-19 as it develops will undoubtedly require making difficult decisions under new and exceptional pressures with limited time, resources or information." The framework, it explains, is intended to "serve as a guide for these types of decisions" and "ensure that ample consideration is given to a series of ethical values and principles when organising and delivering social care for adults."

The section sets out the following values and principles, along with best practice when applying and considering them:

- Respect
- Reasonableness
- Minimising harm
- Inclusiveness
- Accountability
- Flexibility
- Proportionality
- Community

The framework explains that these values and principles should be considered alongside professional codes of conduct and the most recent guidance and legislation. The principles are not ranked in order of significance and, the framework notes, it may not be feasible to consider them all where resources are constrained or there are surges in demand.[55]

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53 DHSC, Coronavirus Bill Summary of Impacts, 19 March 2020
54 Ibid., para 99
55 DHSC, Responding to COVID-19: the ethical framework for adult social care, 19 March 2020.

3.2 NHS continuing healthcare assessments

Clause 13 of the Bill would allow NHS providers to delay undertaking the assessment process for NHS continuing health care (NHS CHC) until after the coronavirus outbreak has ended. NHS CHC is a package of care provided for adults aged 18 or over and is arranged and funded solely by the NHS. In order to receive NHS CHC funding, individuals must be assessed by their local clinical commissioning group (CCG) according to a detailed process to determine whether they have a 'primary health need'. This process is set out in the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care.[56]

The Government has said that this will enable patients to be discharged more quickly, when clinically appropriate, to free up hospital space for those who are very ill and enable clinicians to focus on delivering care. The Impact Assessment for the Bill states that NHS CHC assessments can cause delays to hospital discharge and require significant input from both NHS and local authority employees. It argues that during a coronavirus outbreak it will be essential to ensure that patients who are ready to leave hospital can do so rapidly, and the undertaking of NHS CHC assessments could be a barrier to this. Delaying undertaking NHS CHC until after the peak of the coronavirus outbreak will allow the NHS to make the best possible use of its staff and hospital space. The Impact Assessment notes that this measure "would only be brought into operation for the shortest possible time at the peak of the coronavirus outbreak."[57]

On 19 March 2020 DHSC published Coronavirus (COVID-19): hospital discharge service requirements, which sets out how health and care systems and providers should change their discharging arrangements and the provision of community support during the coronavirus outbreak.

[56] The Commons Library has published a briefing paper on NHS Continuing Healthcare in England (CBP 6128, Feb 2020).

[57] DHSC, Coronavirus Bill Summary of Impacts, 19 March 2020

4. Changes to mental health and mental capacity legislation

A number of temporary modifications to the *Mental Health Act 1983* (the 1983 Act) are provided in **Schedule 7** of the Coronavirus Bill. Further information on these changes, which apply to England and Wales, are set out in the following section. Information on changes to mental health and mental capacity legislation in Scotland and Northern Ireland can be found in section 4.3 of this briefing, and in the Explanatory Notes to the Bill.

4.1 Applications for compulsory admission to hospital for assessment or treatment under the *Mental Health Act 1983* (England and Wales)

The Bill would amend the usual requirement that two doctors must recommend the compulsory detention ("sectioning") of a patient under the 1983 Act, for treatment or assessment in hospital, if this is impractical or would involve undue delay. The Bill would enable just one doctor to carry out this function:

> An application by an approved mental health professional under section 2 or 3 made during a period for which this paragraph has effect may be founded on a recommendation by a single registered medical practitioner (a "single recommendation"), if the professional considers that compliance with the requirement under that section for the recommendations of two practitioners is impractical or would involve undesirable delay[58]

Guidance on the Bill published by the Department of Health and Social Care (DHSC) said:

> This will ensure that those who were a risk to themselves or others would still get the treatment they need, when fewer doctors are available to undertake this function.[59]

This provision applies to applications for detention under Section 2 (detention for assessment) and Section 3 (detention for treatment).

The existing requirement, that one of the doctors must know the patient personally, is removed. Currently, an application for detention under the the 1983 Act must be supported by two medical recommendations (Section 12 of the Act). There is a requirement that at least one of the doctors is familiar with the patient, and for one to be a Section 12 approved doctor (usually a psychiatrist). The Bill retains that a medical recommendation must be given by a Section 12 approved doctor, but there is no requirement that they have previous acquaintance with the patient.

Section 12 sets out the current requirement for two medical recommendations:

> Of the medical recommendations given for the purposes of any such application, one shall be given by a practitioner approved for the purposes of this section by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder; and unless that practitioner has previous acquaintance with the patient, the other such recommendation shall, if practicable, be given by a registered medical practitioner who has such previous acquaintance.

There are current emergency provisions in the the 1983 Act allowing just one doctor to provide a medical recommendation for detention "where the patient's need for urgent assessment outweighs the desirability of waiting for a second doctor."[60] This can be only

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58 Schedule 7, Part 2
59 DHSC, Guidance: What the coronavirus bill will do, 17 March 2020
60 Mental Health Act 1983: Code of Practice, January 2015, page 136

used to detain a patient for up to 72 hours and patients may not be treated without their consent.

4.2 Extend or remove time limits in the *Mental Health Act 1983*

The Bill would extend or remove some time limits for compulsory detention contained in the 1983 Act. The DHSC has said these would be temporary changes to allow for greater flexibility where services are less able to respond:

> These temporary changes would be brought in only in the instance that staff numbers were severely adversely affected during the pandemic period and provide some flexibility to help support the continued safe running of services under the *Mental Health Act*.[61]

The Bill contains various provisions which extend time limits.

For detention in places of safety (Sections 135 & 136), the Bill increases the length of time someone may be detained in a place of safety from 24 to 36 hours.

For applications for compulsory admission for patients already in hospital, the Bill would allow any registered medical practitioner or approved clinician to provide a report for their detention, and not the patient's responsible clinician if this is impractical or would involve undesirable delay. It also increases the period that a patient may be detained in hospital waiting for assessment for detention from 72 to 120 hours, under powers given to doctors, and from 6 to 12 hours, under powers given to nurses.

The Bill also contains various provisions on patients concerned in criminal proceedings or under sentence. For Sections 35 and 36, the Bill would remove the time limit of 12 weeks relating to a period of remand to hospital for a report on the accused's mental condition, and a period of remand to hospital for treatment. The Bill would also extend from 14 to 28 days the maximum period within which accused or convicted persons are transferred to hospital.

The Bill does not amend the main provisions for Section 2, Section 3 and Section 4 – detention for assessment and treatment - which provide the following time limits:

- Patients are detained under Section 2 for a maximum of 28 days, if they need to be detained for a short period for assessment (or assessment followed by medical treatment).
- Patients are detained under Section 3 for treatment in hospital, for up to 6 months. This may then be renewed twice for six months and then annually.[62]
- Patient may be detained under Section 4 for up to 72 hours if they require urgent detention for treatment in hospital, and waiting for a second doctor to give a medical recommendation would cause "undesirable delay". This may be extended beyond 72 hours if a second medical recommendation is received during this period.

See Mind's page on Sectioning for further information on time limits.

Commentary

The Royal College of Psychiatrists, said:

> We're supportive of this during this time of crisis. This is about keeping patients safe. This is to make sure people who are in danger of harming themselves or someone else

61 DHSC, Guidance: What the coronavirus bill will do, 17 March 2020
62 *Mental Health Act 1983*, Section 20

> are cared for in a safe environment. If people are at risk you have to be able to get them into hospital.[63]

Mind raised concerns that the measures could severely impact the rights of patients who are detained under the *Mental Health Act*:

> The Government's emergency coronavirus laws include measures that could severely impact the rights of people with mental health problems detained for hospital treatment.
>
> The legislation will be in place for up to two years and powers can be switched on or off by each of the four UK governments, based on staffing levels. Under the emergency laws the decision to section someone could be made by fewer health professionals and some time limits on detention might be extended or suspended. We recognise that these steps might be necessary to enable the health system to operate with extreme staff shortages but this cannot be at the expense of safeguarding the some of the most vulnerable people in our society.
>
> The last thing we want to see is people left languishing in hospital without regular reviews of why they're there or proper representation and advice, particularly amidst such high demand on hospital beds.
>
> This announcement also comes at a time when a long-overdue White Paper was expected to address pre-existing injustices in the way people are sectioned and treated in hospital. At the earliest possible opportunity the Government must act to change mental health laws to strengthen people's rights in the long-term.
>
> We will closely follow the introduction and effects of these measures and make sure that the voices, rights and choices of people with mental health problems are not forgotten.[64]

4.3 Mental health and mental capacity provisions in Scotland and Northern Ireland

In addition to changes to mental health legislation in England and Wales, the Bill would amend the *Mental Health (Care and Treatment) (Scotland) Act 2003*, the *Criminal Procedure (Scotland) Act 1995*, the *Mental Health (Northern Ireland) Order 1986*, the *Mental Capacity Act (Northern Ireland) 2016* and associated subordinate legislation. Similar to the provisions for patients in England and Wales, these amendments allow certain functions relating to the detention and treatment of patients in Norther Ireland and Scotland to be satisfied by fewer doctors' opinions or certifications. Temporary amendments also allow for the extension or removal of certain time limits relating to the detention and transfer of patients. The Explanatory Notes also set out other specific changes to provisions in Scotland and Northern Ireland:

- In Scotland, provisions will also permit the reduction in the number of members required to constitute a mental health tribunal and permit a tribunal to make a decision without holding an oral hearing.
- In Northern Ireland, provisions temporarily amend the Mental Health (Northern Ireland) Order 1986 and the Mental Capacity Act (Northern Ireland) 2016 to allow for social workers, other than approved social workers, to carry out certain statutory functions in relation to detention and deprivation of liberty. The provisions will also temporarily amend the timelines for carrying out examinations and reports and the operation of the trust panel.

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63 Health Service Journal, Government to make emergency changes to Mental Health Act, 17 March 2020
64 Mind, Mind responds to changes to the Mental Health Act in emergency Covid-19 legislation, 18 March 2020

5. Other public health measures

5.1 Vaccinations in Scotland

Under current legislation, vaccinations and immunisations in Scotland are required to be given by medical practitioners or persons acting under their direction and control. The Bill provides for a wider range of health professionals to administer these, in order to "respond as flexibly as may be required to the pandemic". **Clause 34** amends the *National Health Service (Scotland) Act 1978* to this effect by removing the requirement for vaccinations to be given by Medical Practitioners (and persons under their control) and provides for Scottish Ministers to make arrangements for the provision of vaccination and immunisations. The clause also consequentially modifies the powers of Territorial Health Boards. The clause only extends and applies in Scotland. The measures are supported by the Scottish Government.

5.2 Public health powers

The Bill introduces new powers in Northern Ireland and Scotland around public health which are aimed at ensuring powers are equivalent across the UK. The Explanatory Notes state:

> The Public Health (Control of Disease) Act 1984 (as amended by the Health and Social Care Act 2008) contains regulation making powers that enable a number of public health measures to be taken in situations such as the current covid-19 outbreak. To increase consistency of the powers available across the UK the Bill includes new powers which are broadly based on the existing powers that apply in England and Wales, in respect of Scotland and Northern Ireland.[65]

The Bill introduces new regulation making powers in relation to public health measures for Scotland and Northern Ireland**. Clause 46** introduces Schedule 17 with temporary modifications to the *Public Health Act (Northern Ireland) 1967*. The delegated powers memorandum highlights that the *Health Protection (Coronavirus) Regulations 2020* made on10th February 2020 do not apply to Northern Ireland (see the Commons Library briefing, Coronavirus Bill: Background), and the intention of the much of the schedule is to ensure equivalent powers are available. The clause and schedule only apply and extend to Northern Ireland. It provides a power for the Department of Health in Northern Ireland to make regulations for measures to help delay or prevent further transmission of covid-19; it also provides for a power to make regulations to give effect to international agreements or arrangements. The Explanatory Notes highlight that compulsory medical treatment, including vaccinations, is not included. The Schedule also provides for powers for magistrates to order health measures in relation to people, things and premises. It creates an offence not to comply, while it also creates powers of entry for a person authorised by the Public Health Authority and offences for bodies corporate. The schedule includes regulation making powers for the assembly, including an ability to bring in draft affirmative regulations that have immediate effect if they contain a declaration of urgency from the Department of Health in Northern Ireland.

Clause 47 brings into force schedule 18 which provides Scottish Ministers with a power to make regulations "for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination in Scotland". The schedule sets out the areas where regulations may be made, including duties on medical professionals to record cases, conferring monitoring

65 Coronavirus Bill Explanatory Notes, para 82

functions on public bodies and imposing restrictions or requirements on, or in relation to, persons, things or premises, in the event of a threat to public health. "Special Requirements" are detailed under these powers that "…include (amongst other things) requiring a person to submit to medical examination, be detained to a hospital or other suitable establishment and be kept in isolation or quarantine".[66] The schedule sets out the restricted circumstances in which Scottish Ministers can use the powers. The schedule also sets out that the regulations can, amongst other things, confer functions, create offences and allow levies. Regulations under this Schedule are made by Scottish Ministers under the affirmative procedure, with a provision to make them urgently, and with immediate effect. Compared to the Northern Ireland clause above, Scottish Ministers already have the power to give effect to international agreements or arrangements. The measures are supported by the Scottish Government, while the delegated powers memorandum notes that the provisions:[67]

> …will ensure that Scottish Ministers have powers equivalent to those that the Secretary of State already has in relation to England and Wales under section 45C of the Public Health (Control of Disease) Act 1984 (as added by the Health and Social Care Act 2008 (c. 14))

66 Coronavirus Bill Explanatory Notes, Para 382
67 Coronavirus Bill: Memorandum from the Department of Health and Social Care to the Delegated Powers and Regulatory Reform Committee, para 300

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