Legal Issues re COVID and Contracts

Introduction

The original powers to invoke changes to GMS / PMS contracts in certain situations are contained in Sections 252 and 253 of the NHS Act 2006. As the Government declared a level 4 incident in March, NHSE has enacted its powers under these regulations.

These were brought into effect through Statutory Instrument 2020, No 351 laid before Parliament on 26th March. In effect NHSE can take national command and control of the NHS and providers of NHS funded care. NHS England will direct these services to respond to the incident with national direction communicated through the Regional Director and local offices. More on the nature of these powers later.

The Statutory Instrument

These Regulations may be cited as the NHS (Amendments Relating to the Provision of Primary Care Services During a Pandemic etc) Regulations 2020. They amend regulations for all primary care providers but this summary purely relates to General Medical Contractors. They amend the National Health Service (General Medical Services Contracts) Regulations 2015 and the National Health Service (Personal Medical Services Agreements) Regulations 2015, which make provision in respect of the services provided in England under a general medical services contract and a personal medical services agreement. The full text of Part 4, amendments relating to primary medical services, written in "legalese" is available but is summarised within the document as follows.

Various measures are put in place to deal with matters arising as consequence of a disease being, or in anticipation of a disease being imminently, pandemic and a serious risk or potentially a serious risk to human health – essentially in order to assist in the management of the serious risk or potentially serious risk to human health.

The National Health Service Commissioning Board ("the Board"), which commissions primary care services in England, may need to ask contractors to prioritise delivery of particular NHS services. Where the Board has made an announcement to the effect that specified NHS terms of service of contractors are suspended in specified circumstances for a limited period, during that limited period the suspended terms will not form part of the arrangements to provide primary care which contractors have with the Board. Similarly, if the Board has made an announcement to the effect that a specified NHS term of service need not be complied with in specified circumstances for a limited period, enforcement action cannot be taken against contractors in relation to noncompliance with that term in that period (regulations 2(3), 3(3), 6, 7, 8, 15 and 20).

In the case of GP practice premises, the Board is given powers to require them to open on Good Friday and bank holidays as part of their core hours (regulations 13, 14, 18 and 19).

The Board may also need to require pharmacies and dispensing doctor surgeries to provide a home delivery option for prescription items, in circumstances where certain classes of patients are advised to stay away from pharmacies and dispensing doctor surgeries, and so will need to obtain their prescription items in other ways (regulations 9(2), 10 and 11).

Provision is also made to allow the Board to require GP practices to ensure that greater numbers of appointments can be booked via the NHS 111 telephone and online service, or via a service approved by the Board that is or may be accessed via NHS 111 (regulations 16 and 21).

There are also ancillary provisions dealing with amendment and withdrawal of advice and announcements (regulation 2(2), 3(2), 5, 14 and 19).

So what does this mean?

The statutory instrument is limited in its powers to vary contract terms but can only be enacted by the Sec of State and communicated through Regional and Local Offices. It does not confer powers on local bodies, such as CCGs to impose additional measures.

The legal advice from the BMA is as follows:

1. To what extent can local NHSE or CCGs make their own directions?

The Secretary of State has wide powers to issue directions under section 253 NHS Act 2006, but neither NHS England nor individual clinical commissioning groups are given the power to issue directions to require independent providers of NHS services to take any steps in the absence of any contractual or other legal obligation to which the provider is already subject.

The power afforded to NHS England under section 252A NHS Act 2006 means it can "take steps" to ensure a coordinated response to an emergency such as the present pandemic. The precise construction is far from straightforward because it does not precisely explain how, if at all, the taking up those steps can impose legal obligations on third parties who are referred to within the steps. As the legislation is mainly about giving the power to NHS England to take actions itself and, as a matter of statutory construction, it should not be interpreted as giving NHS England a power to impose a legal obligation on any third party, as that is not specifically referred to within the section of the legislation.

2. To what extend can local NHSE or CCGs unilaterally interpret SoS directions?

The meaning of a Secretary of State's direction is a matter of law, interpreted objectively and in accordance with its true meaning, not a matter for binding local interpretation by NHS England or local CCGs. Accordingly, the effect of any Secretary of State directions should be assessed objectively, rather than by reference to what local NHS bodies interpret the direction to mean.

3. In the context of redeployment of staff, where does the legal responsibility for health and safety lie - with the employing practice, host organisation, or with NHSE/CCGs?

Both the original employer and the so-called 'host' employer have responsibilities to an employee to ensure that the employee is working in conditions which are reasonably safe. The duty of the original employer to ensure that there is a reasonably safe system of work cannot be delegated, as a matter of law, so the original employer retains responsibility, however the 'host' employer also has duties to the employee under the Occupiers Liability Act 1957 or as a quasi-employer. As liability rests on both the original and 'host' employers, the original employer is likely to want to obtain an indemnity from the 'host' employer to whom staff are to be deployed as part of any arrangements for seconding staff.

4. Can CCG/NHSE force practices to redeploy their staff to other parts of the system?

Staff cannot be required to be deployed from one provider of NHS services to another provider of NHS services unless either (a) a direction is made by the Secretary of State to require such deployment or (b) the terms of existing commissioning contract permit the commissioner to require staff to be deployed. From a brief look at the standard form GMS contract, there appears to be no power within that standard form contract to require a GP practice to agree to practice staff being deployed to another location. It may well be different where doctors are employed by an NHS Trust or NHS Foundation Trust.

Conclusion

The emergency regulations confer certain, specific legal powers on the Secretary of State to vary the GMS /PMS contract. Apart from the bank holiday deregulation it is mainly to ask primary medical service contractors to prioritise certain tasks and actions. In doing so it recognises that other tasks will not be prioritised. As a result of this practices will not be penalised for not carrying out these lower priority tasks.

Any enactment of these arrangements, such as suspending Increased Access, simplifying the Network DES will be agreed at a national level and communicated through the service. As a consequence of these changes, certain payments will not be directed as originally intended but will be preserved to general practice to undertake essential COVID work.

These legal regulations need to be born in mind in any local discussions about the local response to the pandemic.

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