September 2020

Resource allocation, age and COVID-19

Deliberative study

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Ipsos MORI

Contents

Executive Summary

Ipsos MORI were commissioned by King's College London[1] to explore public attitudes to intensive care resource allocation during a potential second wave of COVID-19. A series of four deliberative workshops were conducted online across August and September 2020 with the same 22 participants, each a resident of Lambeth or Southwark.

The headline findings of the study are as follows:

- Participants stated that "maximising life years" avoids allocating resource to someone who won't survive, supports getting people into ICU who are likely to have the "quickest turnaround" (recovering more quickly), and frees up the bed for another patient. Furthermore, this is in line with their understanding of triage and maximising the number of lives saved.

- In contrast, there was concern that it is too difficult to accurately estimate someone's life expectancy and that survival chances should be the only, or at least the primary, consideration; saving the most amount of lives rather than the most life years.

- Participants struggled with the concept of prioritising younger patients over older patients – they felt younger people should not be prioritised as older people have value too.

- There was a strong sense that people who are most vulnerable to COVID-19 could be prioritised rather than discriminated against.

- Those who support a "first come, first served" approach based this on its apparent fairness and simplicity, whereas maximising lives saved and prioritising the vulnerable would be based on subjective judgments.

- There was strong support for discretion, for applying recommendations as guidance rather than a mandatory policy. Participants felt that groups of doctors should make decisions, not individuals, as this could reduce burden and bias.

- That said, participants were concerned that if guidance was not applied across the board it would cause people to choose one hospital over another to try and get a 'better deal'.

- 'Frailty' was not initially recognised as a medical term and needed explaining to participants.

- Participants saw merit in including considerations of quality of life when deciding who to escalate. This was felt to be important and there was support for using it as a secondary consideration, time permitting. In terms of implementation, participants sought a means of standardised measurement akin to the frailty scale.

[1] This project was funded through a King's Together Award. Gareth Owen, Alex Ruck Keene and Margot Kuylen were primarily involved in working with Ipsos MORI. Bobby Duffy, Alex Pollitt, Lucy Strang, Ben Wilkinson and Nuala Kane at KCL were also involved. We also thank Anthony David, Scott Kim and the King's College Hospital Clinical Ethics Forum and COVID-19 Ethics group.

Methodology and sample

In the face of a potential second wave of COVID-19 this winter, King's College London want medical professionals to be better prepared to make tough decisions. There are no specific government guidelines about how to prioritise resource allocation among COVID-19 patients if it becomes necessary. This deliberative study was therefore carried out in order to explore public attitudes to intensive care resource allocation during a second wave, and specifically how age fits in to this. The focus on age was taken because of how COVID-19 affects older people. Ipsos MORI ran four deliberative workshops, online, with the same group of participants across August and September 2020 – the workshops took place after the peak of the first wave, with fieldwork finishing shortly before we returned to a Level 4 response[2]. Over the course of these four workshops, participants deliberated on four principles, outlined briefly below:

- The 'Fair Innings' Principle: prioritising the young, so they can reach later life stages
- The 'Maximising Life Years' Principle: prioritising patients with the longest life expectancy, to save the most life years
- The 'Life Projects' Principle: prioritising the young and middle aged so they can complete life projects
- The 'Egalitarian' Principle: not choosing based on any characteristic, using a random or first come first served approach

Participants all lived within the catchment area of King's College Hospital (KCH) in the London boroughs of Lambeth and Southwark. To ensure the 25 participants reflected the demographic composition of the KCH catchment area, quotas were set on gender, age, socio-economic status, ethnicity, and education level. Full demographic details of the participants recruited can be found in appendix 1.

Gender	Male	12
	Female	13
Age	20-29	4
	30-39	5
	40-49	3
	50-64	5
	65+	8
Ethnicity	White	12
	Black	7
	Asian	3
	Mixed	3
SEG	B	4

[2] https://www.gov.uk/government/news/update-from-the-uk-chief-medical-officers-on-the-covid-19-alert-level

	C1	9
	C2	6
	D	2
	E	4
Working status	In full-time employment	8
	In part-time employment	6
	Currently not in paid employment	4
	Retired	7
Highest level of education	No qualifications	3
	GCSE Level or equivalent	4
	A-Level or equivalent/ vocational qualifications	5
	Degree Level or equivalent	12
	Post Graduate Degree Level	1
Length of time lived in Lambeth/ Southwark	3-10 years	5
	10+ years	20

The deliberative approach focuses on deep consideration of issues and is structured to help participants learn about a subject that may be new to them. This enables participants to arrive at an informed opinion by the end of the study, that may be different to what they believed at the start of it.

The four sessions were all held online on Zoom. This platform allowed for plenary discussion and presentations to happen in the 'main room', in which all participants and facilitators were present, and for smaller break-out groups in which Ipsos MORI facilitators ran discussions with smaller groups of participants. Participants were assigned to different break-out groups in each workshop, meaning everyone had a chance to hear opinions from a broad a range of people. Where participants required tech support in order to access and operate the platform, we provided this on an individual basis.

Due to the nature of the topics being discussed, several measures were put in place to protect participant wellbeing. At the end of each session, participants were signposted to where they could find support should they feel they need it. If participants were noticeably distressed during the workshops, facilitators could offer them space to talk in a virtual 'quiet room'. There were also a number of older participants who required technical assistance during the sessions, so we agreed that younger family members could sit with them during the discussion for support. This not only enabled their participation on a technical level, but also a deeper contribution that would not have happened without children acting as 'translators' and enabling their parents to really consider what was being presented to them. Participants also fed back that they felt more able to be honest on video-call compared to how they would have felt discussing these issues face-to-face.

The structure of the study was designed so that all participants had the time and support they needed to discuss in depth the different approaches presented to them to resource allocation and to arrive at a decision about what they thought was the best approach. So that participants were all well informed about what was being discussed, presentations were put

together on important information and ideas that would be part of the discussion. Experts from King's College London (KCL) were closely involved in the design of these informative materials, presenting the principles and a presentation on resource allocation in the NHS. They were also closely involved in designing the discussion guides throughout.

The four sessions were structured in the following way:

- Workshop 1: Learning (24th August): this explored attitudes and knowledge of resource allocation amongst participants. A video presentation put together by KCL about resource allocation and treatment escalation was shown to participants to give them important contextual information. Following this, four video presentations on each of the principles, also put together by KCL, were shown. Initial reactions to the four key principles were then explored in break-out groups.

- Workshop 2: Dialogue (26th August): in small break-out groups, using case study examples, to support their deliberations, participants explored what it would be like to apply the different principles in practice. All case studies were based around a scenario of one intensive care unit (ICU) space available and two people, with differing circumstances, needing ICU care. Participants also received answers to a set of collated questions, which were provided by the KCL team.

- Workshop 3: Deliberation (7th September): in small break-out groups, participants explored Quality of Life (QoL) and how this might impact decision-making, and the four principles, through one further case study. The final discussion of this workshop encouraged participants to begin forming their final recommendations; the principle they support most and any caveats to that.

- Workshop 4: Recommendations (9th September): participants were asked to come to a final recommendation on which principle (or principles) they believed to be the best, including their reasons for and against any recommendations, and any caveats. In a final plenary discussion, facilitators presented back the views of their individual break-out groups before a final reflective discussion that explored how they would want any recommendation to be applied and publicised.

The discussion guides for the four sessions can be found in appendix 2, as can the expert presentations and the three case studies (appendix 3, 4 and 5).

Of the 25 participants recruited, 22 participants attended the first session and committed to the process, with three dropping out for personal reasons before the first session. Of the 22 participants, 2 people missed session 2 for personal reasons but were provided information about what they missed by the Ipsos MORI team and re-joined for the final two sessions. 1 participant was unable to attend the final session due to personal reasons but their son, who had been their supporter throughout the process, attended in their place.

An additional part of the study was tracking participants' views over the course of the three weeks in which it took place. This involved five short online surveys – one before the first workshop, then one after each workshop. The surveys collected information from

participants regarding their attitudes and understanding of issues discussed in each of the workshop so that we could understand if and how these changed over the course of the study. The surveys and their results can be found in appendix 7.

Workshop One: Learning

The purpose of the first session was to introduce participants to resource allocation in healthcare; both to the four allocation principles being explored and to the context in which these principles would be applied.

Participants were first shown a video presentation put together by experts at KCL explaining what is meant by resource allocation and the realities of how it works across the NHS. It also stressed to participants that COVID-19 made the question of how to allocate limited healthcare resources even more pressing. A second presentation then gave participants a summarised version of available research on different factors that influence outcomes for COVID patients. This highlighted the importance of age, frailty, and pre-existing health conditions.

The four principles were introduced in turn to participants through short video presentations, again put together by experts at KCL. Facilitators explored initial reactions to the principles with participants immediately after each video, before a final reflection on all four at the end of the session. Initial reactions to the principles are outlined below.

Healthcare resourcing decisions are recognised as complex and nuanced, so principles need to reflect this.

- Through simply prioritising younger patients over older patients, the **Fair Innings Principle** felt unnuanced and too simple. It ignored other factors that felt important when considering resourcing decisions, e.g. likelihood of survival.

- The age boundaries of the **Life Projects Principle** felt arbitrary. It was hard to believe that a definitive age limit could be set in this context, that the issue could not be so “black and white”.

Younger people should not be prioritised, older people have value too.

- Many of our participants were either approaching retirement, or in it. They saw this time in their life as a time for *living* after a life of work. Therefore, writing off this period in someone’s life, as the **Life Projects Principle** seemed to do, felt counterintuitive.

- Basing resourcing decisions on age alone, as the **Fair Innings Principle** did, felt like it completely ignored the value that older people can bring to a community.

- Likelihood of survival felt more important than age. This came across strongly during discussing the **Fair Innings** and **Maximising Life Years** principles.

People who are most vulnerable to COVID-19 could be prioritised rather than discriminated against.

- Participants recognised that those who are older, more frail, and potentially from a BAME background were more at risk. Their understanding of what NHS England is there to do meant they believed that these groups should receive care before those who are healthier.

- It did not feel like any of the principles addressed treating those most vulnerable.

There may be other factors that could be important when making this decision, but there is a limit to what can go on a medical record.

- Factors such as QoL or the ways in which someone contributes to society came up in initial discussion of the four principles. However, participants felt these would be extremely difficult for clinicians to consider when making this decision in practice and in a hurry.

The Egalitarian Principle initially felt like the most straightforward principle, but in practice would have hidden biases.

- Participants initially believed that this principle would be the most straightforward for medical staff to follow and would also avoid any unconscious bias from medical staff.

- In following a first come first serve basis, it does nothing to redress existing inequalities in society and risks reinforcing them. Participants started to arrive at this realisation after as discussion developed.

'Frailty' was not recognised as a medical term before the session but understanding of its exact definition increased after it had been defined in the first workshop.

- The survey done before the first session revealed that 'frailty' meant something similar to 'weak', 'vulnerable', and 'fragile' to participants. It also showed that 'frailty' meant being dependent on others for basic day to day tasks like cooking and dressing. Being elderly was closely linked with being frail, as was high risk of illness.

- After the session, it was better understood that 'frailty' has a medical definition. Those who previously linked it to age realised this was not necessarily true, as it is more about the ageing process than age itself.

Workshop Two: Dialogue

The second workshop began with a plenary session that answered questions raised in the first workshop and summarised initial reactions (appendix 6) before moving into break-out discussion groups. The discussions reflected the following findings.

The discussions were emotive, and participants did not find it easy to articulate their views. There was discomfort, and sometimes unwillingness, in choosing an approach to deciding between patients in the case studies. Facilitators had to remind participants that this is not an issue that can be solved through increased funding and to avoid simply concluding that clinicians should decide as "they know best".

Age is too simplistic to use as a basis for prioritising health resources. Age is a factor akin to race and gender; to prioritise on this basis would be unfairly discriminatory.

- The **Fair Innings Principle** was felt to support this discrimination and does not reflect the value of older people. It seemed arbitrary.

- Similarly, the **Life Projects Principle** was described as arbitrary and reflected a value system that reflects productivity to society and a stereotypical understanding of life based on children and working. Arguments around retirement being a time to start projects after a life of work were made as well as some people, regardless of age, being more inclined to have "life projects" than others. Again, the value of older people to society was made.

- The value of older people included their inherent value in the 'here and now' and, also, that they have given their energy and time to creating society as it is. This was an emotive issue. Discussion also highlighted the difficulty of agreeing where to put the arbitrary age bracket in order to use an age-based principle. Participants felt most discomfort around these two principles and recoiled from using age as a premise for making decisions on the prioritisation of health resources in the event of a second wave of COVID-19. Age could be used as a secondary consideration for making decisions but should not be the primary measure.

Participants largely talked about "first come, first served" as the premise of the Egalitarian Principle. A lottery, or random, approach was not the basis used by the group for considering this principle.

- Arguments for this approach included it being the least burdensome for clinicians. Another view was that it put the onus on doctors making decisions rather than the Government. This fits with findings from Ipsos MORI's Veracity Index, which shows a 95% and 93% level of trust respectively in nurses and doctors, compared with 17% in Government Ministers and 14% in politicians.[3]

[3] https://www.ipsos.com/ipsos-mori/en-uk/trust-politicians-falls-sending-them-spiralling-back-bottom-ipsos-mori-veracity-index

- The first come, first served approach was also seen as akin to the hallowed “NHS approach” to equal access and our established culture of queueing as a means of fair access to a service; it would be easier for the public to accept this practice.

As previously stated, age alone was not seen as an acceptable way of applying the Maximising Life Years principle. Participants adapted this principle to reflect medical data as the primary premise for making decisions; health conditions such as frailty and the medical knowledge of doctors.

- Arguments for “maximising life years”, on the premise of using health conditions as the primary deciding factor, were based on favouring those with the strongest survival chances, prioritising those who will recover quickest and, therefore, freeing up the bed for another patient, and saving the most life years.

- Participants also saw value in doctors making decisions based on their medical knowledge, rather than leaving it to chance.

- In practice, there were concerns that estimating based on available data is not always accurate and that unconscious bias, either in the data or within clinicians, would be present.

- There were also concerns about how this would work in practice; would doctors wait to see if a better candidate showed up before deciding about whether to allocate an ICU bed?

The case studies drew out discussion around QoL.

- Living with dementia, in particular, drew out discussion about judging someone’s QoL, including how someone’s QoL would be after a stay in ICU and that this could influence decision-making.

- However, a strong argument was made that QoL is too subjective to base decisions on. This was also the case for judgments relating to lifestyle choices.

Participants made counterarguments to the premise of prioritising the young over the old, or those more likely to survive over those less likely.

- Participants described how they understood A&E triage being based on need, rather than survival chances and that that those most in need are prioritised. They argued that this should be applied to decisions about ICU resource. Participants typically likened the triage process in A&E to that used in ICU, likely due to greater personal experience with A&E.

- Another counterargument was related to the premise of “maximising life years”. Given the data showing that younger patients have stronger survival chances, participants argued that prioritising older people would save more lives. However, it was unclear the extent to which participants grasped that younger patients who are deemed in need of escalation are likely to have very low survival chances also.

Ideas arose from discussion that were not discussed in any depth, as follows:

- Participants began to think about principles in combination with each other, rather than choosing one or the other.
- Participants suggested offering patients with low survival chances the option of choosing to give up their bed for someone else and discussed the role of Power of Attorney.
- Participants raised the issue of BAME communities and began thinking about whether this should be factored into maximising life years.

Workshop Three: Deliberation

Workshop three began in plenary, playing back the views facilitators had heard in the second workshop and articulating clarifications around prioritising those in need and the lottery approach (appendix 6). In break-out discussion groups, QoL was covered in more depth along with a final case study that led to a 'taking stock' discussion.

Participants saw merit in including considerations of QoL when deciding who to escalate. QoL was felt to be important and there was support for using it as a secondary consideration, time permitting.

- However, there was a strong view that QoL is too subjective to be used as a means of making these decisions, and that deciding who is escalated should be based on medical information that is quantifiable. Reasons for this included concern around bias in the judgments of others and that QoL can change over time.

- Counterarguments were that mental health, which was essentially used as a proxy for quality of life in this case, can be judged similarly to physical health and therefore treated as a health condition.

- Dementia was viewed to cause distress to patients and those close to them. It was especially important that this condition is degenerative when participants were considering if someone should be prioritised or not – there were concerns that, even if the patient was escalated and survived, they would still suffer in the longer term. There was discussion around judging the experience of someone with dementia, noting that the condition can vary day-to-day, and a sense that it isn't the place of others to make that judgment.

In terms of implementation, participants sought a means of measurement akin to the frailty scale. There was concern about there being a range of options for measuring QoL, unlike the standardised system used to assess frailty.

- They felt that a standard framework would be needed.

- There was also concern about time limitations for decision-making.

- If implemented as a secondary consideration, it was suggested that, in an extreme case where someone's QoL was very low, then you would prioritise the person with shorter life years and higher QoL.

Discussion on using QoL as a factor in decision-making led back to survival chances and the severity of their health conditions.

- Participants felt that the QoL likely to be led after a stay in ICU should be considered and that the individual themselves should be consulted along with their family, carers and medical professionals when defining QoL.

- On the other hand, there was some concern that family or carers would lie in order to bolster the chances of a patient being escalated and an emphasis that people should speak for themselves wherever possible.

Further considerations, not discussed in detail, were:

- The availability, need for, and quality of care.
- Social/family life and caring responsibilities.
- Making judgments in advance, before the decision is needed.

Participants stated that "first come, first served" is fairer.

- Participants felt it does not turn away those who have arrived first (which aligns with cultural expectations), it doesn't discriminate based on protected characteristics, and makes no value judgments (aligning with the underlying principles of the NHS), and it supports rapid decision-making.
- However, there was a fear that this further disadvantages those who are more likely to be already disadvantaged – patients from lower economic groups or and BAME communities. Participants were emphatic that this situation should be avoided, though they were unclear on how to ensure this.

Participants stated that "maximising life years" avoids allocating resource to someone who won't survive, supports getting people into ICU who are likely to have the 'quickest turnaround', recovering more quickly and freeing up the bed for another patient, and sticks to the current approach to triage which maximises the number of lives saved.

- Participants acknowledged that "maximising life years" essentially gives priority to younger people over older people, and is akin to the age-based principles that were strongly opposed in previous discussions.
- However, the process was felt to be fairer as long as the premise is about survival chances based on health conditions such as frailty, rather than age.
- Again, there were discussions that demonstrated a concern about hidden or unintentional biases. For example, the suggestion that this could mean not prioritising BAME patients as they have lower survival chances. Again, participants wanted something to be done to prevent these biases affecting the process. Yet, without more definitive information about how COVID-19 impacts BAME patients, participants weren't sure what to recommend. Unconscious bias training, in a wider context across the NHS, came up as one potential component in any practical solution.

Participants reflected further on their views of vulnerability and re-stated that the vulnerable should be given more of an opportunity.

- Those who are stronger were considered more likely to cope with illness and, much like A&E, the person who is more vulnerable should be prioritised. This was linked to a sense that those who are older, most in need, or more vulnerable should not be 'forgotten' or 'pushed aside'.

- However, vulnerability was voiced as needing a form of measurement akin to the clarity and consistency gained from using the clinical frailty scale.

- Participants also felt more data was needed on the effect of vulnerability before this could be factored in. For example, they felt more information was needed on why people from BAME communities, or men, are more vulnerable. This could also reflect a lack of awareness regarding who is classed as vulnerable and why.

Participants took to merging the principles into combined recommendations, as follows:

- "Maximising life years", unless the patients are of similar status, in which case a "first come, first served", approach should be applied OR discretion based on QoL

- "First come, first served", unless the patient who arrives first has very limited survival chances, then the "maximising life years" principle should be applied

- "Prioritise the vulnerable", except for when the survival chances are very low.

Minimal discussion was held on the lottery approach, but the views provide insight into why egalitarianism was only considered through the first come, first served, lens.

- Participants described 'playing the lottery' with people's lives as arbitrary, inappropriate, and offensive.

There was strong support for discretion; applying recommendations as guidance, rather than a mandatory policy.

- A national approach was supported on the premise of setting expectations, avoiding conflict, and it being easiest to implement and apply.

- Local, or regional, application was supported on the premise of population differences and Trusts/hospital staff knowing their communities.

Participants felt that groups of doctors should make decisions, not just one, as this reduces burden and bias.

Further suggestions included

- Recording how decisions were reached.

- Adjusting any principles put into practice by monitoring local data patterns of survival rates.

- Involving ethicists in decision-making processes.

Participants struggled to picture how a principle, or combined principles, would be applied in practice.

- They queried how triage would work as they wouldn't expect it to be a case of two people competing for one bed; it would be more complex.

- They also acknowledged that decisions would have to be taken case by case, in line with the support of doctors' discretion, as extra information would create a myriad of nuanced factors.

Workshop Four: Recommendations

At the beginning of the final workshop participants were shown a summary of their favoured principles and potential caveats to each of them (appendix 6). They were asked to strive for consensus, agree caveats to each principle, and, if possible, settle on one overall principle. However, no consensus was reached, though there was a sense that participants did not find any of the three approaches unacceptable.

Discussion in the final session led to a stronger differentiation between focusing on survival chances and life expectancy. There was concern that it is too difficult to accurately estimate someone's life expectancy and that survival chances should be the only, or at least the primary, consideration; saving the most amount of lives rather than the most life years.

- Value was still given to saving life years, including saving 'good' life years based on QoL.
- A case was made more strongly for considering who will recover the quickest, in order to make their bed available again.
- Participants alluded to a virtue of this principle being the use of medical professionals' knowledge, which is less arbitrary than "first come, first served", and aligns with the current approach to triaging.
- This guidance would be clear and would reduce burden, particularly when supported by the "first come, first served" approach when it's too close to call. It also ensures the most is gained from resource spent.

A key concern about "maximising life years" is it discriminates against patients based on a protected characteristic i.e. age, as, in practice, younger people would often be prioritised. Furthermore, if this principle is applied rigidly it would mean discriminating based on other protected characteristics, such as ethnicity and disability, as some disabilities equate to lower life expectancies and the impact of COVID-19 on BAME patients is disproportionate.

- A case was therefore made that more research and thinking is needed to ensure this principle does not become inhumane, with a suggestion to focus on individuals' health conditions and not factor in broader statistics based on protected characteristics.

It was acknowledged that participants did not have as much time to deliberate "prioritising the vulnerable". It was emphasised by facilitators that only those in need would be considered for escalation, but some participants still thought of the

younger/stronger candidate, or those with milder symptoms, as having better survival chances.

- Arguments for this approach related to the approach to triage in A&E and a wider cultural concern that not prioritising the vulnerable could 'cost us our humanity' in a post-pandemic society.

- Arguments against taking this approach were around making the most of available resources, including thinking about what society will need to rebuild after the pandemic.

- There was support for caveats to this principle being only prioritising the vulnerable if they can be saved, and if it's a close call then to fall back on the "first come, first served", approach.

Support for the "first come, first served" approach was based on it being simple and fair. This contrasted with maximising lives saved and prioritising the vulnerable, which participants worried would be based on judgments that medical professionals cannot be completely certain about.

- Participants were very concerned about discriminating against older people, and that hospitals would face reputational damage for turning people away on the premise of either maximising lives saved/life years or prioritising the vulnerable.

- Participants acknowledged that this principle would carry the inequalities of society if applied.

- They also described difficulty in application when some people would be calling and others arriving in person.

- Again, there was support for a caveat that this principle should not be applied if the first person to arrive has low survival chances.

While medical judgments were seen to be the primary means of making decisions, there was value placed on factoring in considerations of QoL.

- Participants were particularly supportive of factoring in what QoL would be like *after* treatment when making decisions about whether to escalate a patient.

- Caveats were that it should only be applied in extreme cases and that it should involve input from the person themselves, their family, carers and medical professionals.

- Lifestyle choices and contribution to society were felt to be important but too subjective to apply in practice.

Positive discrimination was viewed as something that can balance societal inequality.

- However, there were concerns that not enough is known to justify applying this.

Providing information to patients and allowing them to give up their bed in favour of another was still viewed as valid – though it's important to note that, with more time to think and deliberate, participants were concerned about the expectations and outcomes resulting from applying this.

- It was considered likely that many people would not opt out of treatment and that asking could cause unfair and unnecessary emotional distress.

Participants were concerned that if guidance was not applied across the board it would cause people to choose one hospital over another to try and get a 'better deal'.

- The counterargument to national application of guidance was that flexibility is needed to account for differences in local populations and regional COVID-19 restrictions.

- Again, support was expressed for ongoing review and responding to what is or isn't working.

There were concerns that promoting an application of any of these recommendations would invite unnecessary trouble for doctors and hospitals. That is, the media was considered likely to focus on 'heart-breaking' stories about those who are *not* prioritised.

- It was noted that the wider public don't currently know how doctors make triage decisions. Yet there is great trust in their ability to make the right decisions based on experience and knowledge.

- If publicised, any principles that are applied to decisions about resource allocation could be easily misread. It could also cause the public to panic and prematurely seek hospital treatment in great numbers.

- Yet the view that any applied recommendation should not be publicised was in direct conflict with the desire to be open and transparent – a conflict that participants struggled to resolve.

    - It was suggested that the information could be made available but not widely publicised in the media.

    - Participants worried about the difficulty in expressing the maximising life years principle without it simply being interpreted as 'culling the old' – something that should be worked through in discussion with the public to ensure they understand the nuance of the principle, i.e. that age is relevant but not the deciding factor.

- Ensure that doctors from different backgrounds and with different opinions work together to make a decision was strongly favoured.

- Participants wanted to see positive statements framing whichever approach is taken – e.g. “saving the most lives” – and to demonstrate how much of a strain different approaches would put on the NHS.

- There was also emphasis on being open and helping the public to understand that whatever approach is taken is about trying to do something positive, considering the whole of society rather than individuals.

Wider reflections

Below are some reflections on what the findings outlined in this report mean for the practical application of principles for resource allocation during a second wave, as well as some thoughts on the impact of using an online approach to deliberation.

- Participants were able to grasp challenging concepts and, importantly, commit to discussing and making recommendations on an uncomfortable subject. Even given the strong tendency to defer to medical professionals' greater knowledge, participants engaged with exploring ways to support the doctors' decision-making. This is encouraging from the perspective of engaging the public in future discussions on similarly contentious and challenging subjects; the deliberative approach lends itself well.

- It seems clear from the participants' caveats that any set of principles will need to be carefully explained to the wider public. Some form of public education campaign will be needed to challenge knee-jerk reactions to the principles, reactions which might be rooted in misconceptions or simplifications of the principles.

- Over time, participants became much more cohesive in their views. As understanding of the issues developed through deliberation, participants came to articulate a focussed set of viewpoints.

- The online approach to these deliberative workshops worked well, particularly given the sensitive and complex nature of the material.

    - Participants felt more comfortable expressing their own views, both through feeling safer and more comfortable in their homes and by virtue of being physical distanced from people they might disagree with.

    - Carers and family members such as the children of older participants were able to facilitate their parents' participation. While this was originally encouraged to support the use of technology, it also enabled the older participants to contribute more meaningfully than they would normally. For example, participants' family members were able to help clarify language issues or hearing problems, as well as aid participants with their own personal deliberation.

    - With the workshops spread over four short sessions, participants also had more reflection time – face-to-face deliberations would usually ask participants to come together once or twice for longer periods of time. Four shorter sessions, providing more time for reflection away from the larger group, time spent engaging in everyday activities which, in turn, gave greater depth and richness to their deliberations.

- Thus, it seems that there are several potential advantages to online deliberation compared to face-to-face: greater comfort expressing opinions about sensitive subjects, the ease with which carers or family members can support older or vulnerable participants to contribute fully to the deliberations, and having time between sessions to contemplate the prior discussions. These factors contributed to a richer and deeper deliberative process than we might otherwise have seen if this study had been conducted face-to-face.

Appendices

Appendix 1 – Sample Profile

	Age	SEG	Gender	Ethnicity	Working status	Highest level of education	Length of time lived in Lambeth/ Southwark
Person 1	54	C1	M	Indian British	In full-time employment	GCSE Level or equivalent	10+ years
Person 2	46	C1	M	White British	In full-time employment	Degree Level or equivalent	3-10 years
Person 3	36	C1	F	White British	In part-time employment	Degree Level or equivalent	10+ years
Person 4	52	C1	M	White British	In full-time employment	A-Level or equivalent/ vocational qualifications	10+ years
Person 5	75	C1	F	White British	Retired	Post Graduate Degree Level	10+ years
Person 6	69	C2	F	White British	Retired	Degree Level or equivalent	10+ years
Person 7	60	C2	M	Black Caribbean	In full-time employment	GCSE Level or equivalent	10+ years
Person 8	65	B	F	White British	Retired	Degree Level or equivalent	10+ years
Person 9	79	B	M	Black African	Retired	Degree Level or equivalent	10+ years
Person 10	44	C2	M	White British	In part-time employment	Degree Level or equivalent	10+ years
Person 11	22	D	M	White and Black Caribbean	In full-time employment	A-Level or equivalent/ vocational qualifications	3-10 years
Person 12	59	C1	F	Black African	Retired	Degree Level or equivalent	10+ years
Person 13	40	B	F	White British	In part-time employment	A-Level or equivalent/ vocational qualifications	10+ years
Person 14	34	C1	M	Pakistani	In full-time employment	A-Level or equivalent/ vocational qualifications	10+ years
Person 15	30	E	F	Mixed	Currently not in paid employment	GCSE Level or equivalent	10+ years
Person 16	29	C1	M	White British	In full-time employment	A-Level or equivalent/ vocational qualifications	10+ years

Person 17	23	C2	F	White British	In part-time employment		10+ years
Person 18	65	C2	F	Black British Caribbean	In part-time employment	No qualifications	10+ years
Person 19	35	E	F	Black Caribbean	Currently not in paid employment	GCSE Level or equivalent	3-10 years
Person 20	72	C1	F	White British	Retired	No qualifications	10+ years
Person 21	72	C2	M	Indian	In part-time employment	Degree Level or equivalent	10+ years
Person 22	69	D	F	Black African	Retired	No qualifications	10+ years
Person 23	26	E	M	White and Black Caribbean	Currently not in paid employment	Degree Level or equivalent	3-10 years
Person 24	30	E	F	Black African	Currently not in paid employment	Degree Level or equivalent	3-10 years
Person 25	58	B	M	White British	In full-time employment	Degree Level or equivalent	10+ years

Appendix 2 - Discussion guides

These guides were for workshop facilitators and were not shared with participants.

Session 1

Time	Activity	Questions and materials
6.30 – 6.45 (15 mins)	**Plenary 1: intro**	*5 break-out groups to be pre-allocated during intro - up to 5 minutes waiting for participants to join/settle.* Chair to introduce (10mins): • Housekeeping – using the chat function to ask questions, name display etc. • Who Ipsos are, who KCH/KCL and King's Health Partners are, the participants role, an overview of the process and the ground rules/working agreement: • Relaxed and informal • No right or wrong answers • We are keen to hear about everyone's views • Please feel free to disagree with one another; just keep it polite • We will make sure everyone gets a chance to share their opinion • Please try to avoid talking over one another – means the recorder does not work so well and harder for our note taker to hear what people are saying • Recording plenary video and audio in break out groups • Plenty to get through, so the moderator may have to move people on from time to time – not that we're not interested in what you have to say • Mention any observers • Clarify end time • Any other housekeeping – phones on silent, other applications/programmes switched off (can slow down the platform), bathroom break whenever you need (just let your moderator know), etc. • Context for the study – there may be a second wave of COVID-19 this winter and KCL want medical professionals to be better prepared to make tough decisions. There are no specific government guidelines about how to prioritise resource allocation among COVID patients if it becomes necessary. We're interested in age in particular because of how COVID affects older people and because this is already being considered in tough, rapid, decision-making. Note that not all pandemics affect older people in this way,

		e.g. the average age of those who died from Spanish Flu was 28. Acknowledge there are other risk factors (ethnicity, gender) but we are focused on age for this discussion. • Outline how their views will be utilised 1) Presented to clinical ethics forums at King's Health Partners 2) Published on KCL webpages and in peer reviewed journals We essentially want to understand their views on how patients should be prioritised, if this is needed. Their views will be presented to clinical ethics forums and shared more widely to influence potential policies. It should be emphasised that this will be a long and careful process, nothing will be immediately implemented.
6.45 – 7.05 (20mins)	**Plenary 2: framing and context**	Chair to let participants know we will be watching two presentations then going to our break-out groups to discuss. • **KCL Presentation of resource allocation and escalation (10 mins)** • **IM Presentation on available research and framing (10 mins)**
7.05 – 7.20 (15 mins)	**Break-out 1: intros and sharing initial views**	• *INTRODUCE YOURSELF AND REQUEST PERMISSION TO AUDIO RECORD DISCUSSION* • *RECAP KEY WORKING AGREEMENT POINTS:* it's good to disagree with each other's points, your perspective is valid so please speak – disagree with the point, not the person - and be mindful of how you're feeling, it's a difficult subject. • **Please introduce yourselves and share your favourite aspect of lockdown** • **What do you think about the lack of guidelines on resource allocation?** *(USE THIS TIME TO ENABLE PARTICIPANTS TO FEEL HEARD ABOUT THEIR VIEWS OF GOVERNMENT.)* • We will use our time together to help NHS trusts make these difficult decisions. Despite our feelings about the Government let's keep our focus on that. It's where we can bring value and support the NHS. I'm going to read out some testimony from doctors in Italy who are in a similar position to doctors here. • *READ OUT THE TESTIMONY HAND OUT (SHARE SCREEN OPTIONAL)*

		• **What had you heard about resource allocation before the presentation?** • How do you feel about it? Are you surprised these decisions have to be made? • How did you feel about the definition of "frailty"? What more would you need to be clear on what this means to doctors and medical professionals? How does this compare to your understanding of frailty? • *REFER TO/ SHARE RESOURCE ALLOCATION/ AVAILABLE RESEARCH HAND-OUTS IF NEEDED* • *TELL PARTICIPANTS TO TAKE A 10 MINUTE COMFORT BREAK AND COME BACK AT 7.20*
Comfort break: 7.20 - 7.30 (10mins)		
7.30 – 7.35 (5mins)	**Plenary 3: premise introduction**	• Chair to introduce: 4 principles presentations, five-minute discussion after each, then 15mins to reflect
7.35 – 7.45 (10 mins)	**Principle 1**	**Plenary: KCL Presentation on principle 1** *(5mins)* *Break-out: immediate reactions pt.1 (5mins)* • Did that make sense? **Do you have any questions?** • What do you think and feel about what you just heard? • **Do you think this principle should be applied in practice**? Why? How?
7.45 – 7.55 (10 mins)	**Principle 2**	***Plenary: presentation on principle 2*** *(5mins)* *Break-out: immediate reactions pt.2 (5mins)* • Did that make sense? **Do you have any questions?** • What do you think and feel about what you just heard? • **Do you think this principle should be applied in practice**? Why? How?
7.55 – 8.05 (10 mins)	**Principle 3**	***Plenary: presentation on principle 3*** *(5mins)*

		Break-out immediate reaction pt.3 (5mins) • Did that make sense? **Do you have any questions?** • What do you think and feel about what you just heard? • **Do you think this principle should be applied in practice**? Why? How?
8.05 – 8.15 (10 mins)	**Principle 4**	***Plenary: presentation on principle 4*** *(5mins)* *Break-out: immediate reaction pt. 4 (5mins)* • Did that make sense? **Do you have any questions?** • What do you think and feel about what you just heard? • **Do you think this principle should be applied in practice**? Why? How?
8.15 – 8.25 (10mins)	**Break-out 6: exploration of four principles**	*REFER TO THE HANDOUT ON PRINCIPLES (SHARE SCREEN OPTIONAL)* • **Which of these principles is closest to what you believe should be done?** Why? • Which is furthest away from your view/are you most uncomfortable with? Why? • Do you think one principle is better than the others? • Would you use different principles in different situations? • **Has this raised any questions?** • What else do you need to know to form recommendations on what principle/s the NHS should apply to resource allocation? • How are you feeling about digging into these principles and helping the NHS to make decisions on who to prioritise? Can we do anything to help?
8.25 – 8.30 (5 mins)	**Plenary: close**	Chair to thank participants and cover: • reminder of phone numbers which participants can call for support • please complete your survey this evening so we have time to read all your responses

		• we'll see you again on Wednesday

Session 2

Time	Activity	Questions and materials
6.30 – 6.45 (15 mins)	**Plenary 1: intro and sharing feedback**	*5 break-out groups to be pre-allocated during intro - up to 5 minutes waiting for participants to join/settle.* Chair to welcome participants back and cover: • analysed views from the surveys and discussions so far • agenda for the session
6.45 – 7.00 (15mins)	**Break-out 1: re-cap and intros**	Intros (15 mins) • **Introduce yourselves and tell us what you remember about the four principles** • What stood out to you? • Did you think of any other questions? *RE-CAP THE FOUR PRINCIPLES, REFERRING TO THE HANDOUT (SHARE SCREEN OPTIONAL)* • **Did your views change between the first session and now?** How? • Did you speak to anyone about what we've discussed? What did they say? • **What are your thoughts on the views of the whole group, that were just presented to us?** To what extent do they echo or challenge y/our own views?
7.00 – 7.15 (15 min)	**Break-out 2: case study one**	Case study (15 min) • We're going to explore what it would be like to apply these principles in practice through case studies. We are considering how individual doctors on the front-line should make rapid bedside decisions on a case by case basis when there are limited resources within their hospital/area.

		• *READ OUT CASE STUDY ONE (AS BELOW)* Angelica is 15 years old and has muscular dystrophy (MD), a long-term health condition that means she is only expected to live to 20-25 at most. Angelica is classified as disabled and is unable to walk but has no cognitive impairments. She enjoys family life and has a relatively high school attendance, with occasional absences due to hospital appointments or when she is experiencing high discomfort. Mary is 50 years old and is in good health. There is no reason for Mary not to reach the standard life expectancy for a woman in the United Kingdom of 83 years old. Mary also has a rich family life and actively participates in her local community; volunteering at the local community centre and caring for her grandchildren. Mary arrives at the hospital shortly before Angelica after calling 111 and reporting severe COVID symptoms. There is only one ICU bed available and both Angelica and Mary are considered by the doctor who has examined them to need a ventilator and specialist treatment. Which principle seems fairest? Why? What other information would you want to make this decision, if you were the doctor? • If we apply the principle of prioritising the young, so they can reach later life stages, Angelica should be prioritised. • If we apply the principle of prioritising patients with the longest life expectancy, to save the most life years, Mary should be prioritised. • If we apply the principle of prioritising the young and middle aged so they can complete their life projects, this could be either Mary or Angelica. Who do you think this applies to most? • If we apply the principle of not choosing based on any characteristic, a first-come first-served approach would favour Mary. A random approach could favour either of them. Which would you apply of these two? • **Which principle/s should be applied in this situation?** Why? • **How do you feel about this outcome?** Why?
7.15 – 7.25 (10mins)	**Break-out 3: case study 2**	• *READ OUT CASE STUDY TWO (AS BELOW)* Geoff is 75 years old and is in good physical health. He has had dementia for several years and lives at home with his wife and is well supported. Codey is 65 years old. He is regarded as frail but is quite low on the frailty score [can refer to point 5 ‘mildly frail’ on the Rockwood Clinical Frailty Score].

		Codey is currently staying in a care home and receives regular visits from his family. Both Geoff and Codey call 111 and report COVID symptoms. They are told to visit the hospital where they will be assessed. There is only one ICU bed available and both Geoff and Codey are considered by the doctor to need a ventilator and specialist treatment. The doctor has limited time to decide and cannot gather any more info. • **Given what we know about frailty and dementia, how would you approach making this decision?** • *READ OUT THE HANDOUT ON FRAILTY AND DEMENTIA IF NEEDED (SHARE SCREEN OPTIONAL)* • **Which principle/s should be applied in this situation?** Why? • **How do you feel about this outcome?** Why?
Comfort break: 7.25 – 7.35 (10mins)		
7.35 – 8.00 (25mins)	**Break-out 4: 'taking stock'**	• **Which principle/s do you think are best for use in practice**? • Which principle makes you most uncomfortable? Why? • How important is age when thinking about prioritising resources? • **What other factors are important to you?** • What other information would you want to have about these individuals so you could decide? • *IF PARTICIPANTS ASK ABOUT DE-ESCALATION/WHAT HAPPENS IN ICU, YOU CAN TELL THEM IT IS STANDARD PRACTICE FOR PATIENTS IN ICU TO BE MONITORED AND IF NO IMPROVEMENT IS SEEN, THEY ARE "DE-ESCALATED". THIS DOES NOT MEAN THAT THEY ARE NO LONGER CARED FOR, BUT THAT THEY WILL BE GIVEN PALLIATIVE CARE i.e. MITIGATING SUFFERING* • *IF PARTICIPANTS PUSH AGAINST SELECTING A PRINCIPLE, YOU CAN SAY FRONT-LINE CLINICIANS CAN CONTINUE TO MAKE DECISIONS ON AN INDIVIDUAL BASIS. REMIND THEM OF THE EMOTIONAL TOLL THIS ADDS TO A CLINICIAN'S WORKLOAD AND THE LACK OF CONSISTENCY THIS WOULD CAUSE. TELL THEM IT WOULD BE HELPFUL FOR THEM TO PROVIDE VIEWS ON WHAT WOULD BE IMPORTANT TO CONSIDER WHEN MAKING THESE DECISIONS.*

8.00 – 8.30 (30mins)	**Plenary 2: feedback and close**	Chair to lead facilitators in feeding back headlines from their discussions *(25 mins)* Chair to thank participants and cover: • reminder of phone numbers which participants can call for support • please complete your survey this evening and email us with further questions if you have them • we'll see you again on [date/time]

Session 3

6.30 – 6.50 (20min)	**Plenary 1: intro, Q&A and feedback**	*5 break-out groups to be pre-allocated during intro - up to 5 minutes waiting for participants to join/settle.* • Chair to welcome back participants • KCL experts present answers to questions • Chair presents the groups collective views so far, focusing on drawing out views on principles, frailty, dementia and QoL, and any other factors that arise from discussion • Chair to explain we will be digging further into factors outside of age which are important when making these quick and challenging decisions, and we're particularly interested in your views on quality of life (QoL).
6.50 – 7.10 (20 min)	**Break-out 1: intros**	Exploring quality of life (20 min) • *READ OUT THE HANDOUT ON DEMENTIA, FRAILTY AND QUALITY OF LIFE (SHARE SCREEN)* • **How important is Quality of Life when deciding who should be given limited resource?** • How would you factor in dementia and frailty to decision making? • What do you think about the other factors that are important to the group, that were presented back just now?

7.10 – 7.25 (15 min)	**Break-out 2: case study three**	Case study (15 min) • *TELL PARTICIPANTS WE'LL BE DISCUSSING ONE MORE CASE STUDY.* • *READ OUT CASE STUDY THREE (AS BELOW)* Barbara is 80 and Robert is 82. Barbara has been in a care home for one year after developing mild dementia. She is physically fit and walks each day. Robert lives at home with his wife. He has severe PTSD and struggles to carry out some daily activities. One of the nurses at Barbara's care home calls 111 and reports Barbara's COVID symptoms. Robert's wife also calls 111 and reports Robert's COVID symptoms. Again, there is one ICU bed and the doctor must choose between Barbara and Robert. This time, however, he can ask for more information about their Quality of Life • **If you were the doctor, what would you ask the people who have called so you could decide?** • **Do you think Quality of Life should be judged by the person themselves, their family, or a medical professional? Why?** • **Which principle/s should be applied in this situation?** Why? • How do you feel about this outcome? Why?
Comfort break 7.25 – 7.35 (10min)		
7.35 – 8.25 (40min)	**Break-out 2: deliberation**	Deliberate (40 min) • **Reflecting on everything; how would you approach resource allocation? Why?** • *CHALLENGE PARTICIPANTS – REMIND THEM WHO LOSES OUT. ASK ARE THEY OK WITH THAT?* • **Putting yourself in the shoes of the doctors, which one policy would you apply to all situations when decisions need to be rapid? PROMPTS: first come first served, lottery, prioritise those most likely to survive, prioritise those who are likely to live the longest, prioritise those who are most vulnerable** • If doctors had more time, what would you want them to take into account? PROMPT: ethnicity

		• Would you want Quality of Life to play a role in decision making? How? • Would you want this provided as guidance, but individual clinicians still have discretion? What makes you say that? • Would you want this applied as a mandatory principle/s at a local level? Or a national level? What makes you say that? • *CHALLENGE PARTICIPANTS – REMIND THEM THAT THERE WILL BE INCONSISTENCY AND BURDEN ON MEDICAL STAFF IF ONE PRINCIPLE/A SET OF GUIDELINES ARE NOT APPLIED* • *STRIVE FOR CONSENSUS/CLARITY ON DIVERGENT VIEWS – UNDERSTAND VALUES AND CAVEATS*
8.25 – 8.30 (5mins)	**Plenary 2: close**	Chair to thank participants and cover: • reminder of phone numbers which participants can call for support • please complete your survey this evening so we have time to collate your views before Wednesday • we'll see you for our final session on Wednesday where we will make recommendations

Session 4

Time	Activity	Questions and materials
6.30 – 6.40 (10 mins)	**Plenary 1: 'our recommendations'**	*5 break-out groups to be pre-allocated during intro - up to 5 minutes waiting for participants to join/settle.* Chair to present: • What we'll cover today • Principles and possible conditions
6.40 - 7.30 (50mins)	**Break-out 1: deliberating recommendations**	Recommendations (40 min) • **Before we discuss anything, please write down which of the three principles you support the most and the least, with reasons why.** *SHARE SCREEN.*

		GIVE PARTICIPANTS FIVE MINUTES TO COMPLETE THE TASK, THEN ASK EACH PARTICIPANT: • **Which principle do you support most and least?** Why? *FOCUS ON THE PRINCIPLES THE PARTICIPANTS HAVE SUPPORTED AND ASK THE GROUP:* • **What are the pros and cons to each of the principles?** *CHALLENGE PARTICIPANTS IN THEIR SUPPORT FOR PRINCIPLES, AS FOLLOWS:* • Maximising life years: may discriminate against BAME communities and de-prioritise those with health conditions and/or those who are older • First come, first served: could result in someone much more likely to survive and live for many years not getting ICU care, in favour of someone unlikely to live for very long afterwards or survive • Prioritising the vulnerable: could lead to people less likely to survive or live for very long afterwards being prioritised over those more likely to survive, and only those who need to be escalated will be 'in the running'. Those who have strong enough survival chances to manage without ICU care would be asked to stay at home and recover there. • **What are we recommending and what conditions do we have?** *IF PARTICIPANTS HAVE DIVERGENT VIEWS, FORM SEPARATE RECOMMENDATIONS AND MAKE A NOTE OF HOW MUCH SUPPORT EACH RECOMMENDATION HAS. SHARE SCREEN.* • **How would you feel if an option you don't support was applied?** Comms (10 min) • How do you think the press would report on this/these recommendations? • **How do you think the public who haven't had these conversations would react to this/these being implemented?** • To what extent do you think people will understand terms like frailty/QoL?

		• How can we best communicate so that people will understand? • **If you were trying to persuade someone to support x approach, what would you say?**
Comfort break 7.30 – 7.40 (10min)		
7.40 – 8.00 (20min)	**Plenary 2: presenting recommendations**	Chair to: • ask facilitators to present their groups' recommendations • probe facilitator for their reasoning/answers if appropriate *(3mins per group)*
8.00 – 8.25 (25mins)	**Break-out 3: final amendments**	• What did you think about the views presented by the other groups? • **Do you want to change anything about our final recommendations**? • **Do you want this applied as guidance or mandatory? At a regional or national level?**
8.25 – 8.30 (5 mins)	**Plenary 3: close**	Chair to cover: • Please complete the **final survey**. • We will provide your recommendations in full, and an analysis of everything we've discussed, and a 'short-list' based on this analysis, to the KCL team to put forward to ethics teams at local hospitals and a wider audience of policy makers for consideration. Massive thanks, close.

Appendix 3 - Scripts from video explanations of the four principles

The videos these scripts are taken from were shown to participants in the introductory session.

The 'Fair Innings' Principle

Hello, my name is Margot, and I'm a Research Assistant at King's College London. I will be explaining the 'Fair Innings' principle today. One of the first people to formulate this principle was John Harris, a moral philosopher.

According to the Fair Innings principle, age *is* a relevant factor when allocating scarce resources. More precisely, this principle holds that we should prioritise younger people.

The reason for this is that everyone has an equal right to live through their whole lifetime. Someone who has had the chance to do so, who has lived through to a reasonably old age, has had their so-called 'fair innings'. Younger people have not had their fair innings yet, as they have not had the chance to live for a fair amount of time.

For this reason, the Fair Innings Principle holds that younger people should get resources before older people, so that younger people also get the chance to earn their fair innings.

In practice, adopting this principle can take different forms. In its most general form, this principle simply prescribes that younger people should be prioritised over older people: when two patients are competing for treatment, whichever patient is younger should get it by default. So, when choosing between a 17-year old and a 60-year old woman, the 17-year old gets the treatment.

Some people take issue with this approach, though. One problem is that, when the ages of competing patients are not so far apart, following this principle can seem a bit *random*. Should we really prioritise a 41-year old over a 42-year old? Did the 42-year old really have more of a chance to live her full life?

For this reason, some people propose a different form of the fair innings principle. They propose that, rather than *always* prioritising younger over older patients, we should establish a '*fair innings threshold'*. This is the age at which a person has had their fair share of life years. For example, we could decide that 70 is our threshold. People who have not reached this age are then given priority over those who have. But, if all competing patients are below 70 years old, *no one* is prioritised on the basis of their age.

Yet, even on this approach, some people take issue with this principle. Some worry that it discriminates unjustly against older people: is it really fair to deny treatment to a happy and active pensioner with a good prognosis for recovery, simply because they are over 70 years old? This is a difficult question. But people who are *for* the fair innings principle would say that this principle does *not* discriminate, because everyone who grows old enough will eventually lose their priority, and so everyone is ultimately treated the same.

So, to summarise, the Fair Innings principle holds that younger people should be prioritised over older people. This because younger people have not had their 'fair innings' of life years yet, and it is only fair to give them an equal chance to live through their whole life.

The 'Maximising Life Years' Principle

Hello, my name is Nuala Kane. I am a doctor working in mental health, and a researcher in healthcare ethics and law. The principle I am going to explain is the 'maximising life years' principle. This principle is a type of utilitarianism, a philosophy which argues that the right course of action is the one which achieves 'the greatest good for the greatest number'. The essential moral principle is that we should try to save as many life years as we can. This means that people with a higher life expectancy will be prioritised for escalation of care, as they have more life years left to live, and therefore, left to save.

In practise, applying this principle would mean that medical professionals would usually prioritise younger people for admission to ICU or for use of ventilators. We know that older age is often a predictor of poor survival in covid-19, but as well as this, older people who do survive will have less years left to live than younger people. The 'maximising life years' principle tries to achieve 'the greatest good' by maximising the amount of benefit available

from limited medical resources, like ventilators. The benefit is not just about lives saved but also how long people will survive for after they recover from illness. A young person may have several decades left to live, whereas an older person may only live a couple of years more. Medical professionals often prioritise care for lives they can save over those they cannot; it is simply an extension of this to take the length of life saved into account. The main advantage of this principle is that it is easy to apply in practice. It will allow clinicians faced with limited resources to make fast treatment decisions using criteria they can measure: age and life expectancy, rather than using more subjective criteria such as frailty, quality of life or ability to access care. The main disadvantage is that it involves discrimination based on age and may lead to older people feeling or being less valued by society.

One way of applying the 'maximising life years' principle would be to have an upper age limit for escalation of care. For example, people over the age of 70 would not be admitted to ICU beds or treated using ventilators but would receive other care. In other words, younger people, under age 70, who have a longer life expectancy and are more likely to survive for longer after their recovery, would be prioritised.

In summary, the 'maximising life years' principle tries to ensure the greatest good by considering how long people are likely to survive after treatment for covid. In order to save as many life years as possible, it prioritises younger people who have a longer life expectancy. This means that people over a certain age may be excluded from escalation of care.

The 'Life Projects' Principle

Hello, my name is Gareth Owen. I'm a teacher and researcher at King's College London. I work in healthcare, ethics and policy. The principle I'm going to introduce to you is called the "life projects" principle.

The principle comes from philosophers interested in moral or ethical problems in healthcare. It mainly comes from an ethicist called "Ronald Dworkin" who worked in universities in the UK and the USA around 1980 and has been developed by others.

The key idea is that our lives have most value at their point when they have the most potential to realise their interests, hopes, plans (our projects).

We all have a right to live a 'full' life - living through the stages of childhood, adolescence, middle age, older age. We feel a loss with any death, yet we feel a greater loss when a death occurs in someone young compared to someone old. Why is this? Because our lives are like journeys of discovery and realisation. Very young people (e.g. infants) have not yet developed their projects and so can't realise them. Very old people have already developed their projects and have had the opportunity to realise them. The point of most importance is therefore when someone is old enough to have discovered things they want to do (they have their interests, hopes and plans) and young enough to realise them. In practice this means that the stages between late adolescence to early middle age (e.g.16 to 45) are especially important and lifesaving resources should be prioritised for this age group.

The pros of this approach is that it fits with our shared feelings that it is more tragic to die young than old and that life involves both personal discovery and personal realisation. The cons of this approach is that it will not save the lives of older people that we might be able to save.

If this principle shaped NHS policy then patients who are ill with COVID-19 and in the age range 16-45 would be more likely to be escalated for treatment. In other words transfer to hospital from home would be prioritised by the GPs or the ambulance service; they would be assessed earlier in A&E; if ICU was needed an ICU bed would be prioritised. Patients younger than 16 or older than 45 would be less likely to be escalated in this way - though other care and treatment would be provided.

So in summary, this principle is called the "life projects" principle. It's essential idea is that life's stages matter and that what matters most is protecting people who a) have been able to develop life projects and b) have had little

opportunity to realise them. When applied to the COVID-19 pandemic it means prioritising those age 16-45 and de-prioritising the elderly.

The 'Egalitarian' Principle

I am Alex Ruck Keene, a barrister and lecturer at King's College London. I specialist in mental capacity and medical law. The principle that I am going to explain is the egalitarian principle. This principle comes from wider political theories of how to construct a society. The essential moral principle is that discrimination is always wrong, so in any attempt to prioritise medical resources it is wrong to pick and choose on the basis of any characteristic of the person. Just as it would be wrong to choose between people based upon their race, it would be wrong to choose on the basis of their age.

In practice, applying this principle means that the medical professionals would be applying a process that ignored as much as possible about the patient. In particular, they could not take into account whether the patient was of a particular age. There are different ways in which the principle can be put into practice. The two main ways that have been suggested are 'first come first served' - in other words, doctors simply treat whoever is before them first – and the lottery – in other words, decisions about who should be treated are made on the basis of a random selection as to who should be getting the last ICU bed. The main advantages of an approach based on this principle are that it means that there is no chance that certain groups will be disadvantaged because of decisions made about who to prioritise. The main disadvantages of the principle is that its application can appear arbitrary, and can also have 'hidden' unfairness built in. For instance, the 'first come first served' approach means that those who are most able to get to hospital are more likely to get treated, which benefits those with strong social networks.

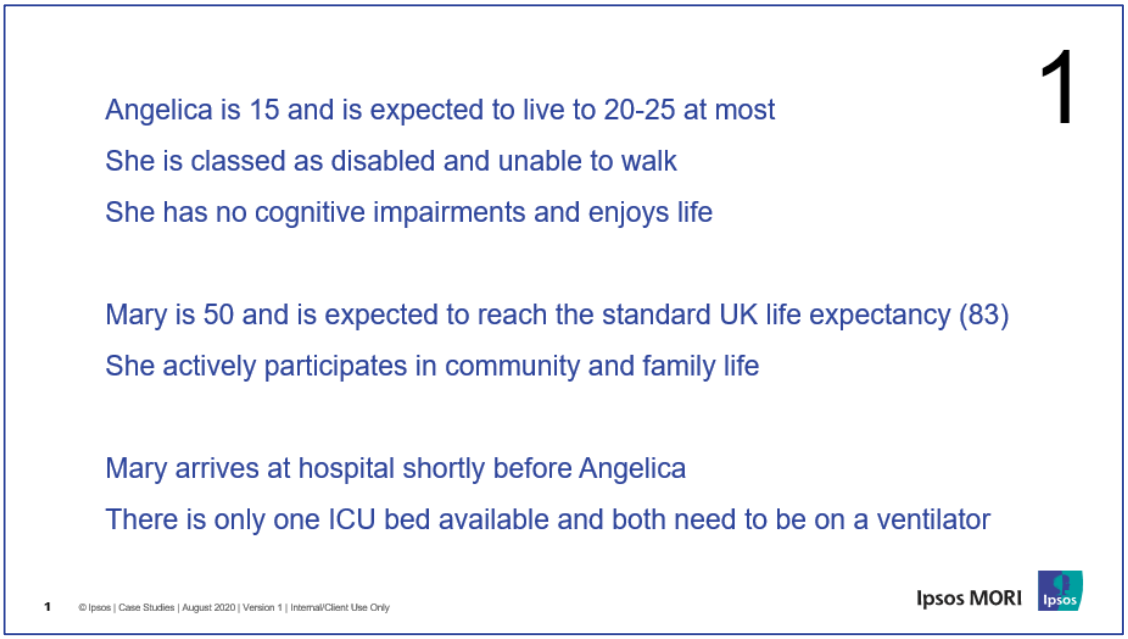
Most attempts to apply this principle in practice have applied the 'first come, first served' approach. This means that those making decisions about who to treat would simply take into account the patient immediately in front of them, and would not try to judge that patient against the possible needs of the next patient. It would be possible to add a 'filter' of either inclusion or exclusion criteria (so long as these did not relate to characteristics such as age), but if the patient passed through the filter then they would be admitted, and the next patient who arrived at the hospital would not.

In summary, the egalitarian basis seeks to require decisions to be made about treatment in a way which is as fair as possible, trying to strip out any external characteristic of the patient. There would either be no prioritisation if decisions were made on the basis of a lottery, or prioritisation would be carried out on the basis of who arrived at the hospital first.

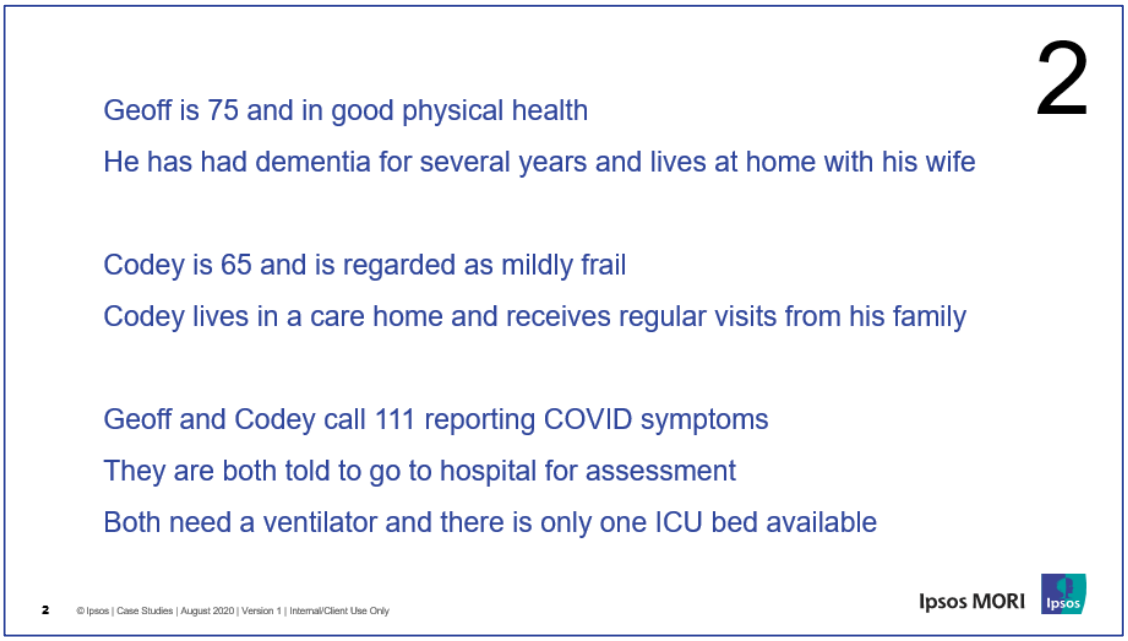
Appendix 4 - Case studies

Case study 1 and 2 were shared during workshop 2, and case study 3 was shared during workshop 3.

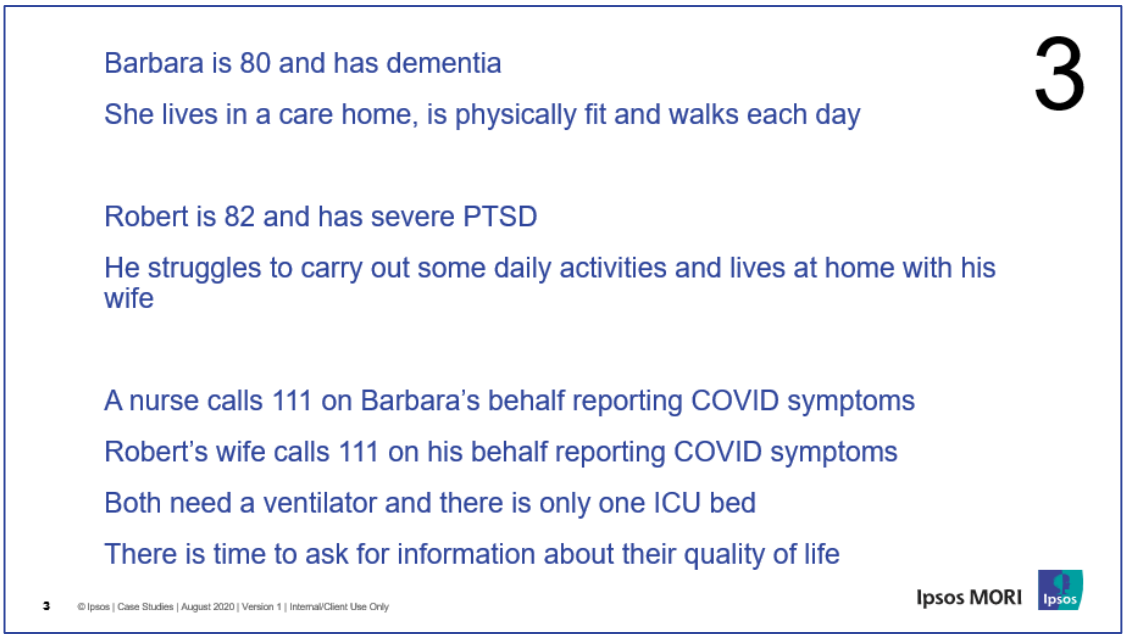
Case study 1



Case study 2



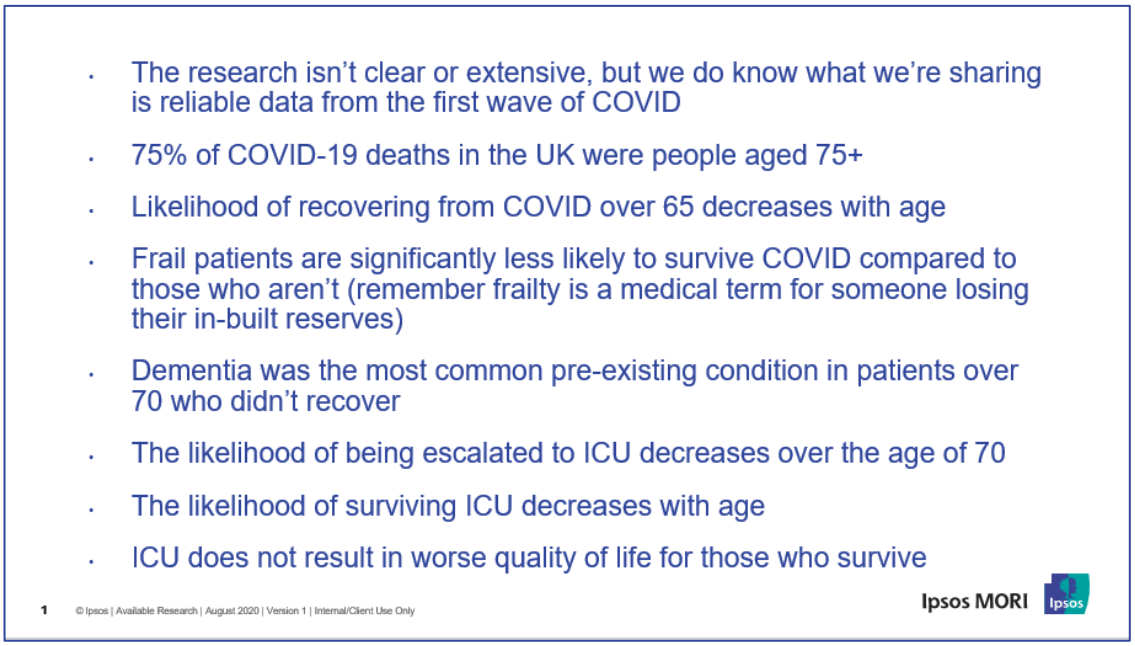
Case study 3



Appendix 5 - Workshop handouts

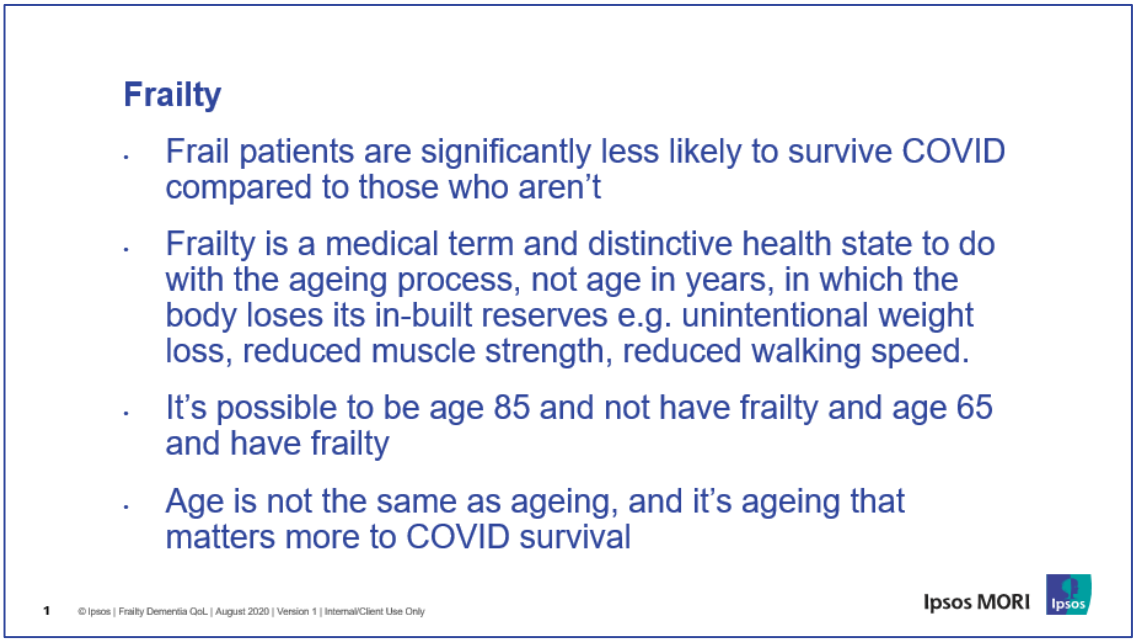
Available research handout

This was shared with participants during workshop 1



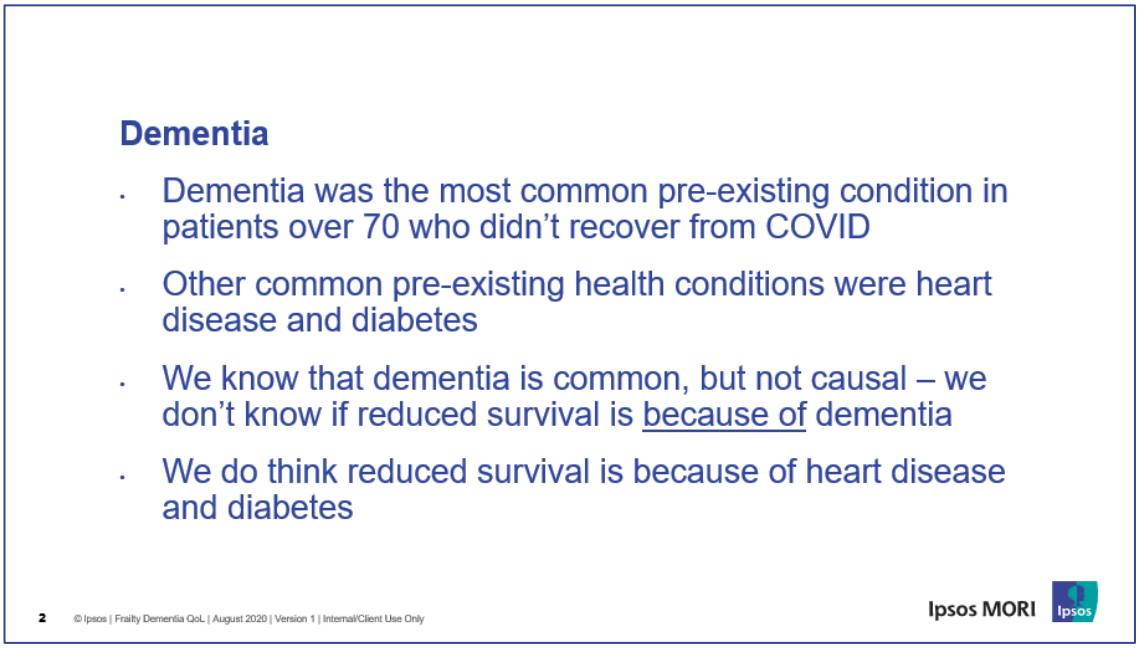
Frailty handout

This was shared with participants during workshop 2 and 3



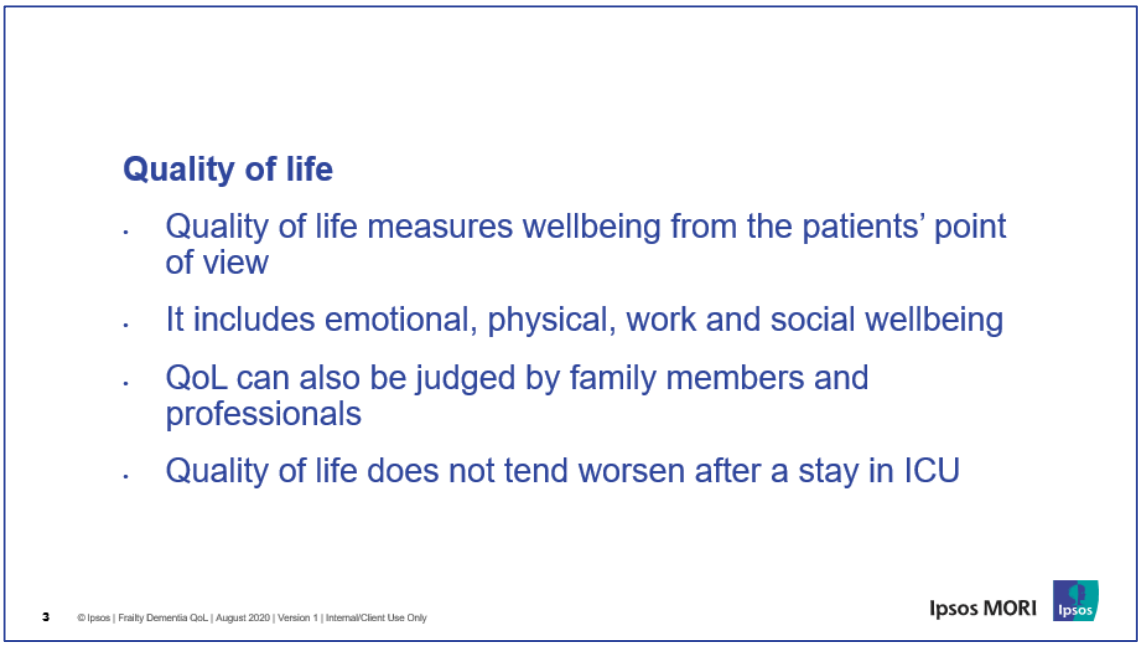
Dementia handout

This was shared with participants during workshop 2 and 3



Quality of life handout

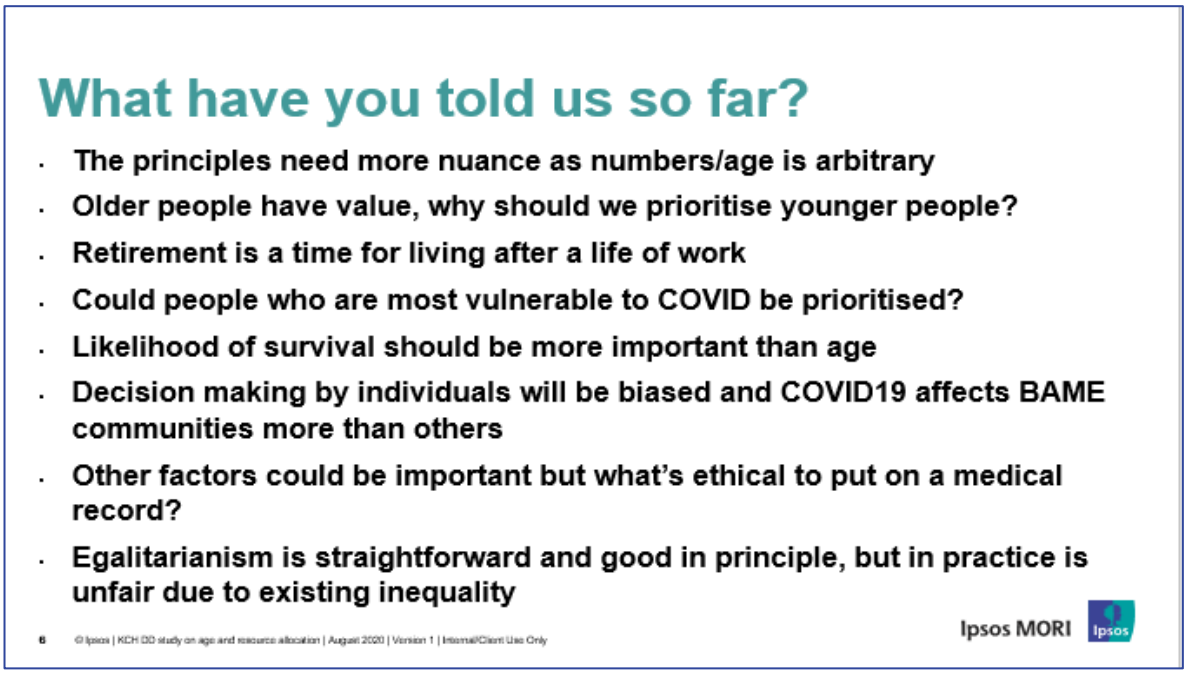
This was shared with participants during workshop 3



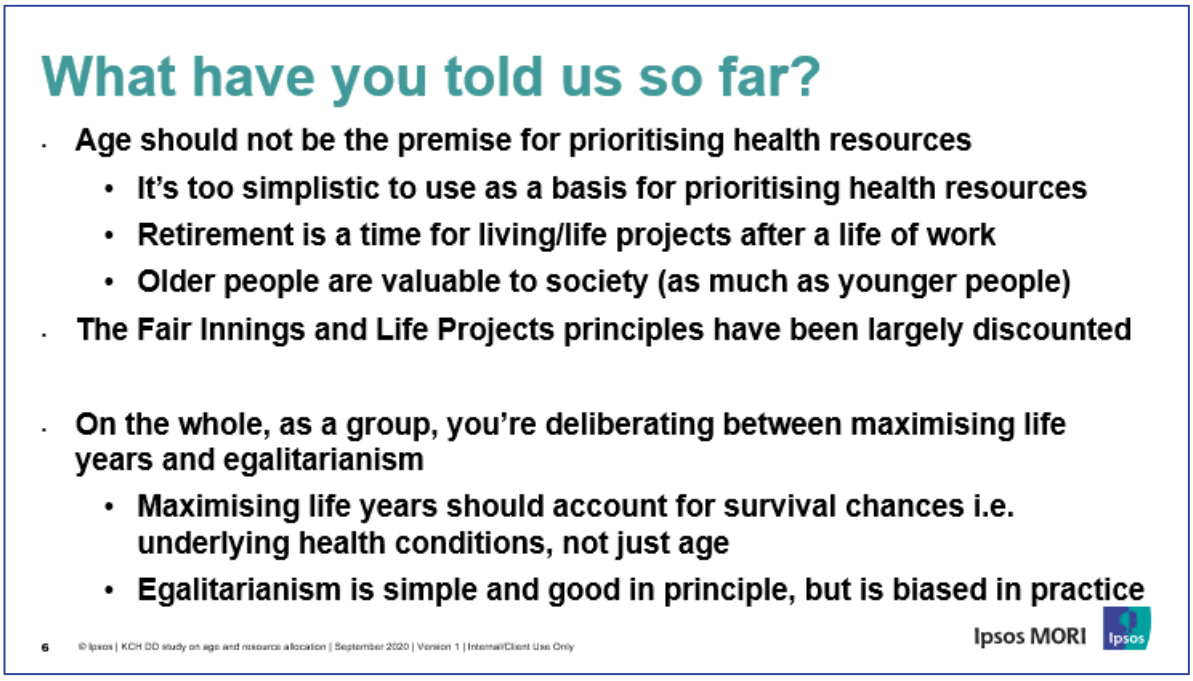
Appendix 6 - Summary slides of previous sessions

These slides were shown to participants at the start of each session (excluding the introductory session)

Session 2



Session 3



What have you told us so far?

- Other factors you've raised that need further exploration are
  - The vulnerability of BAME communities should be considered
  - Should we be prioritising those most likely to survive, or those who are most vulnerable?
  - Egalitarianism could also mean taking a lottery approach (rather than first come, first served)

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Session 4

Principles and possible conditions

1. Maximise life years, accounting for health conditions i.e. survival chances and life expectancy after ICU care
   - Use first come, first served, if it's a 'close call' between two patients
   - Prioritise/positive discrimination for BAME patients
   - Judgments about quality of life (after surviving COVID) should be included in decision making – decisions about QoL should involve patients, their families and clinical professionals
2. First come, first served, in-person or by phone-call
   - With the exception of those with very low survival/life expectancy
   - Patients should be offered information about theirs and other patients survival chances and life expectancy and the choice to give up their treatment in favour of another patient
3. Prioritise the vulnerable over those with stronger survival chances and life expectancy
   - Unless the more vulnerable person is highly unlikely to survive

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Appendix 7 - Survey questions and data

Participants completed survey 1 in the week preceding the first workshop on August 24th.

SURVEY 1 – PRE-WORKSHOP

SHOW ALL

Thank you for agreeing to take part in our research on resource allocation during COVID. Alongside our upcoming group discussions, we'll ask you to complete a series of five short surveys. This first survey will give us a sense of your views before taking part in our discussions, where we'll give you more information. The purpose of this research is to understand your priorities when resources are limited.

It is likely that, if there is a second wave of COVID-19, there will be limited resources for treating patients with COVID i.e. availability of ventilators and intensive care beds. Simply put, resource allocation means sharing out a limited amount of goods. Researchers at Kings College London are considering the problem.

SHOW ALL

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ASK ALL

SINGLE CODE

Q1

Before taking part in this research how much, if at all, would you say you knew about resource allocation in the NHS?

Please select only one option

A great deal

A fair amount

A little

Nothing

Prefer not to say

I don't know

ASK ALL

SINGLE CODE

ROTATE ANSWERS 1-4

Q2

Which of the following statements comes closest to your view about how the NHS should prioritise to who it provides specialist COVID related treatment if resources are limited. The NHS should…

Please select only one option

Prioritise the young as they should have the opportunity to reach later life stages

Prioritise the young and middle aged as they should have the opportunity to meet their life goals

Prioritise patients with the longest life expectancy, to save the most life years

Do not prioritise anyone according to age or any other personal characteristic

I don't know/it's too hard to choose **[FIXED]**

Prefer not to say **[FIXED]**

ASK ALL

OPEN TEXT

Q3

What does frailty mean to you? i.e. if someone is frail, what does that mean?

SHOW ALL

Thank you for completing this survey. Please talk to your friends and family about these questions before we meet on August 24.

SURVEY 1 - Results

	Q1	Q2	Q3
Person 1	ALitle	DoNotPri	i think frailty is when you recover from any kind of mental or physical illness and also person who is frail is like someone who is weak and very fragile like a old person which may have weaker bones.
Person 2	Nothing	_dk	Someone who is vulnerable. Needing assistance.
Person 3	Nothing	DoNotPri	Someone who is old, weak, has mobility issues, has difficulty breathing, and who is recovering from illness
Person 4	ALitle	DoNotPri	to me, frailty means someone, who is too weak to perform normal, everyday tasks without a lot of difficulty or help
Person 5	ALitle	PriYng	You can be frail in many different ways. You may have many physical problems eg with balance, with continence but be quite robust psychologically or you could be mentally frail ie have cognitive difficulties, memory loss but be quite strong physically though

			obviously the mind problems would make you more vulnerable. I guess frailty means vulnerable in some way.
Person 6	Nothing	DoNotPri	They cannot do things for themselves, ie dress, move around easily without help, do their own cooking or cleaning.
Person 7	Nothing	PriYngMidl	Someone who is weak and vulnerable
Person 8	ALitle	_dk	weak, vulnerable.
Person 9	_dk	DoNotPri	Someone who appears weak
Person 10	Nothing	DoNotPri	Poor health. Limited mobility. Vulnerable to illness.
Person 11	AFairAm	PriYngMidl	Someone is old and bones are not fully functional anymore
Person 12	Nothing	PriYngMidl	Weak and not so well
Person 13	Nothing	DoNotPri	Weak, vulnerable, old.
Person 14	ALitle	DoNotPri	Someone who is weak or sensitive physically or health wise
Person 15	Nothing	PrefNtSay	Elderly and vunerable to allsorts of illnessess
Person 16	Nothing	PriLong	Frail to me means someone who is experiencing difficulties in day to day life whether it be from old age or a disability. They would need some form of assistance or be dependent on someone
Person 18	_dk	DoNotPri	To me, it means they are not able to do much physically.
Person 19	ALitle	PriYng	someone who is weak and sickly brittle bones
Person 20	Nothing	DoNotPri	Slight, low weight, illnesses, difficulty getting about and caring for themselves
Person 21	Nothing	DoNotPri	Frailty to me means, something that there is something lacking or diminished and is not as robust anymore as it previously was.
Person 22	ALitle	_dk	Vulnerable, need extra care, fragile
Person 23	Nothing	PriLong	It means someone is weak
Person 24	Nothing	PriYngMidl	Frail is similar to vulnerable/weak
Person 25	ALitle	DoNotPri	They are at risk of compromising their health easily either physically or mentally.

SURVEY 2 – August 24

SHOW ALL

A0 CONSENT

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ASK ALL

SINGLE CODE

Q1

Having attended our first discussion group, how much would you say you know about resource allocation in the NHS?

A great deal

A fair amount

A little

Nothing

Prefer not to say

I don't know

ASK ALL

SINGLE CODE

ROTATE ANSWERS 1-4

Q2

Which statement comes closest to your view about how the NHS should prioritise to who it provides specialist COVID related treatment if resources are limited. The NHS should…

Please select only one option

Prioritise the young as they should have the opportunity to reach later life stages

Prioritise the young and middle aged as they should have the opportunity to meet their life goals

Prioritise patients with the longest life expectancy, to save the most life years

Do not prioritise anyone according to age or any other personal characteristic

I don't know/it's too hard to choose **[FIXED]**

Prefer not to say **[FIXED]**

ASK ALL

OPEN TEXT

Q3

What does frailty mean to you? i.e. if someone is frail, what does that mean?

SHOW ALL

Thank you for completing this survey. We'll see you again on Wednesday, August 26.

SURVEY 2 - Results

	Q1	Q2	Q3
Person 1	AFairAm	DoNotPri	someone is very weak and fragile
Person 2	ALitle	PriYngMidl	That they are medically compromised in some way.

Person 3	ALitle	PriLong	It is related to the aging process. If someone is frail their body is losing its reserves and their muscles get weaker. They are more vulnerable to illness and less likely to recover from illness.
Person 4	ALitle	DoNotPri	Their body is unable to perform to an adequate minimum level which would be required for normal function
Person 5	AFairAm	PriYng	Frailty is something which happens to people when they have setbacks in their health. It could be physical or mental. Apparently it is a reliable way to predict the likelihood of survival. If someone is frail they need more support than someone who is not frail.
Person 6	AFairAm	DoNotPri	That they have a loss of muscle strength, are always tired, find it difficult to get about
Person 7	ALitle	PriYngMidl	Someone who is frail is someone who is weak possibly older has other illness and poor health possibly unaware of what is going on.
Person 8	ALitle	PriLong	Weak, losing muscle strength,
Person 9	ALitle	DoNotPri	People who are weak and unable to do things for themselves .
Person 10	ALitle	PriLong	Weak, existing health conditions.
Person 11	AFairAm	PriLong	Someone who is really not able to move or walk
Person 12	AGreatDeal	_dk	Mobility is limited
Person 13	AFairAm	DoNotPri	Physical wellbeing & resilience to treatment, pre-existing conditions.
Person 14	AFairAm	DoNotPri	someone who is weak and may have psychical issues
Person 15	AGreatDeal	_dk	Vulnerability and elderly. Peopke who are at risks highly of infections
Person 16	AFairAm	DoNotPri	Someone regardless of age that has an impediment that lowers their ability to do day to day tasks
Person 17	Nothing	_dk	Before the talk I was unaware that fragility could be used as a medical term/definition. I thought it was more of a vague description of general old age, thats changed now that I heard what it really means
Person 18	_dk	DoNotPri	Ill-health, sickness or weakness.
Person 19	_dk		
Person 20	ALitle	DoNotPri	Someone with illnesses that make them very frail and vulnerable to getting viruses
Person 21	ALitle	PriLong	They have underlying health issues which may cause them to have issues with their current and future wellbeing. Effecting their quality of life including a reduce life expectancy.
Person 22	AFairAm	PriLong	Someone who is ill, close to death, vulnerabie to illness
Person 23	AFairAm	PriLong	When your bodily processes begin to decline you have frailty.
Person 24	ALitle	PriLong	Loss of built in reserve (muscles and bones)
Person 25	AFairAm	_dk	Their health is easily compromised.

SURVEY 3 – August 26

SHOW ALL

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ASK ALL

SINGLE CODE

ROTATE ANSWERS 1-4

Q1

Which statement comes closest to your view about how the NHS should prioritise to who it provides specialist COVID related treatment if resources are limited. The NHS should…

Please select one answer only

Prioritise the young as they should have the opportunity to reach later life stages

Prioritise the young and middle aged as they should have the opportunity to meet their life goals

Prioritise patients with the longest life expectancy, to save the most life years

Do not prioritise anyone according to age or any other personal characteristic

I don't know/it's too hard to choose **[FIXED]**

Prefer not to say **[FIXED]**

ASK ALL

SINGLE CODE

ROTATE ANSWER CODES

Q2

How should decisions be made about resource allocation for COVID patients? Pick the statement that comes closest to your view.

Please select one answer only

There should be a nationwide approach that everyone follows

Local hospitals/geographic areas should be able to set their own approach

Individual medical professionals should be able to make their own choices

SHOW ALL

Thank you for completing this survey. We'll see you again on Monday, September 7.

SURVEY 3 - Results

	Q1	Q2
Person 1	DoNotPri	NatApprch

Person 2	PriLong	LocHosp
Person 3	PriLong	NatApprch
Person 4	DoNotPri	NatApprch
Person 5	DoNotPri	LocHosp
Person 6	PriLong	Individual
Person 7	PriYngMidl	NatApprch
Person 8	_dk	Individual
Person 9	DoNotPri	NatApprch
Person 10	DoNotPri	NatApprch
Person 12	PriLong	Individual
Person 13	DoNotPri	NatApprch
Person 14	PriLong	NatApprch
Person 16	PriLong	LocHosp
Person 17	PriLong	Individual
Person 18	DoNotPri	LocHosp
Person 20	DoNotPri	NatApprch
Person 21	PriLong	NatApprch
Person 22	_dk	NatApprch
Person 23	PriLong	NatApprch
Person 24	PriLong	LocHosp
Person 25	PriLong	NatApprch

SURVEY 4 – September 7

SHOW ALL

A0 CONSENT

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ASK ALL

SINGLE CODE

ROTATE ANSWERS 1-4

Q1

Which statement comes closest to your view about how the NHS should prioritise to who it provides specialist COVID related treatment if resources are limited. The NHS should…

Please select one answer only

Prioritise the young as they should have the opportunity to reach later life stages

Prioritise the young and middle aged as they should have the opportunity to meet their life goals

Prioritise patients with the longest life expectancy, to save the most life years

Do not prioritise anyone according to age or any other personal characteristic

I don't know/it's too hard to choose **[FIXED]**

Prefer not to say **[FIXED]**

ASK ALL

SINGLE CODE

ROTATE ANSWERS

Q2

How should decisions be made about resource allocation for COVID patients? Pick the statement that comes closest to your view.

Please select one answer only

There should be a nationwide approach that everyone follows

Local hospitals/geographic areas should be able to set their own approach

Individual medical professionals should be able to make their own choices

SHOW ALL

Thank you for completing this survey. We'll see you again on Wednesday, September 9.

SURVEY 4 - Results

	Q1	Q2
Person 1	PriLong	LocHosp
Person 2	PriLong	LocHosp
Person 3	PriLong	LocHosp
Person 4	DoNotPri	NatApprch
Person 5	DoNotPri	LocHosp
Person 6	PriLong	LocHosp
Person 7	PriYngMidl	NatApprch
Person 8	PriLong	Individual
Person 9	DoNotPri	NatApprch
Person 10	PriLong	LocHosp
Person 12	DoNotPri	NatApprch
Person 13	PriLong	NatApprch
Person 14	PriLong	LocHosp
Person 16	PriLong	LocHosp

Person 17	PriLong	LocHosp
Person 18	PriLong	LocHosp
Person 20	DoNotPri	LocHosp
Person 21	PriLong	NatApprch
Person 22	DoNotPri	NatApprch
Person 23	PriLong	NatApprch
Person 24	PriLong	LocHosp
Person 25	DoNotPri	NatApprch

SURVEY 5 – September 9

SHOW ALL

A0 CONSENT

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ASK ALL

SINGLE CODE

ROTATE ANSWERS 1-4

Q1

Which statement comes closest to your view about how the NHS should prioritise to who it provides specialist COVID related treatment if resources are limited. The NHS should…

Please select one answer only

Prioritise the young as they should have the opportunity to reach later life stages

Prioritise the young and middle aged as they should have the opportunity to meet their life goals

Prioritise patients with the longest life expectancy, to save the most life years

Do not prioritise anyone according to age or any other personal characteristic

I don’t know/it’s too hard to choose **[FIXED]**

Prefer not to say **[FIXED]**

ASK ALL

SINGLE CODE

ROTATE ANSWERS

Q2

How should decisions be made about resource allocation for COVID patients? Pick the statement that comes closest to your view.

Please select one answer only

There should be a nationwide approach that everyone follows

Local hospitals/geographic areas should be able to set their own approach

Individual medical professionals should be able to make their own choices

ASK ALL

OPEN TEXT

Q3

Considering everything you've heard throughout our discussions - how do you think the NHS should allocate limited resources amongst patients diagnosed with COVID?

SHOW ALL

Thank you for completing this survey and taking part in our four workshops. It is greatly appreciated.

SURVEY 5 - Results

	Q1	Q2	Q3
Person 1	PriLong	LocHosp	First come first served is still be a good option but taking in account the person condition on how likely they will survive.
Person 2	PriLong	LocHosp	I think they should prioritise those that are most likely to survive treatment - that for me should be the highest priority. There doesn't seem to me to be much sense allocating resources to those who are unlikely to survive much beyond treatment.
Person 3	PriLong	LocHosp	I feel strongly that the maximising life years, accounting for health issues is the best principle for creating a guidance framework for doctors. I do think within this the first come, first served principle has significance when it is hard to call decision (i.e. 2 patients with similar life expectancy or similar health issues). Also, I think the doctors medical training and clinical judgement is very important in making any decision, in consultation with the guidance.
Person 4	DoNotPri	NatApprch	I think resources should be allocated to patients with the greatest need. Patients should not be prioritised or discriminated against based on any Protected Characteristics, such as age, sex etc. as described in the Equality Act of 2010. If 2 equally vulnerable patients need treatment the first to arrive should take president as there is no other reasonable way to chose.

Person 5	PriLong	LocHosp	I have selected the principle of maximising life years but I believe it should not be a hard and fast rule. I believe doctors who have acquired years of clinical excellence will make the right choice (although I guess they use maximising life years anyway). Although quality of life is difficult to measure I hope that it would be considered, especially if the patient was conscious enough to be told the truth. I would not want to waste a bed if it was known that my quality of life after would be very poor.
Person 6	PriLong	LocHosp	They should use the maximise lives (or life) principle in the main, with the caveat that this does not discriminate between groups. Possibly first come, first served could be used in cases where both patients have very similar issues. The judgements should all be based on the medical and physical aspects, not on any other quality of life aspects in order to be as fair as possible.
Person 7	PriYngMidl	NatApprch	I still think the individual need to be taken in consideration as a one size fits all does not work. It also needs to be a panel decision and not just one person deciding what happens to the patient
Person 8	PriLong	Individual	I think guidelines should be set that follow the maximising life years principle, but taking into account potential quality of life after recovery. First come first served would be used if there was still a 'close call' after other factors are taken into consideration. However, these should be guidelines only, which are designed to help medical professionals, rather than binding them to set rules when their experience and knowledge might lead them to make a different decision.
Person 9	DoNotPri	NatApprch	I am of the opinion that with the limited resources first come first serve is most ideal and fair to everyone.. However since the COVID is going to be with us for sometime NHS should urgently plan ahead to meet the need of everyone as everyone is entitled to life.
Person 10	DoNotPri	NatApprch	Prioritise saving the greatest number of lives, regardless of patient age.
Person 12	DoNotPri	NatApprch	I'm inclined to go with the Egalitarian principle where you allocate ICU beds on basis of 1st come first served with a mix of vulnerability and survival rate of the patient
Person 13	PriYngMidl	NatApprch	I believe the best chances of survivors with life on an allocated limited resource should be a Principle 1 - Being Maximise life years but also prioritising the vulnerable who are looking at surviving treatment. I also would like to add I hate the thought of anyone elderly not being given the opportunity of potential life saving treatment due to age discrimination. I would also like to add that a change needs to be made in letting loved ones being able to say goodbye to a patient of covid in the correct ppe equipment, without this only causes a greater deal of grief, physical & mental health problems down the line which the NHS is already under strain with.
Person 14	PriLong	LocHosp	People with a good survival rate should be give priority but not to neglect the most valuable.
Person 16	PriLong	LocHosp	It should be allocated to those with the greatest chance of survival in addition to how many years they are expected to live. This is ensure that patients who can survive/recover quicker will get back on their feet quicker to bring in more patients and thus saving more lives and years

Person 18	PriLong	LocHosp	Thank you for the opportunity to take part in this consultation. We think that the NHS should allocate resources amongst patients diagnosed with Covid-19 in the following ways: - The approach should be holistic and layered/tiered e.g. taking into account various factors including chances of survival, vulnerability, frailty and those more at risk of death due to the virus e.g. BAME patients. - The NHS should consider the maximising life principle but take into account that under extreme pressure or new arising issues it mght be fitting to revise or include other principles in a layered and reasonable way i.e. work towards the maximising life principle but also operate a 'first come, first served' (egalitarinism principle) amongst patients who are comparable. Thanks again and we would be happy to participate in any further discussions and also receive information about findings and analysis. Kind regards, Marcia and Jamila
Person 20	DoNotPri	LocHosp	A mixture of first come first served and maximum life expectancy with life quality
Person 21	DoNotPri	NatApprch	We are still in the view that an initial 1st come 1st serve principle is key, and treatment should be available to all to save as many lives as possible. However after initial treatment if a patient doesn't respond to treatment further aggressive treatment should be available to those who have a fighting chance and more predictable life years remaining. This is based on having a fair non-biased approach to 1st come 1st serve.
Person 22	PriLong	LocHosp	Those who need it the most
Person 23	PriLong	NatApprch	They should allocate resources towards the most vulnerable with the longest life expectancy
Person 24	PriLong	LocHosp	By following a dynamic approach regardless of what principle is chosen. Thinking about issues affecting the geography.
Person 25	DoNotPri	Individual	By taking into account future quality of life and likelihood of benefiting from treatment

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Ipsos MORI's standards and accreditations provide our clients with the peace of mind that they can always depend on us to deliver reliable, sustainable findings. Our focus on quality and continuous improvement means we have embedded a 'right first time' approach throughout our organisation.

ISO 20252

This is the international market research specific standard that supersedes BS 7911/MRQSA and incorporates IQCS (Interviewer Quality Control Scheme). It covers the five stages of a Market Research project. Ipsos MORI was the first company in the world to gain this accreditation.

ISO 27001

This is the international standard for information security designed to ensure the selection of adequate and proportionate security controls. Ipsos MORI was the first research company in the UK to be awarded this in August 2008.

ISO 9001

This is the international general company standard with a focus on continual improvement through quality management systems. In 1994, we became one of the early adopters of the ISO 9001 business standard.

Market Research Society (MRS) Company Partnership

By being an MRS Company Partner, Ipsos MORI endorses and supports the core MRS brand values of professionalism, research excellence and business effectiveness, and commits to comply with the MRS Code of Conduct throughout the organisation.

Data Protection Act 2018

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