

healthcare update

Reference guide to consent for examination or treatment – second edition



In light of the Human Tissue Act 2004, the Mental Capacity Act 2005 (MCA), and recent case-law, the Department of Health has amended the guidance in relation to obtaining valid consent to physical examination or treatment. The guidance was published in July 2009 and can be found in full on the Department of Health website at the following link: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643

Importance of obtaining valid consent

It is a fundamental human right that people can determine what happens to their own bodies; therefore, it is crucial to obtain valid consent, or to have other legal justification, before starting treatment or physical investigation. Failure to obtain such consent may result in legal or disciplinary action.

Process of seeking valid consent

All practical and appropriate steps must be taken to enable persons to

make decisions themselves. Valid consent is described in the guidance as consent which is given voluntarily in light of sufficient information by a person with capacity.

Following Chester -v- Afshar [2004] UKHL 41, 'sufficient information' should cover all significant possible adverse outcomes. The guidance recommends making a record of the information given. It would be sensible to routinely send a letter summarising advice given to a patient who is deciding between treatment options, especially where

the effects on the patient's life are potentially serious.

MCA sets out the statutory test for capacity to make a given decision as being whether the person can:

1. Understand the information given;
2. Retain the information for long enough to make a decision;
3. Use or weigh up the information as part of the decision-making process; and
4. Communicate the decision.

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Welcome

Welcome to our autumn edition of the Hill Dickinson healthcare update. We hope you had a wonderful summer – despite the limited sunshine!

While some of us have been off enjoying our holidays, the Department of Health seem to have been particularly busy over the summer, with the publication of the new revised framework on NHS Continuing Healthcare in July, alongside new guidance on consent to treatment.

Meanwhile, the Health Bill continues to wend its way through Westminster, taking on political hot potatoes such as de-authorisation of foundation trusts, and proposed direct payments in lieu of NHS services.

It seems there is a move to extend the rights of patients on one hand, whilst on the other, the reins are being tightened on NHS foundation trusts.

There has also been a flurry of activity in the courts recently with landmark decisions on assisted suicide and NHS treatment for overseas visitors.

Hopefully we have whet your appetite for what is on the menu in this edition. Enjoy!

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There is a presumption that every adult has capacity to make treatment decisions. If there is any doubt as to the person's capacity, this should be formally assessed, using the statutory test. Healthcare professionals should work through each stage of the test in turn, and show evidence of doing so on the consent form or in the patient's notes.

Refusal of treatment

If an adult with capacity and sufficient information voluntarily withholds their consent to treatment, their wish must be respected. A valid and applicable 'advance decision' to refuse treatment has the same force as a contemporaneous decision to refuse treatment. In this respect, the MCA has given 'advance decisions' a statutory basis. For this to be 'valid and applicable', the person must have had capacity to make the decision at the time they made it, be 18 or over, make clear which treatments they wish to refuse, and in what circumstances.

Withdrawing and withholding life-sustaining treatment

There are circumstances where life-sustaining treatment may no longer be beneficial to the patient. A person with capacity may decide either contemporaneously or by a valid and applicable 'advance decision' that they have reached the stage where they want to stop treatment. There are certain additional formalities that must be observed when making 'advance decisions' to refuse life-sustaining treatment, as set out in the MCA. In this scenario, the legal principles in relation to consent are the same as for any other medical intervention.

A patient should not be treated as lacking capacity because he/she makes what might be seen as an unwise decision. Healthcare professionals are not obliged to act against their beliefs, but it is advisable to transfer a patient's care to another



health professional where they find themselves in an ethical dilemma.

Best interests

The guidance sets out how 'best interests' decisions need to be made for those lacking capacity. Specific reference should be made to the statutory 'best interests' checklist at section 4 of the MCA. Healthcare professionals must consider all the relevant circumstances relating to the decision, including the patient's past and present wishes, the patient's beliefs and values, and whether the patient is likely to regain capacity. The patient should be involved as fully as possible in the decision.

There is now a statutory duty for health professionals to consult those

close to the person when making decisions about their 'best interests', unless the professional concludes it is not practical or appropriate to consult. This might include consulting an attorney who was previously appointed by the patient to act on their behalf should they lose capacity in the future. Previously, it was good practice to consult, but there was no statutory duty to do so.

The guidance recommends that where a decision is made on behalf of a person lacking capacity, it should be noted in the records or on a 'patient unable to consent' form why the treatment was decided to be in patient's best interests.

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Court of Protection

If a person lacks capacity to make a decision relating to their personal welfare, the Court of Protection can issue an order making a decision on their behalf. The court deals with cases of serious dispute on 'best interests', where there is no other way of finding a solution or when the authority of the court is needed to make a particular decision. It is recommended by the courts that certain treatment decisions are always put before the court, given their sensitivity e.g. withdrawal of artificial nutrition and hydration in a PVS patient, or non-therapeutic sterilisation by way of hysterectomy.

Alternatively, the Court of Protection can appoint an individual, known as a 'deputy' to make welfare decisions on the court's behalf. This is used relatively infrequently and only where absolutely necessary (e.g. a deputy may be appointed to make ongoing decisions where there is a history of family disputes).

Protection of vulnerable persons

The guidance warns of a new offence under the MCA of ill treatment or wilful neglect of someone who lacks capacity, by someone with responsibility for their care or with decision-making powers.

Furthermore, the MCA introduced a duty on NHS bodies to involve an Independent Mental Capacity Advocate (IMCA) in serious medical treatment decisions when a person who lacks capacity to make a decision has no one close to them who can be consulted. The guidance makes it clear that IMCAs are not decision-makers, but are there to support and represent the person who lacks capacity. They should ensure that decision-making is done appropriately and in accordance with the MCA.

Young people and children

The guidance covers separately the legal position concerning consent and refusal of treatment by those under the age of 18, as this is different to adults. Those aged 16-17 are classed as 'young people' and, like adults, are presumed capable of consenting to medical treatment. However, the refusal of treatment by a young person with capacity may, in certain circumstances, be overridden by the court. It is less clear whether the consent of someone with parental responsibility will be sufficient to override a refusal of consent, and it is recommended that any such cases are referred to the courts, for clarification.

The capacity of a child under 16 to consent to treatment is measured against the 'Gillick competence test', namely whether the child has sufficient understanding and intelligence to enable him/her to understand fully what is involved in a proposed intervention. Where a child lacks capacity, consent can be given by a person with parental responsibility or by the court.

Consent forms

The Department of Health has, at last, issued long-awaited guidance, in the form of an Information Note, specifically to assist trusts in amending consent forms to reflect the new legislation and case-law. This Note works through each section of the various consent forms, recommending changes that should be made to the wording. Examples include the replacement of 'competent' with 'capacity', and the inclusion of the 4-stage test of capacity as set out in the MCA.

A copy of the Information Note can be found alongside the guidance note on the Department of Health website. It would perhaps have been more helpful if the Department had issued revised model consent forms, incorporating the new legal requirements!

The way forward

The guidance recommends that legal advice should always be sought if there is any doubt about the legal validity of a proposed intervention. Please do not hesitate to contact the Hill Dickinson team should a tricky case arise or should you wish to discuss any of the above in more detail.

We would recommend that all trusts review the new guidance and Information Note carefully and adapt current policies/revise consent forms to ensure compliance. Furthermore, appropriate training should be put in place to ensure that all healthcare staff are aware of the recommendations and any policy changes.

It is important to bear in mind that the new guidance is only an interim stage in the Department of Health's overall review of consent in the NHS. It is anticipated that the review will identify and evaluate the approach to gaining consent and the impact of existing Department of Health guidance and forms. The review will also explore the process by which best practice for obtaining consent can be developed, enhanced and embedded across the NHS. Watch this space...

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Triumph in the House of Lords – law on assisted suicide to be clarified

In our April edition, we reported that Debbie Purdy's plea to the Court of Appeal to clarify the law on medically assisted suicide had been rejected. You may recall she was concerned that her husband, Omar Puente, may face criminal charges if he accompanied her to the Dignitas Clinic in Zurich where she would end her life. Ms Purdy had sought to argue this was in breach of her right to respect for private and family life under Article 8 of the European Convention on Human Rights. Lord Pannick QC had submitted on her behalf that the Director of Public Prosecutions (DPP), Keir Starmer QC, should be required to issue specific policy guidelines to clarify the law on assisted suicide.

However, the House of Lords have now confirmed Ms Purdy's entitlement to clarification in a landmark decision. This overrules the previous decision in the case of The Queen on the Application of Mrs Diane Pretty [2001] UKHL 61 by confirming that Article 8 is engaged in these circumstances. The ruling requires the DPP to state when action would be taken against those who assist another to commit suicide, with new guidelines to be issued as a result. Mr Starmer has recently issued draft guidelines for public consultation concluding on 16 December 2009. Permanent guidelines are currently expected in spring 2010, following the consultation process.

The draft guidelines contain a checklist of public interest factors, sixteen in favour of prosecution and thirteen against, which must be taken into account, and applied to the individual facts of each case, in deciding whether to mount a prosecution.

The factors in favour of prosecution include where the victim is under eighteen years of age, suffering from a mental illness, or where there is evidence they have been persuaded, pressured or maliciously encouraged by the suspect to commit suicide.

The factors against prosecution include where the victim had a clear, settled and informed wish to commit suicide, where the victim was suffering from a terminal illness or a severe and incurable physical disability or a severe degenerative physical condition, from which there was no possibility of recovery. Further, it is clear that the suspect must have been wholly motivated by compassion.

For full details of the guidelines see http://www.cps.gov.uk/consultations/as_policy.html.

In reaching the decision, particular emphasis was placed on the decision letter issued in the recent case of Daniel James, in which the DPP, when considering their discretion as to whether to prosecute his parents, had found that many of the factors listed in the Code for Crown Prosecutors were irrelevant and that there were other factors to be considered in such cases.

However, Lords Hope and Neuberger indicated that it was not part of their function to change the law to

decriminalise assisted suicide which remained a matter for parliament. Thus, at present, assisting another to commit suicide remains a criminal offence under section 2(1) of the Suicide Act 1961, punishable by imprisonment for up to 14 years. The decision as to whether to prosecute in individual cases remains at the discretion of the DPP.

Hopefully the guidelines, once finalised, will provide legal clarity for Ms Purdy, one way or another.

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Freedom of Information Act 2000 complaints and SUIs: what should you disclose?

Two recent decisions of the Information Commissioner have provided important clarification concerning Freedom of Information Act 2000 (FOIA) requests for information relating to SUIs/complaints and how NHS trusts should deal with them.

[Information Commissioner's Office Freedom of Information \(section 50\) Decision Notice dated 14 July 2009 Reference F550222757](#)

The Information Commissioner upheld a complaint about how a FOIA request had been dealt with where an NHS trust had denied holding information which clearly was in their possession.

Background

The complainant had requested copies of statements taken from key members of NHS staff during the course of the trust's investigation of a complaint she had made. The trust's response indicated the information requested was not held and could not be provided. This was on the basis that formal statements had not been taken during the investigation process, although interviews with relevant staff had been conducted and "rough working notes" taken at the time. Once a final draft of the complaint response letter had been produced, these notes had been destroyed. Some additional documents were identified for disclosure as coming within the scope of the request and provided to the complainant.

Decision

On review of the complaints file the commissioner identified documents which included statements from the Matron for the Elderly Care Ward and the Matron for General Surgery, dealing with issues raised by the complainant concerning nursing care

at the hospital. Consequently, the commissioner held that the public authority had incorrectly denied it held "statements" as requested by the complainant.

The trust was required to issue a further response within 35 days pursuant to sections 1 (1) and (2) of the FOIA either disclosing copies of the statements or providing an adequate refusal notice if relevant exemptions were considered applicable.

Additionally, it was noted that the trust's response to the FOIA request was out of time as it had not been provided within 20 working days, contrary to section 10 FOIA.

Although they do not form part of the Decision Notice, the commissioner highlighted the following issues of concern:

- The trust should have clarified the nature of the "statements" requested prior to deciding whether the information was held or not. A description of the nature of the documents held in the complaints file should have been provided to allow the complainant to confirm whether she considered they were captured by her request.
- A written expression of dissatisfaction from the complainant should have triggered an internal review and been treated as a review request.
- It would be good practice for an

internal review to be completed in 20 working days under the terms of the 'Freedom of Information Good Practice No 5' (there was criticism that the review instigated took 44 working days to complete). Where there are any exceptional circumstances causing delay this should be clearly communicated to a complainant and the review should then be completed within 40 working days.

- The commissioner did acknowledge that the FOIA request was made inbetween a lengthy and complex complaint concerning the complainant's late mother's care but expected the trust, in future, to separate these issues and address the FOIA request in accordance with the relevant provisions.

[Gallaway -v- IC \[2009\] UKIT EA 2008 0036 \(20 March 2009\)](#)

The appellant, Mrs Gallaway, appealed to the Information Tribunal concerning a decision not to provide staff witness statements related to the investigation of a Serious Untoward Incident (SUI) involving her husband, following his death. The statements were summarised in an SUI report disclosed to her, following a FOIA request. Prior to the introduction of the FOIA she had made a previous request for the staff statements, which had been refused. The trust maintained that the statements could not be disclosed because section 40 (concerning personal information) and section 41

(information provided in confidence) of FOIA applied to them.

Further discussion took place between the parties concerning whether the statements could be sufficiently redacted to make them anonymous. There was a further letter from Mrs Gallaway disputing the decision treated as a request by her for an internal review, in accordance with the Commissioner's Good Practice Note. Approximately one month later the trust informed Mrs Gallaway that the review had upheld their original decision. It was held that the report previously disclosed to the complainant adequately set out the events surrounding the SUI and provided sufficient information extracted from the witness statements to enable an understanding of the actions of the staff.

Mrs Gallaway complained to the Information Commissioner. A Decision Notice was issued following a review, confirming the witness statements had been correctly withheld under section 40 FOIA and constituted "personal data" because members of staff were referred to by name and job title, with details concerning their actions and opinions in the documents. It was not possible to redact information to a level that would make the statements anonymous.

Appeal to the tribunal

On initial review, the tribunal did not consider that section 40 applied to such an extent that all the requested information could be withheld. The tribunal directed the parties to attend a hearing to argue their case further. The appellant submitted the information concerned did not constitute "personal data" because it would be possible to redact specific sections of the documents. Alternatively, it was consistent with the principles of FOIA to employ an independent person to "interpret" the statements without revealing the

identity of the member of staff who had provided the information. The trust submitted a reasoned response to the effect that some disclosure had been made and disclosure of the statements might compromise the effectiveness of future investigations because staff would be aware their statements were potentially disclosable. This might impede full and frank disclosure by staff and damage the prospects of establishing the root cause of an incident. Thus, the tribunal had to consider the competing public interests; on one hand in maintaining the confidentiality of the information and on the other, the public interest in favour of disclosure within the spirit of FOIA.

Decision

The tribunal confirmed the public interest in not disclosing the statements outweighed the public interest in disclosing them in this case. However, the weight of the competing interests required consideration based on the facts of an individual case. If disclosure of statements would assist in establishing the

truth of a matter or an SUI report failed to summarise the statements adequately, this could indicate that the public interest in ensuring a trust performed its functions properly outweighed the public interest in protecting confidential information by withholding the statements.

Further points of interest

The tribunal confirmed that where a family had queries they wished to raise concerning an SUI, it might be helpful for the investigative team to invite them to submit specific questions they wished the investigation to address.

The tribunal concluded that the risk of prejudice related to disclosure of statements concerning an SUI was high and that it was of primary importance that investigations were able to gather full facts to establish the root cause of an SUI. Where this was a compelling factor on the individual facts of the case, this would be capable of justifying the balance of interest in favour of non-disclosure.

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Summary

These decisions confirm it is important to consider all relevant factors when dealing with a FOIA request, to ensure compliance with law and good practice. When dealing with an individual who remains dissatisfied, we recommend seeking specific confirmation of the nature of the information sought under the FOIA request as part of the review process. When dealing with disclosure related to serious untoward incidents, care should be taken to evaluate the competing public interests at

stake. The decision in Galloway is helpful in highlighting that there will be circumstances where the nature of the information requested may mean the balance of interests weighs in favour of maintaining confidentiality to protect the rights of staff members and to ensure that full and frank SU1 investigations are conducted. Nevertheless, the balance of competing interests must be considered carefully in each case.

If you would like to discuss any issues arising from these recent decisions please contact:

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If you have any training needs associated with FOIA requests or dealing with complaints/SU1s we can arrange training geared to your individual needs.



The Data Protection Act 1998 (the Act) requires all organisations processing personal data to notify the Information Commissioner of their data processing activities, unless they fall within an exemption under the Act. Such exemptions are limited and are unlikely to apply to NHS trusts.

Failure to notify is a criminal offence; until now, notification cost £35 per year and no distinction was made for the size, turnover or nature of the organisation making the notification. All that is set to change.

With effect from 1 October this year, organisations with a turnover of £25.9 million or more and 250 or more staff were required to pay an annual fee of £500. The higher fee of £500 also applies to public authorities with 250 or more staff, which makes it highly likely that most NHS trusts and bodies will be affected and be required to pay the increased fee.

The fee has not changed since 2000; according to an explanatory memorandum issued by the Ministry of Justice at the same time as the (rather catchily titled) Protection (Notification and Notification Fees) (Amendment) Regulations 2009, the higher fee payable

“reflects the amount of resources invested by the [Information Commissioner] in regulating large data controllers”. The extra income generated will also, of course, assist the Information Commissioner in its work generally.

NHS trusts need to be aware of this change, and ensure that they are paying the correct amount. It is likely that a trust will need only one notification, but in the event that a trust has any associated or subsidiary companies, it should bear in mind that unless those companies have a turnover of £25.9million or more and more than 250 staff, they should only pay a fee of £35.

For detailed advice on how these regulations might affect your organisation, please contact Shelley Thomas at shelley.thomas@hilldickinson.com or Emma DiGiacomo at emma.digiacom@hilldickinson.com.

Litigation update

The following recent cases will hopefully be of some interest:

[FP -v- Taunton & Somerset NHS Trust \(2009\) - interim payment](#)

The High Court made an interim payment of £1.2 million in a claim for wrongful birth of a severely disabled child where a cautious view of the evidence justified taking the age of 20 in respect of life expectancy and where there was an immediate need for new accommodation appropriate for the child's disabilities.

[Smith -v- L C Window Fashions Ltd \(2009\) - calculation of lifetime multiplier](#)

The court used Table 1 of the Ogden Tables to determine a lifetime multiplier to be used in its assessment of future damages to be awarded to a claimant for personal injuries. In this case it had been agreed that the claimant's life expectancy had been reduced by 6.5 years.

[Cunningham -v- AST Express Ltd \(2009\) - costs order when defendant's offer not beaten](#)

The Court of Appeal ordered that where a claimant had failed to better an offer made by the defendant in the proceedings, the correct order was for the defendant to pay the claimant's costs until 21 days after the offer to settle had been made and thereafter for the claimant to pay the defendant's costs. The Court of Appeal overturned the decision of the Lower Court which had ordered the defendant to pay half of the claimant's costs from the date of the offer.

[Onay -v- Brown \(2009\) - costs impact of an offer to settle liability](#)

The Court of Appeal held that although an offer made by the defendant in a personal injury action to settle liability on a 75/25 basis in the claimant's favour made no mention as to costs of the contributory negligence issue, the offer was and was intended to be an offer under Part 36. The claimant was therefore entitled to costs under CPR Rule 36.10(1) where the offer was accepted.

[Anita Shah -v- \(1\) Wasim UI-Haq, \(2\) Samara Khatoun, \(3\) Zahida Parveen \(2009\) - The Times 14 July 2009 - fraud](#)

A claimant was not to be deprived of damages that he was entitled to under his own genuine claim in a personal injury case simply because he had supported a fraudulent claim made by another person.

[\(1\) Richard Rabone \(in his own right and as personal representative of the estate of Melanie Rabone\), \(2\) Geillian Rabone -v- Pennine Care NHS Trust \(2009\) - no operational obligation for voluntary mental patient](#)

The High Court held that an NHS trust had no operational obligation under

the European Convention on Human Rights 1950 Article 2 in respect of a patient who committed suicide after being allowed to leave the hospital. The patient was a voluntary mental patient who was not detained under the Mental Health Act 1983 and had capacity to become and remain an informal patient.

[David Charles Middleton -v- \(1\) Vosper Thornecroft \(UK\) Ltd, \(2\) Chloe Trading Ltd, \(3\) Associated British Ports, \(4\) Stuntbrand Mail Steamship Co Ltd, \(5\) Fyffes Ltd \(2009\) - success fee/costs](#)

A claimant's Statement of Reasons justifying the calculation of a success fee under a Conditional Fee Agreement following the settlement of his personal injury claim was not a sufficient Statement of Reasons for the purposes of the CPR. It had not been identified as a proper Statement of Reasons and did not have the appearance of one. Accordingly the costs judge had been correct to disallow the success fee claimed.

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Quantum update

Please find below a number of recently reported cases which will hopefully be of help when valuing claims:

James Pankhurst -v- (1) Lee White, (2) Motor Insurance Bureau June 2009 – tetraplegic

A 48 year old man was struck by a car whilst riding his bicycle. The High Court awarded him £225,000 general damages for his pain, suffering and loss of amenity on the basis that although he was rendered C4 tetraplegic he did not fall to be compensated at the top of the relevant bracket under the JSB Guidelines because of the absence of any effect on his senses or ability to communicate and the fact that he was independently extremely mobile in his electrically operated wheelchair (High Court).

(1) C, (2) P -v- Nottingham City Hospital NHS Trust – January 2008 – pathological grief reaction

The claimants were the mother (C) and father (P) of a baby who died in December 2003 shortly after being born. The mother had suffered a ruptured uterus and there was delay in performing a caesarean section such that, when eventually delivered, the child was in very poor condition and died shortly afterwards. Both mother and father (whose ages were not specified) developed a pathological grief reaction. They were diagnosed as suffering from mixed anxiety and depressive reactions. Both were still adversely affected approximately four years after the accident. General damages were £30,000 for each claimant (out of court settlement). A further £1,000 general damages was for the child's pain and suffering (out of court settlement).

Pamela Robinson -v- Lancashire Teaching Hospitals NHS Foundation Trust – October 2008 – laparoscopic cholecystectomy

A 46 year old lady underwent laparoscopic cholecystectomy in October 2003. She suffered post-operative complications including jaundice, cholangitis, development of a low-output faecal fistula, a small intra-hepatic abscess and an incisional hernia. She required two further operations to deal with biliary peritonitis and to reconstruct her biliary tree. Following the accident the claimant was unable to work and there was a measurable risk that she would suffer adhesive intestinal obstruction, future recurrence of the incisional hernia, anastomotic stricture, ascending cholangitis, cirrhosis of the liver, infection and sepsis. General damages were £65,000 as a provisional damages award with the claimant able to return for a further award if any of the serious deteriorations identified above arose out of her condition (out of court settlement).

J -v- Birmingham Women's Hospital NHS Trust – February 2008 – cerebral palsy

The claimant, a girl, was delivered by induction in January 2002 but suffered from a lack of oxygen during the final 20 minutes of labour. The mother's uterus had been overly stimulated and subsequently ruptured. The claimant suffered anoxia until she was delivered by caesarean section. She suffered cerebral palsy affecting all four limbs, a marked delay of development and microcephaly. General damages of £200,000 were approved by the court.

Patsy Field -v- Lewisham Hospital NHS Trust – January 2009 – shoulder dystocia

The 14 year old girl claimant (newborn at date of accident) suffered a right sided brachial plexus injury graded as a Group 2 lesion affecting C5, C6 and C7 cervical nerves. At eight months old she underwent surgery to repair the brachial plexus by grafting and when she was six years old she underwent muscle transfer surgery. She developed curvature of the spine consequent on the brachial plexus injury and her right arm was shorter and thinner than her left arm. Provisional general damages were approved by the court at £70,000 with the claimant retaining the right to return to court until her 21st birthday to claim further damages should her spinal curvature progress to a level where she required a brace with neck extension or surgery.

K -v- Sandwell & West Birmingham Hospitals NHS Trust – July 2008 – death following pneumothorax

The claimant's son suffered a pneumothorax and died in September 2006. General damages were agreed at £3,000 (out of court settlement).

(1) DH, (2) MT (as Administrators of the Estate of BT, deceased) -v- East Lancashire Hospitals NHS Trust – April 2008 – psychiatric injury following death of child

The claimant was the mother of a newborn daughter who died following a failure to diagnose a ruptured abdominal scar and immediately carry out a caesarean section. She was 29 years old at the time of the incident and lost her daughter. She suffered a post-traumatic stress disorder requiring counselling. General damages were agreed at £25,000 (out of court settlement).

(1) Mr F, (2) Mrs F -v- Lancashire Teaching Hospitals NHS Foundation Trust – March 2008 – psychiatric injury

The claimants were the parents of a child who died aged ten and suffered psychiatric injuries as a result of seeing their daughter's health deteriorate over approximately 60 hours resulting in her death. Both mother and father were aged 37 at the time of the incident. The mother suffered a depressive episode with features of post-traumatic stress disorder; the father suffered a pathological grief reaction but was able to deal with the grief better than the mother. The total damages represented approximately 70% of the value of the claim with 30% representing the risks of litigation. Most of the award was paid to the mother to compensate her for her psychiatric injuries and past and future loss of earnings. General damages were £35,485 (out of court settlement).

B -v- Birmingham Heartlands and Solihull Hospitals NHS Trust – December 2008 – dominant wrist and hand

The claimant, a 48 year old woman at the time of the incident, underwent carpal tunnel decompression but subsequently suffered from swelling of the right hand, hypersensitivity of the wrist and a weak grip in her dominant hand. At the time of settlement she continued to require help and assistance when carrying out tasks involving heavy items. Her condition was not expected to improve. General damages were £12,500 (out of court settlement).

H -v- Maidstone & Tunbridge Wells NHS Trust – February 2009 – hip operation/shortening of leg

The female claimant aged 88 at the time of the incident had fractured her hip in a fall. She underwent hemi-arthroplasty but the prosthesis broke through the bone and protruded through the inner thigh. She needed a girdlestone procedure to remove the implant and there was an initial

two day delay in diagnosing the hip fracture. The revision surgery resulted in her leg being shortened causing a permanent disability and restricting her mobility. She became housebound and dependant on her family and professional carers. Prior to the accident she had a minor disability but it was believed that as a result of the negligence her level of disability had advanced by five years. General damages were £37,000 (out of court settlement).

D (deceased) -v- Mid Cheshire Hospitals NHS Trust – November 2008 – death following substance inappropriately administered orally

An 82 year old lady died in February 2007 after having been given medicine orally which should have been used externally to wash her leg ulcers. General damages were £3,700 (out of court settlement).

X -v- Hammersmith Hospital NHS Trust – November 2008 – failed kidney transplant

A 48 year old lady underwent a kidney transplant in January 2004 which failed leaving her with one kidney. She had to maintain kidney function artificially but was unable to tolerate haemodialysis and so commenced peritoneal dialysis, undergoing this every four hours. She suffered symptoms including pain and fatigue and as a result of her disabilities required assistance from her family. She suffered psychological symptoms. Her life expectancy and chance of finding another donor were reduced. General damages were £100,000 (out of court settlement).

B -v- Hounslow Primary Care Trust – December 2008 – gauze pack left in surgical wound

A 37 year old lady had an operation in July 2005 and a gauze pack was left in the wound. The wound discharged large amounts of pus and she suffered pain, having to undergo an additional operation to remove the gauze. Her back was scarred and she

suffered increasing pain over the eight weeks following the initial operation and further pain for four weeks while she recovered from the second operation. She also suffered emotional pain and distress amounting to post-traumatic stress disorder. She had a pre-existing psychiatric vulnerability. General damages were £10,000 (out of court settlement).

H -v- County Durham & Darlington NHS Foundation Trust – March 2009 – delay in diagnosing breast cancer

A lady, aged 47 at the time of the incident, suffered prolonged pain and suffering because of failure to carry out a mammogram and subsequent delay in diagnosing breast cancer. She required a mastectomy and was later diagnosed with metastatic bone disease but the delay did not have a significant impact on her prognosis or life expectancy. General damages were £10,000 (out of court settlement).

B -v- Royal United Hospital Bath NHS Trust – November 2008 – failure to diagnose tear of achilles tendon

A 43 year old man tore his achilles tendon. It was not properly diagnosed when he first attended hospital and he subsequently required surgery and a below-knee cast. General damages were £5,500 (out of court settlement).

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Duties of NHS bodies to prevent patient suicide - what is meant by “real and immediate risk to life”?

Clarification concerning the interpretation of the “real and immediate risk to life” test established in [Savage v South Essex Partnership NHS Foundation Trust](#) has now been provided in the case of [Rabone and Pennine Care NHS Foundation Trust](#).



The December 2008 decision in [Savage](#) summarised the obligations of health authorities under Article 2 of the European Convention on Human Rights, which concerns right to life, and imposed an additional “operational” obligation on health authorities and their staff to perform adequate risk assessments of vulnerable patients to assess whether there was a risk of suicide. Health bodies had a duty to take steps to mitigate the risk of suicide, where it was assessed as being a “real and immediate risk”.

Judgment handed down in [Rabone](#) examined the operational obligation under Article 2 of the Human Rights Act 1998 (HRA 1998) and clarified the interpretation of the “real and immediate risk” test.

Facts

The case concerned a claim brought by Mr and Mrs Rabone following the suicide of their daughter after she had been discharged from the defendant’s hospital on two days’ home leave at her own request.

She had been admitted to the hospital following suicide attempts and had been treated for severe depression. She was not detained under the Mental Health Act 1983 (MHA).

A claim for clinical negligence was brought on behalf of the daughter’s estate pursuant to section 7 of the Human Rights Act 1998 (HRA), alleging that the hospital had failed to comply with its obligations under Article 2 of the European Convention on Human Rights (ECHR). The trust

admitted breach of its common law duty of care and this element of the claim was compromised. They continued to defend the HRA claim.

The central arguments concerned allegations that the trust had breached its obligation to take preventative operational measures. The family sought to argue that although the deceased was, as a matter of fact, a voluntary patient, in view of her suicidal tendencies she should properly have been detained under the MHA. Systemic failure was also alleged on the basis that a risk assessment should have been performed prior to agreement of home leave and that there had been a failure to properly investigate the death.

Additional arguments were raised concerning limitation because the claim was brought out of time (four months after the expiry of the one year limitation period under the HRA).

Decision

The judge found for the defendant on each issue, confirming that, whilst all hospitals assumed responsibility for safety and treatment of patients, an operational duty under Article 2(1) did not always arise. An operational obligation applied only to “detained mental patients”. He considered there to have been a real but not immediate risk of suicide in this instance. This risk needed to be measured against what steps could be considered reasonable to avoid it. Regard also had to be paid to the patient’s personal autonomy.

On the facts, this fell far short of a failure by the trust to provide a system for the assessment of risk of suicide of mental health patients. Irrespective of the fact that the standard risk assessment forms had not been used in this instance, a proper system of work existed and, therefore, the trust had complied with its obligations.

Where there is a remedy under another statute, such as the Law Reform Act, and this claim has been settled, the claimant cannot constitute a ‘victim’ under the HRA. The court declined to extend the limitation period, although it had been established the action could not succeed in any event.

Implications of the decision

The judgment clarifies the fact that a risk of suicide must be both *real and immediate* and account has to be taken of the extent to which steps to avoid any such risk can be considered reasonable. Again, a ‘common sense’ approach is to be taken in the circumstances.

The operational obligations on health authorities and staff concerning risk assessment can be defined more narrowly than originally envisaged by the decision in Savage to apply to detained mental patients only. This is a helpful indication, particularly in the context of inquests or investigation of serious untoward incidents.

Likewise, it is of note that settlement of other civil claims by the family is likely to represent a bar to an HRA claim being made successfully.

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Ministry of Justice Annual Summary Report relating to Rule 43 reports under the Coroners Rules – statistics, trends and lessons to be learned?

With effect from 17 July 2008 the Coroners (Amendment) Rules 2008 amended Rule 43 of the Coroners Rules 1984.



The amended Rule 43 provides that:

- coroners have a wider remit to make reports to prevent future deaths. It does not have to be a similar death;
- a person who receives a report must send the coroner a written response within 56 days;
- coroners must provide interested persons to the inquest and the Lord Chancellor with a copy of the report and the response;
- coroners may send a copy of the report and the response to any other person or organisation with an interest;

- the Lord Chancellor may publish the report and response, or a summary of them; and
- the Lord Chancellor may send a copy of the report and the response to any other person or organisation with an interest .

In July of this year, following the introduction of the above change in legislation, the Ministry of Justice published its first annual summary of such reports and responses under Rule 43 of the Coroners Rules. This document can be viewed at <http://www.justice.gov.uk/publications/docs/rule-43-bulletin-06-07-2009->

web.pdf. The summary includes a table setting out the number of Rule 43 reports issued by each coroner jurisdiction, details of organisations that have failed to provide responses in accordance with the 56 day time limit and a list of all Rule 43 reports received in the period reviewed. However all reports and responses are not listed in full.

Statistics

During the period reviewed coroners in England and Wales issued R43 reports in a total of 207 inquests, 28% of which accounted for hospital deaths (58 reports). 19% related to circumstances surrounding road deaths (39 reports) and 10% related to accidents at work or health and safety issues (22 reports). The coroner for Greater Manchester South issued the most reports by a single jurisdiction during this time (18 reports). NHS hospitals and trusts topped the table setting out the most common recipients of reports.

Trends

This is to be considered in further detail in future reports. However particular mention is given in this issue with respect to the NHS context, the need for better communication and procedures within hospitals. In terms of those reports that potentially have a wider (rather than local) impact the following issues are also highlighted in the summary:

- In a hospital death case where the deceased had died as a result of an allergic reaction to his antibiotics, the coroner wrote to the DoH raising concerns about the absence of a national allergy service which he believed needed to be addressed. The reply from the DoH advised that a pilot allergy centre was being trialled in the North West, which would be evaluated and thereafter could be used as a model to be rolled out to other regions.
- In a case where a patient was erroneously given a lidocaine overdose, the coroner wrote to the National Patient Safety Agency asking that distinctive marking be placed on intravenous bags to avoid confusion between those bags that contained drugs or fluids. The NPSA in its response set out steps that had already been taken to reduce risk in this area.

Comment

This and future annual summaries will hopefully prove to be a useful tool in assisting organisations such as NHS trusts and other healthcare providers, in learning lessons from previous untoward incidents nationally in order to minimise risks to patients and service users in the future. With the introduction of this report and particularly the arguably 'name and shame' aspect to it, it remains ever more important that trusts and other healthcare providers/commissioners adequately prepare for inquests, investigating such untoward incidents at an early stage so as to identify any steps required to minimise risks to future patients. It is essential such information is shared with the coroner in advance of any hearing, in order to avoid a R43 report being issued and that in complex cases legal advice is obtained at an early stage.

It should also be noted that the existence of such annual reports will make it much easier for coroners or those representing the families of the deceased, to identify trends where appropriate action has not subsequently been taken, or properly audited to see whether the actions are effective. Such evidence may then be used to put together a case for either a system neglect or corporate manslaughter (unlawful killing) verdict at future inquests.

Top tips

- Does your organisation have a senior person who is responsible for coordinating all inquests and feeding back any concerns highlighted to the trust board?
- Diarise the date for response to an R43 report and act expeditiously; if there is insufficient time to respond, seek an extension from the relevant coroner.
- Investigate any untoward incidents thoroughly at an early stage in order to identify any lesson learning steps that need to be taken, and share that information with the coroner to prevent a R43 report being issued.
- Carefully consider how any response to an R43 report is drafted and consider seeking legal advice, as this response could be published in future.
- Are systems in place together with a named, accountable senior individual, to adequately monitor the auditing of actions following all SUIs, to ensure the steps recommended are being followed and effective?

Hill Dickinson provides a comprehensive service at all levels in relation to inquests, including staff support and training. If you would like any information about this please email rebecca.fitzpatrick@hilldickinson.com or kristina.taylor@hilldickinson.com.

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Current issues in NHS Continuing Healthcare

Following our recent health insight on the NHS Continuing Healthcare (CHC) redress cases making the headlines, Joanna Crichton explores the issue of continuing care redress in more detail, and the somewhat daunting budgetary implications that may occur for PCT bodies.

CHC redress

There has been a lot of publicity recently surrounding cases of patients who have succeeded in claiming they were wrongly refused CHC funding by their local PCT, when their needs were assessed under the CHC eligibility criteria. This effectively meant they funded their own care, in some cases amounting to thousands of pounds. Through the local review panel process/Independent Review Panels convened by Strategic Health Authorities, those eligibility decisions have been challenged, and where successful, the claimant has been reimbursed for the care home fees

they paid, which should have been funded by the NHS. Reports suggest that there are many more similar cases waiting in the wings, with potentially millions of pounds worth of liability for PCTs.

We recently reported on the case of Judith Roe, an Alzheimer's sufferer from Worcestershire. Following her death, the Health Service Ombudsman disagreed with the PCT's decision that she was not eligible for CHC, and recommended that her family receive £130,000, the amount that she had paid in care home fees over a period of six years. Mrs Roe felt that she had no choice but to sell the family home

to pay for her care home fees.

Claims for other financial losses

In addition to claims for reimbursement of care home fees, which may be significant, PCTs are also facing claims for financial losses such as the premature sale of a property and interest, together with claims for non-financial losses such as distress and inconvenience. The Parliamentary & Health Service Ombudsman issued a report, in February 2007, entitled 'Retrospective continuing care funding and redress' recommending that the Department of Health issue clearer guidance to PCTs

as to their responsibilities in this area, and their powers to make ex gratia payments in respect of financial losses, where appropriate.

The Department of Health promptly published guidance, in March 2007, entitled 'NHS Continuing Healthcare: Continuing Care Redress'. The guiding principle for PCTs in using their discretion to make ex gratia payments is whether the financial loss incurred is demonstrably attributable to the PCT's wrongful decision on eligibility and the claimant must provide evidence of that loss.

In many cases, families allege that a property was sold prematurely to pay for care home fees and claim that this has led to a financial loss. The argument goes that the property would have increased in value over time so that if it had been sold at a later date, as planned, they would have secured a much higher price. However, there are arguments to the contrary, which may be applicable in a particular case. Is there evidence that the property would have increased in value, over the period claimed? This is particularly pertinent in the face of the unexpected downturn in the property market over the last year or so.

Indeed, the Ombudsman has said it would be unreasonable for the NHS to be held responsible for the vagaries of the housing market, which is a view shared by the Department of Health. It will be interesting to see whether families continue to raise this argument, given the recent slump in the housing market. In some cases, people may in fact have benefitted from having sold their property earlier than planned, before the 'credit crunch' took hold!

When facing such claims, PCTs should consider whether the family had other options available to them such as entering a Deferred Payment Agreement with the local authority, or renting the property to accrue income to pay the care costs. In these circumstances, we would argue that

patients and families have a duty to mitigate their losses, and should seek financial advice.

Legal challenges to CHC decisions

A firm of solicitors in Wales, Hugh James, have been attempting to establish a novel claim in the law of restitution/negligence for individuals who remain dissatisfied with PCT decisions regarding eligibility for CHC. A number of legal claims have been issued in the High Court in the last few years. Broadly, the claimants alleged that the PCTs had been negligent in assessing their needs and/or had wrongly applied the CHC eligibility criteria, and claimed damages for their resulting financial losses.

In a test case decision, (Jones -v- Powys LHB and Neath LHB [2008] EWHC 2562), it was held that issuing a claim for restitution/negligence was not the correct legal route to challenge CHC decisions and that claims should be brought by judicial review. Furthermore, that before bringing a JR claim, claimants should exhaust other remedies such as the local review panel process, and the next tier of resolution (Independent Review Panel/Special Review Panel). There are arguments that claimants should not recover their costs if they have sought legal redress without first exhausting the statutory panel process of (R (on the application of Mr Kemp) -v- Denbighshire LHB and Powys LHB [2006] EWHC 1339).

Direct payments for CHC - the future?

The Health Bill 2008-2009, currently working its way through parliament, contains provision to allow the NHS to make direct payments to individuals in lieu of healthcare services which the NHS has an obligation to provide. This will be by way of a pilot scheme. The advantage of direct payments is that it allows individuals the freedom to choose their preferred care provider. This supports their right to privacy, as provision of personal care,

can by its very nature be intrusive on the individual's privacy and bodily integrity.

Direct payments for healthcare services are not permitted under current legislation, with the existing regulations only applying to the context of social care services. PCTs often face complaints when a patient's needs change such that they become eligible for CHC. They effectively lose their right to choose how their care is provided. Understandably, it can be difficult for people to accept that they no longer have the level of control over their care that they previously enjoyed. The bill is due to come before parliament again on 12 October and the detail of the pilot scheme will be contained in regulations. Watch this space!

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Revised National Framework for NHS Continuing Healthcare – are you up to speed?

In July, the Department of Health issued a Revised National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care. The Revised Framework, effective from 1 October, replaced the previous version published in June 2007.



The thrust of the Revised Framework is to provide greater clarity around the processes and procedures already in existence and to outline new legislation and guidance. The guiding principle of eligibility for NHS Continuing Healthcare (CHC), the 'primary health need' test remains unchanged.

One point of particular interest for our clients is the guidance on the responsibilities of PCTs where a finding of non-eligibility for CHC is being challenged via the panel review process. Annex E, paragraph 12 of the revised framework, reads:

"The eligibility decision that has been made is effective while the independent review is awaited."

This could be interpreted to run contrary to the position under the previous framework which stated, at Annex E, paragraph 8:

"While this review procedure is being conducted, the PCT should continue to fund appropriate care. Any existing care package, whether hospital care or community health services, should not be withdrawn under any circumstances until the outcome of the review is known."

This section is notably absent from the revised framework. On the face of it, this could imply that the PCT no longer has to continue to fund a placement where it has assessed a patient as not being eligible for CHC, pending a

decision of the local review panel/the Independent Review Panel. In some cases, the review process can take months to conclude which would leave the claimant without funding for their care for potentially a significant period. In view of the potential legal risks associated with withdrawing funding in these situations, we sought further clarification from the Department of Health. The Department has confirmed that funding for NHS Continuing Healthcare should **not** be withdrawn under any circumstance until the outcome of the review by the Independent Review Panel is known, or at any stage in the appeal process prior to this.

Other significant changes include:

- A new category of “other significant care needs” has been added to the care domains of the Decision Support Tool. This should be used when the needs of the patient are not easily categorised, allowing these needs to be taken into account when assessing whether a person has a primary health need.
- Guidance is provided on the duties of PCTs and LAs when a person refuses to consent to all, or part of the assessment process.
- Reference is made to the Mental Capacity Act 2005 and the associated Code of Practice. In particular, guidance is provided on dealing with people appointed as a Deputy by the Court of Protection or those appointed as a Welfare Attorney, as well as guidance on the instruction of an IMCA.
- There is also further guidance on the relationship between after-care funding responsibilities under section 117 of the Mental Health Act 1983 and CHC funding, along with consideration of the Deprivation of Liberty Safeguards, and the transitional arrangements when a person moves from child to adult services.
- There is a reminder that carers providing/intending to provide “substantial care on a regular basis”, should be informed of their right to a carer’s assessment and advised to contact their LA – or, with their permission, directly referred for this purpose.
- It is made clear that assessments should look at all of the individual’s needs ‘in the round’, including the ways in which they interact with one another. The revised framework reinforces that the rationale contained in the written conclusions on eligibility for CHC should not be based on the person’s diagnosis.
- Regardless of whether the individual is determined to be eligible for CHC, PCTs and LAs should always consider whether the assessment of needs has identified issues that require action to be taken e.g. referral to a speech and language therapist.
- A Common Assessment Framework for adults, building on the principles of existing assessment arrangements such as the Single Assessment Process and Care Programme Approach, has been developed. These proposals were subject to a wide consultation between January and April 2009.
- The timescale between a person ‘screening in’ as being potentially eligible for CHC, and the funding decision being made should, in most cases, not exceed 28 days. In acute services it may be appropriate for the process to take considerably less time if an individual is otherwise ready for discharge.
- There is more detailed guidance on the use of the Fast Track Pathway Tool.
- With regard to disputes between PCTs as to the responsible funding body, express reference is made to paragraph 2 of the *Who Pays?* guidance. PCTs should agree interim

responsibilities for who funds the care package until the dispute is resolved. SHAs must also be mindful of their role in resolving disputes, as set out in *Who Pays?*

- Reference is made to other recent guidance published by the Department of Health such as the ‘NHS Funded Nursing Care Practice Guide 2007 and Supporting People with Long Term Conditions: Commissioning Personalised Care’. PCTs are asked to consider the additional guidance, where it is relevant to CHC decisions.

So, for the most part, it is a case of ‘business as usual’ but there are also important changes. It is crucial that PCTs work closely with their LA colleagues to ensure that implementation of the new working procedures runs smoothly!

If you have any queries arising from this article, please do not hesitate to contact:

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Can Green Paper fill £6 billion black hole?

“We know that the money in the system at the moment will not be enough to pay for everyone’s care and support in the future”, announced the government in its Green Paper ‘Shaping the Future of Care Together’ published on 14 July 2009.

The government estimates that there will be a £6 billion shortfall in the national care budget by 2027. Heath Secretary, Andy Burnham has invited us all to join the debate on the proposed National Care Service. The nationwide consultation will conclude on 13 November 2009. The government is committed to publishing a White Paper in 2010.

The government has recognised the need for radical reform of the care system due to the ageing population and higher expectations. There is widespread dissatisfaction with the current system with it being seen as confusing and inaccessible. The distinction between healthcare (funded by the NHS) and social care (funded by the local authority or the individual) is blurred; this has resulted in complaints and litigation.

The key proposal is to develop a National Care Service, which will provide prevention services, fair national assessment, ‘joined up’ services, information, advice, personalised care and support as well as fair funding.

The funding

At present the quality and funding of social care varies between different local authority areas. Often people in need are asked to meet the costs themselves. Many people have to rely on their savings or the equity in their homes up to a threshold of £23,000.

Under the new proposals, the cost of social care will be met in one of three ways:

1. Government funding – the government will fund between a quarter and a third of care costs. There will be more support for those on a low income and this applies to people of all ages.



2. Insurance – the government will make it easier to obtain an insurance policy to fund the extra costs of care. The premium is estimated to cost around £20-25,000. Care provision will only apply to those over retirement age (which will be increased to 68 by 2046).
3. A comprehensive solution – everyone pays into an insurance scheme run by the government and everyone can get free care when they need it.

Accommodation costs will still be met by the individual on the grounds that these apply to everyone irrespective of care needs. To help cover these costs the government proposes to set up a ‘universal deferred payment’

scheme, which means that these costs can be paid after death.

Who is the service provider?

The emphasis on ‘joined-up’ working will be of particular interest to the NHS. The Green Paper envisages a more strategic role for local authorities. It raises profound questions about the balance of responsibilities between central government, local government and the NHS including finance and accountability.

The Green Paper offers examples of how local authorities will interact with the NHS. However, no specific proposals on managing responsibilities and integration have been made. A ministerial group has been established to comment upon

barriers to integration, which will report in 2010.

Nationally defined assessment and eligibility arrangements are likely to change existing arrangements between local authorities and primary care trusts. The national framework will also include plans to standardise services by establishing a body similar to the National Institute for Clinical Excellence to monitor practice and procedure.

Which services will be covered?

The government plans to eliminate duplication between the NHS, local authorities, social housing and benefits agencies. However, it does not seek to reform the legislation governing these services, which remains confusing and difficult to navigate.

They have failed to adequately define 'social care' within the paper. However, as an illustration they state that social care currently provides support for those who need help with everyday activities such as washing, dressing and eating because of older age,

learning or physical/sensory disabilities or long-term illness. This clearly overlaps with some elements of NHS Continuing Healthcare. This is likely to lead to confusion and inter-agency disputes over funding.

The future

The proposals are largely welcomed by the NHS and charitable organisations such as the King's fund. There will be a need for PCTs and local authorities to work together closely in order to create simple understandable access to care, without duplication. In order to get a 'head start' current agreements and protocols should be reviewed to take into account the objectives of the Green Paper.

Hill Dickinson has an experienced team who will be able to provide advice and assistance on this subject.

To have your say, please go to <http://careandsupport.direct.gov.uk>.

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Transforming Community Services - an update

In January 2009, the Department of Health published 'Transforming Community Services: Enabling new patterns of provision.' This document sought to clarify how community services should be 'transformed' by providing guidance to PCTs on the separation of their provider and commissioner functions, in order to develop organisations that were fit for purpose whilst providing greater independence for the provider arms of PCTs, as Jenna Tsai explains.



This guidance provided a deadline for the development of future organisational options for providing community services by October 2009. However, David Nicholson, NHS chief executive, issued a letter through the Department of Health on 30 July 2009 which confirms that this deadline has now been removed. This allows a more flexible approach to be taken on this first issue towards developing PCT provider services. The main motivation for this relaxation in timescales has been the concern

that PCTs were spending too much time focusing on future organisational structures at the expense of delivering service transformation. SHAs are now able to determine their own timetable for PCTs.

Key criteria for SHAs to take into account when setting timetables are the readiness and capability to transform services within a robust approach to delivering quality, innovation productivity and prevention, and the strength of local leadership. SHAs must apply rigorous

tests to any organisational proposals and consider whether they will deliver an improvement in quality for patients, using innovation to drive productivity and enhance prevention.

However, it is emphasised that where a PCT already has a clear proposal, the SHA must receive, consider and assure these without delay. For all other cases, the SHA should agree a timetable with PCTs to strengthen leadership, make sufficient progress in transforming patient services and generate cost effective organisational proposals, whilst maintaining a robust approach to quality.

This new flexible approach will undoubtedly aid PCTs in undergoing this division of functions. However this flexibility only has limited applicability as the rest of the initial timetable remains. By October 2009 PCTs must have developed commissioning plans for priority community services as well as ensuring that provider organisations are business ready. In addition by April 2010, community estate strategies must have been agreed between SHAs and their PCTs.

No doubt those of you working on the commissioning plans will have had a busy summer. We would welcome your feedback as to whether the guidance was helpful in practice.

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Update on free NHS treatment for overseas visitors – is the position clear at last?

In a test case judgment handed down on 30 March 2009, the Court of Appeal reaffirmed the original position regarding NHS treatment for overseas visitors in the case of [R on the application of YA -v- Secretary of State for Health \(2009\) EWCA Civ 225](#). The position had been somewhat clouded by an earlier decision of the High Court in April 2008, in the same case.

The current position

The Court of Appeal, in principle, has decided that NHS trusts are required to charge failed asylum seekers for all hospital treatment (apart from the limited treatments which are exempt such as emergency treatment in A&E) as required by the National Health Service (Charges to Overseas Visitors) Regulations 1989 (as amended) (“the Regulations”).

Relevant facts

YA is a Palestinian who was refused the status of an asylum seeker. The court decided that whilst he remained unlawfully in the UK, he could not be deported as he had no travel documentation and his home state would not allow his return. YA had a deteriorating medical condition which meant that he required ongoing NHS medical treatment. He was charged for the treatment he had received by the treating hospital trust however, he was said to be ‘destitute’ and was therefore unable to pay.

The High Court decision

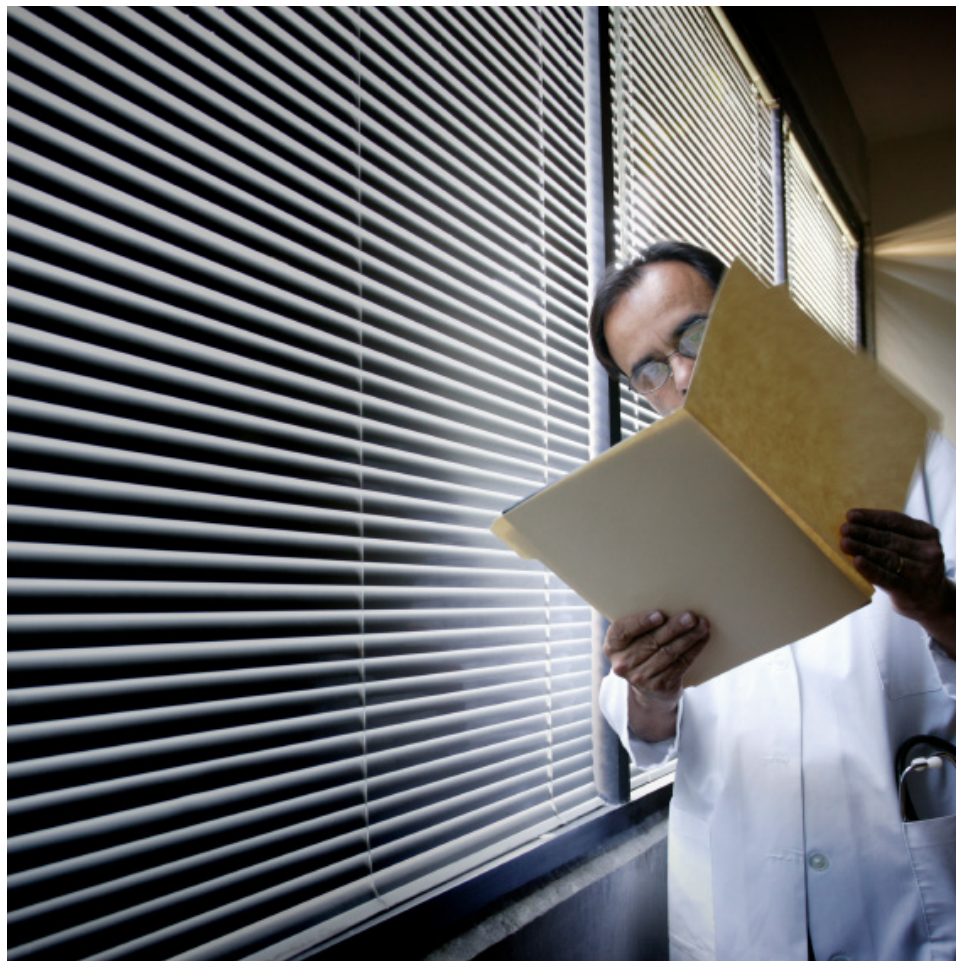
YA sought a judicial review of the government’s guidance to hospitals regarding the way in which failed asylum seekers, unable to return home, were to be treated. YA was successful when the High Court ruled in his favour that the guidance was unlawful. As a result of the decision, the Department of Health advised that failed asylum seekers could, in certain circumstances, pass the ordinary residence test that would enable them to obtain free NHS hospital treatment

or that they would be exempt from charges for hospital treatment after having spent one year in the UK.

The decision of the Court of Appeal

The Secretary of State for Health appealed against the decision of the High Court. The Court of Appeal, departing from the earlier decision of the High Court, ruled that a failed

asylum seeker, who had been in the UK for more than a year, could not be said to have ‘lawfully’ resided in the UK and therefore, qualify for NHS care. The court decided that failed asylum seekers could not be said to be ordinarily resident in the UK since their stay was not ‘ordinary’. Lord Justice Ward clearly stated that a person could only be considered to reside in the UK lawfully when they had the



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right to do so. The Court of Appeal criticised the government's guidance for failing to say what trusts should do in practice when faced with a situation like that of YA.

Catch 22

The Court of Appeal confirmed that trusts have to exercise a discretion. They can refuse to treat the patient unless the patient pays for the treatment up front. However, the court said, *"...there is a discretion to allow treatment to be given where there is no prospect of paying for it."* Therefore, trusts can choose to treat the patient even where there is no prospect of being paid for it.

However, under the regulations, an invoice for the treatment must be raised by the trust. This may seem a nonsensical situation as in effect the trust is accepting the invoice is worthless – unless of course the patient enjoys a windfall! Not to mention the drain on NHS resources generating a vast number of invoices which will have to be written off!

The Department of Health's response

The department issued a letter on 2 April 2009 stating that the decision of the Court of Appeal, *"...is now the law and must be followed with*

immediate effect by NHS Trusts, Primary Care Trusts and NHS Foundation Trusts....", thereby reverting to the position prior to the judgment of the High Court in April 2008!

The department is continuing to look at the issues of access to healthcare for failed asylum seekers in conjunction with the Home Office. The department is currently redrafting its guidance, taking into account NHS feedback – watch this space!

In the meantime, what does the decision of the Court of Appeal mean in practice?:

- Failed asylum seekers no longer pass the ordinary residence test.
- Failed asylum seekers do not become exempt from charges by virtue of having spent one year in the UK.
- Trusts must not ask failed asylum seekers who, under the earlier judgment, they considered ordinarily resident, or exempt from charges, to pay for any treatment they received between 11 April 2008 and 30 March 2009 – the judgment is not retrospective!
- A failed asylum seeker who is already undergoing a course of treatment must not be asked to begin paying for it or have their treatment interrupted – it should remain free until the treatment is complete or until they leave the UK.

It remains to be seen whether the decision of the Court of Appeal will have a real impact on the treatment of failed asylum seekers in a practical sense given that although trusts can charge, and must raise an invoice, there is little prospect of payment being received in the majority of cases!

The case may yet be appealed to the House of Lords so the position could change again! We will keep you up to speed with any developments!

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Authorisation - a privilege, not a right

The government's consultation on deauthorisation of NHS foundation trusts in certain circumstances has recently concluded. Concern has been expressed that this may lead to confusion as to lines of accountability and usurpation of the role of Monitor, the independent regulator of NHS foundation trusts.

In the Department of Health's 'Consultation on deauthorisation of NHS foundation trusts' (available at http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_103359) it states "the government remains committed to the foundation trust model, and to the pipeline of prospective applicants." However, it goes on to say that "In very rare circumstances, foundation trusts may not live up to the high standards that were conditional on them achieving foundation trust status in the first instance. Significant failings may result in such a loss of public confidence that the organisation should lose the right to continue as a foundation trust that can operate autonomously." The premise of this proposal is that foundation trust status is a privilege given to deserving trusts only and can be withdrawn "in order to protect the foundation trust brand and public confidence."

Current powers over failing foundation trusts

As well as the compliance framework and risk rating system, Monitor has broad formal powers of intervention under section 52 NHS Act 2006. These include requiring "the trust, the directors or the board of governors to do, or not to do, specified things or things of a specific description within a specific period." Monitor may also remove any or all of the board or governors and may appoint interim directors or governors. To date, Monitor



has exercised these powers of intervention in three NHS foundation trusts. There is also a power for Monitor to dissolve a foundation trust in certain circumstances pursuant to section 54 NHS Act 2006 (although, to date, no order has been issued by the Secretary of State to confirm who must be consulted and on what matters before this power can be used - as required by section 54 - and therefore it has not been possible to use the power to dissolve a foundation trust thus far). However, this would mean that the organisation would be dissolved completely - as opposed to deauthorising the organisation which would then continue with NHS trust status.

The Health Bill, which is still before parliament, contains new provisions related to deauthorisation but these are directed at "fundamental unsustainability" - which is linked to the organisational form of a foundation trust.

It is also noted that from April 2010, foundation trusts must be registered with the Care Quality Commission (CQC) and if a foundation trust fails to deliver its services appropriately, this may lead to registration being suspended or revoked. However, the CQC has no power to request that a foundation trust is deauthorised.

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Suggested changes

The consultation proposes that:

- Monitor should have the power to deauthorise a foundation trust in certain circumstances and remove its foundation trust status, with the agreement of the Secretary of State. The deauthorised foundation trust will then revert to a NHS trust.
- The Secretary of State should have the ability to formally request Monitor to take specific action to intervene in or deauthorise a foundation trust in certain circumstances. It is envisaged that this would take the form of a Ministerial Statement. If Monitor decides not to deauthorise or take other action, it must prepare a written public report to justify this decision and outline alternative steps that it will take.

Comment

There has been speculation that this consultation is a 'knee jerk' reaction to the public and media attention paid to the events at Mid Staffordshire. This is perhaps evidenced by the fact that the consultation was only

open for eight working weeks until 18 September 2009 – four weeks less than the usual standard minimum 12 week period recommended by the Cabinet Office's 'Code of Practice on written consultations'. This is justified in the consultation document on the basis that the government hopes to introduce legislation on these changes and presumably hopes these changes can be introduced through the Health Bill currently before parliament.

Critics also note that there is now a triple jeopardy for foundation trusts – potentially susceptible to scrutiny by Monitor, the CQC and central government. Chairman of Monitor, William Moyes, is quoted as saying: "Parliament has not yet fully grasped that it is the regulators and the boards of foundation trusts, and not ministers, who are accountable to them for the performance of the regulatory system and individual foundation trusts. So ministers are left feeling that they retain a degree of direct accountability in certain cases of failure, which partly explains the thinking behind the recent consultation document on deauthorisation of NHS

foundation trusts."

The practicalities of deauthorisation will also need to be worked out. What criteria will be used to decide when to deauthorise? How will the impact be managed? Whilst the consultation states "we are keen to explore ways in which the local energy and commitment of members and governors can be sustained even after a foundation trust has been deauthorised", how will this actually be done, possibly at a time when the need for public involvement is at its greatest?

The consultation envisages that this deauthorisation power will be used rarely. However, the implications of this change to regulation of foundation trusts means that it may nevertheless be a major development.

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NPSA consultation concerning serious incident reporting system

NHS staff and managers in England and Wales are asked to provide their views on improving the current system in place for reporting and learning from serious incidents across the NHS.

The National Patient Safety Agency (NPSA) has recently produced a draft 'National Framework for Reporting and Learning from Serious Incidents Requiring Investigation' on which feedback is invited.

The draft framework proposes a 'nationally consistent' definition of what should be considered a 'serious incident' (previously referred to within the NHS as 'Serious Untoward Incidents').

Intended definition

NPSA refer to a serious incident as one occurring in relation to NHS funded services and care resulting in:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm);
- a scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- a person suffering from abuse;
- adverse media coverage or public concern for the organisation or the wider NHS or;

- the core set of 'never events' as updated on an annual basis and currently including:
 - Wrong site surgery
 - Retained instrument post-operation
 - Wrong route administration of chemotherapy
 - Misplaced naso-gastric or orogastric tube not detected prior to use
 - Inpatient suicide using non-collapsible rails
 - Escape from within the secure perimeter of medium or high security mental health services by patients who are transferred prisoners

- In-patient maternal death from post-partum haemorrhage after elective caesarean section
- Intravenous administration of mis-selected concentrated potassium chloride

Further clarification is provided in the document concerning how to define specific terms, such as "incident", "NHS funded services and care", "permanent harm", "major surgery" and "abuse".

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Roles and responsibilities

The proposed framework splits healthcare provider organisations into three broad categories - each with separate lines of accountability:

- NHS trusts are accountable to commissioning PCTs through contracting and commissioning arrangements and to SHAs
- NHS foundation trusts and their board of directors are accountable to their governors and members, regulated by Monitor for compliance with their terms of authorisation and accountable for performance via their contractual relationships with commissioners
- Independent provider organisations and practitioners including GP practices and independent sector provider organisations will be held accountable through contractual relationships with commissioners and through national contracts

Additionally, all organisations providing NHS (and independent sector) care are regulated by the Care Quality Commission.

Intended changes to reporting procedures

The draft framework outlines anticipated changes to the current reporting processes for serious incidents. Currently serious incidents are reported to the NPSA and either the Strategic Executive Information System (STEIS) or local serious incident reporting systems (or other bodies). It is proposed this will be replaced by a new national Serious Incident Management System (SIMS) in 2010 as part of Patient Safety Direct. The framework is intended to form the basis of the newly created SIMS, once established.

All identified serious incidents must be notified to the relevant body "without any delay" and within two

working days of the incident being identified locally. The timescales also apply to evenings, weekends and bank holidays.

Lesson learning

The proposed guidance also includes a section concerning lesson learning and dissemination of information following a serious incident investigation, providing examples of learning as follows:

- Solutions to address incident root causes which may be relevant to other teams, services and provider organisations
- Good practice which reduced the potential impact of the incident
- Early detection or intervention which reduced the potential impact of the incident
- Lessons from conducting the investigation which may improve the management of investigations in the future

An investigation executive summary template has been produced to assist in summarising investigations and to enable the executive summary to be shared appropriately. Learning points are intended to be grouped for referral to applicable teams, services, specialities or divisions or wider organisations, with an example template of an action plan.

Responses concerning the current document are requested by 13 November 2009, when all comments will be considered for inclusion in the final publication. The finalised document is currently intended to be made available by the end of the year. The documents can be viewed on <http://www.npsa.uk/corporate/news/npsa-casts-consultation-net-on-serious-incident-reporting-system/>.

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The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system – what NHS bodies need to know

In December 2007, Lord Bradley was asked by the Secretary of State for Justice to undertake an independent review to examine to what extent offenders with mental health problems or learning disabilities could, in appropriate circumstances, be diverted from prison to other services and the barriers to such diversion. Lord Bradley was also asked to make recommendations to the government about what changes should be made as a result of his review.



The issues

While public protection remains the priority, there is a growing consensus that prison may not always be the right environment for those with severe mental illness. Custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm or suicide.

The government has supported diversion methods from the criminal justice system for mentally disordered offenders for many years, and this is to be welcomed by all those involved in offender health services. However, there remain a number of significant issues that need to be addressed. Some of the most important issues include:

- A need for early intervention. This provides the best opportunity for improving how people with mental health problems or learning disabilities are managed.
- In most cases, the police are the first point of contact with the criminal

justice system. This initial contact is currently the least developed area in the offender pathway in terms of engagement with health and social services, as intervention generally occurs at the court and sentencing stage.

- Lord Bradley commented specifically on the problems arising from the NHS having not commissioned health services in police custody in the past, and that this led to inconsistency in the care provided to an offender, along with less stringent governance of the healthcare services provided.
- At court, different problems arise. In many cases, an individual will arrive at court without any information regarding their mental health problems or learning disabilities. It regularly falls to probation staff, often untrained in mental health or learning disability, to recognise the potential signs of a mental health problem or learning disability.
- Alternatives to custody are available to judges and magistrates when sentencing individuals found guilty of a crime. However, there has been a significant lack of mental health treatment requirements attached to community sentences given to offenders with mental health issues or learning disability.
- Prisoners have significantly higher rates of mental health problems than the general public. Prisons have been struggling to provide an equivalent range of mental health services to inmates to that offered in the community for many years and this has been a key concern for health services.
- Transferring prisoners to hospital for treatment of an acute mental illness has been problematic, and prisoners have had to endure lengthy waits. There has been progress over recent years and a reduction in transfer delays has occurred, but it is still the case that a number of patients have to wait for long periods of time.

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The government response

The government is keen for system reform to take place to ensure a balance between public protection and the needs of offenders. The government has outlined five main components for system reform:

1. A clear national vision and commitment from all agencies involved to improve health and re-offending outcomes for offenders.
2. New governance arrangements that support the joining up of policy, strategy, commissioning and service delivery across the health and criminal justice pathway.
3. Clear statements about what changes to the system will be expected to be achieved in the short, medium and longer term, so that services may direct commissioning and planning accordingly.
4. Measurable outcomes that enable progress and the pace of change to be monitored.
5. An integrated inspection framework that enables the NHS and criminal justice system to be held jointly to account for improving these outcomes.

A new National Health and Criminal Justice Programme Board has been set up by the government to look at how the recommendations of The Bradley Report can be implemented. This is due to report back to parliament in October 2009.

Comment

The Bradley Report is an important stepping stone in bringing about change in how offender health services are commissioned and provided.

The government has attached particular importance to Primary Care Trusts (PCTs) and criminal justice partners jointly planning services to ensure coordinated commissioning and delivery. This is seen to underpin the move away from fragmented service provision.

The National Programme Board will seek to establish the best way to communicate recommendations to the NHS in relation to improving PCT commissioning capability for offender healthcare. There is a clear drive to move commissioning of health services in police stations to the NHS, and to improve the communication between the NHS and criminal justice agencies, particularly with the Criminal Justice Mental Health Teams.

It is essential that the NHS forges strong links with the current aversion and diversion agencies in the criminal justice system, and looks at how existing systems can be improved whilst awaiting the conclusions of the National Programme Board being reported to parliament.

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