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HILL DICKINSON



Healthcare Update

## Welcome

Happy New Year to you all.

2008 was a busy year which saw major changes to the mental health legislation and the introduction of new laws on Corporate Manslaughter.

2009 will see the Coronial system being overhauled and the new NHS Complaints Procedure being introduced. The latest update about this is discussed at page 16.

We are also pleased to announce that Joanne Hughes in the NHSLA team and Louise Wright in Healthcare have been promoted to the role of Associate.

We hope that you enjoy reading the articles produced by the members of the Practice Group.

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# Energy solutions for the NHS

**Rapidly rising energy prices, uncertainty in global energy supplies and pressure on public bodies to reduce carbon emissions are putting the issues of cost effective and sustainable energy provision high on the NHS agenda.**

In 2001, the Government set mandatory targets for NHS and other public sector bodies to reduce their carbon emissions. The target for the NHS is to achieve a 15% reduction in carbon emissions by March 2010.

One way to achieve both cost savings and reduce carbon emissions is by way of an energy services project that uses combined heat and power (CHP) technology. For instance, one NHS Trust client we have advised on such a project saved, in the first year of the project, £124,848 in energy costs and 10,279t in carbon emissions.

## What is CHP?

CHP, sometimes also called “cogeneration” or “trigeneration”, involves the installation and operation of various specialist pieces of plant and equipment (the main one of which being a CHP engine) which provide heat and power to premises. In the case of trigeneration systems, cooling can also be provided through the production of chilled water.

Savings are achieved because unlike normal systems, which generate heat or power, CHP plant and equipment captures the heat generated during the production of electricity and utilises it. Normally, such heat would be wasted. This means that CHP is more efficient than traditional heat or power generating systems.

## How would the arrangement be structured?

Projects such as this normally take the form of an outsourcing arrangement which follows a public private partnership (PPP) structure. Under such a structure, the contractor bears the capital cost of installing the CHP equipment and guarantees savings against the Trust’s existing energy costs and non-energy costs such as capital charges. It may also be possible to structure the arrangement using the £100m Energy and Sustainability Capital Fund, which is available to the NHS in England to support energy efficiency and carbon reduction schemes and which is widely expected to be extended in the near future.

In addition, it is sometimes possible to make provision for sale of heat to a district heating scheme (which typically provides shared heating to local housing or offices) or to sell surplus electricity back to the National Grid. This can be extremely advantageous to the Trust financially.

Alternatively, some energy services projects allow the user simply to pay for the generated electricity, heat and cooling without the Trust making any capital investment, and with

the cost agreed in advance. We can advise on these discount energy purchase arrangements taking into account suitability for purpose and whole-life costing.

## What are the other advantages?

There are various other advantages to installing a CHP system. It allows the Trust to renew ageing plant and equipment with modern, up to date, energy efficient equipment and there are often grants available to assist with capital outlay. There can also be exemptions from or reductions in capital charges. Of course, the main advantages are the savings the Trust can make in its energy bills and the reduced carbon emissions.

## This sounds complicated!

The legal work around these projects can be complex; the contractual documentation often involves elements not normally encountered in PFI or PPP projects. Hill Dickinson has undertaken 13 projects involving CHP technology, more than any other law firm, on behalf of public sector bodies, the majority in the NHS, and all members of our dedicated team are fully familiar with the structure and potential pitfalls.

We also have contacts throughout the CHP industry and would be happy to give you details of consultants and companies who may be able to advise on technical or organisational aspects of such a project.

## Some other ideas ...

Even if your organisation has no immediate requirement for new plant and equipment, there are other aspects to what we do which may be of interest and which, in the context of your organisation’s needs, may be just as relevant. For example, we (or we, acting in conjunction with other specialist consultants in these areas) can advise on:

- outsourcing maintenance services in respect of NHS Trust-owned equipment;
- contracting with third parties to support the purchase of import electricity and/or fuel, and associated financing structures;
- linking an energy services project to a district heating scheme, and associated financing structures;
- contracting with third parties to support the export of surplus generated electricity to the National Grid; and
- procurement strategies and compliance.

We would be delighted to discuss any of these areas with you, or to provide any information. Please contact a member of Hill Dickinson's commerce and technology group.

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# Data Protection:

## Limitations on the right to amend “inaccurate” health records

**Hill Dickinson has recently successfully defended a claim brought by an individual against 12 NHS bodies from across the North West and North Midlands regarding the contents of her health records. According to the Claimant’s health records she had a history of mental disorder. The records contained entries recounting a number of periods of detention under mental health legislation and episodes of violent and threatening behaviour against others over a period of more than 30 years.**

The Claimant argued that the entries in her records with which she took issue were inaccurate in many respects. She felt that these inaccuracies were hampering her ability to obtain appropriate medical treatment on an ongoing basis. This was because she considered that all the clinicians with whom she had contact had their opinion of her tainted by the allegedly inaccurate records of her previous psychiatric history. The Claimant therefore brought what amounted to a claim under s.14 of the Data Protection Act 1998 to have the offending entries in her medical records erased. She also raised a claim for psychiatric injury caused by the “inaccurate” medical records.

The NHS bodies made an application for summary judgment against the Claimant on the basis that her claim had no real prospect of success. They argued that, although members of the public have a right to amend or delete personal data held in respect of them by data controllers where such data is inaccurate, this right is qualified in respect of matters of professional opinion such as health records containing diagnoses of mental illness. They relied in this regard on a Good Practice Note entitled “How does the Data Protection Act apply to recording and retaining professional opinions” published by the Information Commissioner’s Office in April 2008 which states as follows (emphasis added):

*Personal information should be accurate, and where necessary kept up to date. This requirement will be met if a record accurately reflects the professional opinion. The Act cannot be used to challenge a professional opinion on the basis that it is inaccurate just because another person, even another practitioner, may have a different*

*opinion. If the opinion contains factual information that is incorrect then it could be challenged. A challenge to a factual inaccuracy or the reliability of an opinion may be recorded alongside it, since it will usually be important to maintain the original record. This is because, for example, only the entire record will adequately show a medical history, record of care or why a course of action was taken.* However, it is recommended that the fact that a challenge exists should be made clear on the record.

The NHS bodies therefore argued that the accuracy or otherwise of the Claimant’s medical records was, in a sense, immaterial. Even if, which was not admitted, there were inaccurate entries these should be retained with the records so that those treating the Claimant would be able to determine how such entries may have informed subsequent decisions as to the Claimant’s care and treatment.

The only feasible option open to the Claimant was that she be allowed to append an alternative version of events to her records. This approach had been offered to the Claimant by a number of the NHS bodies but in each instance she had rejected this as insufficient. The NHS bodies argued that, if the only remedy which the Court could award to the Claimant was one which she had definitively rejected, then the continuation of the proceedings represented an abuse of process. The Court agreed with the NHS bodies that the Claimant’s case was not one with any real prospect of success and found in their favour without allowing the matter to proceed to a full hearing.

Although the facts of this case are somewhat unusual it serves to reiterate the principle that patients are not free to rewrite their health records as they see fit and NHS bodies should not ordinarily comply with such requests. More widely, the case demonstrates that Courts are unsympathetic to Claimants who commence litigation as an end in itself and for whom whatever remedy the Court may offer will fail to redress their grievances.

This case was dealt with by Andrew Craggs and David Hill.

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# The legal implications of the Inquests into the deaths of Diana Princess of Wales and Mr Dodi Al Fayed

**On 31st August 1997, Princess Diana, her bodyguard and Dodi Al Fayed were travelling in a Mercedes driven by Henri Paul. Shortly after midnight, the Mercedes collided at 65mph with a pillar in the Alma underpass in Paris, after being pursued by paparazzi. The only occupant of the Mercedes to survive the collision was Diana's bodyguard – Trevor Rees.**

In the face of various conspiracy theories, the Diana and Dodi inquests were launched.

## The Inquests

The Diana and Dodi inquest hearings were held concurrently and commenced on 2 October 2007 at the Royal Courts of Justice, with Lady Butler-Sloss sitting as coroner without a jury. Before the inquests started, the High Court ordered that the inquests be held with a jury and, in June 2007, Lady Butler-Sloss' role was taken over by Lord Justice Scott Baker.

The hearings endured for over 6 months, during which time evidence was heard from 268 witnesses, and the total cost of the inquests incurred by the Coroner's Office was little short of £5,000,000. This is in contrast to an average inquest which costs the Coroner's Office around £250.

All of this undoubtedly provided drama and fascination, but will the Diana and Dodi inquests have any more long-term effects on the way in which inquests are conducted?

## The law and the legal implications of the Diana and Dodi Inquests

The Diana and Dodi inquests are likely to have wide-reaching legal implications, particularly in respect of the use of juries, the content of a coroner's verdict, the calling of witnesses, and the use of witness evidence.

## Juries

The law governing the use of a jury at an inquest is found in section 8(3)(d) of the Coroners Act 1988, which states:

"If it appears to a coroner, either before he proceeds to hold an inquest or in the course of an inquest begun without a jury, that there is reason to suspect that the death occurred in circumstances the continuance or possible recurrence of

which is prejudicial to the health or safety of the public or any section of the public, he shall proceed to summon a jury."

As mentioned above, it was decided at the outset of the Diana and Dodi inquests by Lady Butler-Sloss that there would be no jury. Their appearance inevitably slows proceedings down, which thereby increases costs and, as a result, juries are relatively rare. Indeed, at the time Diana died, only around 770 out of 21,500 inquests involved juries.

However, juries are also seen to make inquests more democratic, and in view of this, Al Fayed's legal team sought to challenge by judicial review Lady Butler-Sloss' decision not to have a jury. This challenge was successful, and the High Court justified its decision to require a jury on the basis that the "paparazzi on wheels" are a threat to public health and safety. In particular, the Court stated that other members of the Royal Family and other celebrities might face similar threats, and emphasised that the scope of an inquest must always be considered before deciding whether it is necessary to summons a jury.

It was also held that a coroner should take into consideration the deceased's family's wishes before deciding whether to exercise his discretion under s. 8(4) of the Coroners Act 1988 to summon a jury.

Hence, the implication of this is likely to be a rise in the number of inquests taking place with a jury, and a possible rise in the number of judicial review actions being brought against coroners who decide not to summon a jury.

## The content of a coroner's verdict

The law surrounding the purpose of a coroner's inquest is clearly set out in Rule 36 of the Coroners Rules 1984, which establishes that an inquest must be directed solely to ascertaining:

- who the deceased was;
- how, when and where the deceased came by their death; and
- the particulars required to register the death.

As such, an inquest should be a factual inquiry and Rule 36 confirms that "neither the coroner nor the jury shall express any opinion on any other matters."

In addition, Rule 42 of the Coroners Rules 1984 makes it clear that “no verdict shall be framed in such a way as to appear to determine any question of:

- (a) criminal liability on the part of a named person; or
- (b) civil liability.”

Nevertheless, in the Diana and Dodi inquests, the jury was requested to provide a narrative verdict, commenting not only on the specific causes of the deaths, but also on what caused and contributed to the fatal car crash. Lord Justice Scott Baker stated that this was because “a bare verdict might be unsatisfactory or uninformative”, yet also warning that it is “critical that such narrative verdicts do not offend against Rule 36 and 42”, this is a line that would in fact seem to have been crossed in the Diana and Dodi inquest verdicts. In particular, both verdicts state that:

“The crash was caused or contributed to by:

- the speed and manner of driving of the Mercedes,
- the speed and manner of driving of the following vehicles,
- the impairment of the judgement of the driver of the Mercedes through alcohol.”

The implication here is clearly that Henri Paul and the drivers of the other vehicles were at fault.

Narrative verdicts have become increasingly popular amongst coroners, since it is often very difficult to frame the cause of death in a simple verdict consisting of one or two words, such as “accidental death” or “misadventure”.

However, with the rise in narrative verdicts, it seems probable that inquests are more and more likely to go beyond answering the “who, how, when and where” questions and are increasingly likely to identify areas of concern or system failings.

## Relevance of a witness

Mr Al Fayed’s legal team argued that the jury should consider whether the Royal Family, particularly the Duke of Edinburgh, contributed to a climate in which rogue elements in the secret intelligence services took matters into their own hands and ‘dealt’ with Diana. As such, the Coroner was requested to call the Duke of Edinburgh to give evidence and to present a list of questions to the Queen.

However, the Coroner refused both requests, stating that the purpose of the inquests “was not an inquiry into the life of Diana, Princess of Wales, still less an inquiry into the relationships between the late Princess and other members of the Royal Family.”

This decision was unsuccessfully challenged by judicial review.

Clearly, this reinforces Rule 36 and highlights that witnesses must not be called merely to ascertain evidence that might be of interest. Rather, the evidence sought must be relevant to ascertaining who died, how, when and where. This point hence provides guidance for future inquests in relation to the calling of witnesses.

## The use of witness evidence

Rule 37 of the Coroners Rules 1984 states that:

“a coroner may admit at an inquest documentary evidence relevant to the purposes of the inquest from any living person which in his opinion is unlikely to be disputed, unless a person, who in the opinion of the coroner is [a properly interested person], objects to the documentary evidence being admitted.”

In the Diana and Dodi inquests, a number of witnesses were outside the jurisdiction and could not be compelled to attend. Consequently, Lord Justice Scott Baker decided that Rule 37 did not apply and, under his common law powers, decided that he could simply read the witness statements to the jury. However, this was challenged by judicial review, primarily because Henri Paul’s family wanted the paparazzi to be cross examined, and Lord Justice Scott Baker’s decision was set aside so that the statements which were disputed by interested parties could not be read to the jury without calling the witnesses.

This decision was unsuccessfully appealed and it was made clear that Rule 37 is a complete code which does not allow the admission of a document where an interested party wishes to dispute it, even where the maker is unable to attend. In addition, it was held that a coroner should rarely, if ever, admit documentary evidence without the calling of a witness.

Although this decision has led to Lord Justice Scott Thomas referring to the Coroners Rules 1984 as “lamentable”, “hopeless” and “wholly improper for the modern age”, it sets clear guidance for coroners in relation to witness evidence and the use of Rule 37.

## Comment

Only time will tell what impact the Diana and Dodi inquests will have on this area of law. However, narrative verdicts are becoming increasingly popular and it would not be surprising if the number of juries being used also begins to rise now that the wishes of the deceased’s family have been expressed to be a key factor that the coroner must consider when deciding whether or not to appoint a jury. In addition, it seems likely that there will be a rise in the number of judicial review actions being brought against coroners who decide not to summon a jury, given the success of such an action in the Diana and Dodi inquests.

A rise in the use of juries and an increase in the number of judicial review actions would both clearly act as an obstacle to inquests being carried out in a speedy and efficient fashion, and this would invariably make inquests more expensive than is currently the case. Hence, it seems that the cost implications of the Diana and Dodi inquests may prove much more far-reaching than it first appeared.

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## Loss of Legal Challenge to Law on Assisted Suicide

In our September edition, we advised that the High Court was to consider further a legal challenge raised by Debbie Purdy from Bradford, a woman suffering from a progressive form of multiple sclerosis. She was seeking for her husband to assist her in travelling to the Dignitas Clinic in Zurich for a medically assisted suicide, free from any threat of criminal prosecution. Lord Justice Latham had accepted that there was an arguable case which should proceed to a full Hearing.

On 29 October 2008, two Senior High Court Judges rejected Ms Purdy's application for a ruling from the Director of Public Prosecutions (DPP) to confirm in advance whether her husband would face criminal charges if he accompanied her. Ms Purdy had sought to argue the DPP was in breach of her right to respect for her private and family life under the European Convention on Human Rights for failing to clarify the law.

Whilst Lord Justice Scott Baker expressed sympathy, he said any reform of the law on assisting suicide was a matter for Parliament, echoing the recent comments of Sir Ken MacDonal QC, former Director of Public Prosecutions.

Thus, the position remains that assisting another to commit suicide constitutes an offence under s. 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.

Interest in the decision has been heightened by the recent publicity surrounding the case of Dan James, 23, a former England under-16 rugby player, left paralysed from the chest down after his spine was dislocated in training in March 2007, who died in November 2008 after travelling to a Swiss euthanasia clinic with his parents. A police investigation followed and it was recently announced that the DPP does not intend to prosecute his parents, even though there was sufficient evidence they had helped their son end his life.

Permission has been granted to Ms. Purdy to Appeal, with the matter anticipated to be heard shortly. We will keep you updated as to the outcome.

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## Inquest Cash Gap Fears – the NHS Perspective

On 18 September 2008, an article published in the Law Society Gazette entitled Inquest Cash Gap Fears raised the concerns of Amanda Stevens, President of the Association of Personal Injury Lawyers (APIL), that government proposals aimed at reforming the coronial system do nothing to address the inadequate legal aid funding for inquests. The key criticism contained in the article was that, due to the lack of funding, many bereaved families must attend coroners' courts without legal representation.

However, from the perspective of NHS bodies, the 'Inquest Cash Gap' is more of a benefit than a burden.

The key reason for this is that where bereaved families are legally represented, the inquest process becomes lengthier, with advocates for families undertaking an in-depth analysis of the evidence, perhaps with a view to using the inquest as a forum to gather evidence for a clinical negligence claim. More witnesses may be called to give evidence, the inquest will take longer, perhaps running to several days, and the advocate may push for the inquest to be heard with a jury.

Hence, the fact that there does not seem to be any immediate change on the horizon in relation to legal aid funding for inquests is undoubtedly a positive thing insofar as NHS bodies are concerned!

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# Consultation on National Framework for assessing children's continuing healthcare needs

The Department of Health has recently consulted on proposals for a National Framework for assessing children and young people's continuing care needs. The Framework will apply to children and young people under the age of 18 years.

## Why?

The consultation on Guidance on provision of continuing care for adults, published by the Department of Health in 2006, acknowledged that the needs of children are different. Since that time Ministers have committed to developing a Framework for children. Currently there is no single tool for assessing children and young people's continuing care needs so PCTs have adopted their own procedures/the adult framework. The decision is therefore based on local procedures and may vary from area to area.

## What are the objectives?

- To assist PCTs and Local Authorities to develop consistent joint decision-making processes for the provision of continuing care for children in a fair and equitable manner according to need.
- To promote a more objective approach to the provision of continuing care.
- To promote confidence of families and professionals that the needs of the child and family will be assessed and decisions based on a common assessment of need.
- To ensure that future development of services will be better informed by consistent data.

## The proposed National Framework

The National Framework provides, for the first time, a tool to assist PCTs and Local Authorities to identify children and young adults (below 18 years) who have a continuing care need and to assess the level of need. It comprises of best practice guidance including:

- A set of key principles, core values and best practice for considering continuing care needs.
- A Decision Support Tool (DST) for use by health practitioners assessing whether a child or young adult has a continuing care need. The DST sets out a series of domains intended to ensure that the assessor gets a rounded picture of the child or young adult's health needs.



- A continuing care pathway, drafted by the Association of Children's Palliative Care based on their model Care Pathway for children and young adults with a life limiting or life-threatening condition.
- A summary of the Haringey judgment – 2005 Court case which clarified the boundary between health and social care provision.

The main purpose of the Framework is to assist PCTs and Local Authorities to obtain a complete picture of the child/young adult's health needs in order to make a decision whether to fund a continuing care package.

The consultation has now closed. A summary of the response will be published by the end of March 2009 and will be placed on the consultations website <http://www.dh.gov.uk/en/Consultation/Responsestoconsultations/index.htm>.

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# “Mad”, “bad”, “dangerous” ...?

The impact of the Mental Health Act 2007 on our prison population.

**A 1991 Home Office study found 37% of male and 54% of female sentenced prisoners to be suffering from psychiatric disorders. A later 1998 Department of Health study of 3200 prisoners found as many as 78% of prisoners suffered from some form of personality disorder, with much higher instances of other mental disorders than in the normal population.**

Subsequent studies suggest as much as 90% of the prison population has a diagnosable mental health problem and that 2% of the prison population will attempt suicide in any given week.

It is therefore vital that prisoners' mental health needs are adequately assessed and provided for. Failure of the agencies involved to do this can lead to successful judicial review, human rights and other legal challenges in the courts. More importantly such failures may also put prisoners and staff at unnecessary risk.

The field of “clinical justice” as some prefer to call it, within the context of the prison service, appears to be a growing area of the law. Examples of some successful legal challenges include:

- In *Riviere -v- France* [2006] the European Court of Human Rights held a prisoner's Article 3<sup>1</sup> rights were violated when a seriously mentally ill prisoner was detained in normal prison conditions without proper facilities or treatment for his mental disorder.
- In *McGlinchey -v- UK* [2003] abrupt detoxification was found to breach Article 3. Similar arguments are currently being put forward with respect to an ongoing group action within the UK centring on withdrawal of methadone treatment for prisoners.
- The case of *Ryan St George -v- Home Office* [2008] again stressed the importance of proper medical management of addiction and withdrawal.

A detailed framework exists under the Mental Health Act 1983 to enable the formal assessment and transfer of prisoners to psychiatric hospital for specialist mental health care and treatment where necessary.

Judicial review claims such as *R -v- (1) Secretary of State for the Home Department and others* (2004) have stressed that once the prison service has reasonable grounds to believe a prisoner requires treatment in a psychiatric hospital, the Secretary of State is under a duty to expeditiously take “reasonable steps” to obtain medical advice and effect the prisoner's transfer to a psychiatric hospital under the provisions of the Mental Health Act 1983 if appropriate.

The Mental Health Act (MHA) 2007 which came into force on 3 November 2008 amended virtually every section of the 1983 Act. Of particular significance in this context, the new Act changes the definition of a mental disorder to “any disorder or disability of the mind”, removing the previous four categories of mental disorder<sup>2</sup>.

The new Act goes further, by removing the earlier “treatability test”, replacing it with an “appropriate treatment” test. What this means in practice is that whereas previously it was necessary to show that certain categories of patients were treatable<sup>3</sup>, now one must simply be satisfied “appropriate medical treatment is available” for the patient<sup>4</sup>.

Whilst these may be subtle distinctions, there is an argument that the amended legal framework makes it more likely that certain prisoners suffering from serious personality disorders (particularly those that are self harming or putting others at risk) now meet the criteria for detention in hospital rather than in prison and so should be transferred. Successful judicial review, human rights and other legal challenges may follow, where prisoners do not receive appropriate treatment.

For those providing care for prisoners therefore, it remains crucial that the first reception health screen appropriately assesses such issues. Organisations' policies and staff training should also accurately reflect the new legal framework including the relevant provisions of the MHA and Mental Capacity Act.

The use of the MHA 1983 should be considered where appropriate. In cases of serious delay in location of a suitable hospital bed, provision of specialist in-reach services may be required.

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<sup>1</sup> the right not to be subject to ...inhuman and degrading treatment

<sup>2</sup> Previous definition; “mental disorder means mental illness, arrested or incomplete development of mind, psychopathic disorder or disability of mind” and subsequently referred to “mental impairment, severe mental impairment and psychopathic disorder”

<sup>3</sup> Previous requirement was that it had to be shown the treatment to be provided to the patient would alleviate or prevent a deterioration in their condition

<sup>4</sup> That is, specified treatment aimed at alleviating or preventing a deterioration of the disorder or one or more of its manifestations, is actually available (not that the treatment actually “works” as such).

# Lexcel-lent news for the Countess of Chester

**The legal department at the Countess of Chester has become the first Trust in the country to obtain Lexcel certification. What is this and how was it obtained? Cheryl Turbitt from the Trust explains...**

It was one of those rare days in the office, files seemed to be up to date, the sun was shining and all was well with the world. A day when you fleetingly enjoy your job after all and when it ceases to matter that you've still got a few years before you can draw your pension.

It was on that Swallows and Amazons day that the newly appointed Trust Foundation Secretary, a solicitor by profession, met with me to discuss my role and department. You've heard about Lexcel he said? I lied. Rushing back to the office to research Lexcel on the Internet, I found that "Lexcel is the Law Society's practice management quality mark. Written specifically for the legal profession, it allows any type and size of practice to undergo independent assessment to certify that the Lexcel Practice Management Standards are being met."

That's when reality hit. If there are two words that initiate palpitations it's 'standards' closely followed by 'assessment'. I downloaded the Self-assessment Checklist from the website and began to realise that many of the things which were needed were already in place and equally comforting was that certain sections weren't relevant, particularly those sections relating to clients' money and fee earning. (I should be so lucky). I started to fill in the checklist and then, even without the benefit of a cheeky Australian Chardonnay I was hooked - we could do this. It would be a 'good thing' for the department to be possibly the first Trust in the country to obtain Lexcel certification. Thus six months of preparation began!

I was lucky that the Trust agreed to pay for an assessor to come into the Trust at an early stage and undertake a pre-assessment identifying where procedures were lacking, which documents should be prepared and also to pull together the relevant information needed for the department's Lexcel manual. The help was invaluable. It was at that point that we decided that we wouldn't necessarily treat the preparation for the two assessments, the NHSLA and Lexcel, separately - what was developed and used for one we used for the other.

As with all assessments a major part of the preparation involved a review of all our policies and procedures. We had the department policies and procedures which had developed over the years but being homespun we weren't certain if they would stand scrutiny. Our claims handling policy had been written and re-written over the years but we knew that yet again it needed re-vamping and would probably not meet

the NHSLA's requirements. This became the first task. The new policy was sent to the Trust Board for ratification. Within a month the NHSLA published a sample policy that had very little similarity to our new one! One of the benefits of being part of a large organisation is that many of the key policies have been written for you. For example, in a legal practice they will have to produce all their own policies such as those related to induction, training, development and health and safety. As we could state that the department was required to follow Trust policies then there was little more that we had to do.

The significant part of the preparation was the file review.

In addition to our day to day work we gradually pulled all the legal files and checked that everything was up to date and in good order. File checklists were inserted into each folder recording all key tasks and dates. These checklists were subsequently used to monitor our compliance with timescales and targets. We also set up a peer review system. Each month some of my legal files are randomly selected and reviewed by a colleague. Any non-compliance with procedures is identified. In the same way I review other colleague's files. This review is invaluable particularly with those difficult files - the ones that you push around the desk in the hope that the legal fairy will deal with them whilst you sleep.

Three months after the work started we underwent the NHSLA assessment and passed. Confidence increased at that point but quickly waned. It's one thing to be part of a large assessment but I knew that failure of the Lexcel assessment was down to me; no-one else to point the finger at.

The assessment took place over one day. My staff and I were separately interviewed, documents were produced and files randomly reviewed. At the end of the day I was told I had one point of non-compliance - a loose sheet of paper not inserted correctly into a file! Apart from that we had passed, Lexcel certification is ours and I can start all over again ready for the next visit!

This article was kindly written by [Cheryl Turbitt](#), Legal Services Manager, at the Countess of Chester NHS Foundation Trust. We are grateful for Cheryl having taken the time and effort to write this submission.



# Framework agreement set aside due to breach of EU Procurement Rules

**Our series of articles on developments in the field of procurement continues in this edition with a look by Chris Brennan at a decision of 30 October 2008 by the High Court in Northern Ireland. It relates to a framework agreement, put in place by the Northern Ireland Department of Finance and Personnel.**

The purpose of the framework agreement was to set up a panel of construction companies to carry out works for the Department. Whilst not specifically relevant to health, the decision was significant - and impacts across all sectors, including health.

It is, however, largely relevant only to fully-regulated procurements – that is to say, procurements where an OJEU advertisement is mandatory, rather than those which are less regulated (such as clinical services). In the NHS context, the decision will be relevant to services commonly procured via framework agreements (such as facilities management and perhaps certain IM&T, design services and building work).

The procurement rules now contain specific requirements relevant to framework agreements. A framework agreement is an agreement between an authority (for example, a Trust) and a provider which sets out the terms under which the provider will enter into one or more contracts with the Trust over the period covered. It is perfectly possible to have framework agreements with more than one authority purchasing, and more than one provider on the panel. It is expected that price and, as appropriate, quantities to be purchased are dealt with in this “over-arching” framework agreement, rather than in individual call-off contracts placed under it.

The procurement rules, and the underlying EU law, require that providers wishing to be appointed to framework agreements must be informed of the criteria which will be used in the evaluation of their bids. In addition, they must be treated equally, and must not be discriminated against. Wherever selection is made on the basis of the most economically advantageous bid (i.e. not merely the lowest price), the criteria taken into account have to be linked to the subject matter of the contract. In other words, they have to go to actual service delivery, and cannot be used to evaluate matters which are extraneous to service delivery. Wherever non-price criteria are used in the selection, the

relative weightings of each of the criteria must be stated in the advertisement (or somewhere in the tender invitation). As a result of other recent caselaw, it is now clear that such criteria, and their weightings, need to be disclosed to bidders before they actually prepare their bids.

In the Northern Ireland case, the Department of Finance and Personnel was taken to Court by a construction company which narrowly missed appointment to the framework agreement (there were five places on the framework, and it came sixth). The Court found that the Department had breached procurement law by not disclosing a number of sub-criteria which were used in the evaluation of the bids, in advance, to bidders. The company which had complained was therefore entitled to a remedy.

The thrust of recent case law makes it unsurprising that the Department was found to have breached public procurement law in this way. However, what makes this decision particularly interesting is that, even though the framework agreement had been signed by the Department and was being treated as up and running, the Court ordered that it be set aside. Why?

The answer lies in the way in which the Court interpreted what is meant by a “framework agreement” in the procurement rules. It decided that a “framework agreement” is different from a “contract” – the latter expression being used by the procurement rules to refer to the call-off arrangements taking place at the level below the over-arching framework agreement. The regulations say that once a “contract” has been entered into, the only available remedy for a bidder is damages: by then, it is too late to unwrap the contract itself. Because, on the face of the regulations, there is a clear distinction between a “contract” and a “framework agreement”, the Court did not feel limited to awarding damages, but instead considered that it was perfectly at liberty to set aside the framework agreement – even though it had been signed. It left up to the Department the question of whether a new competition should be run to establish a new framework agreement.

## Conclusion

At first, this decision seems startling: a UK Court has ordered the undoing of a signed agreement. However, the Court’s judgment is certainly in line with the view of the European Commission, which is that there is a clear distinction to be made between an over-arching “framework agreement” and a “contract” made under it. The former, says the Commission, is not expected to constitute a legally-binding arrangement between purchaser and provider. Instead, a binding contract comes only in the form of the call-off between purchaser and selected provider. Indeed, framework agreements are often clear in saying that they do not guarantee any work for the provider.

Even though there is currently nothing in the UK’s own procurement regulations which allows signed, binding contracts to be set aside, the position will change later this year when the Courts will be given new powers to order contracts made in breach of procurement law to be rendered ineffective in certain situations. But for now, the message is clear – always award any contract, whether it is a framework agreement or not, with full regard to the requirements of procurement law around the full and timely disclosure of criteria for the evaluation of providers’ bids.

# You must act when told about stress

## In November 2008, the Court of Appeal in the case of Dickins -v- O2 sent out another clear message to employers that positive steps must be taken when an employee says that he or she is “stressed out” and having health problems.

The Court of Appeal upheld the Trial Judge’s decision to award the Claimant damages of £109,754 after she went off work in mid-2002.

### Facts

One aspect of the Claimant’s job was to carry out a quarterly audit of the management accounts. She was psychiatrically vulnerable and found the audit in February 2002 to be extremely stressful. After a holiday, she returned to work and asked her line manager in early March 2002 for a different and less stressful job. She was told that the matter would be reviewed in three months as there were no vacancies available at that time.

On 23 April 2002, she requested a six-month sabbatical and advised her employers that she was stressed out, having difficulties getting out of bed in the mornings because she felt so tired and did not know how for long she could continue to work.

The response by her employers was that she should contact their confidential counselling helpline and that the sabbatical request would be considered. At an appraisal on 30 May 2002, she repeated her concerns and was referred to Occupational Health. However, before an appointment was arranged, the Claimant suffered a breakdown and did not return to work.

### Court of Appeal decision

- There was a sufficient indication of impending harm to health – it was reasonably foreseeable to any employer that there was a risk of the Claimant suffering psychiatric injury from 23 April 2002 onwards.
- The Court of Appeal agreed with the original decision that the employer was in Breach of Duty for not sending the Claimant home and making an immediate referral to Occupational Health on 23 April 2002. This was despite the fact that there was no medical evidence adduced to support the fact that either step was likely to do any good.
- Following the decision last year in Daw -v- Intel Corporation, the Court of Appeal confirmed that it was insufficient for an employer to offer a confidential

counselling service in order to discharge its duty of care.

- In relation to causation, the appropriate question to ask was whether the employer’s failure had made a material contribution to the onset of the illness. Lord Justice Smith stated that the “obvious inference” was that the Claimant had been tipped over the edge because her employers had taken no steps to address her request for less intensive work.
- Another important aspect of this decision (which was not an issue on the Appeal) was that the Court of Appeal was critical of the original decision to reduce the Claimant’s damages by 50% because of the causative effect of other non-work factors which had caused her stress. It was stated that the psychiatric injury was truly indivisible and if it can be proved that the breach of duty made more than a minimal contribution to the injury then an employer should be liable for the whole injury. This is a departure from the leading authority of Hatton -v- Sutherland which stated that an employer should only be liable for psychiatric injury for that proportion of the injury caused by the breach of duty.

### Comment

This is a further decision which confirms that once an employer is told by an employee of having difficulties at work due to stress which is affecting his or her health then positive steps and intervention must be taken. It is too late to wait until the next appraisal. In this case, the Court of Appeal said that the Claimant should have been sent home immediately and referred to Occupational Health for an early appointment. It also appears that having a confidential counselling service available to staff will not prevent a successful claim being made.

It is important to ensure that all managers are aware of their legal obligations in referring staff who complain of suffering from stress to Occupational Health and for supportive action to be taken.

In dealing with stress, ultimately, the employer might have to dismiss if there are no feasible alterations that can be made or if they have insufficient beneficial effect. Such a decision needs to bear in mind the likely application of the Disability Discrimination Act and that, as well as reasonable adjustments, alternative work needs to be considered.

# Quantum and Litigation Update



**The shortage of quantum updates in this issue is more than made up for by the number of interesting cases for the litigation update, some of which showing the Court can and does sometimes take opposite views in similar situations:**

[Ian Richard Paterson -v- Surrey Police Authority](#) – November 2008 – *psychiatric injury not reasonably foreseeable*

The Claimant developed a psychiatric condition he alleged was due to having been permanently on-call out of hours to respond to any emergency during much of the period of his service. The High Court held that it was not reasonably foreseeable that the Claimant would suffer the breakdown as a result of stress at work. The Claimant and his wife had not expressed any view to the Police Authority about his stress and he had never submitted a self-certification form mentioning stress. Although a booklet had given the Police Authority an indication of the Claimant's stress, that booklet was provided to them several years before the breakdown and was far too remote in point of time from the occurrence of the breakdown for it to be relied on. Further, it was not obvious from the number of hours that the Claimant had worked each week during normal hours and the amount of standby duty which he had undertaken that the Police Authority should reasonably have foreseen the risk of him developing psychiatric illness as a result of stress.

[XXX -v- A Strategic Health Authority](#) – November 2008 – *damages assessed for cerebral palsy child*

The High Court assessed the damages to be awarded to a 17 year old child who suffered from cerebral palsy severely limiting his physical abilities and reducing his intellectual ability. The Court held that the child required top quality carers providing 24 hour care. Whilst the child would not require attention from two carers for much of the time, two carers were required to move him and it was therefore appropriate and reasonable for him to have two carers except for eight hours of the night.

[Ben Brewis -v- Heatherwood & Wrexham Park Hospitals NHS Trust](#) – November 2008 – *substantial interim payment made despite possible effect on Periodical Payments*

As a result of errors during his mother's labour, the Claimant suffered from asphyxia which caused serious brain injury. He went on to develop cerebral palsy and was profoundly disabled. An interim payment was sought to fund purchase of accommodation together with necessary modifications. The Court held that the child's parents had been extremely prudent in their expenditure since he was born. The interim payment sought did not need to be reduced because of a future Periodical Payments Order that could be made as it

would not affect the level of such a Periodical Payments Order. Moreover the child was entitled to suitable accommodation sooner rather than later and ought to recover a capital sum to reflect that need. The Court held that the fact that an interim payment was made that reflected the child's needs could mean that at Trial there would have to be some discount to or postponement of Periodical Payments was not a reason to reduce the amount of the interim payment. The Court acknowledged that it needed to take note of the property price decline since the date of the child's architectural expert report.

[James Denis Henry Pitcher \(Suing by his Father and Litigation Friend\) -v- \(1\) Headstart Nursery Ltd, \(2\) Caroline Gooding, \(3\) Mayday Hospital NHS Trust](#) – November 2008 – *interim payment assessed by reference to likely amount of lump sum*

The Claimant had suffered a severe and permanent brain injury when he fell from a changing table whilst in the care of the First and Second Defendants. There had been a delay in diagnosing the injury by the Third Defendant NHS Trust. Interim payments had already been made totalling just over £1m and an Application was made for a further interim payment this time a little under £1m. On a conventional lump sum basis the Claimant assessed his total damages claim as £5m. The High Court held that it was very likely that at the Trial on quantum the Court would consider that some of the future losses and in particular the cost of future care and Case Management, should be by way of a Periodical Payments Order. The Court would therefore approach the matter by considering the Claimant's Schedule of Losses and assessing for the purposes of the Application only the likely reasonable awards for general damages for pain, suffering and loss of amenity, past losses and expenses and for future losses that might be capitalised. Taking those factors into account the Court granted a further interim payment of £320,000.

[Omar Gossland \(A Child by his Mother and Litigation Friend\) -v- East of England Strategic Health Authority](#) – September 2008 – *rapid fetal heart rate not sufficient to mandate emergency delivery*

A CTG trace taken during labour showed that a mother's unborn baby had a rapid fetal heart rate. However, the trace was not such that it ought to have alerted a competent Obstetrician to fetal distress. In the circumstances it was not necessary for a blood sample to have been taken from the fetal scalp or for the baby to have been delivered by caesarean section. The Health Authority was not negligent in its treatment of the mother during labour for failing to do.

[Ayesha Canning-Kishver \(by her Mother and Litigation Friend\) -v- Sandwell & West Birmingham Hospitals NHS Trust](#) – October 2008 – *cardiac collapse contributing to cerebral atrophy*

The Claimant child was born prematurely and developed several medical complications including recurring metabolic acidosis. She was extubated at six days old and two days later, she suffered a cardiac collapse. She survived but had continuing disabilities consistent with cerebral atrophy. The Court held that had there been timely medical intervention in relation to the decline in the Claimant's condition, her condition could have been stabilised and reversed without the need for the extensive measures required after extubation. The evidence did not establish on the balance of probabilities that the Claimant's brain injury had arisen simply from her immaturity at birth and although that could not be excluded as a possibility, there were other residual possible causes which could not be ruled out. The Court held that, on the balance of probabilities, the Claimant's cardiac collapse occasioned by the Trust's breach of duty constituted a contribution to the cerebral atrophy that was more than negligible and the claim succeeded.

[Janet Birch -v- University College London Hospital NHS Foundation Trust](#) – September 2008 – *duty to warn of risks of procedure*

The Claimant was displaying symptoms of nerve palsy. An MRI scan was recommended and she was transferred to a Neurology Ward from which she was then transferred to a Neurosurgical Ward where the Neurosurgeons decided to perform catheter angiography, a mildly invasive procedure that had carried increased risks for people in the Claimant's position. The risks of the procedure were explained but the Claimant developed complications that led to a stroke.

At the time there was no consensus within the medical profession as to whether MRI or angiography was the better imaging method and there were certainly other large and responsible medical units that would have performed angiography in the same circumstances. The decision not to use MRI was not of itself negligent. However, if there was a significant risk that would affect the judgement of a reasonable patient then, in normal circumstances, it was the responsibility of a doctor to inform that patient of the risks. By logical extension, the duty to inform a patient of significant risks would not be discharged unless and until the patient was made aware that fewer or no risks were associated with another available and alternative treatment.

In this case the Claimant had been informed of the risks involved with catheter angiography but not the comparative risks of MRI and the Claimant would have opted to undergo the less invasive procedure of MRI had she been properly appraised of the comparative risks. The Claimant had therefore been subjected to an unnecessary procedure that had caused a stroke and the Trust's failure to discuss the implications of the various imaging methods and the comparative risks rendered the Trust liable to the Claimant for breach of duty.

[Anthony Peter Crofts \(by his Wife and Litigation Friend\) -v- Alan Murton](#) – September 2008 – *calculation of life expectancy*

In a Personal Injury claim the Judge had not decided the Claimant's overall expectation of life. The Judge had only decided by how much his pre-morbid statistical life expectancy had been shortened. In such circumstances it was appropriate for the purposes of calculating the multiplier to use table 1 of the Ogden Tables rather than table 28 and to add the reduced life expectancy of the Claimant onto his actual age.

[\(1\) H B Farraj, \(2\) B Farraj -v- \(1\) King's Healthcare NHS Trust, \(2\) Cytogenetic DNA Services Ltd](#) – October 2008 – *both Defendants liable for failing to identify blood disorder*

The Claimant parents were carriers of a gene that could cause an inherited blood disorder that was seriously disabling (Beta Thalassaemia Major). The Trust had undertaken to carry out a pre-natal DNA test on a chorionic villus sample which was taken by the Trust and cultured by Cytogenetic DNA Service. The sample taken had raised the possibility of maternal contamination and although the Obstetrician had offered to provide another sample, the possibility was not pursued. The Court determined that the case was essentially one about communication. The person who had carried out the culturing process had expressed doubts about whether she was setting up a culture of fetal cells. She should have informed the Trust of those doubts and accordingly Cytogenetic DNA Services were liable. However the Trust should have proactively asked for information about the sample. If the underlying concerns about the sample had been communicated to the Trust and in turn to the mother's Obstetrician, a second sample would have been provided which would have been analysed in time for termination of the pregnancy. The mother's Obstetrician had taken the Trust's report as confirming that maternal contamination had been completely excluded because the offer of a second sample had not been taken up although that was not what the report conveyed.

The Court held that the communication failure on the part of each of the Defendants was of equal causative potency although Cytogenetic DNA Services was more culpable than the Trust because it was in possession of the relevant information and failed to pass it on. The problems with the sample were within the knowledge of Cytogenetic DNA Services and these were problems within the specialist knowledge of Cytogeneticists. There was no proper basis on which Cytogenetic DNA Services could assume that the Trust shared its understanding of the inherent problems associated with a sample of that nature. The Trust was however also culpable because it had worked on an assumption that all was well. On that basis two thirds of the responsibility rested with Cytogenetic DNA Services and one third with the Trust.

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# QUANTUM

# UPDATE

**There have been very few reported settlements in the recent months but the following case will hopefully be of assistance when valuing general damages:**

[Romy Smith \(by her Mother and Litigation Friend\) -v- East & North Hertfordshire Hospitals NHS Trust](#) – October 2008 – *brain injury*

The Claimant's doctors had negligently given her an excessive infusion of dextrose when she was 6 days old causing severe and permanent brain damage. She required adult care and attention and was unlikely to achieve any meaningful communication skills. The Claimant's mother wished to provide home care for her as opposed to care in a specialist autistic setting. The High Court held that the Claimant's disability was at the very top end of the scale in terms of her loss of ability, amenity and enjoyment of life. Although there would be no insight into her condition, her life

expectancy was very long and her physical limitations would be moderate. General damages were assessed at £210,000. In relation to the future losses, the mother's proposal that the Claimant received care at home was "perfectly reasonable" – it was what the mother wanted and was, in her opinion, in the Claimant's best interests. The Claimant was therefore entitled to receive an award of damages for the cost of such home care as was required together with the costs of further physiotherapy as well as other therapies, aids and equipment. The Claimant also recovered the costs of moving into a more suitable property and the mother's future loss of earnings and pension (High Court).

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# Making experiences count

**The Department of Health is due to publish new regulations to unify the complaints procedures in relation to all NHS and Social services bodies. This may be the most radical overhaul since the introduction of the NHS complaints procedure in 1996.**

## Background

In March 2001, the Department of Health published an evaluation of the NHS complaints system, which was by then some five years old. The results overwhelmingly demonstrated that the system was poorly perceived by the public. Almost 30% of complainants were dissatisfied with the time taken to deal with their complaint at a local level and a majority were dissatisfied with the outcome. In relation to independent reviews, only 13% of complainants felt they had received a satisfactory result.

The NHS (Complaints) Guidelines in 2004 introduced the Healthcare Commission's role in the independent review of complaints. However, further research in 2005 demonstrated ongoing concerns, particularly in relation to a lack of clarity in the process. There were further amendments to the guidelines in 2006, incorporating lessons from the Shipman inquiry, yet public perception remained negative.

In April 2009 a new complaints procedure comes into force.

## Consultation

The Department of Health published the response to its consultation on the handling of health and social care complaints, entitled "Making Experiences Count", in February 2008. The broad aims were to introduce greater flexibility, simplify procedures and ensure that people's experiences assisted in the improvement of services.

Whilst there were 14 questions in the consultation, the aim was to identify what were perceived to be the key criteria for any complaints procedure. These can be summarised as follows:

- Quick and efficient handling – to include early acknowledgment and resolution of simple complaints immediately in order to prevent escalation;
- Rigorous and unbiased investigations;
- Flexibility, to include roles for mediation and conciliation if appropriate;
- Timely and effective communication with a single point of contact and clear information about the process, with specialist help for vulnerable groups, including access to advocacy services;
- Willingness to offer meaningful apologies;
- A process that enables data from complaints to be analysed in order to identify trends and patterns.

It is these themes and principles which will underpin the new procedures.

## New procedures

In a letter to all NHS Chief Executives and Directors of Adult Social Services on 25 November 2008, the Department of Health confirmed that a new system covering complaints in relation to NHS and Social Services will come into force as of 1 April 2009.

The focus of the procedure is to be very much on resolution at the local level. Indeed, it has been determined that the complaints role of the Healthcare Commission diluted that local focus and, consequently, its involvement in this area will cease from 1 April 2009. New complaints will no longer be accepted by the Healthcare Commission unless they are capable of resolution by that date. The Health Service Ombudsmen will continue as the point of contact for complainants who are unhappy with the way a matter has been addressed locally.

The new complaints regulations are now available on the Department of Health website ([www.doh.gov.uk/mec](http://www.doh.gov.uk/mec)) and a number of feedback events were arranged throughout England during December.

Additionally, there have been a number of "early adopter" sites, operating under the existing complaints process, but with support from the Making Experiences Count team in the development of their local procedures. Their experiences (good and bad) are due to be published in spring 2009 and this document is likely to be very informative.

## Implementation

It is clear that the new regulations will place even greater responsibility on local complaints managers. The expectation is that the vast majority of complaints will be resolved locally, with the emphasis on speed and efficiency to avoid escalation and, indeed, to avoid potential litigation. There must be a determination to eliminate, insofar as possible, the difficulties which have led to so much dissatisfaction in the current complaints procedures.

It is likely that internal policies will need to be reviewed and updated in light of the new regulations and the experience of the "early adopters", when these are published. Additional staff training may be required and, conceivably, the re-printing or production of patient information leaflets may be necessary. The 1 April 2009 is likely to come around very quickly indeed.

We will review the new regulations in our next bulletin.

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# Perfecting Your Protocol



**The Civil Procedure Rules provide useful guidance on what a valid Letter of Claim should contain and the response to be provided for personal injury and clinical negligence claims. These are addressed in the Pre-Action Protocol for Personal Injury claims and Pre-Action Protocol for the Resolution of Clinical Disputes.**

## What constitutes a valid letter of claim

### Personal injury claims

Section A of the Annex to the Pre-Action Protocol for Personal Injury claims provides a sample Letter of Claim by way of example. In summary, the Letter of Claim should contain:

- A clear summary of facts.
- A description of the nature of injury sustained.
- Details of any financial loss sustained.

### Clinical negligence claims

Annex C1 of the Pre-Action Protocol for the Resolution of Clinical Disputes contains a sample Letter of Claim which is appropriate where a clinical negligence claim is concerned. This confirms a valid Letter of Claim should detail:

- The main allegations of negligence
- The Claimant's present condition and prognosis
- If complex, provide a relevant chronology
- Where relevant, offer to provide the Claimant's medical records, inclusive of but not limited to GP and hospital records.

## Timescales

### Acknowledgment

In either case, the Letter of Claim should be acknowledged. An Acknowledgment is due within 21 days where a claim for personal injury is brought and within 14 days for clinical negligence claims.

### Investigation

A period of three months is provided for initial investigation of a claim, with a Letter of Response to be provided within this timescale. Where a Letter of Response cannot be provided within this timescale, this should be communicated prior to conclusion of the timescale for a response. Clearly, this may be relevant for a complex clinical negligence claim, particularly in light of the requirement for medical evidence and an appropriate expert opinion to address allegations of breach of duty and causation.

## Responding to Letters of Claim

Subject to indications as a result of investigations upon breach of duty and causation, a Letter of Response should

be provided addressing the Claimant's allegations in detail and referring specifically to the Claimant's medical records, where applicable. In the event of a denial of breach of duty and/or causation, if possible, copies of any relevant documentation should be annexed to the Letter of Response provided in support of the stance taken. Documentation should be "material to the issues", i.e. likely to be ordered to be disclosed by the Court in any Application for Pre-action Disclosure or Disclosure during proceedings.

Such documentation may include:

- Post-accident incident investigation documentation.
- Earnings information.
- Risk assessments.

Where a chronology of relevant records has been provided and is contested, the Healthcare Provider's version of events should be made clear. Likewise, where in clinical negligence cases internal protocols or other relevant practice guidelines are relied upon, copies should be disclosed to the Claimant.

## Drafting Letters of Response

In common with other legal documentation, the stance taken to allegations raised should be clear, with responses provided in clear wording. If the claim is admitted, this should be stated categorically or confirmation provided in the event of a partial admission as to which elements of the claim remain in dispute. Care should be taken to ensure issues related to breach of duty and causation are addressed as necessary. In the event of any admissions, specific confirmation should be provided as to whether it is intended for these to be binding or not.

## Practice points to note

- Address all issues raised, with full explanation in the event that the allegation is disputed.
- Provide copies of relevant documentation relied upon, where applicable, in support of your arguments to add weight to your position and in the interests of early disclosure.
- Respond promptly where possible or maintain an open approach as to realistic timescales for a reasoned response to be provided, with indications on likely timescales provided at an early stage.
- Use references from the Claimant's medical records for example to aid your case.

In the event that you consider there are issues of validity related to a Letter of Claim received or you require assistance in drafting a Letter of Response, please do not hesitate to contact a member of our NHSLA Team who would be happy to assist.

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# Revised Clinical Negligence Reporting Guidelines

**The 5th Edition of the CNST Reporting Guidelines became effective on 1 October 2008 and can be found on the NHSLA website:**

[www.nhsla.com/Claims/Schemes/CNST](http://www.nhsla.com/Claims/Schemes/CNST)

This document sets out the circumstances in which Member Trusts should investigate and report clinical negligence claims to the NHSLA. The definition of a “claim” is unchanged, as follows:

“Allegations of clinical negligence and/or a demand for compensation made following an adverse clinical incident resulting in personal injury, or any clinical incident which carries significant litigation risk for the Trust” (s. 3.6)

Normally a claim is reportable once a “significant litigation risk” has been established and a realistic valuation has been made. In addition the Guidelines have always set out a number of specific situations in which a claim should always be reported immediately (s. 4.1). The new edition adds to this list, with the new features highlighted below:

- Incidents reported (e.g. a major obstetric mishap), graded red/serious and investigated under the healthcare governance arrangements. Those revealing a possible breach of duty leading to a potential large value claim (i.e. damages of over £250,000) must be reported as soon as possible, usually before a claim is made.
- Incidents which have the potential to become a group action involving a number of patients (e.g. there has been a failure of a screening service such as cytoscreeing or breast screening).
- Claims arising from the alleged negligence or serious professional misconduct of a clinician or team which has affected a cohort of patients (“Serial Offenders”).
- Claims arising from a complaints investigation where the response, on the facts, indicates that an admission of liability has been implied.

- Requests for disclosure of records where the preliminary analysis indicates the possibility of a claim with a significant litigation risk, regardless of value.
- Letters of Claim as the first indication of any action.

S. 8 of the Guidelines is also new and concerns the reporting of prison healthcare claims by PCTs. It is stressed that the PCT may not necessarily be the appropriate defendant in such cases and this will depend upon the specific circumstances. To assist with investigations the following information should be provided when reporting this type of claim:

- When the PCT was first formally involved in the provision of healthcare services.
- Whether the PCT has been a commissioner and/or provider of services. If so, confirm the date when each role commenced and provide copy contracts where available.
- Confirm the employment status of each individual involved in the care of the claimant at the relevant time e.g. PCT employee, prison employee, GP contractor. You will also need to confirm any changes in employment, with dates.
- Explain how prisoners access healthcare services in the particular prison.
- Provide the name and contact details of the manager in your organisation with key responsibility for the PCT’s relationship with the prison.

If you are uncertain whether a claim should be reported we recommend that you contact the NHSLA for clarification. We are of course also happy to assist with any enquiries.

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# Valuing People Now: The Practicalities and Realities of The Transfer of Learning Disability Resources on 1 April 2009

To give effect to the strategy set out in the consultation document [Valuing People Now: from progress to transformation](#) published in 2007, funding and commissioning responsibilities for the provision of social care to adults is to be transferred from the NHS to local authorities on 1st April 2009. By the time this article is published, Primary Care Trusts and Local Authorities should have reached agreement on the amount of the resource transfer, based on PCT spend on adult social care in the financial year 2007/08. However, reaching agreement on the transfer of money is only one of the actions to be undertaken by PCTs and LAs before commissioning and funding responsibilities are transferred on 1st April 2009. Rebecca Wakefield presents a practical guide for PCTs working towards the implementation of the Valuing People Now: from progress to transformation strategy.

## The story so far...

The road to [Valuing People Now: from progress to transformation](#) has been long and winding, dating back to the White Paper [Our health, our care, our say](#) in 2001 which set out a vision for high-quality support by making services flexible and responsive to people's needs. A Healthcare Commission audit published in December 2007 found that learning disability services did not meet 21st century standards, and that they were regularly neglected, old-fashioned and institutional. The publication of the paper [Putting People First](#) in 2007, looked at the wider social care spectrum, not just learning disabilities, and found that service providers needed to look at: universal services, i.e. those available to us all; early intervention support, such as helping people to recover from long-term illness; self-help or personalisation of services (people receiving bespoke services to meet their needs); and integration into the wider community to ease the burden on carers.

## What is the intention of "Valuing People Now"?

Achieving the objectives of "Valuing People Now: from progress to transformation" should go a long way towards achieving the principles of Putting People First by putting all social care commissioning with local authorities and enabling PCTs to focus on their primary obligation of providing health care.

The transfer of LD funding and commissioning will give local authorities the lead role in commissioning social care for adults, with the intention of the government to free up the NHS to focus on commissioning and providing health services. With each organisation able to focus on its own specialist role, they should have greater ability to achieve the aims of world class commissioning and service provision.

"Valuing People Now" also encourages partnership working. The benefits of working in partnership to PCTs and local authorities are manifest, particularly in terms of the economies of scale that can be achieved by reducing the scope for duplication of commissioning and service provision. Working in partnership should also enable greater understanding by each party of the other's ultimate goals and intentions and should reduce the likelihood of disagreement upon issues of responsibility for client care.

One of the caveats to the transfer of funding and commissioning is that there should be continuity of care – PCTs and local authorities must ensure that there will be no alteration to the services received by LD clients until they have their scheduled review of needs. However, local authorities will need to look at whether it is appropriate for LD clients to begin paying for some of their services, subject to resources and means testing.

## Reaching Local Agreement and Working in Partnership

One of the main components of "Valuing People Now" is that PCTs and local authorities should work together to achieve agreement on the amount of funding to be transferred. The deadline for notifying the Department of Health of the agreed amount was 1 December 2008. It is anticipated that in many areas, where s.75 pooled budget arrangements and s.256 partnership agreements are already in place, it will be a more straight forward exercise to agree on the transfer amount and the process for transfer. Other areas not benefiting from such arrangements or agreements may find it a slower process to reach agreement, but help and support is available from agencies such as the Strategic Health Authorities, the Care Services Improvement Partnership, and the regional "Valuing People" support teams.

Where there are no s.75 or s.256 arrangements in place, it is expected that PCTs and local authorities will begin negotiations to put these in place, if not for the beginning of 2009/10, then certainly by 2010/11. These can be lengthy legal documents and both parties should consider instructing solicitors to begin drafting and negotiating the agreements sooner rather than later.

## So what next?

Ultimately, the intention is to transfer all funding for LD services to the local authority by the beginning of the financial year 2011/12. During the interim period, PCTs and local authorities will need to work closely together to ensure a smooth transition of both the commissioning and budget responsibilities. While PCTs will continue to receive that proportion of the LD budget, it is intended that by the year 2011/12 these monies will be paid direct to local authorities by central government. Initially, and so as to achieve the transfer of the funding and commissioning by 1st April 2009, PCTs will need to:

1. Reach agreement on the budget transfer and submit a return to the Department of Health, if they haven't already done so.
2. Assess whether any staff will need to transfer from the NHS to local authorities and if so, seek advice on whether Transfer of Undertakings (Protection of Employment) Regulations, aka TUPE, will apply.
3. Assess whether any property needs to be transferred, for example residential accommodation and/or offices. Where property needs to be transferred, PCTs should examine the legal title to ensure that it is possible to transfer it, as recent [EU case law](#) has decided that where there are staff transfers under the TUPE regulations and the offices they work from are held under a lease, the landlord does not have to consent to the assignment of the lease. An application for permission to assign the lease should be made to the Landlord without delay. For freehold properties, the transfer will need to be by way of a sealed deed which should be prepared as soon as possible.
4. Assess whether the benefit of any legal charges need to be transferred. Historically, and particularly following the closure of long stay hospitals, health authorities and PCTs made grants to housing providers to purchase houses for LD clients to live in the community and the grants were secured by legal charges, or mortgages. If legal charges do need to be transferred, PCTs should begin the process of identifying the properties and agreeing the terms of the transfer, as this will need to be formally documented in a sealed deed.
5. Begin negotiating a s.75 or s.256 agreement, if one is not already in place. If there is such an agreement in place, both parties should review it with a view to agreeing any necessary amendments.

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