

healthcare update

Foundation trusts: ensuring effective governance

The investigation by the Healthcare Commission into the standards of care provided by Mid Staffordshire NHS Foundation Trust at Stafford Hospital and the Commission's subsequent report have recently become the subject of much press interest. The report concluded that there had been serious service failings. As a result, Monitor (the independent regulator of foundation trusts) concluded that the trust was in significant breach of its terms of authorisation and exercised its statutory powers of intervention to appoint an interim chair and interim chief executive.



Effective governance – interaction and joint working between the two boards

A number of issues emerged from the investigation. Some of these issues highlight the need for effective governance within an organisation, ensuring that appropriate structures are in place for concerns and complaints to be investigated and remedial action taken, and for the board of directors to be held to account.

Monitor's Code of Governance states that the governors of a foundation trust should hold the board of directors to account for the performance of the trust, including ensuring that the board acts within the terms of its authorisation. To undertake its role, the board of governors will therefore need access to relevant information. They are entitled to see the annual report and accounts and the annual plan. They should be consulted on forward planning and any significant changes to the trust's business plan. They will need access to clinical and operational data.

Governors may invite directors to their meetings and raise questions about the

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Welcome

Welcome to our summer edition of the Hill Dickinson healthcare update.

As readers of this update will be all too aware, there has been much activity in the healthcare legal world since the last update and we have an interesting line up for you in this edition. In the wake of the Mid Staffs investigation by the then Healthcare Commission, Emma Di Giacomo sets out some key points in relation to effective governance; Kristina Taylor updates us on the latest news on the coroner's and justice bill; we also have our regular litigation and quantum updates and a range of other topical articles. We hope you enjoy your summer holidays, although we doubt many MPs will be - they are probably feeling the heat at the moment and not because of the tropical temperatures!

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affairs of the foundation trust. There must be a willingness to share information and engage to ensure maximum effectiveness in the governance arrangements. Governors must also understand the crucial role they have in holding the board of directors to account and their important role in appointing and removing the chair and non-executive members of the board of directors.

Monitor has recently published draft guidance for consultation, which sets out the statutory responsibilities of governors and how they might be expected to discharge these. All governors and directors are encouraged to respond with their comments. The consultation closes on 13 July.

Effective governance – Monitor's compliance and monitoring regime

Monitor's approach to ensuring that foundation trusts comply with their terms of authorisation is risk-based. Foundation trusts are required to self-certify actual and anticipated compliance in their annual plans and quarterly. These self-certifications are used as evidence of effective governance and Monitor will follow up on issues which indicate potential concerns about the governance of a trust. Risk ratings are issued for each trust in three areas: governance, finance and mandatory goods and services, and are designed to indicate the risk that a foundation trust faces, of breaching its terms of authorisation.

Effective self-governance is therefore essential. The board of directors must monitor the performance of the foundation trust in an effective way and satisfy itself that appropriate action is taken to remedy problems as they arise.

Boards must self-certify that:

- All significant risks have been identified
- Effective risk and performance management processes are in place and all issues raised by external assessments and audits have been addressed
- Plans are in place to ensure ongoing compliance with all existing and future targets and national core standards
- Effective arrangements are in place to monitor and improve the quality of healthcare provided to patients
- The foundation trust is registered with the Care Quality Commission (CQC)
- Plans are in place to ensure ongoing compliance with the CQC's registration requirements
- It is satisfied with board roles, structures and organisational capacity

Monitor will consider seven elements when assessing the governance risk that a foundation trust may face over the coming year:

- 1 Legality of constitution
- 2 Growing a representative membership
- 3 Appropriate board roles and structures – Monitor will look for evidence that a collaborative relationship exists between the board of governors and directors and that directors have the skills to ensure that the foundation trust continues to meet the requirements of its terms of authorisation
- 4 Service performance – ongoing compliance with existing targets and national core standards and prospective compliance with future known targets

- 5 Clinical quality and patient safety
- 6 Effective risk and performance management
- 7 Cooperation with NHS bodies and local authorities – for example, co-operation with commissioners to ensure a legally binding contract for the provision of mandatory services

Governance risk is rated using a traffic light system of red, amber and green. An amber governance risk rating is likely to lead to Monitor monitoring the foundation trust's performance more intensely. Where a foundation trust is rated red for governance risk, the board of directors will be required to present to Monitor the steps being taken to address all areas of non-compliance with its terms of authorisation. Monitor's board will then consider the need for formal regulatory action.

Monitor's intervention powers are broad and range from requiring a board to take, or not take, a specific action to removing any or all of the directors or governors and appointing replacements, as happened in the Mid Staffordshire case.

Changes afoot...

The statement made to the House of Commons by the Secretary of State for Health (following the publication of the Healthcare Commission's report) lists a number of steps he's taken to ensure the quality of services delivered by an applicant trust is thoroughly assessed before he formally supports its application to apply to Monitor for authorisation.

The statement also refers to the following intentions:

- To give extra support to LINKs across the country including the distribution of a 'how to be heard' guide for the public and a national publicity campaign to promote awareness of the role of LINKs in influencing local decision making around NHS services.
- NHS organisations will be required to publish an annual statement of involvement to demonstrate how they are implementing the legal duty to involve patients and the public in the development of health services.

- The reformed and strengthened NHS complaints system sets the expectation that hospitals need to do better at resolving complaints at a local level.
- It is expected that any member of staff who reports concerns about the safety or quality of care will be listened to by their managers and that action will be taken to address their concerns.
- The CQC will be given an explicit and formal role in agreeing that there are no significant concerns about the quality of care that trusts are delivering before they can be authorised as foundation trusts.
- Subject to the successful passage of the current Health Bill through parliament, the production of formal quality accounts will shortly become a statutory requirement for all providers. There is an intention to introduce a legal requirement for commissioners to validate provider quality accounts prior to publication. This will ensure commissioners have a central role in overseeing and improving the quality of care provided to their patients.

The assessment process has therefore been strengthened by Monitor so as to place more emphasis on an applicant trust's clinical quality and service delivery and it is probable that more demands will be made of foundation trusts by Monitor going forward in ensuring compliance with the compliance framework and ensuring high quality service delivery.

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Recent developments in inquest law and practice

Inquests are increasingly becoming more complex and the actions of NHS bodies are being more closely scrutinised, particularly in the context of an inquest which engages the coroner's duties under Article 2 of the Human Rights Act 1998.

With the advent of the amendment to Rule 43 of the Coroner's Rules 1984 (which enables the coroner to issue a report to prevent future deaths) lesson learning is key! It is crucial to ensure that any adverse incidents are investigated as quickly as possible and that you can demonstrate to the coroner that action plans have been put in place and are working. It is no longer sufficient to simply highlight an action plan on paper - you need to be able to show the coroner that it is working in practice.

Coroners and Justice Bill

The bill received its second reading in the House of Lords on 18 May 2009 during which much discussion took place on the use of juries in inquests. The bill enters the committee stage (i.e. line by line examination of the bill) on 9 June 2009.

The introduction of the bill follows several separate reviews of the law on coroners and justice. The key areas relating to coroners are:

- Introduction of a new death certification system - including the appointment of medical examiners to review cause of death given by a medical practitioner who attended the deceased prior to his or her death.
- Independent inspection.
- Right of appeal to the chief coroner on a range of issues (including decisions taken by the coroner about whether to hold an inquest, to request a post mortem examination, to summon a jury)

and regarding the verdict.

- Coroner given power to summon a jury where the coroner thinks, "...that there is sufficient reason for doing so".
- Definition of "interested persons" extended to include more family members (including brother, sister, grandparent and grandchild).
- Coroner will have power of entry, search and seizure - this includes the power to inspect and take copies of any documents.
- Power to report any matters where the coroner considers there is a risk of other deaths occurring in the future. The person to whom the coroner makes his or her report (including PCTs and acute trusts) must provide a written response.

Originally the bill included provision for so called "secret inquests" which would have allowed for jury inquests to be dispensed within cases involving highly sensitive information which could not be made public. However, on 18 May 2009, Jack Straw announced that these plans would be dropped.

The debate regarding the bill continues to evolve. Most recently, further defects in the inquest system were highlighted in the case of Secretary of State for Defence (Appellant) -v- R (on the application of Catherine Smith) (Respondent) & HM Assistant Deputy Coroner for Oxfordshire (Interested Party) [2009] EWCA Civ 441. The Court of Appeal ruled that the Human Rights Act 1998 applied to British troops, even on the battlefield. The court stated that where deaths involve an agent



of the state [including NHS bodies] inquests are of a different kind – Article 2 inquests. The court highlighted that Article 2 inquests allow for a wider verdict and wider scope of investigation.

Whilst the bill retains the distinction between the two types of inquest (Article 2 and traditional), it does not define the difference between them. The court suggested that it would be helpful for the bill to clearly set out the difference between the two types of inquest.

The bill's passage through parliament is unlikely to be trouble free.... watch this space!

Case update

How wide is an Article 2 inquest?
[R -v- \(on the application of Keith Lewis\) -v- HM Coroner for the Mid & North Division of the County of Shropshire \(Defendant\) & Secretary of State for Justice \(Interested Party\): R \(on the application of Gwendoline Calvert \(Claimant\) -v- HM Coroner for Inner North London \(Defendant\) & Secretary of State for Justice \(Interested Party\): R \(on the application of Susan Woods\) \(Claimant\) -v- HM Coroner for Oxfordshire \(Defendant\) & Secretary of State for Justice \(Interested Party\)](#) [2009] EWHC 661 (Admin)

NHS bodies may find some reassurance from the decision of the Court of Appeal in the above case when faced with an Article 2 inquest. The case involved

three separate appeals by the families of prisoners who had hanged themselves. The families argued that a jury could consider facts that were not directly causative of the death on the basis that a proper investigation, within the meaning of Article 2 of the European Convention on Human Rights 1950, required an examination of the practices and procedures in prison. However, the court held that the requirement to investigate a death under Article 2 was to be construed narrowly so that the only relevant circumstances for the inquest to investigate were those that bore a causal relationship to the death. This suggests that, even in the context of an Article 2 inquest, the coroner will not have carte blanche to investigate all processes and procedures operating in an NHS organisation and will only be able to investigate those which are linked to the death in question.

The inquest -v- criminal investigation

[Alison Faith Marie Moss -v- HM Coroner for the North & South Districts of Durham & Darlington](#) (2008) [2008] EWHC 2940 (Admin)

The claimant applied for judicial review of the defendant coroner's decision not to resume an inquest into the death of her father (F) who had been given a lethal dose of opiate by his general practitioner (D) whilst being treated for cancer. The coroner opened an inquest into F's death but when D was charged with F's murder he adjourned it pending

the decision in the criminal proceedings. D was acquitted. The coroner refused to resume the inquest, concluding that it was unlikely that it could improve on the thoroughness of the criminal investigation.

The issue was whether there was anything, not explored in the criminal proceedings, which required further investigation pursuant to the state's obligations under Article 2 of the European Convention on Human Rights 1950. The court held that in a straightforward case of potential clinical negligence the combination of a conventional inquest and the possibility of civil proceedings were sufficient to discharge the state's obligations under Article 2. However, the court went on to state that in cases where the nature of the alleged default might amount to a breach of the state's positive obligation to protect life, then a wider inquest would be required to look at the means and the circumstances of the death.

The court concluded that this case fell into the wider category as there was reason to suspect that there had been unlawful killing rather than mere negligence. The court stated that it was clear the state's obligation, under Article 2, applied to all doctors and other staff engaged in the treatment or care of patients as part of the public health system.

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Draft guidance on 'end of life' issues - consultation

The General Medical Council (GMC) is currently consulting on draft guidance to advise doctors how to approach 'end of life' issues, including the withholding or withdrawal of treatment from terminally ill patients like turning off life support systems or ceasing resuscitation attempts.

The draft guidance, once finalised, will apply to all 150,000 practising doctors in Britain and will cover patients suffering from any life-threatening condition or permanent disability, including heart failure, brain damage and cancer. It also covers end of life care for children and premature babies. The draft guidance avoids any reference to assisted suicide, or active measures to help a patient to die, which remains illegal, despite recent calls for a change in the law.

Current legal precedent indicates that doctors, as opposed to the patient, have the final decision as to whether to withdraw or withhold life-sustaining treatment or nutrition. Whilst there is a strong presumption in favour of preserving life, doctors can withdraw/withhold treatment at the point where it could be considered futile or is not otherwise in the "best interests" of the patient, e.g. as a result of the extent of pain or suffering.

The draft guidance emphasises that doctors must comply with the wishes of a patient wherever possible, in terms of whether they want to receive life-sustaining treatment or not, provided they have capacity to make that decision, in accordance with the Mental Capacity Act 2005 ("MCA"), and provided such

treatment remains ethical. If the patient's wishes are explicit, acting against them "should be deemed to be causing harm". Serious or persistent failure to follow the draft guidance is indicated as capable of putting a doctor's registration "at risk". They would be required to be able to "explain and justify" their actions.

Additionally:

- Doctors are advised to discuss decisions with colleagues, as opposed to reaching them independently, when considering a "life-limiting" condition. The emphasis is on ensuring a patient is not left in avoidable pain and there is early consideration of a patient's palliative care needs.
- Further decisions include whether or not to withhold treatment from the terminally ill, to turn off life-support machines, withdraw feeding or hydration tubes or attempt resuscitation.
- All "reasonable steps" should be taken to consider a patient's wishes and discussion should start before they lose capacity or consciousness, where practicable.
- Where patients are not capable of making decisions, family, close friends, and appointed representatives should be consulted about what the individual

would have wanted, and what may be in their best interests, in accordance with the MCA. If the patient has made a valid advance decision refusing life-sustaining treatment, complying with the MCA formalities, this must be respected.

The Association of Anaesthetists of Great Britain and Ireland is also to issue guidelines on the issue shortly.

Jane O'Brien, Assistant Director of Standards and Ethics at the GMC, has been quoted as saying "clinicians still have the final say on "best interests", but we are asking them to give greater weight to patients' wishes in a more formal sense than we have before...those who have strong feelings about how they want themselves or their loved ones to be treated should expect those feelings to be considered".

The current consultation process runs until 31 July 2009 and the draft paper for consultation titled "End of life treatment and care: Good practice in decision-making" can be viewed on the GMC website at http://www.gmc-uk.org/end_of_life_care/index.asp.

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Patient safety: the issues

Imagine a patient who falls into a pothole on his way to a clinic, whilst walking on the main footpath within the NHS premises.

He sustains severe head injuries and subsequently dies.

From a legal perspective, the consequences will be far-reaching. This is likely to result in an investigation of the trust by the Health and Safety Executive (leading to a prosecution and fine), the requirement to prepare for and attend a coroner's inquest and also having to deal with the personal injury claim brought by the family. In addition, if there was evidence of similar falls occurring in the same place previously, which had not been acted upon by the estates department or the trust board, then a prosecution for corporate manslaughter may be considered.

So, what issues do you need to bear in mind?

1. Lesson learning

Trusts must review and act upon all adverse incident forms, accident forms, complaints and legal claims. From a risk management perspective, it is important to ask what lessons can be learned to avoid repeat incidents? It is imperative to immediately act upon problem areas such as poor lighting or faulty equipment.

2. Training

Particular attention should be paid to any staff training needs arising out of developments in practice or the introduction of new equipment. Bank staff should receive appropriate training and information. Training records should be kept up-to-date, and it is important to ensure that copies of slides/handouts are retained and archived to confirm exactly what advice was given to attendees at a particular course.

Documentation is important. Ensure that a system is in place for adequately storing and indexing all emails and telephone calls received

to your department. Inspections and maintenance must not only be carried out regularly, but must also be documented to demonstrate compliance and performance. Can you show that the alarms on theatre equipment have been routinely tested?

3. Safety on wards

Guidance issued regarding the use of equipment must be acted upon, for example, the use of colour-coded cleaning equipment to minimise the spread of infection and suitable shower curtain rails in a mental health unit where patients are at risk of suicide. The HSE and PASA regularly issue guidelines on commonly occurring incidents and it is important to implement recommendations to comply with health and safety obligations.

4. Contractors

Trusts must have systems in place to appoint and properly monitor external contractors such as those managing domestic staff, building contractors and lift servicing companies. Regular inspections and pre-contract questionnaires should be used and documented. It is also important to retain signed copies of contracts with third parties.

Under the Occupiers' Liability Act 1957, the trust owes a common duty of care to all lawful visitors to take such care as is reasonable to ensure that the visitor will be reasonably safe in using the premises.

If a specific task such as cleaning has been sub-contracted and a patient slips on a wet floor, the trust would have to show that it has acted reasonably in appointing an independent contractor, that steps have been taken to establish that the contractor was competent and that the work was properly performed to escape a claim under this Act. It is clear that appointing a contractor does not automatically absolve a trust of all responsibility to patients, as well as staff.

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Management of dual diagnosis for prisons – new guidance

New guidance was published on 9 April 2009 by the Department of Health, “A guide for the management of dual diagnosis for prisons”. Dual diagnosis refers to the co-existence of mental health and substance misuse problems for individuals. The new framework set out in the guidance is to be adapted by individual establishments to provide co-ordinated services to offenders, as Louise Wilson explains.

Defining dual diagnosis

The term ‘dual diagnosis’ can mean different things to different service providers, but is summarised in the new framework within four principal definitions:

- A primary mental health problem that provokes the use of substances
- Substance misuse and/or withdrawal leading to psychiatric symptoms or illnesses
- A psychiatric problem that is worsened by substance misuse
- Substance misuse and mental health problems that do not appear to be related to one another

Inmates with dual diagnosis are more likely than those with a singular diagnosis to have experienced problems with education, employment, accommodation, and abuse, amongst other social factors.

Responsibility for the management of dual diagnosis

Everyone working for the prison service has a duty of care towards every prisoner, as do the healthcare professionals working for the NHS within the prisons.

Primary care trusts have responsibility for commissioning healthcare services in public prisons. The primary healthcare manager is responsible for facilitation and co-ordination of primary health interventions (for the management of non-severe mental health problems). The primary healthcare manager also has responsibility for physical health services and facilitating the delivery of substance misuse services.

There are strong links between physical well-being and mental health, and it is

imperative that all healthcare providers are well linked to help facilitate the utmost well-being of inmates. In most prisons, the healthcare manager will delegate responsibility for the direct delivery of clinical substance misuse interventions to the clinical misuse manager or a senior practitioner.

The IDTS (Integrated Drug Treatment System) which is being piloted in some prisons at present is attempting to integrate CARATs (Counseling, Assessment, Referral, Advice and Throughcare) and other substance related health services into a single multi-disciplinary treatment team.

It is important to ensure that pharmaceutical services provide more than just a supply service in order to ensure safe and effective use of medicines. Responsibility for the management of medicines lies with the chief pharmacist.

Mental health – legal framework

Inmates with mental health issues, including those with a dual diagnosis, must have access to Care Programme Approach (CPA) and responsibility for access to CPA rests with the head of mental healthcare services within each prison.

Mental disorder is now defined as “any disorder or disability of the mind”. The widened scope for individuals to be encompassed within the definition of suffering mental disorder, since the Mental Health Act 1983 was amended by the Mental Health Act 2007, means that a higher percentage of the prison population than ever before may require mental health services.

There is a large proportion of prisoners with personality disorders, many undiagnosed, and whereas the introduction of DSPD (Dangerous and Severe Personality Disorder) services in HMP Frankland and HMP Whitemoor may have been a step forward in dealing with this issue within the prison estate, there are many offenders who would not fit the criteria for these units, but may still require mental health intervention.

Clinical presentation is often complicated further by substance misuse, and those with personality disorder may have a further mental health issue such as a psychotic or major affective disorder.

Current practice within the prison service

At present, a parallel approach is adopted in most prisons, whereby care is provided by more than one treatment service at the same time. Prisoners with dual diagnosis may receive care from a mental health team, drug treatment services, and the primary healthcare team providing other clinical services.

The advantage of this approach is that inmates will receive specialist help for each aspect of their health problems. The disadvantage is that there can be a breakdown in communication between treatment teams and treatment can appear fragmented.

IDTS plans to establish a more integrated approach involving healthcare teams and CARATs teams becoming involved in joint care planning, case reviews and co-ordinated through-care.

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Recommended approaches

The new framework sets out two options for the treatment approach for dual diagnosis.

1. Specialist dual diagnosis team

Some prisons have already established such teams and in the main are comprised of professionals with a background in psychiatry, psychology, social care and substance misuse. Specialist teams offer four services:

- **Assessment** – assessment of mental health, cognitive ability, social functioning, skills for living and substance use – early assessment is essential
- **Consultation** – if direct involvement is not required, the specialist team remains available for supervision and consultation by the referring team
- **Individual case work** – if specialist help is required, this service is provided including care co-ordination as part of the CPA
- **Education and advice** – training is provided to primary healthcare and substance misuse teams with ongoing supervision

There are some drawbacks to this option in that there is a risk that the responsibility for dual diagnosis lies with too limited a number of practitioners, and in a fragmented model such as this, progress may be undetected in one service which can adversely affect treatment overall. Also, decisions made by one service can be detrimental to the treatment offered by another service.

2. Utilising and integrating existing services

This is viewed as the more practical approach for most prisons. The framework indicates that primary healthcare, mental health and substance misuse teams should meet in order to decide how best to manage prisoners with dual diagnosis. A protocol should be implemented including statements on the following:

- What is dual diagnosis?
- What is the most practical way of providing care to patients/clients from each of these four categories?
- Confidentiality?
- Who co-ordinates care?
- How will training and supervision be provided?
- What will be the model of care?

Further guidance on this model can be found in the framework.

Good practice

Some important elements of good practice include:

- Early identification of need – specially trained staff to determine needs
- Safe prescribing – mental health trained pharmacists should be available for advice
- Management of opiate or benzodiazepine dependence – if combined with mental health problems, may be that the inmate should be stabilised, rather than detoxified, for a minimum of 2 weeks – a joint care plan should be devised
- Child protection and welfare – reducing harm, with inter-agency working
- Specialist skills
- Flexibility – care must be planned on an individual basis

Continuity of care

For inmates with mild to moderate mental health problems, upon release, they will not normally be subject to the CPA. Care must be continued through CARATs/ offender manager referral to the prisoner's local drug/alcohol service, and referral to the inmate's GP for continuity of mental/ general healthcare.

For inmates managed under the CPA, where a substance misuse issue remains, the care co-ordinator must take the lead on release planning, with direct contact with the community mental health team.

Summary

Each prison must adopt its own policy regarding dual diagnosis in accordance with the framework. It must include guidance on all of the above issues, and consider therapeutic issues relating to inmates with dual diagnosis, referred to in the guidance in detail.

It is essential that integrated working between healthcare teams and substance misuse teams is established in order to ensure that inmates are diagnosed appropriately and treated accordingly. The treatment afforded to inmates must be cohesive so that recommendations of one service do not conflict with another.

Sharing of information, subject to the relevant legislation, is key to a successful integrated approach to dual diagnosis. A trust protocol, in line with the guidance, and summarised above, will assist in ensuring that there is consistency of approach to this issue, and that service users receive the most appropriate interventions.

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Horizon scanning - what are the current legal issues arising in offender healthcare?

Advance decisions - offenders refusing life sustaining healthcare treatment

PPO reports and clinical reviews - disclosure to the coroner and the use of their findings at inquests

Data Protection Act 1998 and confidentiality - disclosing medical records to non-healthcare staff i.e. drug treatment services.

Preparing for the Corporate Manslaughter Act -

specific duty of care to those in custody due in force 2011


Telemedicine - providing specialist medical appointments via video-link for prisoners in the high secure estate.

Drug detoxification and the Human Rights Act 1998 - claims for compensation

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Review of interesting litigation claims



In this article we look at some recent claims we have dealt with (not that we like to blow our own trumpet....!)

[A -v- B NHS Trust - discontinuance of stress at work claim](#)

The claimant had been employed as an anaesthetic theatre nurse at the trust since January 1978. In late 2003, it was alleged the claimant was frequently asked to carry an emergency cardiac arrest bleep between 8:00 am and 9:00 am each morning. It was the claimant's case that she was not sufficiently experienced, qualified or trained to perform this task. This led to her going off work with a stress-related condition in September 2005.

In fact, investigations revealed that the claimant had told her line manager that the reason she required time off work was because she had a number of very close relatives who were seriously ill.

The claimant returned in August 2006 on a phased basis, working in recovery, which was thought to be a "less stressful" position. However, the claimant suffered a major anxiety attack and went off work

again in May 2007. She returned to work again in April 2008.

It was accepted that the first absence from work was not foreseeable but it was alleged that the trust had been negligent in placing her in an acute environment in recovery following her return, without anaesthetic back up and facing the possibility of having to intubate in life and death situations.

The claimant served psychiatric evidence which stated that her depressive illness and post traumatic stress disorder-type symptoms followed from a protracted period when she was effectively bullied into accepting responsibilities beyond her capabilities. The report did not address the causal effects of the second absence when she was not required to hold the bleep.

Our defence asserted that the decision to move the claimant to recovery was made with her agreement, in conjunction with her union and occupational health. She

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had attended an immediate life support course and the trust could have done no more in the circumstances. We took the view that a robust defence was warranted.

Perhaps unusually for this type of claim, the claimant continued to be employed by the trust. The claimant has now discontinued and we are seeking recovery of our costs.

This claim was handled by Andrew Craggs.

C -v- D NHS Trust - nervous shock claim brought by secondary victim struck out

This claim arose out of the death of the claimant's mother following treatment at the trust. The claimant brought a claim in her own right for nervous shock. It was accepted that the death had been caused by negligent treatment.

The claimant alleged that she had suffered psychiatric injury as a result of seeing her mother in intensive care after suffering a cardiac arrest caused by negligent treatment. She did not witness her mother having the cardiac arrest, but merely the treatment she received afterwards.

The parties exchanged medical evidence, Dr B, psychologist for the claimant and Dr C, consultant psychiatrist for the trust. Whilst it was accepted that the claimant had suffered an adjustment disorder, in their joint report the experts disagreed as to the cause of the illness. Dr B considered that the adjustment disorder was caused by the traumatic images of her mother, the suddenness of her deterioration and the inexorable progress towards death. Dr C felt that the major cause was self-blame for allowing her mother to go to hospital in the first place.

We applied to strike out the claim as in Dr B's initial report, no reference was made to shock and this was only addressed in her later report. In entering judgment for the defendant the judge considered that seeing a close relation in intensive care prior to death did not constitute shock as defined in Alcock and others -v- Chief Constable of South Yorkshire Police [1992]1 AC 310, i.e. "the sudden appreciation by sight or sound of a horrifying event, which violently agitates the mind".

Comment

Whilst this was of course a very sad case, it is pleasing to note that the court was unwilling to contemplate an extension of the Alcock principle, which meant that we were able to establish that the claimant had no real prospect of success with the claim.

This claim was handled by Jonathan Heap.

E and F -v- G Trust - costs order against the first claimant on discontinuance by a related second claimant

Mrs E (a type 1 diabetic) gave birth to her fourth child, F, on 3 June 1992 who has a range of problems including learning difficulties.

Initially the claim was pleaded in terms of wrongful birth on the basis that with proper advice, Mrs E would have opted for a termination. The case was subsequently amended to add F as a second claimant and his claim was pleaded in the alternative to Mrs E's claim. It was alleged on behalf of F that a failure to properly monitor and control Mrs B's diabetes during the pregnancy had led to his injuries.

At a conference arranged prior to the exchange of expert evidence Dr R, our consultant paediatric neurologist, raised a potential genetic cause for F's problems.

The court subsequently granted permission for the parties each to rely on evidence from a neuro-geneticist and a clinical geneticist and at a meeting of those experts last year the claimant's experts conceded that on the balance of probabilities F has a mitochondrial disorder, which is responsible for the vast majority of his problems. The claimant's solicitors offered no order for costs in relation to the discontinuance of F's claim. They indicated that, if pushed, they were prepared to concede a costs order against him, not to be enforced without leave of the court. However, as he is a disabled minor this was in our view in effect the same as no order for costs. Mrs E has public funding and we confirmed to the claimant's solicitors that we would be seeking that our costs in connection with investigating F's claim would be payable by Mrs E by way of set off against any damages and/or costs she receives. Advice from counsel confirmed that there was sufficient mutuality in the two claims to argue that defence costs should be met by Mrs E. At a hearing permission was given for F's claim to be discontinued and for service of re-amended Particulars of Claim which allege, as before, a claim in wrongful birth only. Having sought advice from leading counsel the claimant's solicitors conceded the costs point and agreed our order terms. This order was particularly important as the costs of investigating F's claim will be in excess of £50,000 and in the event that Mrs E's claim succeeds this will make a considerable difference to the damages and/or costs payable.

This claim is being handled by **Joanne Seery**.

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JS -v- A Foundation Trust – success at Trial

The claim arose out of surgical treatment for a fracture to the claimant's left radius and ulna sustained on 11 March 2004 during a motor cross accident. The claimant underwent urgent surgery in the form of an open reduction and internal fixation of the left radius and ulna with plates and screws.

On 16 April 2004 an x-ray identified delayed union but no failure of the metalwork. The treating surgeon made a clinical judgement not to insert a bone graft at that stage. On 11 June 2004, the claimant was listed for re-plating and bone grafting of the left forearm, which took place on 18 July 2004.

The claimant then developed post-operative sepsis requiring re-admission and removal of the metal work. In October 2004, he underwent surgery to transplant the fibula from his right leg to his left arm. The surgery was successful but he developed a DVT which led to a post thrombotic syndrome, as a result of which the claimant is now prone to recurrent ulcerations of his leg.

The claim for damages was originally put at over £1 million but reduced to £561,000 shortly before trial. The parties' vascular surgeons agreed that the claimant would probably have developed post thrombotic syndrome in any event by the age of 40. Breach of duty, causation and quantum were all in dispute.

The allegations were initially wide ranging but by the time of the trial, the allegations left for the judge to consider were simply that the length of the screws used in the original operation were too short, there was a failure to consider the suitability of the bone graft and an unreasonable delay in the surgery taking place.

By way of causation, it was the claimant's case that the length of the screws led to the metal work failing before the bones had healed and that with earlier bone grafting the infection would have been avoided. Consequently the DVT which developed after the October 2004 operation could have been avoided. The parties agreed that the October operation was an inevitable consequence of the infection of the earlier bone graft and the issue was therefore whether the infection was caused by any breach of duty.

Judgment was handed down on 27 April 2009 in favour of the defendant. In his judgment, the judge made reference to the orthopaedic joint statement in which the experts had agreed that the size of the screws was sub-optimal but had chosen not to answer the remaining part of the question, which asked whether or not this also amounted to substandard practice, with reference to the Bolam principle. The claimant's expert had not provided any literature to support his assertion, made in oral evidence, that the length of the screws would amount to a breach of duty. Neither did he state in his report that the screw length amounted to substandard practice. The trial judge stated that it was "puzzling" that the claimant's expert did not confirm in the joint statement that the use of short screws was negligent, rather than merely being sub-optimal. The conclusion reached was that the claimant's expert had changed his position, whereas in contrast, the defendant's expert opinion had remained consistent.

In respect of the failure to proceed to bone grafting on 30 April 2004, the judge found the credibility of the claimant's expert evidence to be weakened by the fact that the criticism emerged late in the day and was entirely contingent on the state of the wound. In the joint statement, both experts had already deferred to the treating surgeon as to the state of the wound and the treating surgeon's

evidence was that the wound would not have been suitable (on 30 April 2004) for bone grafting.

With regards to delay in bone grafting after 11 June 2004, it was agreed that the trust should have and could have done better. However the consultant was on annual leave. The defendant's expert agreed that the delay was disappointing but that this did not amount to a breach of duty of care. The claimant's expert advised the operation would have been listed within one week of the decision being made at his hospital. The court agreed with the defendant.

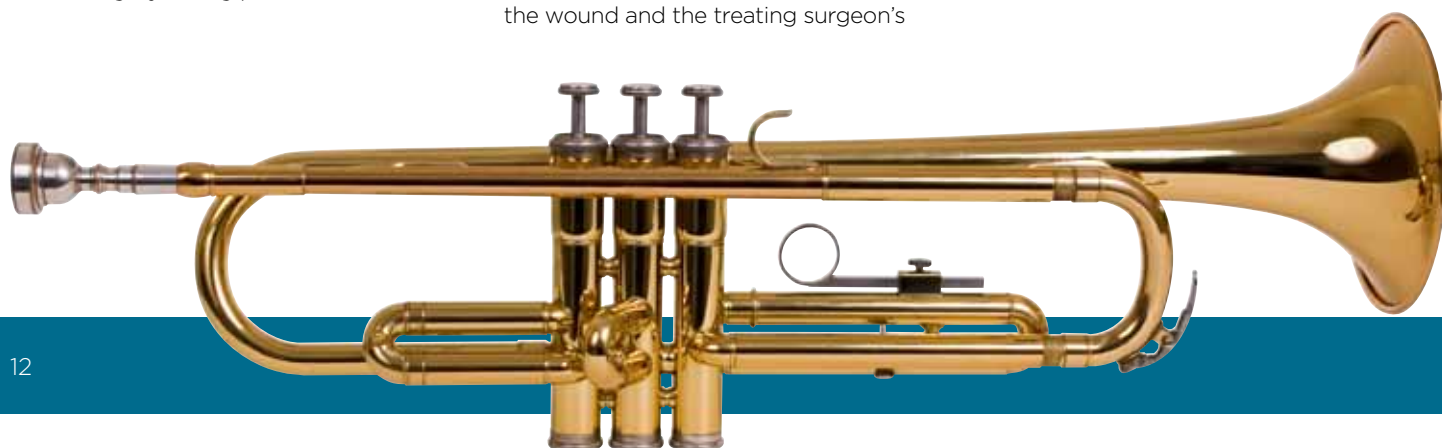
Causation was not dealt with in detail in light of the findings on breach of duty but the court again preferred the evidence of the defendant's expert and stated that the claimant could not prove more than a negligible increase in the risk.

The claimant, whilst initially an assisted person, entered into a Conditional Fee Agreement 8 months prior to trial. Indemnity costs were sought and awarded from the date of expiry of a 'drop hands' offer which had been made in January 2009.

Comment

This was clearly a very pleasing outcome, with costs recovered on an indemnity basis for the latter stages. The awarding of indemnity costs was considered to represent judicial disapproval of the continuation of this claim to trial, despite much of the claim falling away and without strong evidence in support of the remaining allegations. The drop hands offer served to highlight that the claimant should have given serious consideration to their prospects, which they failed to do.

This claim was handled by [Joanne Hughes](#) and [Monia Sood](#).



Litigation update

In recent months there have been a number of interesting cases, as Tony Steel highlights.

[Smith -v- Northamptonshire County Council \[2009\] UKHL27 - work equipment](#)

This case has previously been reported in an earlier litigation update but the case has since been heard by the House of Lords. A carer/driver went to collect a patient and was hurt when a wooden wheelchair ramp collapsed as the claimant pushed the patient down it. The ramp had been installed by a third party NHS trust and showed no sign of disrepair. The claimant brought a claim against her employers under the Provision and Use of Work Equipment Regulations 1998.

The House of Lords held that the ramp was, in an abstract sense, work equipment but an entirely literal approach to the words "or used" in Regulation 3(2) could not be correct. Before an employer came under the strict responsibilities imposed by the regulations, some specific nexus beyond the mere fact of use was required between his undertaking and the equipment. Regulation 3(2) deals with situations where there was a direct employment relationship and the test was whether the work equipment had been provided or used in circumstances in which it had been incorporated into and adopted as part of the employer's business or other undertaking. Such incorporation could either be the result of the equipment having been provided by the employer for use in his business or as a result of it having been provided by somebody else but used by the employee in the employer's business with the employer's consent and endorsement.

The ramp had neither been incorporated into nor adopted as part of the local authority's undertaking nor was it under their control. It had not provided the ramp, did not own nor possess it and did not have any responsibility or indeed any right to repair it. The ramp was no more than part of the environment that an employee had to face when performing his functions at work away from any premises occupied by his employer. The fact that the local authority had inspected the ramp showed merely that it was careful, not that it controlled the ramp or had incorporated it into its undertaking,

nor that it should be strictly liable for any defect in it. The defect was latent and was not observable on inspection.

The court went on to say that the courts should be careful not to impose on employers responsibilities that went far beyond those at which the Directive 89/655 and regulations were aimed.

The House of Lords were however split 3-2. The two dissenting judges felt that the regulations would apply if the employee's use of the equipment for the purposes of his work was known to or authorised by the employer, and the employer could inspect and assess the equipment and could reasonably instruct the employee not to use it.

[Rault \(By his Mother and Litigation Friend\) -v- North West Strategic Health Authority \[2009\] EWCA Civ 444 - court cannot vary/ revoke a final settlement under CPR 3.1\(7\)](#)

The claimant had been starved of oxygen at birth and suffered from cerebral palsy. The health authority had accepted liability for his injuries and the parties reached a settlement for damages which was approved by a judge. The settlement stated that the claimant would be cared for in a specialist group home (as opposed to living in privately-bought accommodation with the need of full time care staff) which would be quantified at a later date. The claimant served a revised schedule seeking damages for future care in privately-obtained accommodation with privately-engaged carers saying that he had moved into a group home but it had been unsuitable and had left. The Court of Appeal held that the settlement approved by the judge was a final disposal of many of the issues between the parties and the court's power to vary or revoke an order under CPR 3.1(7) could not be used to vary or revoke an order for approval to a final settlement.

[Whiston -v- London Strategic Health Authority \[2009\] EWHC 956 - cerebral palsy claim brought within limitation period](#)

The claimant was born in 1974 and suffered from cerebral palsy after experiencing

hypoxia around the time of his birth. His claim was commenced in 2006 and it was accepted that he was aware that his disability was significant for the purposes of the Limitation Act 1980. What remained an issue was when he acquired actual or constructive knowledge that the disability might possibly be attributable to acts or omissions by medical staff at the time of his birth. Although the claimant knew that his disability was linked to the circumstances of his birth, that there had been a forceps delivery and that he had been deprived of oxygen shortly before that, he had not inferred that any of those circumstances were, or might be attributable to any act or omission on the part of the medical staff. Mere knowledge of hypoxia and of the forceps delivery were not sufficient and the claimant had neither actual nor constructive knowledge for the purposes of the Limitation Act.

[Bruna Long \(A Protected Party proceeding by her Litigation Friend\) -v- Norwich Union Insurance Ltd \[2009\] EWHC 715 - costs of proving life on specified dates to be included within claimant's professional deputy's costs](#)

The claimant had sustained injuries in a road traffic accident and the defendant insurer was to pay a lump sum of £900,000 and periodical payments at a rate of £25,000 per annum. One of the provisions of the order was that the defendant would be entitled to require the claimant to produce evidence that the claimant remained alive before making each instalment. The court held that the costs of complying with the requirement to provide proof of life, if significant, should be included within the professional deputy's costs in each case or elsewhere as appropriate in the damages if it was thought worthwhile so to do.

[Haitwaite -v- Thomson Snell & Passmore \[2009\] EWHC 647 - lost chance of pursuing a negligence claim against an NHS trust](#)

The claimant argued he had lost his chance of pursuing a clinical negligence claim against an NHS trust due to the admitted negligence of a firm of solicitors in respect of

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the conduct of the action against the trust. The court determined the value of the loss of chance having regards to the prospects of establishing the trust's negligence and also the prospects of showing that the negligence had caused at least some loss which was more than minimal. The court assessed the prospects of the claimant establishing negligence at 40% with a 75% chance that he would show that any such negligence had caused some loss. The claimant's overall prospects of success against the NHS trust were therefore assessed at 30% to reflect the litigation risk of not being able to establish that some harm was caused by the negligence. The court then applied that 30% figure to the sum it calculated as being the likely quantum award and the claimant was awarded that amount as being the overall value of what he had lost by reason of the defendant firm's negligence.

[Benjamin Eeles \(By his Mother and Litigation Friend\) -v- Cobham Hire Services Ltd \[2009\] EWCA Civ 204 – approach to be taken by court when considering an interim payment in a personal injury case where the trial judge may wish to make a Periodical Payments Order](#)

The claimant, aged 11, had suffered a serious head injury in a car accident when he was only 9 months old. Liability was not disputed and judgment was given for damages to be assessed. The claimant had received interim payments amounting to £450,000 and requested a further interim payment of £1.2 million to pay for a family home and refurbishment costs so as to meet his needs. The defendant had previously made an offer of £3.25 million to settle the claim.

The court held that the court had no power to make an order for an interim payment of more than a reasonable proportion of the likely amount of the final judgment. The approach which a judge should take when considering whether to make an interim payment in a case where the trial judge may wish to make a Periodical Payments Order was:

a) Assess the likely amount of the final judgment leaving out of account the heads of future loss which the trial judge might wish to deal with by a periodical payments order.

b) Assessment should comprise only special damages to date and damages for pain,

suffering and loss of amenity, with interest on both.

c) It would usually be appropriate to include accommodation costs in the expected capital award given the usual practice of awarding accommodation costs, including future running costs as a lump sum.

d) Assessment should be carried out on a conservative basis.

e) Save in certain circumstances the interim payment would be a reasonable proportion of that assessment. A reasonable proportion may well be a high proportion provided that the assessment had been conservative – the objective was not to cheat the claimant out his money but to avoid any risk of over-payment.

f) For that part of the process the judge need have no regard as to what the claimant intended to do with the money.

g) Additional elements of future loss can be included in the judge's assessment of the likely amount of the final judgment when the judge could confidently predict that the trial judge would wish to award a larger capital sum than that covered by general and special damages, interest and accommodation costs alone.

h) Before taking such a course the judge had to be satisfied by evidence that there was a real need for the interim payment requested and if the judge was satisfied with that, to a high degree of confidence, then he would be justified in predicting that the trial judge would take the course indicated and he would be justified in assessing the likely amount of the final award at such a level as would permit the making of the necessary interim award.

[Chantelle Peters \(By her Litigation Friend\) -v- \(1\) East Midlands Strategic Health Authority, \(2\) P Holstead \(Defendants\) and \(3\) Nottingham City Council \(Part 20 Defendant\) \[2009\] EWCA Civ 145 – liability of health authority and local authority to a patient for future care costs](#)

This case was reported in an earlier litigation update but has now been heard by the Court of Appeal.

The Court of Appeal held that there was no reason in policy or principle why a

claimant should not opt for self-funding and damages to fund future care in preference to reliance on the statutory obligations of a public authority, provided there was no double recovery. An effective way of dealing with the risk of double recovery where a claimant's affairs were being administered by the Court of Protection was to provide that court with a copy of the judgment of the personal injuries claim and seek an order that no application for public funding of the claimant's care under the National Assistance Act 1948 should be made without further Order. There should also be provision for the defendants to be notified of an application for permission to apply for public funding. The risk of double recovery could not justify not awarding the claimant the full cost of care and accommodation in her damages.

[C J L \(A Child by his Mother and Litigation Friend\) -v- West Midlands Strategic Health Authority \[2009\] EWHC 259 – trust liable for obstetrician's failure to intervene timeously in delivery](#)

The claimant had suffered brain damage at birth as a result of an acute profound hypoxic-ischaemic insult at the end of labour, most likely as a result of cord occlusion as his head descended through the birth canal. The midwives had called the obstetrician who failed to arrive within the expected timeframe. It was common ground that had the claimant been delivered earlier he would have either suffered no brain damage or minor brain damage. The court held that medical assistance should have been called when the midwives were unable to confirm fetal wellbeing and had evidence to indicate that the claimant's condition was deteriorating. The midwives had called for an obstetrician at the correct time but a reasonably competent obstetrician would have been able to deliver and resuscitate the claimant earlier than had actually occurred which would have negated the risk of brain damage/serious brain damage.

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Quantum update

Quite a number of useful cases have been reported in recent months to assist in valuing claims as follows.

[Edward Guy Tibbatts -v- British Airways PLC - May 2009 - shoulder injury](#)

A baggage handler injured his shoulder unloading baggage in August 2003. He suffered a small tear in the rotator cuff which required physiotherapy but not surgery. By May 2004 he had fully recovered from the injury and was fit to return to work. Symptoms subsequently identified on examination in April 2007 were the result of degenerative changes rather than continuing consequences of the injury. Leaving aside contributory negligence, the claimant's general damages to cover the injury period from August 2003-May 2004 were assessed at £2,500 (High Court).

[Re H - April 2009 - severe brain damage](#)

Mr H had suffered severe injuries during a violent crime in January 1987 when he was three months old (22 years old at the date of the award). He sustained fractures of his skull and left rib, a cerebral haemorrhage and infarction and severe brain damage. His eye had to be removed and he was incontinent of urine and faeces. He suffered from epilepsy and was unpredictable. As he was seen as a potential threat to women, because of his behavioural problems, he effectively had to be contained, residing in a private residential care home. He had no insight into his injuries and his condition. His life expectancy was not affected. General damages were assessed at £225,000 (CICA award).

[Michael Harvard -v- North Bristol NHS Trust - March 2008 - arm injury](#)

A 37 year old man's right arm was injured when a cannula inserted in hospital tissue. He suffered a swollen arm and subsequently compression syndrome and carpal tunnel decompression leading to significant functional impairment of his right arm. He was unable to continue working as a HGV driver but was able to return to work as a bus driver instead. His impairment was permanent. General damages were £25,000 (out of court settlement).

[K -v- Bolton Hospitals NHS Trust - March 2008 - psychiatric problems](#)

The claimant's daughter died, aged one,

after receiving negligent medical treatment. The claimant mother suffered a complicated bereavement reaction with Post Traumatic Stress Disorder which was expected to last for approximately four years after the death of the child. General damages were £10,000 including £600 for the cost of therapy (out of court settlement).

[\(1\) Mrs H, \(2\) Mr H -v- Frimley Park Hospital NHS Trust - March 2008 - psychiatric injuries](#)

A 34 year old woman and a 34 year old man suffered psychiatric injuries and subsequently attended counselling after their baby was stillborn. They suffered the emotional trauma of the stillbirth of their first child and the psychological injury and grief both suffered caused considerable strain upon the relationship and the marriage broke down. Mrs H suffered a moderately severe depressive episode and a pervasive sense of loss; Mr H suffered nervous shock injury. General damages were £15,000 for Mrs H and £4,000 for Mr H (out of court settlement).

[C \(By her Mother and Litigation Friend\) -v- Portsmouth Hospitals NHS Trust - August 2008 - development dysplasia of the hip](#)

The defendant hospital failed to diagnose that a girl was suffering from developmental dysplasia of the hip when she was examined shortly following her birth. She required an arthrogram and was put in traction for one week, later undergoing a closed reduction. Aged six at the time of settlement, her only residual symptom was weakness of the left abductor around the hip which caused her a small amount of difficulty in balancing on one leg. She required more extensive treatment as a result of delay in diagnosis of her condition and remained in a plaster cast for 12 weeks but made a good recovery. General damages were £8,000 (out of court settlement).

[Warrilow -v- Norfolk & Norwich NHS Trust - April 2006 - bladder damage/psychiatric injury and chronic pain](#)

In 2001 the claimant, aged 34, gave birth to her third child. Following the birth she failed to pass urine and the staff failed to monitor her urine output or catheterise her.

She suffered an over-distended bladder such that self-catheterisation was to be her lifelong method of passing urine. She suffered psychiatric injuries and ongoing chronic pain that was both neurological and neuropathic in nature. Her sexual relationship with her husband stopped and the marriage deteriorated. She was awarded general damages of £105,000 (High Court).

[F -v- University Hospitals of Birmingham NHS Foundation Trust - January 2008 - fractured neck of femur](#)

An 87 year old woman had previously fallen and fractured the neck of her left femur, which required a hemi-arthroplasty and was undergoing rehabilitation at the trust. During that rehabilitation she fell again and sustained a second fracture to the neck of her left femur. The claimant suffered diminished function in the left leg which was short and also instability of her left hip. The claimant's evidence was that this was due to the second fall; the defendant's evidence was that she would have had leg shortening, stiffness and instability in any event. General damages were £20,000 (out of court settlement).

[\(1\) EA, \(2\) AA -v- Kings Lynn & Wisbech Hospitals NHS Trust - September 2007 - psychiatric injuries/failure to screen for Down's Syndrome](#)

Mrs A (aged 25) and Mr A (aged 31) suffered an adjustment reaction and a depressive episode following the birth of twins who were born with Down's Syndrome and were dependant upon the parents. The hospital had failed to offer the option to have the twins screened for Down's Syndrome prior to the birth in February 2000. Mrs A suffered a moderately severe adjustment reaction from which she recovered but remained at increased risk of developing a depressive illness in the future. Mr A developed a moderately severe major depressive episode which was ongoing. General damages were £25,000 (out of court settlement).

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Two fingers in one pie? The law on procurement

On 19 May 2009, the European Court of Justice handed down a ruling dealing with the position where two businesses, which are linked to each other, bid separately for the same contract.

This case involved a bidder, Assitur Srl, taking issue with the participation in a tendering process by two other companies (with whom it was in competition), on the basis that those two other companies were linked to each other (which indeed they were). The purchasing authority, Milan Chamber of Commerce, looked at Italian law and came to the conclusion that it did not prohibit participation in a public procurement by two companies which were linked by a relationship of control.

And so Assitur went to court. It tried first, in the Italian Court, to have the award decision annulled – on the basis that a separate Italian law did indeed prohibit the simultaneous participation in competitive procurements by companies which were linked by a relationship of control, and that this principle should be applied to the case at hand. The Italian court, in turn, referred the matter to the European Court, asking whether an EU member state must permit participation by businesses linked by common control. The following describes the European Court's findings.

- First, the relevant European directive on public procurement sets out grounds for excluding businesses from tendering on the basis of their professional qualities. That list does not prevent member states from adopting their own rules designed to ensure that

the key principles of equal treatment and transparency are observed. Any additional grounds for exclusion are therefore allowed, if they are intended to guarantee respect for those principles – and provided that they do not go beyond what is necessary to achieve that objective.

- However, it would be contrary to the purpose of public procurement law to exclude systematically from a procurement businesses which are affiliated to one another. To do so would reduce competition – whereas procurement law sets out to achieve the widest possible participation by candidates in a competitive procurement procedure.
- Therefore, a national law which prohibits participation in the same procedure by affiliated businesses (whether or not that relationship were to have any effect on their conduct) would go beyond what is necessary to achieve fulfilment of the equal treatment and transparency principles. A law operating on those lines would, of necessity, be founded on a presumption that bids submitted by affiliated businesses will have been influenced by one another.
- This breaches the principle of proportionality – in that it does not allow those businesses an opportunity to demonstrate that (in their case) there is no real risk of occurrence of practices which could jeopardise transparency and distort competition.
- The court went on to make the point that groups of businesses which are under the same control do not necessarily lack autonomy in the conduct of their commercial policy and their economic activities. Therefore, the question of whether the relationship of control might have influenced the content of two tenders submitted in the context of the same procedure, requires

individual assessment on a case-by-case basis – and it is for the purchasing authority to carry out this assessment. Whilst a finding of influence is sufficient for those businesses to be excluded, a mere finding of a relationship of control linking two or more candidates is not sufficient to justify automatic exclusion, in the absence of a determination of whether the relationship had a specific effect on their conduct.

This case is rather reminiscent of a previous case in the European Court – [Fabricom](#), in which it was established that it is unlawful (whether as a matter of national law or of procedure) to exclude automatically from a procurement a candidate whose participation might distort competition or generate a conflict of interest, without that person being given the opportunity to prove that (in the circumstances of the case) it has not received unfair advantage. The theme common both to [Fabricom](#) and [Assitur](#) is that they both point to a requirement to provide the businesses concerned with an opportunity to demonstrate that their position is unproblematic. This is directly relevant to commissioning by NHS organisations – and, in the case of [Fabricom](#), it is especially relevant in circumstances where there may be perceived conflicts of interest in the form of practice-based commissioner representatives, with roles straddling a provider arm, which might be in competition for a contract alongside the private sector.

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Foundation trusts - challenges and opportunities

This article focuses on two possible areas of income generation that foundation trusts may or may not have previously considered - namely franchising and service provision, together with some legal issues that may arise.

Franchising

Franchising is a business model whereby an individual or company trades using another company's trade mark and business model - McDonalds is perhaps one of the most famous example of a franchised business, although there are many others.

This is not an area of business that has greatly affected the NHS thus far, so how might a trust be involved in a franchise? Although there is no legal reason why a trust could not be a franchisee (or indeed a franchisor) it is most likely that a trust could be involved as a lessor, leasing part of its site to a franchisor who will then sub-let it to a franchisee. The most obvious example of this is perhaps the example of a coffee shop.

So what would be the benefits for the trust of doing this? Most obviously, the trust could receive rental income and perhaps a share of the profits from the coffee shop (depending on how the lease was structured). The trust might also cut its overheads, if it had previously been operating the coffee shop itself, or if the space had been empty. The shop is also likely to be refurbished at the cost of the franchisee, so the trust will receive a smart, refurbished shop without spending any money. The trust might also outsource the provision of 'coffee carts' around its premises, which might boost its income through a profit share arrangement, and/or reduce its overheads if it had been providing the carts previously.

On a more intangible level, the introduction of a well known brand may improve patient and staff experience, who will be pleased to see a brand they recognise available to them at the trust's premises.

As a lessor of premises for a franchised business, there are the obvious property issues that arise; a trust should take legal advice before entering into a lease of premises. When choosing the franchisor, it should undertake due diligence and talk to other lessors - ideally any within the

NHS. Although one of the big advantages of franchising is that the offering is consistent, and the trust will hopefully know what the refurbished shop will look like, (it should look like all of the other franchisor's stores!) this should be checked carefully.

If a franchisor is a member of the British Franchising Association, this means that they are signed up to the BFA's Code of Conduct and have attained certain requirements of the BFA. Not all good franchisors are members of the BFA, but choosing a franchisor that is a member would give the trust some indication of how long the franchisor has been in operation, and how many franchisees it has etc.

Lastly, the trust should ensure that there is nothing in the franchisee's agreement which could prevent the trust from removing the franchisee from the premises if it needed to.

Service provision

The NHS has always been a customer for goods and services of all kinds, and it has always provided healthcare services in one form or another. However, the advent of foundation trusts has allowed trusts to start to provide services outside the traditional healthcare field. For instance, a trust might look at using its laundry, which is running at less than capacity, to provide laundry services to another trust (on a commercial basis) or a nearby private hospital.

This demands that the trust starts to think more like a commercial business, and to consider its prices and the service levels it is able to commit to. It might want to consider undertaking due diligence on the potential customer, particularly if the customer is outside the NHS, to ensure that the customer is able to pay for the services in a timely manner. This is particularly important given the current economic climate.

Perhaps most importantly, the trust must think about its contracts, and ensure that it has a written contract in place with the customer. The contract needs to set out, clearly, how the relationship will work, and needs to be comprehensive and clear enough for a court to understand what the intentions of the parties were, in case the contract is ever the subject of a dispute.

The contract must set out clearly:

- What is to be paid, and when; does the payment include VAT and other taxes or are these added on? Can interest be charged on overdue payments, and at what rate?
- What is to be provided, to what standard, and when; in the case of the laundry, the trust would want to set out how often laundry is to be collected from and returned to the customer, what types of items will be cleaned, and what standard of cleaning is expected?
- How will disputes be dealt with? Will there be a dispute resolution process setting out which individuals, within the trust and the customer organisation, is responsible for trying to resolve disputes?
- What will the trust be liable for? What will the trust's maximum liability be?
- Can the trust cease to provide the services in certain circumstances, such as in event of 'Force Majeure' i.e. where something unexpected happens?

Summary

Foundation trusts should always remember that they can no longer contract using non-binding NHS contracts, as they do not fall within the definition of "NHS bodies" under the NHS Act 2006. All their contractual arrangements will therefore be enforceable through the courts, and it is essential that the contracts put in place are comprehensive and represent accurately the arrangement agreed between the parties.

In both of the cases set out above, it can be seen that a written contract, on which legal advice has been taken, is essential. There are, of course, other issues relating to procurement of services that are outwith the scope of this article, but trusts should remember that as a potential provider they are subject to procurement regulations if they are bidding for work from another public body.

Hill Dickinson's commercial team regularly works with NHS trusts of all types on their commercial agreements and we would be delighted to discuss with you any particular issues you might have.

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Protecting your business in volatile times

How can you reduce the risks of bad debts occurring?
Read on to find out how you could help save your business.

1. Think before you contract to supply

Properly identify your customer. Merely having a trading name on a letterhead can leave you unable to enforce payment. Obtain a credit report against the customer prior to agreeing each order. This will provide you with some idea of the financial risk. The ultimate question is, can your business carry the cost if it goes wrong? Below are some points to help you reduce the risk.

- Obtain credit insurance. A refusal to insure means greater risk.
- Obtain payment or part payment in advance.
- Have the customer purchase directly or pay in advance for any raw materials which you may be installing or using solely in the supply of goods/services.
- Obtain a parent company guarantee for large or regular debt balances. Even parent companies can become insolvent leaving you without payment.
- Seek a personal guarantee from the director/shareholder/proprietor/s. As with parent companies, a personal guarantor is only as good as their own financial status.
- Obtain a letter of credit from the customer's bank. Primarily used in overseas sales and purchases, whereby the customer's bank agrees to pay the seller on specified terms.
- Obtain a legal charge or debenture over the customer's assets (larger amounts). The customer's bank will probably have a first legal charge and there may be others who have priority over your right to payment. Seek legal advice.
- Have the customer place funds in a joint account (Escrow account) with a bank or law firm which sometimes requires both parties' signature to draw down, or allows draw down on specified events, such as delivery of goods. This requires legal advice.
- Increase the price to reflect a greater risk.

2. Contract on your terms and conditions

Ensure that you are contracting on your standard terms and conditions and not theirs. Make clear at the outset and then at every stage that it is your terms and conditions which will apply. Where in doubt, have the customer sign a specific agreement.

Ensure that your standard terms and conditions contain appropriate protection such as:

- A retention of title provision so that if it goes wrong, you can reclaim your goods. Note, there are exceptions to being able to reclaim goods under this provision.
- Details on labelling, insuring and storage of your goods while under the control of the customer, until payment is received.
- A right for you to enter onto the customer's premises to retrieve your goods for non-payment.
- Requiring the customer to inform you where the goods are stored.
- Allowing you to set off sums from other orders or sums which you may hold.

3. Cashflow: cash is king

Good businesses can still fail if they do not have cash in the bank. Invoicing month end means that your invoice reaches the buyer in the following month and if they run a month end payment system, it is at least another 30 days for payment.

Improve your cashflow by:

- Requiring up front payment in whole or in part.
- Invoicing immediately on delivery and/or part instalment.
- Invoicing mid month or the end of each week.
- Reducing the payment time in your terms and conditions and strictly enforce the rule.

- Considering offering a reduction for early payment.
- Encouraging direct bank transfer rather than cheque.
- Sending a reminder for payment mid-way before the final due date. We can provide an appropriate suite of letters.
- Having a robust credit control system.
- Considering invoice discounting. For a fee based on a percentage of the gross invoice value, the supplier receives an advance on the invoice payment. The supplier retains responsibility for collecting the debts, administering the sales ledger and for accounting to the finance company.
- Considering factoring your debts. In factoring, the supplier invoices the customer and assigns the debt to the finance company for a percentage of the sales value. The finance company assumes responsibility for collecting the debts and administering the company's sales ledger for a proportion of the sales value.

4. Enforcement of payment

When payment is not received within the specified time, act promptly. Consider referring the account to your solicitor who can issue a letter before claim and where payment is still not received, institute legal proceedings. Hill Dickinson provides a full debt recovery services. Note that issuing a winding up petition is frowned upon by the courts, if issued merely as a debt collection tool.

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NHS property update

Rebecca Wakefield looks at some recent problems encountered by NHS clients and provides practical solutions.

An acute trust client rings us for some advice: they have a tenant who runs the newsagent's shop in the hospital foyer. Whilst the shop is well used, the tenant, in common with most other businesses, has been experiencing harder trading conditions and is struggling with his cash flow. He asks the trust to agree to a deed of variation to the lease to change his rent and service charge payment dates from quarterly in advance to monthly in arrears, effective next month when the next quarterly payment is due. The trust wants advice on the risks in agreeing to this course of action.

From a practical point of view, the trust would like the tenant to remain in occupation and does not want to see him go out of business. They are inclined to agree to the request but they should bear in mind the following considerations:

1. Do they want to make this a permanent arrangement?

Whilst a shop rent is a relatively small part of a hospital's cash flow, the interest generated on a quarterly rent payment deposited in the trust's bank account is worthwhile additional income and payment in advance is more secure. We would suggest that the arrangement should be limited to six months, to be reviewed before the next quarter date, ie after the initial six months.

2. Should they agree to vary the lease to give effect to the request?

If the lease is varied, the arrangement becomes permanent but it also means if the tenant decides to assign the lease the arrangement will apply to the new tenant. Our advice would be to limit the arrangement to a side letter between the Trust and the tenant so that it will not apply to any future tenants.

A PCT client is seeking advice: there is a pharmacy on adjoining land to the PCT premises. A few years ago the PCT gave a licence for access to the pharmacy

across the PCT's land to enable the pharmacy to install disabled access. The pharmacy have asked for this licence to be upgraded to a right of access as they hope to sell their business soon and they are conscious that the licence is personal to them. The PCT has no objection to this and instructs Hill Dickinson to prepare a deed of easement.

When considering whether to grant an easement, landowners should always consider the effect this could have on the value of their land and their ability to deal with the land in the future. A particular concern is that the grant of the easement could prevent development of the land, depending on its position, meaning there would be an adverse effect on the land's value.

An easement is granted "in perpetuity" which means that it will always burden the land and it can only be withdrawn with the consent of the owner of the benefitting land. In reality, this will mean a substantial pay off because the benefit of the easement increases the value of the benefitting land. In this case, even though our client had no current plans to develop the site, we advised our client to seek the advice of the district valuer on the effect that granting the easement would have on the PCT's land. The district valuer recommended that the PCT should seek a five figure premium for the granting of the easement and in light of this the pharmacy decided not to proceed.

A PCT client was selling some land to its private sector partner upon which would be built a new health centre. Prior to exchange of contracts, our client sought an amendment to retain a right of way across a corner of the land, to gain pedestrian access to some offices that the PCT were retaining. The amendment was agreed, the contract was re-drafted and exchange of contracts took place. Shortly after exchange, it came to light that the chief executive of the private

sector partner was on holiday at the time of the re-draft and exchange and now wished to object to the retention of the right. It became apparent that their solicitor had obtained his signature to a previous draft of the contract and had simply added the signature page to the new version. Our client wanted to know whether this meant the exchange had not taken place and whether they would have to re-negotiate the retention of the right, as claimed by the private sector partner.

Section 2 of the Law of Property (Miscellaneous Provisions) Act 1989 requires contracts for the sale of land to be in writing and to incorporate all of the terms agreed between the parties. The Court of Appeal found in a case decided in 2001 that amendments to a contract would not invalidate it unless it constituted a material change and it was potentially prejudicial to the legal rights or obligations of the affected party. So, amendments to correct typographical errors would be acceptable but a change to the material terms would not be. A case decided by the High Court in 2008 considered the effect on substituting pages of a deed. Section 1 of the 1989 Act sets out the requirements for the execution of deeds and the Court found that "recycling" signature pages did not satisfy the requirements of the Act.

In this case, it would appear that the contract has not been validly signed and exchange has not correctly taken place. The fact that the private sector partner gains an advantage through its own mistake is no defence and the parties must re-commence negotiation of the contract. Parties to contracts and deeds must remember that there are legal requirements to satisfy before documents can be validly executed and that those requirements must be respected even though time constraints may tempt parties to cut corners.

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Supplementary guidance issued on access to patient records under section 130B of the Mental Health Act 1983

The Department of Health has been asked for advice on whether Section 130B of the Mental Health Act 1983 (“the MHA”) allows Independent Mental Health Advocates (IMHAs) to see information in records which the patient themselves would have no right to see – and, if so, whether IMHAs may share that information with patients. The IMHA service, available for “qualifying patients” in England from 1 April 2009, is designed to assist patients in understanding the provisions of the MHA to which they are subject and to help safeguard their legal rights.

Supplementary guidance issued by the Department of Health on 5 May 2009 in response to a request for clarification confirms that:

- Record holders are not permitted to withhold information from IMHAs simply because it would not fall to be disclosed to the patient under the Data Protection Act 1998 (“DPA”) as “personal data”, either because it is provided by or relates to a third party, or because it would risk serious harm to the patient or anyone else if disclosed.
- IMHAs have a statutory right to access to records relating to a patient’s detention or treatment in any hospital or registered establishment or to any after-care services provided for the patient under Section 117 of the MHA where the records in question are relevant to the support to be provided to the patient by the IMHA. The exception is where this conflicts with a decision made on a patient’s behalf by a donee of a Lasting Power of Attorney, a court-appointed deputy or a decision of the Court of Protection under the Mental Capacity Act 2005 (“MCA”).
- Anyone who refuses to produce records within these circumstances without reasonable cause may be guilty of the offence of obstruction under Section 129 of the MHA.
- However, there may be specific exceptional circumstances in which

confidential third party information should not be disclosed if the need to protect the third party information overrides the IMHA’s statutory right of access. Where a record holder considers this may be the case, they are advised to seek legal advice.

- IMHAs are required to make clear to record holders whether they wish to see information within the records which would not be disclosable to the patient in accordance with the provisions of the DPA.
- Where records disclosed to IMHAs include third party information which would not have been disclosed to the patient, the record holder is to ensure the IMHA is made aware that information is being shared in these circumstances.
- On a general basis, where a duty of confidentiality arises, IMHAs should not share information about or relating to third parties without their specific consent. The guidance confirms that whether or not consent should be obtained in these circumstances will depend on the individual case concerned.
- IMHAs are not permitted to share information which would not be disclosed to the patient as a result of a risk of serious harm.

The supplementary guidance on access to patient records under Section 130B of the Mental Health Act 1983 is available via the Department of Health website at <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH098828>

If you have any queries concerning the supplementary guidance, please do not hesitate to contact a member of our mental health team, who will be happy to assist.

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