

health law newsletter

February/ March 2015

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what is 'purdah'?

What is purdah?

'Purdah' is a political convention, which formally applies to government ministers and civil servants in central government during the period immediately before a general election. It is now sometimes referred to as the "pre-election period".

During a period of purdah, ministers and civil servants refrain from taking decisions or making policy announcements which are significant or may be politically contentious.

What is the purdah period?

As we know exactly when the next election will take place, we already know when the purdah period will be. Strictly, it runs from the date that Parliament is dissolved (30 March), to (and including) polling day (7 May).

Having said that the purdah period finishes on polling day, in effect, because it takes time for MPs to be

sworn in and ministerial posts filled, there is generally a further delay before decisions can be taken to progress matters/programs. If a new parliament is not formed (i.e. there is a hung

“During ‘purdah’, ministers and civil servants can not make decisions or policy announcements that are significant, or may be politically contentious”.

parliament), it is likely that purdah rules would continue to apply in a slightly more restricted form until such time as a parliament can be formed. The Cabinet Office guidance may well include information about such an eventuality.

Who is caught by it?

Primarily, it applies to civil servants, ministers and MPs (note that in this context, executive agencies like Public Health England are treated as part of central government).

Whilst it does not apply directly to non-departmental public bodies (like CCGs) there is a strong steer that such bodies should apply the principles of the Cabinet Office guidance.

What can and can't happen in purdah?

Unfortunately, what is and is not permitted within purdah is nowhere exhaustively defined. In essence, for Central Government, ministers and civil servants will continue to take decisions on a "business as usual" basis. However, decisions will not be taken, or new policies announced, if they are, or may be, politically contentious.

As set out below, the Cabinet Office guidance for the election has not yet been published. However, the guidance which was published prior to the 2010 election said the following on the remit of purdah:
"It is customary for Ministers to observe discretion in initiating any new action of a continuing or long-term character. Decisions on matters of policy and other issues such as large and/or contentious procurement contracts on which a new Government might be expected to want the opportunity to take a different view from the present Government should be postponed until after the Election, provided that postponement would not be detrimental to the national interest or wasteful of public money."

Where there is any doubt about whether purdah applies, it will generally be resolved in favour of delaying that action until after the election.

For NDPBs, the previous Cabinet Office guidance said the following:

"NDPBs and other arm's length public sector bodies do spend public money and make policy announcements, use Government property and a small number can employ civil servants. Accordingly, the general principles and conventions set out in this guidance apply to NDPBs and similar public bodies.

As always, it is important that NDPBs and other public sector bodies avoid becoming involved in party political controversy. Decisions on individual matters are for the bodies concerned in consultation with their sponsor Department who will wish to consider whether proposed activities could reflect adversely on the work or reputation of the NDPB or public body in question."

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Cabinet office guidance

During the last election, Sir David Nicholson wrote to NHS trusts following the publication of the Cabinet Office guidance and provided guidance specific to the NHS which was based on that guidance. Whilst it dates from the last election, and is expressed only to apply to NHS trusts, we anticipate that similar guidance will

be issued to CCGs, trusts and other NHS organisations this year. We would recommend that affected organisations read it in full, but some of the key points are summarised below:

- Appointment of Chairs and non-execs - no new appointments processes to start during purdah. If a process has begun, it can continue up to short listing, but interviews to be deferred during purdah. Likewise, no formal appointments or re-appointments to be made.
- Announcements of significant NHS expenditure to be deferred unless such postponement would be detrimental to the public interest or wasteful of public money.
- In relation to requests for information from candidate MPs - deal with these if possible under FOIA. In terms of responding to other FOIA requests, or publication of information required in the public interest, these should continue but no press release or similar should be published and any public comment should be purely factual.
- Letters from MPs should be answered in the normal way, but be aware that letters are more likely to be published/politicised. Keep responses as factual as possible.
- Media questions should be responded to in a factual way, and where possible with reference to already published information.
- Regular, planned meetings (ie Board Meetings) can continue, but avoid discussing politically contentious issues.
- Public consultation meetings should be deferred wherever possible unless to defer would be detrimental to the public interest or a waste of public money.
- Avoid promotion of government policy/other party policy.
- Public talks by NHS employees can continue, but avoid covering politically contentious issues and avoid Q & A sessions for that reason.
- Advised not to start a consultation during the period unless it would seriously impede NHS business to do so.
- If a consultation has already begun, consider extending the period for responses until after polling day, and avoid publicising it in the meantime.
- As a general rule, nationally developed promotional toolkits should not be used during purdah unless to do so would cause public health issues, or impede normal NHS business.
- Avoid bulk distribution of leaflets. Provide only if asked for.
- Discontinue news tickers, blogs and similar for the duration of the election period.

In circumstances where it was felt that not doing something would be detrimental to the public interest or a waste of public money, trusts were advised to contact the SHA to discuss. Clearly SHAs no longer exist, but we anticipate that NHS England or the DH itself will fulfil a similar role for CCGs/trusts in this election. This will no doubt be clarified in due course.

Available guidance

As stated above, the new Cabinet Guidance is not yet in existence, and nor is there, as yet, any new NHS guidance. Previous versions of both are available.

Next steps

NHS bodies should identify any projects or planned activity which could be affected by purdah and make plans as to how to deal with these issues. Given that in this election we have far more warning than normal about when purdah will begin, we anticipate that there will be less sympathy for arguments that something should occur in the national interest, or to avoid wasting public funds, if better planning would have avoided the issue arising.

Once organisations have identified which projects or planned activity might be affected, and where there are genuine arguments that the activity should continue notwithstanding purdah restrictions, we would recommend that CCGs seek guidance from NHS England/DH to ensure that they will not be criticised in relation to the approach taken.

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2015/16 standard contract

The final version of the 2015/16 NHS Standard Contract was released on 17 March 2015

<http://www.england.nhs.uk/nhs-standard-contract/15-16/>

This followed an engagement and consultation process which started last Summer and included the release of a consultation draft in December.

NHS England has also released updated technical guidance to accompany the contract. This guidance sets out when the NHS Standard Contract must be used, and contains detailed guidance regarding completion and operation of the contract:

<http://www.england.nhs.uk/wp-content/uploads/2015/03/7-nhs-contrct-tech-guid-fin.pdf>

What's changed?

The technical guidance helpfully highlights (in appendix 1) which sections in the final 2015/16 version differ from the 2014/15 NHS Standard Contract and December consultation versions. Comparisons showing the changes can be found on the 2015/16 NHS Standard Contract webpage (see link above).

What other guidance and materials are available to support the 2015/16 NHS Standard Contract?

The 2015/16 NHS Standard Contract webpage also contains a number of other useful documents and resources including (for example): the technical guidance mentioned above; National Variation agreements (to update existing NHS Standard Contracts that continue into 2015/16); guidance on CQUIN for 2015/16; pensions materials and guidance; new model collaborative commissioning agreements; details regarding the applicable dispute resolution process where new contracts cannot be agreed; and (a key development for 2015/16) an additional schedule that should make the NHS Standard Contract APMS-compliant, so enabling the inclusion of primary medical services alongside other services.

If you require any advice regarding use of the NHS Standard Contract, or the changes for 2015/16, please do get in touch.

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new models of care

Simon Steven's vision for the health and social care system laid out in his Five Year Forward View (FYFV) has shown further acceleration by the announcement of 29 "vanguard" sites around the UK.

These sites are expected to spend the next 12 months developing one of the new models of care described in the FYFV with 9 sites testing the primary and acute systems models (known as PACS), 14 sites developing and trialling the multi-speciality community provider model (known as MCP) and the remaining areas looking at ways of enhancing health in care homes.

No new governance models or structures have yet been put forward but it is possible that these vanguard sites will look towards the US for some ideas around what these new structures may look like. One of the approaches to integrated care in the US has been to develop accountable care organisations (ACO) the basic concept of which is to give a group of providers the responsibility for providing all of the care (health and social) for a specific population for a specified period of time. Commissioners enter into a contract with the ACO which will usually have a capitated budget in return for agreed quality outcomes. The ACO will then often sub-contract all or part of the required services to other providers but will remain accountable under the overarching contract.

There has been some confusion around ACOs in the UK with some taking the view that CCGs themselves could become ACOs. This is not the case as ACOs are designed to deliver care not commission it and are instead intended to be groups of accountable providers working together in a formal organisational structure under a contractual arrangement with a commissioner. Many of the vanguard proposals would not all fit within the ACO model as whilst some have a clear lead provider, such as a Foundation Trust or GP federation, others are built on a genuine collaboration of commissioning and providing organisations. Even if the chosen models of care do develop along different lines to the ACOs, there are undoubtedly lessons the UK can learn from the US experience of ACOs and the briefing paper on ACOs published by the Kings Fund in March last year identified the following key themes:

- prevention and early intervention are key to any integrated care system so that it ensures that resources are targeted on caring appropriately for high risk groups;
- effective risk assessments and prioritisation and predictive modelling will enable the creation of flexible case management programmes for those with long-term care needs who are most likely to benefit. In the UK, GPs are seen as central to this with their first-hand knowledge of patients;
- integration can only succeed if the information technology and data analytics are there to support it. Only when those platforms are in place can the information then be shared by all those who need access to it to provide the care;

- patients and their carers need to be engaged in managing their own care and any integrated system should support shared decision-making and ensure collaborative care planning.

So what might these systems look like in the UK? The Stockport Together vanguard, for example, is described as an “active partnership” between Stockport Metropolitan Borough Council, NHS Stockport Foundation Trust, NHS Stockport CCG and NHS Pennine Care Foundation Trust. Their vanguard proposal is to develop an MCP. The legal form which will support this collaboration has yet to be finalised but some of the proposed outcomes are that hospital urgent care will be redesigned with a single point of access that is integrated with community teams and that people with complex conditions or at the end of life will have an integrated team working with them to support them and help them make the best decisions about their plan of care. This integration will take place at neighbourhood, locality and borough level. In this example, there are a number of ways this could work from a legal perspective: one of the providers could take the lead in contracting with the CCG and sub-contract some or all of the services to other organisations; a separate legal entity could be formed and run by representatives from each organisation; a series of parallel contracts could be entered into between the CCG and the various providers.

The Salford vanguard proposal is to create a PACS and the stated intention here is that the parties involved (which include the local CCG, Salford City Council and two local Foundation Trusts) will create what they describe as an “Integrated Care Organisation”. This organisation will give one of the Foundation Trusts, namely Salford Royal, lead responsibility for meeting the health and social care needs of the population and it will do this by direct provision as well as sub-contracting services.

Transparent governance and accountability will be essential to the success of these projects and guidance will need to be provided by commissioners on the organisational form these partnerships should take. Guidance around legal structures should facilitate rather than hamper the development of these organisations as the desire for providers to integrate and work collaboratively can only benefit the health and social care economy provided quality is preserved and, where necessary, improved and required cost savings are achieved.

If do wish to talk about any of the issues arising from the FYFV and these new models of care, please do get in touch as we have considerable experience of dealing with projects of this nature.

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The Care Act - in practice

A nutshell guide to the frontline implications for health and social care professionals

Most of the Care Act 2014 comes into force on 1 April 2015. It is the largest overhaul of social care law in 60 years, and abolishes lots of the older legislation, to consolidate the law on social care (mostly) in one place. At 167 pages, don't print it all unless you really have to (and it's supported by 506 pages of guidance!). As a consolidating Act, a lot of the substance will look familiar - a fair analogy is to think about furniture that had been scattered all being brought together into one large room - but there are some significant new bits, and as always a lot will depend on how it is used in practice.

The fundamental approach to social care is intact - a local authority must assess individuals' needs, determine the support necessary to meet those needs, and then make appropriate provision for those needs. There should be national approach to eligibility (rather than a "postcode lottery").

There is a new overarching principle of promotion of the person's "well-being", which is defined very widely indeed and goes far beyond clinical health. There is also more emphasis on the needs of carers, on prevention of needs arising, on continuity of care when moving between areas, and on personalisation and involving the fully-informed individual in planning their care.

There are some key changes - each local authority must now have a Safeguarding Adults Board (SAB), putting this on the same statutory basis as children's safeguarding. In replacing the "No Secrets" (200) guidance, the definition of abuse is broadened with new categories including as "self-neglect" (which may be very hard to reconcile in practice with a capacious adult's "unwise decision") and "modern slavery". The threshold for safeguarding changes from "significant harm" to just "at risk of harm", prompting fears of the system being swamped.

Implementation of the Dilnot Commission

The most headlines, though, have been about the implementation of the Dilnot Commission recommendations as a cap on lifetime care costs at £72,000. This aspect will not come into force until April 2016, and will mean a huge increase in the workload of the local authority as even those who privately pay for care will need to be assessed to make sure that the council properly tracks the spend towards the cap.

The financial threshold for access to services will be raised. The local authority may, or must in some cases, commission services on behalf of private payers, if they wish, exposing a much wider part of the private sector provision to the buying power of the state, which could have enormous commercial consequences.

New obligations are introduced on the local authority to provide oversight of the care provision market, and to step in if a provider fails (as we saw with Southern Cross), and the CQC have new duties to assess the financial stability of large providers, not just their quality.

Otherwise, the regulatory structure is unchanged, with the CQC registering, and inspecting, but Regulations made under the Care Act have introduced 12 “Fundamental Standards” (in place of the previous “Essential Standards”) against which the CQC will inspect:-

1. Care and treatment must be appropriate and reflect service users' needs and preferences.
2. Service users must be treated with dignity and respect.
3. Care and treatment must only be provided with consent.
4. Care and treatment must be provided in a safe way.
5. Service users must be protected from abuse and improper treatment.
6. Service users' nutritional and hydration needs must be met.
7. All premises and equipment used must be clean, secure, suitable and used properly.
8. Complaints must be appropriately investigated and appropriate action taken in response.
9. Systems and processes must be established to ensure compliance with the fundamental standards.
10. Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed.
11. Persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (fit and proper persons requirement).
12. Registered persons must be open and transparent with service users about their care and treatment (the duty of candour). Note that for the NHS there is both a generic obligation - “a health service body must act in an open and transparent way...” and a set of specific obligations (to explain ASAP, apologise and confirm in writing) in the event of a “notifiable patient safety incident” - ie any unintended / unexpected incident during provision of care that has or could cause moderate or severe harm or death, regardless of fault. This has been in force for the NHS since November 2014.

Many of these come with stringent financial sanctions attached and much will depend on how the CQC enforce these, but you can expect there to be a fresh enthusiasm about this, after scandals such as Winterborne View and Mid Staffs. The requirement of a prior warning notice before a prosecution has now been abolished and the CQC are committed to targeted and focused enforcement in the future.

Alongside all this, the new criminal offence of ill treatment and wilful neglect by an individual who has care of another (Criminal Justice and Courts Act 2015, s20 for individuals and equivalent corporate offence in s 21), carrying up to 5 years in prison, and the even newer “zero harm” expectations set out in the Health and

Social Care (Quality and Safety) Act, passed on 26 March 2015, means that the spotlight of regulation on frontline provision will feel brighter than ever.

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achieving the personal touch

The release of the technical guidance supporting the NHS Standard Contract 2015/16 provides guidance on the contractual arrangements underpinning personal health budgets.

Why is the guidance so important?

It is so important because of the expansion of personal health budgets. Those eligible for NHS Continuing Healthcare, and children in receipt of continuing care, have had a “right to have” a personal budget since October 2014. However, more recently the publication “Forward View into action: planning for 2015/16” (December 2014) declared that commissioners are expected “to lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit”.

In clarifying what was meant by “major expansion” NHS England confirmed (in its “Frequently asked questions: Introducing personal health budgets beyond NHS Continuing Healthcare”) that commissioners should not only be considering the groups mentioned in the planning guidance mentioned above, but should also consider other groups that could benefit from personal health budgets. It lists various examples including (for example): people who have high levels of need, but are not receiving NHS Continuing Healthcare, and who have suitable health needs; people with learning disabilities or autism and high support needs (in line with Sir Stephen Bubb’s report); people who make ongoing use of mental health services; people with long-term conditions for whom current services aren’t working effectively; people who need high cost, longer term rehabilitation.

Consequently, there will be an increasing number of occasions where commissioners will need to consider how to contractually capture the range of potential personal health budget scenarios.

What does the technical guidance cover?

Although the technical guidance notes that commissioners will need to exercise local discretion and common sense to ensure that a proportionate approach is adopted, section 23 of the technical guidance explores the contracting options (and whether the NHS Standard Contract should be used) for the three main ways of managing personal health budgets (notional budgets, third party managed budgets and direct payments).

The guidance also deals with situations where personal health budgets are spent on non-clinical services or services which are not routinely purchased by the NHS.

It also briefly mentions integrated personal commissioning (where an integrated personal budget covers health and social care needs) and states that “NHS England will consider the use of the Standard Contract within the emerging personalised commissioning approaches and share learning and good practice from the programme where appropriate”.

Commissioners will need to ensure that their approach to personal health budgets is robust and in line with relevant guidance. We can provide a range of services to support implementation of personal health budgets, including audits of your current proposals and policies, so please do get in touch if you need any support.

<http://www.england.nhs.uk/nhs-standard-contract/15-16/>

<http://www.england.nhs.uk/wp-content/uploads/2015/03/7-nhs-contrct-tech-guid-fin.pdf>

<https://www.gov.uk/government/publications/nhs-mandate-2015-to-2016>

<http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf>

http://www.personalhealthbudgets.england.nhs.uk/library/Resources/Personalhealthbudgets/2015/150303-FAQ_Introducing_PHB_beyond_CHC.pdf

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new guidance from Monitor on commissioning community services

Many 'community services' contracts were awarded at the time of the Transforming Community Services (TCS) initiative in 2010/11, and most of those contracts are reaching (or have reached) their original expiry dates.

CCGs are considering what approach to take to these services going forward and, of course, this is often not straightforward due to the need to consider the scope for integration, the implications of local Better Care Funds, the Five Year Forward View etc.

Monitor has clearly been concerned enough to conduct some research into CCGs' plans, and has published a report, entitled 'Commissioning better community services for NHS patients', which provides some useful information based on responses from 147 CCGs (so about two-thirds of those asked) and subsequent discussions with stakeholders (including CCGs, patients' representative groups and community services providers).

As well as trying to define which services are within the scope of 'community services', the report has some useful statistics based on the CCG responses. 93% of contracts held by the responding CCGs are 'block' contracts and (as we know) many CCGs extended or renewed their TCS community services contracts in 2014. 78% (by value) of the community services contracts are expiring in 2015 and 61.5% of those are to be extended or renewed (32% being undecided, leaving only 6.5% that are to be competitively procured). The report also contains some interesting statistics about the types of provider holding community services contracts (87% are NHS providers) - and 92% of the CCGs reported that their community services are provided by (or mainly by) one provider.

The report mentions that a lack of information and data (particularly due to the predominance of block contracts) seems to be making redesign of services more challenging, and it highlights that Monitor is publishing a guide to help local areas create 'person-level linked datasets that will 'support local health economies to understand the patterns of care and associated costs of their local populations across all settings', and how Monitor is working (with NHS England) to support innovative local pricing structures.

Although CCGs will be aware of their statutory duty in relation to public involvement and consultation, the report also emphasises that effective engagement with patients and the public is critical to improving community services.

Importantly, the report also looks at: 1) how the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 apply to decisions about community services contracts (although Monitor also directs readers to its substantive guidance on those regulations), 2) how it will approach complaints it receives about rolled-over community services contracts, and 3) factors to consider when exploring more innovative contracting models (prime/lead, alliance etc.).

The annex to the report also contains some useful case studies.

While the report will give CCGs that are considering extending their community services contracts some comfort that they're at least not alone, it does highlight the risks of extensions (particularly if the decision-making process surrounding an extension is not appropriate and robust). We're currently advising various CCGs on plans for their community services contracts, so do get in touch if you'd like to discuss your options.

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primary care premises funding

In the Chancellor's Autumn Statement he announced that a total of £1bn was being invested into primary care facilities (that is in addition to a £200m 'transformation fund' to support the creation of new models of care as required by the Five Year Forward View). In December 2014, the Health Secretary advised that GP practices would be "encouraged to join up closely with local job centres, social services and other community services, in order to ensure that the NHS is also supporting people back into the labour market" in return for the £1bn funding.

Whilst the announcement of additional funding for practice premises has been welcomed, there are still many voices of concern as to how practices will benefit from the funding. For some time the GPC has been stressing the 'essential and urgent need to invest in general practice premises'. However, the funding that has been announced is considered to be only a fraction of what is really needed and it does of course come with significant conditions attached.

The headlines are about funding for GP premises. However, there is concern that the proposals don't really address the need for investment in premises to make the current estate fit for purpose but instead only provide a fund for those practices willing and able to offer enhanced services. Indeed, Mr. Hunt's December 14 statement refers to the 'bringing together of GPs, nurses and specialists' with the fund paying for 'modern premises and technology that will give patients access to advanced care, such as chemotherapy and dialysis, in their local communities'. In announcing the investment, NHS England last week also said that GPs bidding for the funding 'will need to set out how [improved] premises will give them the capacity to do more; provide value for money; improvements in access and services for the frail and elderly'.

These concerns are put in context when we consider that a recent BMA survey suggested that four out of ten practices in England felt that their facilities were struggling to provide even basic care. However, we should not lose sight of the fact that £250m of additional funding is to be provided over each of the next four years and that is substantial investment. There is no doubt that this level of investment, delivered properly, could really help to address current issues with the primary care estate.

Bids for investment in 2015/16 had to be submitted to NHS England by 16 February 2015.

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freedom to speak up

An independent review into creating an open and honest reporting culture in the NHS.

On 11 February 2015, Sir Robert Francis' **Freedom to speak up review** was published. Two years on from Sir Robert's final report on the Mid Staffordshire scandal, and despite the 'speaking up charter' launched in 2012 and the 'sign up to safety campaign' introduced last year, the review still found evidence of a real problem regarding whistleblowing. This included deterrents to speaking up in the first place, poor handling of complaints and vindictive treatment of those raising concerns.

Although the NHS is not alone in dealing with the challenges involved with whistleblowing, it is in a unique position for a number of reasons such as its public and political profile and its complex structure. Further, the NHS can act as a monopoly when it comes to excluding individuals from employment; this can act as a significant deterrent to employees who are fearful of repercussions, should concerns be raised.

The Review emphasises that steps have been taken in recent years to try to encourage staff to speak up, including the new statutory duty of candour, the fit and proper person test and the Care Quality Commission's new inspection and ratings regime. The review did not comment on the success of such schemes, concluding that it was too early to make an assessment of their impact, but did state that all steps were helpful to reinforce the correct message that speaking up is integral to patient safety and care.

Over 600 individuals and 43 organisations contributed to the Review and over 19,500 individuals responded to staff surveys. The Review highlights the need for reform within the culture of the NHS; six of the twenty principles identified by Sir Robert are cultural. The other principles relate to the procedure for handling cases, support for good practice, protection for vulnerable groups and additional legal protections.

Looking at these themes in more detail:

Cultural changes

Principles 1 to 6 deal with the cultures needed within the NHS and include safety, raising concerns, freedom from bullying, visible leadership, valuing staff and reflective practice. The review includes a real focus on changes within the leadership of NHS organisations and recommends that Boards ensure that the correct cultural values are being adopted. Visible leadership is included as a principle in its own right but leadership roles are also referenced in the other cultural principles.

Handling cases

The review identifies that in many cases, the poor handling of complaints has led to a great deal of pain and expense which could have been avoided. In particular, the time taken to deal with historic complaints has

been too long. Principles 7 to 9 are intended to improve the handling of cases and include developing the structures which are in place to allow informal and formal complaints to be raised, handling the investigation of complaints and consideration of mediation and dispute resolution. The review does not insist on investigations being conducted by external investigators on every occasion or impose strict timescales on an investigation; instead more general principles are included - that investigations should be prompt, swift, proportionate, fair and blame-free, and that consideration should be given at an early stage to expert intervention to resolve conflicts and rebuild relationships.

Measures to support good practice

Principles 10 to 17 set out the additional support measures which are identified by the review as being necessary to ensure that the system works as it should do. These include training - both on how to raise concerns and how to deal with concerns which are raised - and a system of accountability, again both when raising and dealing with concerns. The review also highlights the need for greater support; it recommends that there is a range of persons to whom concerns can be reported easily and without formality. Given the mobility of staff between NHS organisations, the review also suggests having a similar role within all organisations - a freedom to speak up guardian - so that those who move between organisations know immediately where to go for help.

Support should also be given to those individuals who raise concerns and then feel that they cannot continue in their current employment; assisting them to find alternative positions within the NHS is referred to as a 'moral obligation'. Suggested support includes remedial training or work experience for those who have been away from the workplace for a long period of time; advice and assistance in respect of applications for new roles; the development of a pool of employers willing to offer trial employment; and guidance to employers to encourage viewing the historic raising of concerns as a positive, rather than negative, attribute.

The review emphasises the need for greater transparency; in this context, the blanket use of confidentiality clauses within settlement agreements is criticised. Instead, such clauses should only be included if they are genuinely in the public interest and, as a matter of good practice, should be approved by the CEO. All settlement agreements should be available for inspection by the CQC.

External review should also be carried out by an independent national officer who should review the handling of concerns raised, advise NHS organisations to take appropriate action, act as a support for freedom to speak up guardians, provide national leadership, offer guidance on good practice and publish reports on their activities. The INO should not, however, review or investigate historic cases.

Lastly, within this theme, the review calls for both coordinated regulatory action when an organisation's record for dealing with complaints is poor and CQC recognition of organisations demonstrating good practice.

Measures for vulnerable groups

Principles 18 and 19 cover the groups identified by the review as being particularly vulnerable - locums, agency and bank staff, students and trainees, staff from black and minority ethnic backgrounds and staff engaged in primary care. The review places obligations on boards to consider whether these particular groups are adequately protected or whether additional measures are required to ensure support.

Extending the legal protection

The final theme set out in the review is to recommend enhancements to the legal protections available by adding to the list of prescribed persons to whom disclosures can be made and by extending protection to those who are seeking employment from discrimination on the grounds that they are known to be a whistleblower.

Next steps

The government has already accepted all of the recommendations made by Sir Robert and confirmed that consultation will now take place on how best to implement them. NHS organisations will therefore need to review the procedures and systems that they have in place to deal with concerns that are raised and consider whether any additional support is necessary for those who raise, or who are to deal with, concerns.

talk to us...

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The Department of Health has just published a consultation document entitled ‘no voice heard, no right ignored’ on the rights of people with learning disabilities, autism and mental health conditions, with a closing date for responses of 29 May 2015.

It describes it as ‘an exploratory consultation which sets out a range of potential options’. With the date of the next general election less than two months away there must be a question mark as to how many of the consultation proposals will be carried forward; as the document itself acknowledges ‘what happens as a result of this consultation will be determined by the next government in the context of a spending review.’ However, the four general aims set out in the foreword are ones you would expect to enjoy cross-party support:

1. people (i.e. service users/patients) should be in charge, supported by their family and friends
2. people with these conditions should be included in the community, and given as much independence as possible
3. they should receive the right care in the right place; and
4. there should be very clear accountability and responsibility throughout the system.

The proposed reforms need to be seen in the context of two recent pieces of legislation: the Children and Families Act 2014 and the Care Act 2014. The latter stresses ‘the importance of beginning with the assumption that the individual is best-placed to judge the individual’s well-being’ and the duty to have regard to ‘the individual’s views, wishes, feelings and beliefs’. As the document notes, ‘Similarly, duties in the Children and Families Act require Local Authorities to have regard to the views, wishes and feelings of the child or young person and to enable them to participate in decisions relating to themselves (or their child in the case of families)’.

The reforms also need to be seen in the context of measures taken in the last 50 years or more to avoid people becoming ‘institutionalised’. The consultation notes the closure of asylums and NHS longstay hospitals and campuses and puts forward its proposals as part of that wider progress, alongside the concerted recent policy of moving patients from hospitals into the community in the wake of Winterbourne View.

The third and final backdrop to the consultation is the new Mental Health Act Code of Practice, due to come into force on 1 April this year. The stated aims of the consultation and the revised code tally to a large degree.

In all 50 questions are asked in the consultation. Annex A to the document sets out a summary of the issues and these questions. It also sets out the Department's 22 aims.

Their 'vision', as set out in the document, reflects the language of Lady Hale in the landmark Cheshire West judgment, (on deprivation of liberty), about the universality of human rights.

"All disabled people, including those with learning disability, autism or mental health needs, have a right to lead their life like anyone else, with the same opportunities and responsibilities and to be treated with the same dignity and respect. They and their families and carers are entitled to the same rights as others."

We can't cover the whole of the consultation document in detail here. Some of the most significant points concern possible changes to the Mental Health Act 1983.

It is proposed that, when completing an application for someone to be 'sectioned' under section 2 or section 3 MHA, AMHPs or doctors be asked to provide more information on the appropriate reasons for doing so, and should explain 'why the person could not be assessed and treated in the community'. Coupled with this the idea is floated of changing the law so that patient's rights and the safeguards to protect them are the same, whether they are detained, assessed and/or treated under section 2 or section 3 MHA.

To ensure that someone's rights under the MHA are protected more effectively it is suggested that information is shared with them by a named professional, either a specific social worker or someone else of the patient's choice. This person will be obliged to provide them with 'their own personalised summary of rights that are relevant to their individual circumstances'. The intention is 'to enable active participation in the processes of admission, care planning, review and discharge'.

The department also aims to enable the patient to 'choose their own nearest relative if they are able to do'. The document continues: "we propose to retain a hierarchical list of persons who could be identified as the 'nearest relative' as a back-up". If this approach were adopted, we would need to consider and consult further on such issues as:

- whether there would need to be any restrictions upon who could be eligible to be chosen by the patient;
- how to manage a situation where a chosen person declines to act as 'nearest relative';
- what to do if the clinical team determines a chosen person is unsuitable to be the 'nearest relative' and the process for displacing an unsuitable 'nearest relative' who the patient has chosen
- whether patients who lack capacity would need another decision maker on their behalf, e.g. a deputy appointed by the Court of Protection or the donee of a lasting power of attorney
- whether the right to choose the nearest relative would also be given to children under 16 who are competent"

The Department is concerned that some people have expressed the view that: ‘in practice, individuals are detained for treatment under the MHA purely because they have behaviour which is challenging as a consequence of their learning disability or autism, even where there is in fact no appropriate medical treatment available for that person in the hospital in relation to such behaviours’. The document goes on to say: “This is unacceptable and illegal. The availability of appropriate medical treatment in hospital is required in order for someone to be detained for treatment under section 3 of the MHA”.

One suggestion to counter this is to expressly exclude those with learning disabilities and autism from the MHA, which could also result in seeking ‘more deprivation of liberty authorisations under the Mental Capacity Act 2005 ... or other court orders’. Already faced with the huge implications of the Cheshire West decision, this would have a real impact on local authorities, health bodies and the court system.

There are many proposals the department are considering in its efforts to cater for the needs of this group of the population. Established law and practice is being looked at afresh and an attempt made to achieve some kind of harmony with new legislation. No stone is being left unturned in its efforts to bring treatment of this disadvantaged group of people in line with current ideas of best practice.

The implications for the legal framework in mental health and capacity cases could be enormous, and so it is important that everyone with an interest takes the chance to respond to the consultation and influence the policy. We would, of course, be pleased to discuss this with you.

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Montgomery v Lanarkshire Health Board (Scotland)...

The Supreme Court has handed down judgment in the case of *Montgomery v. Lanarkshire Health Board* with the effect of reversing the previous House of Lords authority on the law governing informed consent. The claimant's claim was allowed and damages of £5.25 million were awarded.

The test now requires an explanation of all material risk to a patient unless the situation is one of medical emergency or where the practitioner considers that explanation of the risk would be to the detriment of the patient's health.

The judgment brings the law into line with current GMC guidance and supports the approach adopted by the lower Courts since 1999.

Mrs Montgomery's Case

Mrs Montgomery brought a claim on behalf of her son in respect of his birth in 1999.

As the claimant suffered with diabetes, the pregnancy was deemed to be high risk, by virtue of the fact that diabetic mothers are likely to have babies that are larger than normal, with a particular concentration of weight round the shoulders. This creates 9-10% risk that during delivery the shoulders are too wide to pass through the birth canal, a process known as shoulder dystocia.

If this occurs there is a small risk (put at 0.1%) that the umbilical cord will become occluded, causing hypoxia and resulting in consequential cerebral palsy or death.

Mrs Montgomery was not informed of the risk of shoulder dystocia, but claimed that if she had been informed, she would have opted for a delivery by caesarean section.

At birth shoulder dystocia did occur and the cord became occluded, causing hypoxia and resulted in her son sustaining severe brain injury. A claim was brought against the health authority on the basis of the failure to explain the risk of shoulder dystocia.

The law as it stood

The Supreme Court overturned *Sidaway* unanimously. The test now to be applied was outlined by Lord Reed:

- In all adults of sound mind, there is a duty to take reasonable care to ensure the patient is aware of any material risks involved in any recommended treatment.

- A risk is material if it is one where, in the circumstances of the particular case, a reasonable person in the partner's position would be likely to attach significance to the risk or the particular individual patient has attached significance to a risk.
- The patient is required to understand the seriousness of the risk and the anticipated benefits and risk of the proposed treatment and reasonable alternatives.
- Informed consent is neither "*bombarding the patient with technical information which cannot be reasonably understood*" nor a process "*demanding a signature on a consent form*".

There are two exceptions to the rule:

1. A medical practitioner is entitled to withhold from the patient information as to the risk if it is considered that disclosure would be seriously detrimental to the patients' health (the therapeutic exemption);
2. In circumstances of necessity, where treatment is required urgently but the patient is unconscious.

The Court agreed that Mrs Montgomery would have opted for a caesarean section had the risk been explained.

Implications

1. In cases of informed consent, there is no longer a defence that a medical practitioner failed to explain a minimal risk, even those risks with a grave consequence, on the basis that a reasonable body of opinion would support that omission. The law now requires explanation of all material risks.
2. The requirement explicitly applies to all those engaged in healthcare provision. From a current practice point of view, this mirrors the GMC guidance which has been in place since 2008. The test effectively codifies the approach of the lower Courts in England

(see *Pearce v. United Bristol Healthcare NHS Trust 1999*)

1. The test of materiality will be applied retrospectively. It is noteworthy that Mrs Montgomery's case pre-dated the GMC guidance and the new test will apply in all cases.
2. The circumstances where the therapeutic exception defence will be very rare. The Court did not give any example of this other than the exception "should not be abused" and is "limited".

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claiming inquest costs in civil proceedings

An analysis of the judgment in *Amelda Helen Lynch (Representative of the Estate of Colette Lynch) and Others v Chief Constable of Warwickshire Police, Warwickshire County Council, Coventry and Warwickshire NHS Trust (2014)*.

On 14 November 2014 the Senior Courts Costs Office handed down judgment in the case of *Lynch* which marked a significant curtailment of the Claimant's recoverability of inquest costs as part and parcel of the claim.

Background

Colette Lynch was murdered in 2005 by her former partner. The inquest was heard in 2009 and ran for three and a half months. The family were represented by senior and junior counsel with support from a Partner and a trainee solicitor. The civil action was settled in 2012. The Claimant sought to recover the costs of preparation for and attendance at the inquest totalling £750,000, representing almost 50% of the total bill of costs.

Since the 2009 decision of *Roach v Home Office*, the claimant has enjoyed a period of relative ease in convincing costs judges that their attendance at inquest was an entirely necessary part of the claim process. This has led to some eye-watering bills of costs, as demonstrated in *Lynch*.

Previously, under *Roach*, the claimant has been able to recover costs associated with the inquest where they can show that the costs are 'of and incidental to' the civil proceedings. The costs judge would then have regard to the principles of proportionality and benefit to the civil claim when determining the extent of recoverability as set out in *Gibson's Settlement Trusts [1981] Ch 179*.

However, *Lynch* marks somewhat of a sea change from the position in *Roach* in light of the improvements made to the inquest disclosure process by the implementation of the Coroners (Inquests) Rules 2013 on 25 July 2013.

Coroners (Inquests) Rules 2013

The Rules implemented a disclosure regime that sees full disclosure to the interested parties, which automatically includes the family of the deceased, occurring at the earliest opportunity and certainly before the inquest commences.

The defendant averred that full and frank disclosure to the claimant prior to the hearing meant that it was no longer necessary or proportionate for the claimant to be represented at the hearing by a senior legal team.

The thrust of the opposing arguments was set out in paragraph 69 of the judgment:

“The Claimant’s approach is to take events as they happen and, as long as they were of some use and benefit in the civil claim, then they must be recoverable. The Defendants’ approach is to cut out periods of time which can be said to be incidental to the civil claim from the overall inquest process.”

Master Rowley determined that his task was very much as contended for by the Defendants. He decided that it was necessary to extract from the overall inquest proceedings those aspects which are of and incidental to the civil claim and to allow reasonable costs for only those aspects.

Where there is an inquest exploring some medical wrong, there is generally a wrongful death claim waiting in the wings. The argument raised in *Lynch* can readily be applied to many healthcare inquests.

The addition of the Duty of Candour to the NHS Constitution places more emphasis than ever on the Trust to identify service delivery problems and to communicate them to the family of the deceased expeditiously. In the case of a sudden and unexpected death, the Trust is likely to have prepared an internal investigation report which sets out the areas of care that fell below the standard expected and conclude whether this played a role in the outcome. If disclosure of this document occurs prior to the inquest, what more is the Claimant likely to adduce from the hearing to assist when drafting the Particulars of Claim? Candour coupled with early disclosure may well reduce the time spent by the claimant at inquest which can legitimately be classed as ‘of and incidental to’ the claim, thus reducing costs.

So, in summary, *Lynch* does not mark the end to claimants’ recoverability of inquest costs per se and Master Rowley was eager to stress that his learned observations were case specific. However, the judgment does perhaps mark a new era of welcomed scrutiny of claimants’ costs.

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