

Health legal update
March 2010

Introduction	3
NHS MANAGEMENT	4
Mid Staffordshire NHS Foundation Trust inquiry report published	4
NHS National Leadership Council Launches <i>The Healthy NHS Board: Principles for Good Governance Body</i>	5
NHS Constitution: a reminder of the obligations for NHS bodies	6
The National Health Service (Quality Accounts) Regulations 2010	7
Transforming community services: new guidance published	8
FOUNDATION TRUSTS	8
Monitor’s private charges cap for NHS foundation trusts	8
PROCUREMENT	10
Public contracts regulations may need redrafting after Uniplex judgment	10
Co-operation and Competition Panel criticises PCTs for poor procurement practice – and OFT is asked to review Government policy on NHS as the preferred provider.....	10
PATIENT MATTERS - OUT OF HOURS CARE	11
Out of hours deaths: coroner’s verdict	11
GP out of hours care: tighter controls for the future.....	12
Department of Health publishes interim guidance on assessing the English language competence of GP applicants.....	13
PATIENT MATTERS - CORONERS	14
High Court rules that the coroner does not have an unlimited discretion to call evidence in a non-Article 2 inquest.....	14

PATIENT MATTERS – ASSISTED SUICIDE	14
Assisted suicide: new guidance.....	14
PATIENT MATTERS – FERTILITY ISSUES	15
Final report of the expert group on Commissioning NHS Infertility Provision published	15
The Human Fertilisation and Embryology Act 2008 (HFEA): implementation of provisions to assist research projects	16
PATIENT MATTERS - MENTAL HEALTH ACT	17
New ruling on importance of consultation with nearest relative.....	17
PATIENT MATTERS - CHILD LAW ISSUES	17
Court of Appeal decision prompts calls for new guidance on the use of children’s evidence in the family courts.....	17
Child prescription errors.....	18
Vetting and Barring Scheme.....	18
PATIENT MATTERS - MENTAL CAPACITY ACT	19
Mental Capacity Act update published	19
PATIENT MATTERS - GENERAL	20
Help for those receiving contaminated blood could be on its way.....	20
Healthcare for people with learning disabilities: recommendations of the Parliamentary and Health Ombudsman	20
Department of Health publishes checklist for reporting and managing information governance serious untoward incidents (IG SUI).....	21
Complaints handled by Patient Advice and Liaison Services (PALS): Department of Health issues guidance	22
Department of Health issues guidance for access to health records requests.....	22
Military veterans to receive priority access to NHS medical treatment.....	23
National Victims’ Service to be rolled out for ‘forgotten victims’	24
The Department of Health consults on charging arrangements for residential social care.....	24
Clinical governance and adult safeguarding guidance published.....	25
REGULATORY	25
GMC allows Gosport War Memorial doctor to continue practising	25

EMPLOYMENT	26
Likely loss of livelihood might lead to legal representation	26
Illegality of employment contracts	26
Whistleblowing protection: a careful balancing act	27
PROPERTY	28
Construction contracts: damages for delay	28
Latest on the carbon reduction commitment	29

Introduction

Welcome to this month's *Health legal update*.

Quality and governance issues have been most prominent in recent weeks with the Mid-Staffs inquiry report, the coroner's verdict on out of hours care, launch of the Health NHS Board and the enactment of the Quality Accounts regulations. Similarly accompanying the increasing focus on information governance, the Department of Health has, since the beginning of the year published a checklist for reporting serious untoward incidents, guidance on complaints handling and guidance on dealing with requests to access health records.

The challenge for many NHS bodies is one of balancing high quality and governance standards in an environment of increasing financial pressures. Here at Mills & Reeve we are keen to work with our clients to help reduce their legal spend. To do this we are developing a range of pricing structures to meet clients' needs and focus our services on supporting clients manage risk and facilitate knowledge transfer as part of partnership working.

As part of this, our Spring 2009 seminar programme, which has just been launched and can be accessed [here](#), focuses on providing practical solutions to key issues. These include workforce challenges in a cold climate, complying with the principles of cooperation and competition and with more performers list cases being appealed from local decisions, how PCTs can ensure that their processes for investigating and presenting cases are robust.

Similarly the firm's partnership with the national health think tank the King's Fund creates opportunities for us to share ideas and expertise on areas such as patient mobility and EU competition policy and be involved in consideration of policy in a variety of areas.

We also have several new documents on the Healthcare resource centre (HRC) including *Parental responsibility*, *Project bank accounts*, *Adjudicating and withholding notices*, *Weather: its effect on construction projects*, *Who owns construction materials on site in an insolvency situation*, *Inquest update: Implications for PCTs in relation to contracts with out of*

hours (OOH) providers and medical performers following coroner's recommendations and TUPE 2006: a basic guide; The HRC can be accessed [here](#).

Do call us if you want to know more.



Gill Thomas
Partner
01223 222220
gill.thomas@mills-reeve.com

NHS MANAGEMENT

Mid Staffordshire NHS Foundation Trust inquiry report published

The inquiry report into Mid Staffordshire NHS Foundation Trust (Mid Staffs) has now been published and includes 18 recommendations for improvement. All the recommendations have been accepted by the Department of Health and the Mid Staffs board.

The recommendations directed towards Mid Staffs include:

- making its first priority the needs of patients;
- promoting links with other NHS organisations to enhance its ability to deliver services;
- reviewing staff training;
- reviewing audit procedures;
- reviewing the management of complaints ;
- reviewing policies relating to professional discipline;
- encouraging openness;
- reviewing the management of nursing staff;
- reviewing the management structure to ensure that the views of clinical staff are represented at all levels;
- reviewing record keeping procedures;
- ensuring that wards admitting the elderly hold regular multidisciplinary meetings;
- ensuring that steps are taken to ensure nurses work to a published set of principles focusing on safe patient care; and
- considering steps to enhance the rebuilding of public confidence in the trust.

The report also includes recommendations directed at the Department of Health which include:

- The Secretary of State for Health should consider whether he ought to request that Monitor de-authorise Mid Staffs (and he has indicated that he will ask Monitor to consider this).
- The Secretary of State and Monitor should review the arrangements for the training, appointment, support and accountability of executive and non-executive directors to create professional standards for those posts by means of standards formulated and overseen by an independent body with powers of disciplinary sanction.
- The Department of Health should set up an independent working group to look at mortality statistics with a view to making recommendations as to how mortality statistics should be collected, analysed and published, to promote public understanding of the process, and to assist hospitals in using the statistics as a prompt to examine particular areas of patient care.
- The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital to learn lessons about how failing hospitals are identified.

The final recommendation reads:

“All NHS trusts and foundation trusts responsible for the provision of hospital services should review their standards, governance and performance in the light of this report.”

This final recommendation has been swiftly followed by a letter from Sir David Nicholson to NHS Chairs asking them to ensure that boards read the report as a matter of urgency and review their standard, governance and performance in the light of the report.

The report can be accessed [here](#) and a joint response from Monitor and the CQC can be accessed [here](#). The Department of Health has published three reports aimed at helping NHS organisations to ensure that they have in place effective governance practices, which in the wake of Mid Staffs, will remain an issue at the top of the political and NHS agenda - more information is given about one of these reports, *The Healthy NHS Board*, below.

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8404.

NHS National Leadership Council Launches *The Healthy NHS Board: Principles for Good Governance Body*

The NHS National Leadership Council has launched *The Healthy NHS Board: Principles for Good Governance*, highlighting the critical role boards play in ensuring that quality, centred on patient safety, effective care and patient experience, is at the heart of the NHS.

The guidance explains that boards have three key roles:

- to formulate strategy:

- ensure accountability: and
- to shape a positive culture for their organisation.

Success is built upon a sound understanding of the local and national context, effective use of intelligence and proactive engagement with patients, the public, staff and local partners. All this and more is explained in the document, which also sets out the key responsibilities of health service leaders.

The guidance can be accessed [here](#).

For further information or advice please contact [Tania Richards](#) on 01223 222476.

NHS Constitution: a reminder of the obligations for NHS bodies

Since 19 January 2010, all NHS organisations have been legally required to follow the provisions set out in the Health Act 2009 relating to the NHS Constitution (Constitution).

The key legal obligations for NHS organisations include:

- when performing any NHS function, organisations now have a legal duty to “have regard to the Constitution”; and
- requiring all providers (both public and independent sector) of NHS services commissioned by an NHS organisation to be aware of their duty to also have regard to the Constitution.

Whilst the wording of the obligation to “have regard to the Constitution” is somewhat vague, we advise that as a minimum the wording requires NHS organisations and providers of NHS services, when making decisions on the performance of NHS functions, to show that they have considered the principles of the Constitution. However, the true extent of this obligation will not be established clearly until it is tested in the courts.

The practical effect of this is that if a decision by an NHS organisation departs from the Constitution, that organisation must have good reasons for such departure. Therefore, it will be necessary for NHS organisations to put in place robust processes/procedures to ensure that records are made demonstrating that the Constitution has been noted and complied with and similarly, contract clauses that require the same consideration from providers of NHS services.

The NHS Constitution and the Health Act can be accessed [here](#).

For further information or advice please contact [Emma Tully](#) on 01223 222485 or [Julie Jordan](#) on 01223 222478 or [Tim Winn](#) on 0121 456 8355.

The National Health Service (Quality Accounts) Regulations 2010

The National Health Service (Quality Accounts) Regulations 2010 (regulations) come into force on 1 April 2010. As mentioned in previous updates, Quality Accounts are reports to the public on the quality of services of a healthcare provider and their introduction derives from the Health Act 2009. The publishing of Quality Accounts is seen as a way of increasing public participation in the demand for improved health services.

A certain amount of flexibility has been built into the regulations for the first year of their existence. For example, although all acute trusts have to publish Quality Accounts by 30 June of this year, community health and primary care providers are currently exempted. There are, however, ongoing consultations in this area and it is expected Quality Accounts will be introduced next year for these two sets of providers. Therefore other entities (eg organisations classed as “small providers”) which are currently exempt may find themselves subject to the regulations in future.

The Quality Accounts themselves will comprise four parts:

- A statement made by the provider as to the overall quality of the services provided (or carried out by a third party on the provider’s behalf) for the relevant period. This statement must be signed off by an individual holding a position of seniority (as listed in the regulations) within the provider.
- Information relevant to the services provided. A list of such required information is set out in the schedule to the regulations.
- Information to be determined locally by the provider consulting with stakeholders.
- A statement from the Commissioning PCT or SHA, and (if received) from the Local Involvement Networks (LINKs) and Overview and Scrutiny Committees (OSCs) as to whether the draft Quality Accounts accurately reflect the quality of services provided.

What happens next year will depend in part upon a review of Quality Accounts submitted this year and the regulations may be amended in light of this. The National Quality Board in its first annual report (released 8 February 2010) states that it intends for Quality Accounts to “become as reliable and robust as financial accounts” and intends to work towards ensuring that the whole process is strengthened towards achieving that aim.

The National Health Service (Quality Accounts) Regulations 2010 can be accessed [here](#) and the Quality Accounts toolkit can be accessed [here](#).

For further information or advice please contact [Rona McPherson](#) on 01223 222299 or [Gill Thomas](#) on 01223 222237.

Transforming community services: new guidance published

As promised in the Operating Framework 2010/11, the Department of Health has published further guidance on the options available to PCTs' provider services, *Transforming Community Services: The assurance and approvals process for PCT-provided community services*, which can be accessed [here](#).

Whilst the language used is not as categorical as some statements attributed to Sir David Nicholson previously, there are some clear hints. For example, whilst community foundation trust may still be an option for more than the six initial pilots, they are "not expected to be the norm" and SHAs were required to give the department their shortlist of community foundation trust candidates by 12 February, only one week after the guidance was published.

This fits with some commentators' observations that the imposition of a 31 March 2009 deadline for PCTs to agree their plans with their SHAs, coupled with the disadvantages and risks associated with moving to a social enterprise, means that for most PCTs' provider arms the only realistic option is to be acquired by an acute or mental health trust. There is also a sense that whereas the initial guidance stressed that the primary goal was to achieve better services for patients, the current guidance is as much about driving change in organisational form, to allow PCTs to focus on improving their skills as world class commissioners.

For further information please contact [Tim Winn](#) on 0121 456 8355 or [Gill Thomas](#) on 01223 222237.

FOUNDATION TRUSTS

Monitor's private charges cap for NHS foundation trusts

Last month Monitor, the foundation trust regulator, published revised rules for the calculation by NHS foundation trusts of their "private charges" - the name given to a foundation trust's earnings from goods and services provided to non-NHS patients, which can be accessed [here](#).

Monitor was obliged to change its rules following the court's decision (on the application of Unison, the public sector union) that Monitor was not correctly applying section 44 of the National Health Service Act 2006, which obliges it to restrict the proportion of a foundation trust's income that can be derived from private charges.

Under section 44, it is irrelevant who made the charges to the private patient or how the foundation trust's receipt is categorised. This means that Monitor's previous practice of counting only income from services provided to private patients by the foundation trust was too narrow. Consequently, some structures that Monitor previously regarded as outside private charges will now count towards a foundation trust's private charges cap. For example, if a trust were to conduct its private patient work through the trading subsidiary of a charity which then donates its profits to the foundation trust, the income of the foundation

trust will be private charges because the donation will have been “derived from” the charges made to non-NHS patients by the trading subsidiary of the charity. The nature of the income reaching the foundation trust is irrelevant (so it could be a donation, a dividend, payment of rent), as is the number of intervening layers, provided it ultimately comes from someone who has received it from a non-NHS patient in return for goods and services.

Another potentially important distinction confirmed by the judgment is that section 44 applies only to income of the foundation trust itself - income is, after all, what comes in. Mr Justice Cranston was unequivocal in saying that in this case Hansard (which Unison had sought to rely on to prove that the income of companies that are joint ventures or in which the foundation trust has a minority interest were also intended by Parliament to be included) is irrelevant. This is because section 44 is perfectly clear, even though it does not say exactly what Monitor would have liked it to say, and under rules of statutory interpretation, Hansard is only admissible to clarify ambiguity. This means Monitor is not legally required to look beyond income derived from private charges received by the foundation trust itself, whether the income of other bodies would be consolidated with the foundation trust’s income under accounting convention or not.

In its new guidance Monitor expressly acknowledges that an accounts-driven approach is inappropriate *“The judgment has made clear that the accounting treatment of particular types and sources of private charges should not be the driver as to whether income from certain goods and services falls within the definition of private charges for the purpose of section 44 (2)”* but either misunderstands the judge’s remarks or (perhaps more likely) feels that as a responsible regulator it should adopt rules that capture the income of subsidiaries, investments and joint ventures even though the income may not have been remitted to (received by) the foundation trust. Monitor is perfectly entitled to adopt this approach: it is always open to Monitor to impose greater restrictions than the minimum required by the Act.

One practical consequence of the changes is that foundation trusts will need to recalculate their private charges for their “reference year” (the baseline by reference to which the trust’s private charges cap must be set) which in most cases will be the financial year 2002/3. This means foundation trusts need to be recalculating their private charges for 2002/3 now so that they can evaluate properly how the change in the private charges rules will affect their business in the future. Recognising that not all foundation trusts will have retained (or in the case of arrangements with third parties have access to) all of the records that would be necessary to establish precise amounts, Monitor is allowing foundation trusts to estimate where that is necessary and appropriate.

For further information please contact [Tim Winn](#) on 0121 456 8355, [Julie Jordan](#) on 01223 222478 or [Catherine Fawlk](#) on 0121 456 8287.

PROCUREMENT

Public contracts regulations may need redrafting after Uniplex judgment

Procurement rules may undergo redrafting after a recent judgment by the European Court of Justice (ECJ). In January 2010, the ECJ ruled that the Public Contracts Regulations 2006 (the 2006 regulations) provision which states that claims for breach of the procurement process must be brought “*promptly and in any event within three months from the date when grounds for the bringing of the proceedings first arose unless the Court considers there is good reason for extending the period ...*” is not an accurate translation of the relevant EC law into UK law. Although some of the time periods for claims under the new Public Contracts (Amendment) Regulations 2009, differ from those in the 2006 regulations, they too may be subject to review under the Uniplex ruling.

Uniplex (UK) Ltd participated in a tender run by NHS Business Services Authority (NHSBS) and lodged a claim against NHSBS in March 2008, which was three months from the date NHSBS informed Uniplex of the detailed evaluation of the bids. NHSBS countered that Uniplex had left it too late as the time period for making such a claim had started to run from the moment Uniplex was informed of its unsuccessful bid. However, Uniplex held that the time period for claims had started later, only after NHSBS sent out full details of its evaluation process.

The High Court sought guidance from the ECJ which ruled that it was only once the tenderer obtained sufficient information that it could establish the existence of a breach. This ruling could now mean uncertainty in procurement procedures. For example, how much information will be deemed “sufficient”, will tenderers be obliged to seek relevant information and at what stage will sufficient knowledge be deemed to have been gained? This latter point may become clearer as a High Court decision concerning that issue is expected shortly, watch this space.

The case can be accessed [here](#) courtesy of © European Union, <http://eur-lex.europa.eu/>,

For further information or advice please contact [Rona McPherson](#) on 01223 222299 or [Gill Thomas](#) on 01223 222237.

Co-operation and Competition Panel criticises PCTs for poor procurement practice – and OFT is asked to review Government policy on NHS as the preferred provider

This month the Co-operation and Competition Panel published its commentary on its first 12 months in operation. In its first progress report, which can be accessed [here](#), the panel reviews its cases to date and comments on recurring themes, such as the often-overlooked point that for the panel any bringing together of control amounts to a “merger” even if the parties think all they are doing is agreeing to work together as an interim arrangement. This

was not news because the panel has been publishing its advice and findings alongside its decisions.

However, the panel appears to have taken the Department of Health by surprise with the following paragraph, criticising PCTs for poor procurement practice: *“In the panel’s experience, a significant number of commissioners take procurement decisions at risk of challenge under the principles and rules. Problems we have observed include using different criteria to evaluate bidders than initially described in the bid documents, excluding potential bidders on grounds unrelated to their ability to deliver the services tendered, and failing to select the best-performing service provider as the preferred bidder.”*

The department was swift to point out that no cases have been referred to the panel so far on procurement grounds (implication: so how would it know?), which was true up to the referral of Great Yarmouth and Waveney PCT for (in its view) following Department of Health policy that the NHS is the preferred provider. What this analysis overlooks however is the considerable amount of informal advice the panel has been giving both to PCTs and SHAs on procurement cases that have not (or not yet) been referred to the panel. It is also true that some of the formal merger referrals to the panel have been about mergers forged through procurement by commissioners - so even though the panel’s remit was to evaluate the merger, it may have been difficult for staff who are, after all, procurement experts too, not to notice any shortcomings in procurement practice.

As readers may be aware, in the last few days it has been announced that the Great Yarmouth and Waveney procurement has been cancelled on the instructions of the Department of Health and the CCP has closed its file. In response, the shadow health minister Andrew Lansley has asked the Office of Fair Trading to investigate the “NHS as the preferred provider” policy. The question is limited to Government policy (which is outside the remit of the CCP), rather than the actions of NHS bodies, but as Government policy is what drives the behaviour of NHS bodies the move does have the potential to extend into other areas of Government policy if the OFT accepts the case. Obvious candidates are Transforming Community Services, NHS mergers and all of the work of the CCP. In addition, NHS Confederation Partners (the private-sector-providers-to-the-NHS section of the NHS Confederation) has issued a statement that excluding the private sector from competition to provide NHS services is “unacceptable and potentially unlawful”. We await further developments with interest!

For further information please contact [Tim Winn](#) on 0121 456 8355 or [Gill Thomas](#) on 01223 222237.

PATIENT MATTERS - OUT OF HOURS CARE

Out of hours deaths: coroner’s verdict

Mills & Reeve represented Cambridgeshire Primary Care Trust at the recent inquest into the deaths of David Gray and Iris Edwards. Both patients were treated by Dr Ubani, a locum doctor from Germany who was working his first out of hours shift in this country. Dr Ubani was engaged by the PCT’s provider, Take Care Now.

On 5 February, HM Coroner William Morris returned verdicts of unlawful killing in respect of David Gray – who was given a 10 times overdose of diamorphine - and natural causes in respect of Iris Edwards. He made a number of recommendations under Rule 43 of the Coroners Rules 1984 to the Secretary of State for Health concerning guidance that should be issued to PCTs.

These recommendations impact on both PCT contracts with out-of-hours (OOH) providers and PCT management of Medical Performers Lists. The key recommendations are:

- Guidance should be issued to PCTs requiring them to risk assess every non-UK based doctor involved in OOH services care including an assessment of their experience in the NHS and whether the doctor gained accreditation in his home state via the acquired rights system or through examination.
- There should be a nationally drawn up protocol for PCTs to follow when deciding whether to admit performers to the list to avoid regional variation in standards.
- When considering applications to the Medical Performer's List, PCTs should:
 - check that GPs have sufficient knowledge of the English language;
 - establish an intention to deliver services in the PCT's area;
 - check whether an applicant has failed to progress applications to other PCTs or whether any applications have been refused; and
 - ensure an appropriately qualified person is responsible for robustly applying regulation 6 of the Performer's List regulations.
- PCTs should ensure that the providers of OOH services remain responsible for assessing the quality of the OOH doctors they engage and they should not delegate that responsibility to any recruitment or locum agency.
- PCTs should ensure that all contractual arrangements with OOH providers provide for a thorough induction procedure and robust clinical governance and risk management structures.
- All contracts between PCTs and OOH providers should be regularly and robustly monitored to ensure quality service standards

A fuller Mills and Reeve briefing on the case can be accessed [here](#) .

For further information or advice please contact [Lucy Johnston](#) on 01223 222366.

GP out of hours care: tighter controls for the future.

A letter dated 4 February 2010 (the day before the Gray verdict) has been sent to all PCT Chief Executives informing them that the report commissioned in October 2009 in response to the death of Mr Gray called *General practice out of hours services* has now been published.

The report found that there is an unacceptable variation in the implementation and monitoring of out-of-hours services and has outlined 24 recommendations to improve the commissioning and provision of out-of-hours services. The Minister of State for Health has accepted the recommendations relating to the NHS in full.

PCTs are expected to review the report and implement the recommendations urgently to ensure that safe out of hours care is being delivered. The Minister has also announced further measures to improve commissioning and provision of out of hours services which include:

- reviewing the national quality requirements in place for out-of-hours services to develop a stronger set of minimum standards and a national model contract;
- supporting out-of-hours providers to become a valued and integral part of the local health community; and
- stronger performance management by SHAs.

The report can be accessed [here](#).

For more information or advice please contact [Katrina McCrory](#) on 0121 456 8451 or [Lucy Johnston](#) on 01223 222366.

Department of Health publishes interim guidance on assessing the English language competence of GP applicants

On the same day that the GP Out of Hours Services report (referred to above) appeared, the Department of Health published a raft of recommendations and interim guidance relating to the commissioning of such services, the selection and training of out-of-hours clinicians, and the management of Medical Performers Lists operated by PCTs.

Regulation 6(2)(b) of the National Health Service (Performers Lists) Regulations 2004 (as amended) states that a PCT must refuse to include a performer in its performers list if it is not satisfied that he has the necessary knowledge of and proficiency in the English language to perform medical services properly and without jeopardising himself or his patients. Once a doctor has been included in the list of one PCT, he is entitled to perform primary medical services in any other PCT's area in England.

Many doctors coming from overseas to practise in England will already have provided evidence of their language competency to the GMC, but this is not required if they are from a country within the European Economic Area (EEA), like Dr Ubani. Nevertheless, before deciding to include an EEA national in their list, PCTs must consider the sufficiency of the evidence provided with the application and decide whether or not they require the applicant to provide any further evidence of language competency, so that their knowledge of English may be properly assessed.

The department has now issued interim guidance to assist PCTs in reaching their decision about whether or not a doctor has a sufficient knowledge of English to perform primary medical services. The guidance can be accessed [here](#).

Although the department intends to review and revise all of its current guidance on the Performers Lists as part of the implementation of the Performers Lists review, it was clearly felt that the urgency of the situation, as highlighted by the Gray inquest, warranted an interim publication and a reinforcement of the message that, for the safe practise of medicine, English language proficiency is critical.

For further information or advice please contact [Jane Williams](#) on 0121 456 8421.

PATIENT MATTERS - CORONERS

High Court rules that the coroner does not have an unlimited discretion to call evidence in a non-Article 2 inquest

In a recent judicial review of a coroner's decision, the High Court was asked to consider, among other things, the correct scope for a non-Article 2 inquest. The judgment of the case, *R(on the application of Butler & anor) v HM coroner for the Black Country district (2010)* can be accessed [here](#).

The inquest was held into the death of an employee who was run over by another employee as he fitted a water pump in a flooded manhole. The coroner wished to adduce evidence from a Health and Safety Executive (HSE) inspector and two police officers in the belief that the jury might consider a verdict of unlawful killing.

The High Court held that the coroner's view that he had an unlimited discretion as to the evidence he could call was incorrect. The High Court ruled that where Article 2 did not apply, the coroner was restricted to calling evidence of fact as to the matters set out in Rule 36 namely, who, when, where and how.

The coroner should also have regard to the verdicts realistically available when determining the scope of the enquiry. In this case the coroner was not entitled to adduce evidence from the HSE Inspector or the police officers because the evidence, even taken at its highest, would not support a verdict of unlawful killing.

For further information or advice please contact [Laura Jolley](#) on 01223 222448.

PATIENT MATTERS – ASSISTED SUICIDE

Assisted suicide: new guidance

The guidance has been published following a public consultation on the draft guidance which was published last year. The final guidelines, published by the Director of Public Prosecution (DPP), Keir Starmer QC, are slightly different to the draft guidance with the

focus now being more on the motivation of the suspect rather than the characteristics of the victim. The DPP has stressed that the guidance is not about changing the law; assisted suicide remains illegal and carries a prison term of up to 14 years and he does not believe that the guidance will result in more or less prosecutions. Among the most obvious changes from the draft guidance is the removal of the reference to a person's terminal illness or disability. The DPP said this was done because it was felt it could discriminate against people with these conditions and suggest they are less protected.

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8404.

PATIENT MATTERS – FERTILITY ISSUES

Final report of the expert group on Commissioning NHS Infertility Provision published

Following the issue of its interim report in August 2008, and the publication of a commissioning aid in June 2009, the final report of the independent expert group on Commissioning NHS Infertility Provision (the report) can be accessed [here](#).

The group's remit was to identify the barriers to the implementation of the NICE fertility guideline (CG11), published in 2004, and to produce a commissioning aid for PCTs to encourage gradual progression towards full implementation. The report confirms progress in the following key areas:

- A national tariff is being developed by the Department of Health for regulated fertility services and is scheduled for introduction in 2012.
- In the interim, the national tariff working group will be gathering and sharing (on an anonymised basis) between PCTs information on current tariffs and prices to help PCTs assess whether the prices they are paying locally are a fair reflection of the national pattern.
- The department has commissioned research, to be shared with commissioners, to ascertain how fertility treatment patients themselves would prioritise improvements in the provision of services.
- The fertility patient support group, Infertility Network UK, has received further funding from the department for their work with PCTs to encourage awareness of infertility issues and to offer assistance to commissioners.

In the meantime, commissioners will no doubt eagerly await the results of the review of CG11 which was scheduled to get underway this year.

For further information or advice please contact [Jane Williams](#) on 0121 456 8421.

The Human Fertilisation and Embryology Act 2008 (HFEA): implementation of provisions to assist research projects

One of the final implementation stages of the HFEA takes place on 6 April 2010 when the Human Fertilisation and Embryology (Disclosure of Information for Research Purposes) Regulations 2010 (regulations) are due to come into force. The aim of the regulations is to allow relevant research bodies within the United Kingdom who cannot approach individuals directly, to apply to the HFEA for the disclosure of information concerning certain individuals who have either been conceived as a result of an assisted fertility process or those who have undergone such process. There will be a charge made for access to this information based on the time taken by the HFEA to collate and prepare the relevant information for each applicant.

The information for which applicants can apply for disclosure is information relating to

- the provision to an identifiable person of fertility treatment services other than basic partner treatment;
- the procurement or distribution of reproductive cells collected in the course of providing non-medical fertility treatment for an identifiable individual;
- the retention of reproductive cells or embryos taken from identifiable individuals; and
- the use of reproductive cells or embryos from identifiable individuals.

The regulations set out a list of exceptions to what can be disclosed and the exceptions are dependent on when the information was recorded by the HFEA. Of most importance, information cannot be disclosed if the individual concerned has not consented to disclosure for research purposes.

The application process is set out in the regulations and applications may be turned down on the following basis:

- no research ethics committee has given a favourable view of the project for which the applicant requires the information to be disclosed;
- the HFEA does not consider that the information requested is necessary for the project;
- an individual could be identified from the information if it was disclosed and there are other means of achieving the aim of the research project (taking into account cost and available technology); or
- the security arrangements which an applicant has put in place are insufficient.

The HFEA also has the right to visit an applicant's premises to ensure that it complies with the regulations. The regulations can be accessed [here](#).

For further information or advice please contact [Rona McPherson](#) on 01223 222299 or [Gill Thomas](#) on 01223 222237.

PATIENT MATTERS - MENTAL HEALTH ACT

New ruling on importance of consultation with nearest relative

The role of consultation with the nearest relative has been reinforced as a necessary safeguard by the court in the recent case of *R (on the application of V) v South London & Maudsley NHS Foundation Trust*.

The main issue to be considered in this case was whether the requirements of section 11(4) of the Mental Health Act 1983 (MHA) had been complied with. This section prevents an Approved Mental Health Professional (AMHP) from making an application for admission for treatment under the MHA without first consulting that person's nearest relative, however this does not apply if it appears to the professional that "in the circumstances" such consultation is not reasonably practicable or would involve unreasonable delay.

In considering the relevant circumstances in this case, the court had to consider the circumstances that were known to the AMHP at the time or believed by him/ her to exist.

In this case the evidence before the court was that the AMHP made the decision at 12:15 hours that there was not sufficient time to consult with the nearest relative, believing that the current period of detention (under section 5(2) MHA) was not due to expire until 19:30 hours that day. This would have allowed the AMHP over seven hours in which to contact the nearest relative. The court found that this was not a reasonable decision. There was also no evidence that a consultation would have caused unreasonable delay.

The AMHP also gave evidence that she believed that the nearest relative would consent, as consent had been given in the past. The court found that it is not appropriate for a professional to make assumptions as to what the result of the consultation would be.

For further information or advice please contact [Charlotte Mawdesley](#) on 0121 456 8402 or [Jill Mason](#) on 0121 456 8367.

PATIENT MATTERS - CHILD LAW ISSUES

Court of Appeal decision prompts calls for new guidance on the use of children's evidence in the family courts

The judgment in the case of *Re W (children) (2010) EWCA*, which can be accessed [here](#), was handed down by the Court of Appeal on 9 February 2010. It involved a case brought on appeal by an appellant father following a county court judge's refusal to allow his 14 year old step daughter to be called to give evidence at a finding of fact hearing within care proceedings. She had alleged serious sexual abuse by the father and the matter is the subject of criminal proceedings.

It will be of particular interest to practitioners providing evidence to the family court or involved in the care or treatment of young people who are the subject of proceedings. Where

allegations of abuse are made, practitioners need to be familiar with what processes a young person may be involved in outside of any NHS interventions.

The Court of Appeal looked carefully at the case law and relevant non-statutory guidance relating to this area. Whilst they upheld the decision of the county court judge, the court was of the view that it is now appropriate that consideration be given to the approach of the court with regard to children and young people giving evidence. The starting point currently is that it is considered undesirable for children to give evidence in care proceedings and that particular justification will be required before that course is taken.

The court has referred this matter to the President of the Family Division for consideration, including suggesting a possible referral to the Family Justice Council. This may result in updated guidance about children and young people giving evidence in care proceedings/the family court.

For further information or advice please contact [Helen Burnell](#) on 020 7648 9237 or [Ruth Creed](#) on 0121 456 8323.

Child prescription errors

A study of five hospitals undertaken by the University of London, has revealed that a fifth of drugs given to children in these hospitals over a two year period were administered incorrectly. On five occasions, one of the investigators had to intervene to prevent potentially fatal consequences. A high percentage of dosing errors was also identified.

The University of London commented that “prescribing for children is very difficult”, not least because most drugs are formulated for adults, not children. Doctors have to formulate their own dose calculations based upon the child’s age, weight and clinical condition.

In addition, many drugs given to children are unlicensed as they have not been tested and approved for use on children. It is crucial for staff involved in treating children to look for ways of minimising the risk of errors.

The National Patient Safety Association (NPSA) has considered patient safety among children in hospital and has identified some helpful action points for NHS organisations. A copy of the NPSA review can be found [here](#).

For further information or advice please contact [Charlotte Mawdesley](#) on 0121 456 8402 or [Helen Burnell](#) on 020 7648 9237.

Vetting and Barring Scheme

There has been some confusion over the media coverage in the autumn last year about when the Vetting and Barring Scheme will require people to register with the Independent Safeguarding Authority (ISA). The Department for Children, Schools and Families (DCSF) has produced guidance clarifying when a person does not have to register with the ISA

regarding personal and family arrangements, and also sets out other exemptions from the new Vetting and Barring Scheme.

The key principles that govern when the scheme does not come into play are as follows.

- where an arrangement is a family arrangement;
- where an arrangement is made personally between friends, and is not on a commercial basis;
- where an activity is not a "regulated activity", because it is not:
 - an activity specified by the scheme;
 - work for an organisation specified by the scheme; or
 - a post specified by the scheme.
- where an activity is exempt from the scheme.

Whether the scheme's requirement to register with the ISA will apply depends in particular on two key principles, if an activity is arranged by an organisation (as opposed to being a private arrangement) and if that activity is "frequent or intensive".

More information can be found on the DCSF website which can be accessed [here](#) .

For further information or advice please contact [Tania Richards](#) on 01223 222476.

PATIENT MATTERS - MENTAL CAPACITY ACT

Mental Capacity Act update published

The first edition of the 2010 MCA update can be accessed [here](#).

The update includes items on the following topics:

- the Office of the Public Guardian's consultation on its amendments to secondary legislation which we referred to in last month's *Health legal update* (which can be accessed [here](#));
- the publication of the independent Mental Capacity Advisory Service and second annual report;
- an update on Deprivation of Liberty Safeguards; and
- it also contains contact details for the regional leads for Deprivation of Liberty Safeguards and regional leads for the Mental Capacity Act.

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8404.

PATIENT MATTERS - GENERAL

Help for those receiving contaminated blood could be on its way

The Contaminated Blood (Support for Infected and Bereaved Persons) Bill, currently going through Parliament, was drafted and introduced in the House of Lords by the President of the Haemophilia Society, the RT Hon Lord Morris of Manchester.

If the Bill proceeds into law, its provisions will:

- Establish a haemophilia advisory committee to advise on the condition in the United Kingdom.
- Implement a system to ensure haemophiliacs who have received blood from the NHS are offered testing for a range of conditions including hepatitis B and C, and HIV. Blood donors will also be regularly tested.
- Introduce a financial compensation scheme for individuals who have been affected after receiving contaminated blood under the NHS in such a way that they have contracted certain conditions (including hepatitis B and C, and HIV). Primary carers or widows and other dependents of such individuals will also have the right to apply for compensation.
- provide, free of charge, certain treatments (such as home nursing and counselling) to those who have been treated with and infected by contaminated blood.

The Bill came about following the Archer Inquiry: an investigation presided over by Lord Archer of Sandwell QC and held in relation to the transfusion of contaminated blood by which over 4,500 people suffering from haemophilia were infected with HIV and Hepatitis C.

It should be noted that should the Bill become law it will only apply to England and Wales.

The Bill can be accessed [here](#).

For further information or advice please contact [Rona McPherson](#) on 01223 222299 or [Gill Thomas](#) on 01223 222237.

Healthcare for people with learning disabilities: recommendations of the Parliamentary and Health Ombudsman

There have been two investigatory inquiries undertaken over the last year in relation to healthcare for people with learning disabilities by Sir Jonathan Michael and the Parliamentary and Health Service Ombudsman. The reports, *Healthcare for All* and *Six Lives* reported failings in health and social care services.

In *Six Lives*, the Ombudsman recommended that all NHS and social care organisations in England should review urgently:

- the effectiveness of the systems they have place to enable them to understand and plan to meet the full range of needs of people with learning disabilities in their area; and
- the capacity and capability of the services to provide and/or commission for their local populations to meet the additional and often complex needs of people with learning disabilities.

The Ombudsman recommended that the reviews should be reported to those responsible for the governance of those organisations by March 2010. The Department of Health has encouraged all NHS organisations to ensure the reviews recommended by the Ombudsman are completed by March this year. A copy of his letter can be found [here](#). A suggested structure for reporting on the progress against the Ombudsman’s recommendation using the self assessment framework is also attached to the letter to assist NHS organisations.

The information that will be provided by the NHS organisations will be reviewed by the Department of Health which expects to publish a progress report in the autumn of this year.

For further information or advice please contact [Sonal Lala](#) on 0121 456 8248 or [Dawn Brathwaite](#) on 0121 456 8224.

Department of Health publishes checklist for reporting and managing information governance serious untoward incidents (IG SUI)

The checklist was published in January and can be accessed [here](#).

The checklist defines an IG SUI as “any incident involving the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals should be considered as serious”.

It includes the loss of both electronic and paper records. The checklist should be read in conjunction with previously released national guidance on the management of SUIs as well as local guidance.

The checklist includes the following advice:

- staff should be encouraged to report IG SUI “near misses”;
- all staff should know to whom they should report suspected or actual IG SUIs;
- the checklist should be incorporated into the incident response plan which each organisation should already have in place; and
- PCTs are responsible for performance managing the investigation of SUIs in their main providers.

The checklist provides a useful list of steps to be taken into account when investigating IG SUIs.

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8404.

Complaints handled by Patient Advice and Liaison Services (PALS): Department of Health issues guidance

The Department of Health has issued clarification on the legal position surrounding complaints handled by PALS in cases where legal proceedings are instituted.

In relation to complaints handled by PALS, the advice provides the following clarification:

- all complaints to PALS that are not resolved by the next working day need to be resolved as a complaint;
- written or emailed complaints should be recorded irrespective of how quickly they are resolved;
- the Local Authority Social Services and NHS Complaints (England) Regulations 2009 (the regulations) must be applied to the handling of such complaints;
- complaints must all be handled within the terms of the regulations regardless of whether the complaint is addressed to PALS, the complaints manager or another member of staff; and
- if a complainant has intimated that they are planning to take legal proceedings, discussions should take place with the relevant authorities, for example legal advisors or the NHS Litigation Authority to determine whether proceedings to answer the complaint would prejudice subsequently legal action.

The regulations can be accessed [here](#).

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8404.

Department of Health issues guidance for access to health records requests

The Department of Health has issued guidance covering requests for access to health records of both living and deceased patients. The guidance considers the provisions of the Data Protection Act 1998 (DPA), the Access to Health Records Act 1990 (AHRA), the Freedom of Information Act 2000 (FOIA) and the Access to Medical Reports Act 1988 (AMRA).

The guidance includes consideration of the following:

- the requirement of a valid request;
- the need to record the request;
- applicable fees;
- the appropriate health professionals to consult when considering a request for access;

- situations where access can be denied or limited;
- requests from patients living abroad;
- parental requests for access to children's records;
- how to deal with release of the records;
- dealing with requests for viewing of the records; and
- amendment to health records.

The guidance includes model consent forms as well as a useful question and answer section.

The guidance can be accessed [here](#).

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8404.

Military veterans to receive priority access to NHS medical treatment

The Department of Health (DOH) has released a circular reminding all PCTs, NHS acute, mental health and foundation trusts of the priority treatment guidance in place for military veterans that was established by the DOH's letter dated 1 January 2008.

A recent survey by the Royal British Legion has revealed that 81 per cent of GPs knew nothing or little about veterans' right to priority care and that 94 of the 170 acute trusts in England also said they had no records on priority treatment and five said they were unaware of the scheme.

GPs have been reminded that when making referrals relating to a military veteran for diagnosis or treatment, they should :

- Record the veteran's status as part of the referral (unless the patient objects to their veteran status being disclosed).
- State whether the condition might be related to military service and whether they consider that priority treatment might be appropriate because the condition is likely to be related to the veteran's time in service.
- Prioritise veterans with service related conditions over other patients with the same level of clinical need. However, veterans should not be given priority over other patients with more clinical need.

The guidance can be accessed [here](#).

For more information or advice please contact [Katrina McCrory](#) on 0121 456 8451

National Victims' Service to be rolled out for 'forgotten victims'

The Justice Secretary, Jack Straw, has recently announced details of a new National Victims' Service. This service has been set up to give victims of crime the same kind of one-to-one attention that offenders receive through the probation service. The service, which will be delivered in partnership with Victim Support, will initially concentrate on families whose lives have been torn apart by murder or manslaughter. Families will be given a named, dedicated, professional support worker who will meet regularly with them to identify their needs and liaise with the authorities, including the NHS, on their behalf.

From 1 April 2010, the service will also be rolling out for all victims of crime across England and Wales.

Jack Straw's speech, announcing details of the new National Victims' Service can be accessed [here](#).

For more information or advice please contact [Katrina McCrory](#) on 0121 456 8451.

The Department of Health consults on charging arrangements for residential social care.

The issues on which the Department of Health is seeking comments are changes to the charging regulations in relation to the following:

- Whether local authorities should be allowed to take into account the "care" element of a personal injury compensation award in assessing what a care home resident can afford to pay for residential care. Current policy is that personal injury compensation awards should be disregarded in the financial assessment of people for residential care. Currently the circumstances in which it can be taken into account are limited.
- Whether single premium investment bonds (into which personal injury compensation has been paid) should be taken into account in the financial assessment.
- Whether the value of pre-paid funeral plans should be included when included when considering an individuals ability to pay for social care.
- Whether residents should be able to top-up nursing home fees during the initial twelve week period in which the value of their property is disregarded when they go into local authority supported accommodation that costs more than the local authority would normally be expected to pay.

The consultation closes on 23 April 2010 and can be accessed [here](#).

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8404.

Clinical governance and adult safeguarding guidance published

The Department of Health has published guidance which aims to ensure that NHS clinical governance systems and adult safeguarding processes are fully integrated. *Clinical governance and adult safeguarding: an integrated process* can be accessed [here](#).

The guidance follows the Department of Health's consultation on reviewing *No secrets* which is the guidance that governs adult protection processes. The guidance encourages organisations to develop robust local arrangements to ensure that adult safeguarding issues are appropriately addressed and provides a flow chart setting out how adult safeguarding and clinical governance processes should be integrated. It is hoped that an integrated approach will avoid duplication of investigations and permit greater learning from adverse events.

The flow chart indicates the stages at which NHS organisations should consider whether incidents raise adult safeguarding issues and, if so, how these issues should be dealt with. The guidance also provides some useful practical examples to help explain the integrated process for managing adult safeguarding and clinical governance concerns.

The guidance refers to there being a perception that adult safeguarding issues within the NHS are largely dealt with "in-house" rather than through the multi-agency process advocated by the *No secrets* guidance. The integrated process advocated should help NHS bodies to correctly determine when a multi-agency safeguarding investigation is appropriate.

For further information or advice please contact [Jill Mason](#) on 0121 456 8367 or [Lee Parkhill](#) on 0121 456 8420.

REGULATORY

GMC allows Gosport War Memorial doctor to continue practising

Many of you will recall the highly publicised inquests which were held last year into the death of ten patients in the 1990s at the Gosport War Memorial hospital in Hampshire.

The inquest concluded that three of the patients had been given painkillers that were not appropriate to their condition and symptoms and although it was held that medication also contributed to the death of two other patients, the jury found that it was given for therapeutic reasons and was appropriate for their condition.

Many family members believed that sedatives including diamorphine had been over prescribed and that this led to the deaths of their relatives.

Jane Barton, who worked as a clinical assistant at the hospital and who prescribed the drugs in question, has now been found guilty of serious professional misconduct by the GMC

although she will be allowed to continue to work as a doctor. She was found to have prescribed diamorphine at various levels and the panel found that her failings included “*the issuing of prescription drugs at levels which were excessive to the patients’ needs and which were inappropriate, potentially hazardous and not in the patients’ interests*”.

The case is now to be reviewed by the Council for Healthcare Regulatory Excellence, the ombudsman for misconduct cases. If found to be unduly lenient the decision could be overturned.

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8404.

EMPLOYMENT

Likely loss of livelihood might lead to legal representation

In *R (on the application of G) v Governors of X School* (which can be accessed [here](#)), the Court of Appeal has held that a teaching assistant was entitled to legal representation during internal disciplinary proceedings.

An allegation of sexual misconduct was made that G had kissed a 15-year-old boy and disciplinary proceedings were brought against him. G requested that he be allowed legal representation at the internal hearings but the governors of X school refused. G was dismissed and, consequently, he sought judicial review of the decision not to allow him legal representation.

The Court of Appeal held that the governors’ decision to dismiss G would ultimately result in him being placed on the children’s barred list that would prevent G from working with children again. While G had recourse through an independent procedure once the internal disciplinary proceedings were exhausted, the Court of Appeal held that the governors’ finding of fact would inevitably influence the decision to place G on the children’s barred list. Therefore, in this case, legal representation would have a significant impact on the outcome of the internal disciplinary proceedings and should be allowed.

The Court of Appeal heard arguments on Article 6 of the European Convention on Human Rights – the right to a fair trial. In these circumstances, Article 6 did include a right to legal representation. However, this was not an automatic right but would depend on the circumstances and what was at stake. As a simplified rule – the greater the charge, the greater the level of protection under Article 6. In this case, the employee was in danger of losing his ability to practice in his chosen profession not just that specific job.

For further information or advice please contact [Stuart Craig](#) on 01223 222280, [Martin Brewer](#) on 0121 456 8357 or [Jog Hundle](#) on 0121 456 8207.

Illegality of employment contracts

The recent judgment in the case of *San Ling Chinese Medicine Centre v Lian Wei Ji*, says that an employee’s work permit must have actually been revoked in order for their contract of

employment to be tainted with illegality. A contract will not be illegal merely because circumstances exist that could potentially lead to the employee's work permit being revoked.

In making this finding, the Employment Appeal Tribunal has followed the recent judicial trend of narrowing an employer's ability to rely on illegality as a defence against unfair dismissal claims.

In this case the employee was pressured by her employer to state that she was paid less than the salary declared for her work permit. However, it was held that a contract of employment may remain valid even if an employee is working for less salary than that stated in a work permit application.

The result of this decision is that employers will not be able to prematurely argue that an employee's contract is illegal. Up until a work permit expires or is actually revoked, employers cannot use "illegality" as a potentially fair reason for dismissal.

For further information or advice please contact [Anna Youngs](#) on 0121 456 8359.

Whistleblowing protection: a careful balancing act

The recent judgment in the case of *Neikrash v South London Healthcare NHS Trust*, highlights the need for NHS employers to consider very closely any decision to suspend (exclude in the case of doctors and dentists) NHS employees. Case law has established for some time that suspension is a measure of last resort and alternatives eg restriction of practice, need to be considered first. The decision to suspend/exclude is governed also by the employer's disciplinary policies, and needs to be exercised very carefully, particularly when a worker alleges s/he has made a whistleblowing allegation.

The claimant in this recent case was a consultant urologist employed by the trust. From May 2007, the claimant raised a large number of concerns with management about a variety of issues, which concerned patient care, closures of clinics, bullying and harassment and poor supervision. It was felt that the claimant was damaging working relationships and the reputation of the urology department, and as a consequence the claimant was excluded and an investigation into his behaviour was undertaken. Subsequently his exclusion was lifted but his day-to-day activities were restricted.

The claimant raised a grievance about his exclusion. The trust called a meeting at which his grievance was dismissed. Further correspondence and meetings took place but he filed a whistleblowing claim at the Employment Tribunal where he alleged he had suffered detriments as a result of making whistleblowing disclosures. He alleged that his detriments related to his job plan, delay in allowing him to operate at Guy's and St Thomas', his exclusion, including detriments arising from the exclusion (loss of private practice income, loss of reputation, injury to feelings and health), the making of defamatory allegations by management and in relation to prospective on-call payments.

The tribunal found that the claimant had been subjected to a detriment on the grounds of protected disclosures made by him at the time, but only in relation to his exclusion. In all other respects they found that no detriment had been suffered due to the claimant's protected disclosures.

This case illustrates the great cost involved when taking decisions which impact detrimentally upon workers who have made protected disclosures in circumstances where working relationships are breaking down. Employers must ensure that they fully explore alternative methods to suspension/exclusion in such situations.

For further information or advice please contact [Jog Hundle](#) on 0121 456 8207.

PROPERTY

Construction contracts: damages for delay

If the provision of a new NHS building is delayed and it is the contractor's fault, the NHS body (as "employer" under the building contract) will want the right to recover the costs of the delay.

The building contract could allow the employer to recover by proving the losses it has suffered, known as damages "at large" or unliquidated damages.

However, a building contract usually creates a right to "liquidated damages", a fixed charge for each day or week of delay. This allows the contractor to quantify his risk when entering into the contract, and the employer to know with certainty what he can recover if the contractor causes delay.

All standard form building contracts contain a liquidated damages clause with a space to fill in the amount of damages to be paid by the contractor per day or week. The amount chosen must be a genuine pre-estimate of the employer's loss. If it is not representative of the employer's loss, it will be an unenforceable penalty clause. If it is too low, the employer will be left out of pocket.

An employer may not want to use liquidated damages, perhaps because the level of losses that it will incur depends on factors which are unknown at the date of contract. If so, under no circumstances should the employer write "nil" in the space in the contract for liquidated damages, or leave the space blank, as both could mean that it has forsaken its right to claim any damages for delay at all. Instead, the building contract should be amended to delete the liquidated damages clause, and wording should be inserted setting out the right to claim damages at large.

For further information or advice please contact [Alexandra Price](#) on 01223 222513.

Latest on the carbon reduction commitment

After a lengthy consultation process the Government is, next month, set to introduce the Carbon Reduction Commitment Energy Scheme (CRC). This scheme will affect many NHS organisations and participation will be compulsory for those who are caught.

The CRC is a new emissions trading scheme which will provide financial and public relations incentives to encourage public and private sector organisations to reduce their carbon dioxide emissions and invest in energy saving initiatives. A key point is that, from April 2011, participating organisations will have pay to emit CO₂.

You will have to participate in the scheme if, in 2008, you had at least one "half-hourly" electricity meter and you consumed 6000 megawatt hours (the equivalent, at the time, to a spend of around £500,000) or more of electricity. If you had a half hourly meter but consumed less than 6000 megawatt hours, you will not have to participate in full but you will have an obligation to report information to the Environment Agency.

The CRC is the first major policy initiative to come out of the Climate Change Act 2008, which included a commitment from Government to reduce UK greenhouse gas emissions by at least 80 per cent (compared with 1990 levels) by 2050. The need to reduce CO₂ emissions is also emphasised in the NHS's own carbon reduction strategy, published last year but recently updated, which sets its own challenging targets. The CRC is one of the ways in which these targets will be met.

More information on the CRC and how Mills & Reeve can help you prepare can be found [here](#).

For further information or advice please contact [Oliver Ennis](#) on 01223 222322.

The contents of this document are copyright © Mills & Reeve LLP. All rights reserved. This document contains general advice and comments only and therefore specific legal advice should be taken before reliance is placed upon it in any particular circumstances. Where hyperlinks are provided to third party websites, Mills & Reeve LLP is not responsible for the content of such sites.

Mills & Reeve LLP is a limited liability partnership regulated by the Solicitors Regulation Authority and registered in England and Wales with registered number OC326165. Its registered office is at Fountain House, 130 Fenchurch Street, London, EC3M 5DJ, which is the London office of Mills & Reeve LLP. A list of members may be inspected at any of the LLP's offices. The term "partner" is used to refer to a member of Mills & Reeve LLP.