

Health legal update May 2010

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INTRODUCTION

Welcome to the May edition of our *Health legal update*. If these briefings have a theme, this one is "regulation and guidance", with extracts covering the CQC regulatory system, the revised framework for "Never Events", guidance on health protection law, and the role of the Caldicott Guardian to pick a few. We learn of the serious incidents requiring investigation (SIRI) which will replace serious untoward incidents (SUIs). This is an important development when considered against, for example, the changes to the Coroners Rules and in particular Rule 43 reports coroners issue where the facts at the inquest suggest there are matters that should be addressed with a view to preventing future deaths. We suspect (hope) health bodies will use the SIRI as an early means of identifying, and then discussing with the coroner, in advance of an inquest, those matters that ought to be addressed so that the overuse of Rule 43 reports will be avoided. Also, to be read in conjunction with the new manual for Caldicott Guardians are the extracts on the security of health records and information management. There is also a wealth of material on funding. This edition comes to you as the country is gripped by general election excitement. It will be interesting to see what changes occur in the regulation, funding and governance of the health sector in the time between now and the next edition. On the subject of themes, a clear message from all our clients is that they welcome our input on how they might save money, especially in their use of lawyers. On this subject you will see more of our checklists and proforma guides to using lawyers effectively.

Do also remember our Healthcare Resource Centre which can be accessed [here](#) and includes several new items including *Top tribunal tips for Community Treatment order cases*, *Example clinician's report/first tier mental health tribunal* and *disclosure/non-disclosure of documents in first tier tribunals and under the data protection act* and feel free to ask us to post to it additional material you would find helpful. We would be delighted to see you at one of our seminars, the programme can be accessed [here](#). Finally as this edition is 28 pages, please think before you print!



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NHS MANAGEMENT

All NHS trusts now registered with the CQC: a tougher new regulatory system is now underway!

On 1 April 2010 and after just a year in existence, the Care Quality Commission (CQC) completed the registration of all 378 NHS trusts in England that provide health care services.

All NHS trusts must be registered with the CQC by law to provide care and in order to be registered, trusts need to demonstrate that they meet the essential standards of quality and safety.

The CQC will monitor trusts regularly by carrying out more unannounced inspections and checking on the quality of the care people experience; rather than on systems and processes. If the CQC finds that trusts are not meeting standards, it has stronger enforcement powers than ever before and can issue warning notices, which can escalate to fines, prosecution, restrictions on activities or in extreme cases, closure.

In October this year, the new registration system will extend to cover independent healthcare and adult social care providers, which are currently registered with the CQC under a different system. For the first time, all these organisations will have to comply with a common set of essential standards.

From April 2011, the registration system is set to cover dentists and private ambulances.

From April 2012, it is set to also include primary medical care services such as GPs and private midwives.

To find out more about the CQC's new registration system, please click [here](#).

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

NHS MANAGEMENT – INCIDENT INVESTIGATIONS

Never Events: an updated framework for 2010/11

The *Never Events Framework* was published by the National Patient Safety Agency (NPSA) in April 2009 to introduce a policy on Never Events into the NHS in England. To coincide with the beginning of the second phase of implementation, the NPSA introduced an *Updated Framework for 2010/1,1* which can be accessed [here](#), for PCT boards as commissioners in

March 2010. The update outlines new aspects for 2010/11 and confirms processes in the existing framework that continue to apply.

The key changes which now apply are:

- The strengthening of discussion and reporting of Never Events. PCTs should observe the standards of reporting and investigation of Never Events outlined in the new NPSA *National framework for reporting and learning from serious incidents* (see below).
- Commissioners and providers must report Never Events to the NPSA, within the relevant timescale, to comply with the statutory notification requirements imposed on them by the Care Quality Commission.
- PCTs must now seek to recover from the provider the cost of procedures or treatment resulting in a core Never Event (with one exception) and make sure there is a remedial action plan to avoid future breaches.

The same core list of eight Never Events will be used but with changes for 2010/11 in respect of the definitions of wrong site surgery and retained instruments post-operation.

The Department of Health makes it clear that NHS Chief Executives should ensure their organisations comply with the updated framework.

For further information or advice please contact [Stuart Knowles](#) on 0121 456 8461.

The SUI is dead: long live the SIRI!

In March, the National Patients Safety Agency (NPSA) published its new governance framework for investigating and reporting serious incidents in the NHS.

The *National Framework for Reporting and Learning from Serious Incidents requiring Investigation* which can be accessed [here](#) was developed in consultation with key NHS stakeholders to provide a nationally agreed approach to the reporting and management of serious incidents, previously known as serious Untoward Incidents (SUIs).

The framework aims to harmonise reporting and investigation arrangements employed by NHS organisations in England and Wales and outlines good practice. It provides a consistent definition of the newly termed “serious incidents requiring investigation” (SIRIs), and clarifies the roles and responsibilities of healthcare organisations and the NPSA. It provides guidance on statutory obligations to report SIRIs to the Care Quality Commission and confirms that most of these are fulfilled by reporting to the NPSA. Useful templates and flow charts for investigation are set out, as well as information on grading incidents and responses required.

Anyone who holds a brief for clinical governance in the NHS must read and digest the new framework. You should review and amend local policies and procedures, and definitions of “serious incidents”. Make sure you comply with the new framework.

Mills & Reeve offers a full or half day seminar on *Investigations as part of good clinical governance – getting it right* for the NHS. This bespoke training ensures that those staff carrying out investigations are trained in incident investigation and governance. Governance directors and senior managers, and all staff involved in investigations, should attend.

For further information please contact [Stuart Knowles](#) on 0121 456 8461 or [Duncan Astill](#) on 0121 456 8318.

NHS MANAGEMENT - HEALTH PROTECTION

Health Protection Legislation (England) Guidance 2010

At long last the Public Health (Control of Diseases) Act 1984 has been updated. It has been brought into the 21st century to give public authorities modernised powers and duties to prevent and control risks to human health from infection and contamination.

It was amended by the Health and Social Care Act 2008 and the Health Protection (Notification) Regulations 2010; Health Protection (Local Authority Powers) Regulations 2010 and Health Protection (Part 2A) Orders Regulations 2010. At the time of writing the amended act has not been published.

A helpful explanation about the changes contained in the Health Protection Legislation (England) Guidance 2010 can be accessed [here](#).

The main features of the legislation are:

From 6 April 2010

- Registered medical practitioners attending a patient are required to notify the proper officer of the local authority in which the patient resides when they have reasonable grounds for suspecting that the patient:
 - has a notifiable disease as listed in schedule 1 of the notification regulations;
 - has an infection not in that schedule but which presents or could present significant harm to human health;
 - is contaminated in a manner which could present significant harm to human health; and
 - has died with but not necessarily because of a notifiable disease or other infectious disease or contamination that presents, or could present .
- Local authorities can use two types of powers to deal with incidents and investigations:
 - specific powers to be exercised directly by the local authority; and
 - part 2A orders granted by a Justice of the Peace to impose restrictions or requirements on persons, things or property (where voluntary co operation to avert a health risk cannot be secured).

With regard to part 2A orders, NHS bodies will be particularly interested in paragraphs 9.1.2 and 10.1.2.

From 1 October 2010

- Diagnostic laboratories will have a duty to notify the Health Protection Agency when they identify evidence of infection caused by specific causative agents that are listed in schedule 2 to the notification regulations.

Notification is set out in detail in the guidance at pages 7-42 and powers are covered at pages 43-100. The guidance gives some 41 examples and 10 algorithms about how the powers should work in practice. A helpful summary of transitional arrangements is set out at appendix 3.

Most of the updates took effect on 6 April 2010. One applies from 1 October 2010.

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

INFORMATION MANAGEMENT

A timely lesson to make sure you get your handling of Data Protection Act requests right!

Highland Council got into hot water with the Information Commissioner's Office recently when staff managed to confuse two subject access requests. Sensitive personal data relating to several members of one family was inadvertently disclosed to an individual who had submitted a separate subject access request on approximately the same date.

The red faced officials confessed the mistake happened because the member of staff who normally dealt with requests had gone on holiday after the requests were received but before the responses were sent. Systems were not in place to make sure covering staff were aware of the number, status and nature of outstanding requests.

You would not make such a mistake would you? Make sure you have a formal log of requests, times, information and responses accessible to all relevant staff!

For further information or advice please contact [Stuart Knowles](#) on 0121 456 8461.

New national archive records management code goes live

Section 46 of the Freedom of Information Act (FOIA) is the section that set up a code of practice for record keeping, management and destruction. It also deals with the transfer of records to the public records office.

As NHS organisations you need to be aware of formal section 46 assessments. This could mean having your corporate records management tested against a large stack of

compliance requirements, namely the Lord Chancellor's code of practice on the management of records under section 46 of the FOIA.

Serious failings in dealing with FOIA requests could lead to such an investigation.

The National Archives have just published the new self assessment tool to support compliance with the records management code issued under section 46 of the FOIA, as revised in July 2009, which can be accessed [here](#).

For further information or advice please contact [Stuart Knowles](#) on 0121 456 8461.

Health records security way too 'lax' - possible breach of patient's human rights?

NHS organisations are coming under intense pressure to clean up their act when it comes to access to medical records and basic security measures for both electronic and paper records.

"At least 101,272 non-medical personnel working in NHS trusts in Britain have access to confidential medical records".

That's the finding of a recent report by Big Brother Watch - a campaign group fighting intrusions on privacy.

The report is based on responses from 151 NHS trusts, found an average 723 staff in each trust not directly involved in patient care had access to medical records. This includes domestic, finance and IT staff.

The report suggests this is not only a breach of the Data Protection Act but also breaches the human rights of patients. Access to medical records without "good reason" is an offence and, following *I v Finland* [2008] ECHR 20511/03 which can be accessed [here](#) breaches Article 8 of the European Convention on Human Rights.

The report concludes that the number of non-medical personnel with access to confidential medical records leaves the system wide open for abuse. Lost or misused data could leave people open to data fraud or publication of their information causing damage and distress to patients.

The report campaigns for stricter regulation and highlights the need for robust systems to track and audit access to medical records.

The report has served to resurrect concerns about the NHS Spine, the electronic medical records database. The report asserts this will "drastically increase" the number of people with access to confidential records. But the Department of Health says the new electronic systems restrict access to those directly involved in a patient's care. The department argues

that access to electronic records is controlled by smartcards which allows all access to be tracked and audited so that any abuse can be traced and dealt with.

For further information or advice please contact [Stuart Knowles](#) on 0121 456 8461.

Don't mess with the Information Commissioner!

As we have previously reported, from 1 April 2010 the Information Commissioner (the IC) has the power to fine any organisation that breaches data protection rules up to £500,000. This brings the UK in line with many other countries in Europe where the power to fine lax and wayward organisations has been in existence for some while.

A word of warning however, we must all be watchful since the level of the potential fine at half a million pounds is one of the highest in the European Union. We have heard how the IC wants to flex his muscles in future and he has been pushing to get this power to fine for ages. I am prepared to place a little wager that Mr Graham will soon become one of the most high profile and most powerful information regulators in Europe.

Against this background, NHS bodies will be concerned to learn that the IC has announced that the NHS has reported the greatest number of serious data breaches of any UK organisation since the end of 2007, 287 in that period which accounts for more than 30 per cent of the total number of complaints received.

For further information or advice please contact [Stuart Knowles](#) on 0121 456 8461.

New Caldicott Guardian Manual published

The Department of Health has published a new version of the Caldicott Guardian Manual which replaces the 2006 version and takes into account developments in information management since the publication of the Caldicott report. The manual can be accessed [here](#).

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8453.

Recent High Court decision regarding remedies for breach of confidentiality

The recent case of *Vercoe & Ors v Rutland Fund Management Ltd & Ors*, which can be accessed [here](#), concerned disclosures of information about a potential acquisition target made by the claimants to the defendants. The disclosures were protected from being used by the defendants under a confidentiality agreement between the parties. The defendants subsequently acquired the target business without involving the claimants and made a substantial profit from its acquisition and subsequent sale.

The claimants claimed breach of confidentiality and argued that they were entitled to an account of profits (ie, a percentage of the defendants' substantial profit) rather than merely an award of damages. Due to the substantial profit made from the acquisition and sale, if an

account of profits was ordered by the court, the claimants would receive significantly more money than any sum payable as damages for breach of contract.

The court awarded damages (as opposed to the discretionary remedy of an account of profits) following existing case law. The court confirmed that either remedy could be awarded for a breach of confidentiality but highlighted that the court's decision would depend upon what would be a just response to the particular circumstances (ie, that the remedy awarded should not be oppressive and should be proportionate to the wrong done to the claimant).

The *Vercoe* case will be of importance to NHS bodies in light of increased information governance provisions that include rigorous confidentiality provisions and the use of confidentiality agreements. In the event of any breach of confidentiality, this case will influence the damages that could be claimed by the NHS body.

For further information or advice please contact [Julie Jordan](#) on 01223 2222478 or [Emma Tully](#) on 01223 222485.

NHS MANAGEMENT - PHARMACEUTICAL SERVICES

Statutory requirement for PCTs to develop and publish pharmaceutical needs assessments

The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) (Amendment) Regulations 2010, which can be accessed [here](#), and which come into force on 24 May 2010 insert into the National Health Service (Pharmaceutical Services) Regulations 2005 (which can be accessed [here](#)) new requirements relating to pharmaceutical needs assessments.

PCTs are required to publish a statement of needs for pharmaceutical services by virtue of Section 128A of the NHS Act 2006.

Any PCT established on or before 1 April 2010 must publish its first pharmaceutical needs assessment on or before 1 February 2011, whereas any PCT established after 1 April 2010 must publish its first needs assessment within ten months of the date on which its PCT order comes into force.

Further, the Regulations describe procedural requirements for subsequent assessments and also includes, at Regulation 3F, an obligation on PCTs to consult certain relevant bodies (as listed in the Regulations) about the contents of any assessment made for the purposes of publishing those assessments.

The Regulations also provide unrelated, minor amendments to the 2005 Regulations and to the National Health Service (Local Pharmaceutical Services etc.) Regulations 2006.

For further information please contact [Lara Hayward](#) on 01223 222292 or [Gill Thomas](#) on 01223 22237.

PATIENT MATTERS – CHILDREN’S LAW

Care proceedings: revisions to the Public Law Outline

On 6 April 2010 revisions to the *Practice Direction Guide to Case Management in Public Law Proceedings*, commonly known as the Public Law Outline (PLO), came into force.

The PLO, introduced in April 2008, provided a simpler, more streamlined process designed to minimise unnecessary delay, with greater emphasis on case management and advocacy preparation in care and supervision proceedings.

The overall framework of the original PLO has not been affected by the changes. There are still the same four stages. The same timescales also apply to each stage as before.

The revision has focused on three key areas:

- Reducing the burden of documentary requirements at issue: the pre-proceedings checklist now specifies documents which need to be provided at issue and documents which are to be disclosed by the first appointment, or as directed by the court. Inter-agency materials, eg health, do not need to be provided at issue.
- Clarifying the “timetable for the child” principle: information about the significant steps in the child’s life will need to be provided by the local authority at issue to enable the court to set the timetable for the child and to review that timetable in the light of new information.
- Improving the PLO forms to streamline and simplify them.

The practice direction and new forms can be accessed [here](#).

For further information or advice please contact [Ruth Creed](#) on 0121 456 8323 or [Charlotte Mawdesley](#) on 0121 456 8402.

One year on: the first report from the National Advisory Council for Children’s Mental Health and Psychological Wellbeing

In 2008 a national Children and Mental Health Service (CAMHS) review found that local services had made significant progress in recent years, but that more needed to be done to improve the consistency, accessibility and suitability of services. The final report, *Children and Young People in Mind*, contained 20 recommendations for Government.

The National Advisory Council for Children's Mental Health (NAC) is an independent body that was set up following the CAMHS review to ensure that the recommendations were carried out.

On 20 March 2010 the NAC published their first report. This highlights progress made and identifies examples of emerging practice. It also raises significant challenges and barriers in four areas:

- stronger and more coherent leadership at Government and local level;
- improved commissioning of needs-led services;
- developing a confident and skilled workforce; and
- real and meaningful participation of young people.

Over the next 12 months, the NAC will explore these issues with stakeholders and report back on progress made in their second report.

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

For further information or advice please contact [Ruth Creed](#) on 0121 456 8323 or [Sonal Lala](#) on 0121 456 8248.

Working together to safeguard children updated

As practitioners working in the child safeguarding area will be aware, the 2006 version of *Working Together* was the subject of a review, following the recommendations of Lord Laming in his progress report (published March 2009). Part 1, which includes the responsibilities of health professionals, has been issued as statutory guidance.

Part 2 (non statutory guidance) outlines the general principles and specific issues such as research principles.

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

Chapter 8, relating to Serious Case Reviews, was updated in 2009.

The remainder of the guidance has been amended to accord with the recommendations made by Lord Laming. Points of note include:

- Chapter 2 emphasises the importance of the Children's Trust Board working in consultation with the Local Safeguarding Children Boards (LSCBs) to put in place appropriate systems and practices to ensure that children in need have early access to effective specialist services and support to meet their needs.
- Chapter 4 sets out the elements of high quality supervision for staff working, or in contact with, children and families. The guidance also highlights the key role that the LSCB play in ensuring that single-agency and inter-agency training on safeguarding in promoting the welfare of children is provided in order to meet local needs.
- Chapter 5:

- Stresses the importance of high quality record keeping. LSCBs have a responsibility to ensure that all the partners follow the Government's *Information Sharing Guidance*.
- Reiterates the importance of training, expertise and support to manage referrals where there are child welfare concerns and in particular concerns about children's safety.
- States the need for all professionals (working in both adult and children's services) to refer the concerns to local authority children's services in all circumstances where they believe a child may be suffering, or be likely to suffer, significant harm. It also emphasises the responsibility of local authority children's services to act appropriately in response to the referral and the responsibility of professionals making referrals to make these as high quality and comprehensive as possible (consistent with a clear understanding of locally agreed thresholds).
- The guidance also encourages the development of co-located services.

The revised guidance runs to nearly 400 pages. We would recommend that those involved in safeguarding work for children and young people familiarise themselves with it. Readers will be aware that we offer regular training on child safeguarding/child protection issues and would be happy to offer assistance in this regard, if required.

For further information or advice please contact [Helen Burnell](#) on 020 7648 9237 or [Sonal Lala](#) on 0121 456 8248.

Draft guidance on the wellbeing of looked-after children published

The above draft guidance has been produced following a request from the Department of Health that the National Institute for Health and Clinical Excellence and the Social Care Institute for Excellence produce joint guidance on improving the physical and emotional health and wellbeing of looked after children and young people.

The guidance is intended for all those who have direct or indirect roles in, and responsibility for promoting the quality of life of looked after children and young people. It will be particularly relevant for colleagues working in Child and Adolescent Mental Health Services; health visitors; and school nurses and designated/named professionals. The draft guidance is subject to a consultation and it is anticipated that final guidance will be produced by September.

In relation to health, the guidance emphasises:

- the importance of recording information about looked after children and young people in a factual and non judgmental manner;
- the importance of ensuring that health information held on looked after babies, children and young people is accurate and kept up to date and that it is transferred at the right time; and

- multi-agency working is emphasised and in particular chief executives of PCTs are being called to take action to ensure that effective multi-agency working plans are in place.

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

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

National framework for children and young people's continuing care

At long last we now have best practice guidance on this topic. It was published on 25 March 2010 and can be accessed [here](#).

It is a 28 page document with three separate annexes as follows:

- A. Assessment toolkit and decision support tool;
- B. Continuing care pathway; and
- C. Legal framework.

It states that it is not aiming to give guidance on the content or funding of the actual packages of continuing care.

It specifically notes that PCTs are responsible for leading the continuing care process set out in the framework, leading the commissioning and establishing and managing governance arrangements. It highlights that all partners are responsible for funding their own contributions in line with their statutory functions.

Nominated children and young people's assessors have a key role to play.

The framework describes three phases of activity:

- Assessment phase (paragraphs 49–64);
- Decision making phase (paragraphs 65–68); and
- Arrangement of provision phase (paragraphs 69–71).

It then sets out the key principles which should be considered during the process. In particular it notes that a decision on the package that may be provided should not be budget or finance led; the primary consideration should be supporting the child or young person's assessed needs. It also states that wherever possible continuing care should be provided in the home.

For further information or advice please contact [Jill Mason](#) on 0121 456 8367, [Katrina McCrory](#) on 0121 456 8451, [Lee Parkhill](#) on 0121 456 8420, [Julie Jordan](#) on 01223 222478 or [Jayne Herlihy](#) on 0121 456 8280.

Lord Justice Wall appointed president of the family division

Lord Justice Wall was appointed President of the Family Division on 13 April 2010, following the retirement of Sir Mark Potter.

A variety of cases in which we represent NHS clients are heard by the family court, including where they are a party/witness to Children Act 1989 proceedings, inherent jurisdiction applications and Court of Protection applications (relating to those over 16 who lack capacity), where those cases relate to complex medical treatment they are heard by High Court Judges in the family division.

For further information or advice please contact [Helen Burnell](#) on 020 7648 9237 or [Lucy Johnston](#) on 01223 2222366.

LIST MANAGEMENT

Personal representatives cannot exercise the contractual rights formerly exercisable by a deceased dental contractor

Mills & Reeve recently acted for Worcestershire Primary Care Trust (the PCT) in the case of *R (Bue and Sharma) v Worcestershire Primary Care Trust* (as of yet unreported). The administrators of the estate of a deceased dentist (the claimants), applied for judicial review of the PCT's decision not to award a General Dental Services (GDS) contract to the claimants as administrators. They had purported to request the GDS contract under the "right of return" set out in Regulation 21 of the National Health Service (Personal Dental Services) Regulations 2005 (the PDS Regulations), which can be accessed [here](#).

This was an unfortunate case where the deceased dental contractor had served notice of his intention to terminate his PDS agreement and convert to a GDS contract. It was apparently his intention that, after converting to a GDS contract, he would enter into partnership with Ms Sharma (who was also one of the administrators of the deceased's estate) and eventually sell the practice to her. Unfortunately the dental contractor died before his rights of conversion could be exercised. The claimants sought to take advantage of either the notice served by the dental contractor prior to his death, or a notice served after his death by them in their capacity as personal representatives to argue that they were entitled to a GDS contract under regulation 21.

The PCT refused to grant Ms Sharma the requested GDS contract broadly because they believed:

- She did not have any entitlement to a GDS contract under the regulation 21 "right of return".

- The deceased's PDS contract terminated in accordance with the mandatory "termination on death" clauses set down by the PDS Regulations.
- In the absence of any legal obligation to contract with Ms Sharma, procurement law and policy (along with the PCT's own contestability framework), meant they should tender for a new provider of primary dental services in the area following termination of the PDS agreement (particularly as they had received expressions of interest from other dentists in addition to Ms Sharma).

Mister Justice Beatson handed down judgment in the PCT's favour on 31 March 2010. He determined that there was no contractual or statutory basis to compel the PCT to award a GDS contract. More specifically, it was held that the rights under regulation 21 are personal to the contractor and not capable of transfer and the administrators failed to satisfy the eligibility requirements to be a GDS contractor. The result of the decision had the claimants been successful would have been that the administrators of the estate would have been entitled to exercise the same personal contractual rights as the deceased dental contractor. This would have been significant as it would have allowed administrators to choose who the PCT must contract with for replacement primary dental services following the death of a contractor. This decision makes it clear that it is for PCTs to decide whether and with whom to contract for further services.

For further information or advice please contact [Sarah Berry](#) on 0121 456 8370 or [Fiona Boyse](#) on 0121 456 8302.

PATIENT MATTERS - FUNDING OF TREATMENT AND CARE

National Health Service (Reimbursement of the Cost of EEA Treatment) Regulations 2010

While the draft directive on cross-border healthcare was making a conspicuous lack of process through the European legislative system, the Department of Health issued, in October 2009, draft regulations and guidance to assist local health commissioners to handle requests from patients to go to EEA countries for healthcare under Article 49 of the EC Treaty (now Article 56 of the Treaty on the Functioning of the European Union). Following the subsequent stakeholder engagement, the National Health Service (Reimbursement of the Cost of EEA Treatment) Regulations 2010 were laid before Parliament and will come into force on 1 June 2010, alongside the accompanying directions and revised guidance.

The regulations, by means of amendments to the National Health Service Act 2006, give effect to the judgment of the European Court of Justice in *R (on the application of Watts) v Bedford Primary Care Trust* [2006] where it was held that Article 49 gave rise to an obligation to reimburse the cost of hospital treatment provided in another member state even under a tax-funded, rather than an insurance-based, healthcare system. The regulations, however, go beyond the ambit of the decision in *Watts*, to the extent that they cover non-hospital treatment too.

The regulations stipulate when prior authorisation will be required and set out information relating to qualifying services, limitations on reimbursement and permitted deduction of NHS charges. Provision is also made, by way of amendment to s183 National Health Service Act 2006, for the repayment of travelling expenses to the patient.

The regulations, which will only apply to expenditure incurred on or after 23 August 2010, can be accessed, together with the directions and DH guidance [here](#).

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

NHS direct payments as from 1 June 2010

The NHS direct payment regulations come into force on 1 June 2010. These regulations allow the pilot schemes for personal health budgets and direct payments to make such payments from that date.

The regulations govern who direct payments may be made to, what they may be made for; how they may be made; when they have to be repaid; and when they may be stopped. It is important to remember that the regulations only apply to the health bodies who are a part of the pilot schemes and do not provide an ability for any other health bodies to make such payments.

The regulations also place restrictions on what payments may be used for. Payments may not be used for; the supply or procurement of alcohol or tobacco; the provision of gambling services or facilities; or to repay a debt otherwise than in respect to a debt for a service specified in the care plan.

Payments can be made to children or persons lacking capacity through a nominee if considered appropriate, as well as to adults with capacity.

The regulations are largely based on the social care direct payments regulations and anyone familiar with those regulations will see the similarity of the provisions.

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

For further information or advice please contact [Jayne Herlihy](#) on 0121 456 8280.

The Personal Care at Home Act 2010

Although it appeared that the House of Lords had managed to block the introduction of the Personal Care at Home Bill because of cost concerns, the Bill was in fact been rushed through before the pre-election dissolution of Parliament to become the Personal Care at Home Act 2010 (the 2010 Act); an Act to amend section 15 of the Community Care (Delayed Discharges etc) Act 2003 (the 2003 Act), so as to remove the restriction on the period for which personal care at home might be provided free of charge to persons living at home. The Act can be accessed [here](#).

Local authorities providing certain social care services, including personal care, have the power (under s17 Health and Social Services and Social Security Adjudications Act 1983) to recover “reasonable” charges for those services. Under s15 of the 2003 Act, however, the Secretary of State had power to make regulations requiring *certain* social care services to be provided by local authorities free of charge. However, the Act provided that any such regulations could not require some of those services (including personal care provided to someone in any place where that person is living) to be provided free of charge “for any period exceeding six weeks”.

The 2010 Act amends s15 of the 2003 Act to enable regulations to be made requiring personal care to be provided free to people in their own homes (including those in sheltered housing, extra care housing and adult placement schemes) for an indefinite period. The amendments will not apply, however, where the personal care is provided to someone living in accommodation that an establishment provides “together with” personal care (eg a care home or accommodation provided under Part 3 of the National Assistance Act 1948).

The 2010 Act aspires to enable, support and encourage more people to avoid or delay entering residential accommodation, to improve their life quality and to provide more choice over the setting in which they spend their final days. It remains unclear, however, when the Act will come into force.

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

Launch of the National Care Service: free care for the elderly by 2015

“Everyone who needs care when they are old or disabled will get it for free” announced the Health Secretary, as he launched the National Care Service (NCS) on 1 April 2010.

With the ever growing older population the way care is paid for and provided must be reformed in order to meet the changing needs of our population, economy and society.

Many people with high needs do not get help from the state towards paying for their care and support: a means test is currently applied which means that only those with £23,000 or less are eligible for state-funded residential care.

The cost of the new NCS system will be shared collectively between the state and individuals, who will be required to pay in to the service and get free care in return.

The NCS will:

- from 2014 extend the coverage of free care so that people will receive free care if they need to stay in a residential home for more than two years;
- introduce a NCS Bill to establish the legal foundation of the NCS;

- set up an independent commission, who will advise on the fairest and most sustainable way that people can make their contribution to the care system; and
- introduce a nationally consistent eligibility criteria for social care which will help remove the “postcode lottery” that exists now.

To find out more about the National Care Service please click [here](#).

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

PATIENT MATTERS - MENTAL HEALTH

Statutory reporting requirements in relation to Mental Health patients

The Care Quality Commissions (Registration) Regulations 2009 require NHS service providers registered under the Health and Social Care Act 2008 to report certain “notifiable events” to the Care Quality Commission (CQC). Regulation 17 requires the notification of any deaths or unauthorised absences of persons detained or liable to be detained under the Mental Health Act 1983 (the Act) without delay. This includes persons on section 17 leave of absence from hospital or detained under short-term powers of section 5, 135 or 136.

Deaths must be notified if the person dies “while receiving, or as a result of, the care, treatment or support provided by the service”, as soon as possible after the incident. Separate notification of the death should not be sent to National Patient Safety Agency under regulation 16.

Reporting requirements for unauthorised absences vary depending on the security level of the service. Low, medium and high security services, and psychiatric intensive care units must notify the CQC of all incidences of absence without leave as soon as possible after the incident, but without obstructing practical steps the service provider is taking to deal with it. All other services (general security level) must notify the CQC of absences that continue after midnight on the day they started, on a weekly basis or as they happen. Reporting the return of patients absent without leave is optional but the CQC considers this helpful to inform its monitoring.

The notification requirements came into force for NHS service providers on 1 April 2010. Failure to comply constitutes a breach of the regulations and may result in enforcement action. The “registered person” (ie the NHS body) must submit the appropriate notification form directly to the CQC within the relevant timescale. In practice, responsibility will be delegated to appropriate staff members. Notifications must not include personal information ie the individual’s name or any other identifying information. A unique identifier or code must be used to comply with the Data Protection Act 1998, and a record kept by the service provider should the CQC need to make further enquiries.

NHS service providers must also report certified treatment under section 61 MHA. Where a patient is given treatment under section 57, 58, 58A or 62A MHA (ie certified by a panel, or

requiring consent or a second opinion) the approved clinician in charge of that treatment must report to the CQC on the patient's treatment and condition if their detention is renewed or if required by the CQC.

Further information relating to statutory reporting can be accessed [here](#).

For further information or advice please contact [Ami Patyal](#) on 020 7648 9257.

PATIENT MATTERS- CONTINUING CARE

More Department of Health guidance on continuing health care!

March was a very busy month for someone at the Department of Health a further publication implemented on 1 April 2010 was *NHS Continuing Healthcare Practice Guidance*.

It is designed to support practitioners and others with responsibilities for NHS continuing health care. However it is not a substitute for the framework itself. It provides a practical explanation of how the framework should operate on a day to day basis and cites examples of good practice.

It covers a multitude of topics such as:

- Key principles
- The role of the local authority
- Person centred approach
- Refusal of consent
- Advocacy
- Legal representation
- Public information
- Equality monitoring
- Mental capacity
- Section 117 Mental Health Act 1983
- Partnership working protocol
- Fast track
- CHC checklist
- Hospital discharge
- MDT assessments
- DST completion
- Panel processes
- Disputes
- Care planning/personalisation
- Equipment and adaptations
- Case management
- Commissioning
- Choice and costs
- Support in patient's homes
- Carers
- Personal health budgets
- Payment for additional services/topups

There are two particularly useful sections. The first is that covering "primary health need" at paragraphs 4.1 to 4.11. It highlights that primary health need is not about the reason why someone requires care or support nor is it based on their diagnosis; it is about their overall

day to day care needs taken in their totality. It sets out questions for multidisciplinary teams to think about around nature, intensity, complexity and unpredictability. Unfortunately paragraph 4.11 itself is not as helpful in trying to explain the difference between healthcare and social care needs.

The second is that covering patient choice at paragraph 11.7. It highlights the case of *Gunter* (in which we represented the PCT) and notes that cost has to be balanced against other factors in the individual case.

For further information or advice please contact [Jill Mason](#) on 0121 456 8367, [Katrina McCrory](#) on 0121 456 8451, [Lee Parkhill](#) on 0121 456 8420, [Julie Jordan](#) on 01223 222478 or [Jayne Herlihy](#) on 0121 456 8280.

Continuing healthcare: further guidance

Readers will recall that when the *Revised National Framework* which can be accessed [here](#) was published in July 2009. Paragraph 12 of Annex E indicated that further guidance on responsibilities whilst awaiting the outcome of a request for an independent review, would be issued later in 2009.

Better late than never as they say, that guidance has now been published, which can be accessed [here](#).

Paragraph 12 of Annex E had stated that “the eligibility decision that has been made is effective while the independent review is awaited.”

It was thought to be unclear at that stage whether this referred to the initial panel decision or to the subsequent local review.

The guidance now specifically states, at paragraph 14, that “the decision remains in effect until the PCT revises the decision.”

This provides clarity and means that PCTs are not responsible for any care costs following the initial panel decision.

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

Continuing healthcare: refunds guidance

The above guidance contains quite a lot of other information. It was published on 30 March to go live on 1 April (so lots of time to take it all in!).

It covers what to do about refunds in three situations:

- In non hospital discharge cases - where there is a need for health or community care services during the period in which a decision on continuing healthcare eligibility is awaited (paragraphs 2-6).

- Where a PCT has “unjustifiably” taken longer than 28 days to reach a decision on eligibility (paragraphs 7–13).
- Where, as a result of an individual disputing an eligibility decision, a PCT has revised its decision. (paragraphs 14–17).

Finally it indicates that PCTs and local authorities should have clear jointly agreed processes for resolving any disputes that arise between them which should include an identified mechanism for final resolution.

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

PATIENT MATTERS - CORONERS

Government consultation published on the implementation of the Coroners Act

The Government has launched a consultation on the implementation of the Coroners and Justice Act. Although the Act received Royal Assent in late 2009, it is not expected to come into effect until 2012. The latest consultation document contains further details of how the new law is likely to work in practice, and raises several important issues for healthcare organisations. The Government’s intention is to publish a further consultation in 2011 attaching the new coroners’ rules.

The Government has provided more detail of its proposals in relation to the reporting of deaths to the coroner and the scrutiny of death certificates. For the first time, there will be a specific duty on medical practitioners to report deaths to the coroner. Although the Government has, at this stage, rejected the need for a separate criminal offence for breaches of this duty, it is likely that deliberate or wilful failure to report would be notified to the GMC and/or relevant NHS trust. Healthcare providers will need to ensure that the new obligations are understood within their organisations.

Currently, there is no useful national guidance to assist medical practitioners in deciding which cases have to be referred to the coroner, and varying local arrangements have been established. The consultation document sets out a list of circumstances in which deaths should be referred – including those where the death “may be a result of neglect or failure of care” or where the death “may be related to a medical procedure or treatment”. The definition is very wide and may lead to more deaths being referred to coroners, rather than fewer, as envisaged by the Government.

Deaths not referred to the coroner are to be scrutinised by a medical examiner (a new PCT post), who will carry out a “proportionate review” of medical records, as well as considering the circumstances leading to the death and any concerns raised by the family. The examiner will either confirm the cause of death on the death certificate or refer the death to the coroner.

There is discussion as to whether there should be a new list of short form verdicts (to be renamed “determinations”), for example adding a verdict currently used by some coroners “died from an unforeseen complication of a necessary therapeutic procedure”. It is anticipated that the Chief Coroner may consider issuing guidance on the circumstances in which narrative determinations should be used.

The document sets out the Government’s view on some important policy issues, such as encouraging advance disclosure of evidence. We are already seeing changes in the way in which many coroners conduct inquests, and we expect this document to encourage further change pending implementation of the new law.

The *Reform of coroner system* consultation can be accessed [here](#).

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

Poor hospital communication criticised by coroner

An inquest has now taken place concerning the death of a 21 month old boy, who died of meningococcal septicaemia at Leicester Royal Infirmary in May 2009.

He was taken to hospital by his mother and died 12 hours after admission. The coroner (Catherine Mason) stated that the written and verbal communication during doctor and nurse handovers was poor. She went on to say, “this led to a delay in the involvement of other members of the multi-disciplinary team and earlier treatment being given.”

If treatment had been given at an earlier stage, the coroner found that based on the evidence, although the little boy may still have died, “on the balance of probabilities his chances of survival would have been better”. The coroner recorded a narrative verdict.

This case highlights the importance of good record keeping. It is good practice for all communications to be properly and thoroughly documented. If your organisation would like any advice or training in relation to record keeping or inquests we would be happy to help.

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

PATIENT MATTERS – PRESCRIBING

Proposals to introduce prescribing responsibilities for paramedics: stakeholder engagement

The ambulance review *Taking Healthcare to the Patient: Transforming NHS Ambulance Services* recommended that prescribing for paramedics should be actively explored. The engagement exercise, which can be accessed [here](#), sets out the background to paramedic prescribing and invites opinions from patients, ambulance services, providers and commissioners within the wider NHS on extending responsibilities to paramedics.

Current medicines legislation enables paramedics to supply and administer a number of medicines when treating sick or injured persons. However, paramedics cannot write a prescription for a patient. Although it is unlikely that paramedics would need to write prescriptions in emergency situations in fact, only ten per cent of the cases that paramedics attend are life threatening.

It is thought that the introduction of paramedic prescribing would result in an improved patient experience as the paramedic could prescribe the drugs and therefore save the patient making an appointment and going to see a doctor or other healthcare professional, which would also result in a more productive use of NHS services. There are risks inherent in any prescribing and it is acknowledged that the risks in relation to paramedic prescribing would need to be addressed through a system of safeguards. Possible risks include inappropriate prescribing and failure to share information with other health professionals caring for the patient, for example the patient's general practitioner.

The Medicines and Healthcare Products Regulatory Agency (MHRA) plan to consult formally on proposals for reform, drawing on the comments and views from the engagement exercise.

The request for views remains open until Friday 11 June.

For further information or advice please contact [Jacqueline Haines](#) on 0121 456 8453 or [Alison Fielder](#) on 0121 456 8454.

PATIENT MATTERS - GENERAL

New GMC guidance for doctors on good practice in research

New guidance published by the GMC entitled *Good practice in research and Consent to research* (the guidance), which can be accessed [here](#), provides a framework to steer all doctors through the various stages of a research project, from research design, recruiting participants, seeking consent and the publication of research.

The guidance supplements the principles relevant to research in *Good Medical Practice* guidance documents and further sets out the good practice principles that doctors are expected to understand and follow if they are involved in research activity. The guidance will replace the current guidance booklet, *Research: the roles and responsibilities of doctors* (2002) which can be accessed [here](#) and will come into effect on 4 May 2010.

The guidance seeks to highlight that maintaining patients' dignity, safety and wellbeing is more important than developing treatments and furthering knowledge. It includes advice on avoiding conflicts of interest; considering young people's role in research; the duty of doctors to tell patients about the risks and benefits of research; involving vulnerable patients and making sure research is open to all.

The guidance takes account of recent changes to legislation and includes two useful legal annexes. Annex A, which can be accessed [here](#), details the relevant legal and governance framework for research whereas Annex B, which can be accessed [here](#), deals with the key elements of the legislation that governs clinical trials of investigational medicinal products in the UK.

For further information please contact [Lara Hayward](#) on 01223 222292 or [Gill Thomas](#) on 01223 222237.

More flexible rules on allocation for organ transplantation

New Department of Health guidance for transplant teams allows for donors to request that their organs are given to a family member or a close friend in need of a new organ.

Organ allocation will remain subject to clinical priority, meaning that people on the super urgent heart or liver lists or those who will not live beyond 72 hours without a transplant will still have priority over any request to donate an organ to family or close friend. Consent to donation can never be conditional on the requested allocation going ahead.

The new guidance will become relevant where there are no appropriate candidates for an urgent transplant, meaning that it will be possible for an organ to be given to a family member or close friend as long as it is a clinical match. The Requested Allocation Oversight Group will provide expert guidance to frontline staff where required.

Sally Johnson, Director of Organ Donation and Transplantation at NHS Blood and Transplant has said:

“this guidance will enable us to consider, as we always do, what the donor wanted but also to take into account the health and wellbeing of a sick patient who is known to them.”

There is also new Department of Health *Guidance for Coroners and donor co-ordinators*, which can be accessed [here](#), setting out the processes involved in organ retrieval and the necessary legal requirements for coroner intervention after some deaths. Practical guidance is set out for coroners in deciding whether a donation can proceed in the hope that this will prevent organ wastage and lead to greater availability of viable organs.

The new Department of Health guidance, *Requested allocation of a deceased donor organ* can be accessed [here](#).

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

Guidance issued on longer opening hours for GP practices

The Department of Health has issued guidance (the guidance) for primary care trusts (PCTs) on the new Extended Hours Access Scheme (the scheme) introduced by way of the Primary Medical Services (Directed Enhanced Services) (England) Directions 2010 (the directions).

In summary, the new scheme specifies that PCTs must offer, by 30 April 2010, all existing GMS and PMS contractors (GP practices) in their commissioning area the opportunity to enter into arrangements for extended hours under the directions. The guidance takes this a step further and states that PCTs should “encourage” (rather than merely offer) as many GP practices as possible to enter into the scheme. Subject to a number of exceptions in the directions (covered in more detail in the guidance), PCTs must ensure that extended hours arrangements with GP practices are entered into before 1 July 2010. Furthermore, all extended hours arrangements will continue until 31 March 2011, must be in writing between the PCT and the GP practice and the directions specify the minimum requirements which must form part of any extended hours arrangements.

The guidance also highlights that extended opening hours should be arranged in accordance with patients’ expressed needs and wishes and provides useful information on issues for PCTs to consider when commissioning extended hours services including: access to medical records, payment mechanisms, patient choices and preferences, monitoring and other more general issues relevant to any form of extended hours access.

A complete copy of the guidance can be accessed [here](#).

For further information please contact [Gill Thomas](#) on 01223 222 237 or [Emma Tully](#) on 01223 222485.

Human Fertilisation and Embryology (Parental Orders) Regulations 2010

On 6 April 2010, the Human Fertilisation and Embryology (Parental Orders) Regulations 2010 came into force. This was the final phase of the implementation of the Human Fertilisation and Embryology Act 2008.

The HFE Act 2008 introduced parental orders. These are orders made by a court providing for a child to be treated as the lawful child of the applicants for the order following the birth of a child by a surrogate. Like an adoption order, a parental order reassigns parenthood, extinguishing the parental status of the surrogate parents, and conferring full parental status and parental responsibility on both intended parents.

The new regulations allow unmarried and same sex couples to apply for a parental order. Intended parents must submit their parental order application within six months of the child's birth. Unmarried and same sex couples, who were not eligible to apply for a parental order until these regulations came into force, are able to apply within six months of 6 April 2010.

The Parental Order Regulations 2010 are wide ranging covering provisions such as the legal status of a person who is the subject of a parental order, how the parental order register functions and the factors a court must take into account when considering an application for a parental order.

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

For further information or advice please contact [Ruth Creed](#) on 0121 456 8323 or [Sonal Lala](#) on 0121 456 8248.

EMPLOYMENT

Court of appeal decision on recruitment and retention premiums under agenda for change

Mills & Reeve's employment team have successfully defended a large NHS client in the Court of Appeal in the case of *Briggs et al v Nottingham University Hospitals NHS Trust*.

This was a test case of nationwide importance to the NHS, concerning the construction of the NHS collective agreement, Agenda for Change (AfC). The case was originally brought in the Nottingham Employment Tribunal by a number of maintenance supervisors who claimed that, under AfC, they were entitled to a recruitment and retention premium (RRP) payment over and above their basic pay. The purpose of RRP is to allow trusts to pay a premium to attract staff in shortage occupations.

The claimants argued that as qualified maintenance supervisors they were entitled to the RRP along with the qualified maintenance workers they supervised. The trust disputed this arguing that the RRP applicable to maintenance workers was not applicable to those who supervise them as supervisors were not in short supply.

Martin Brewer, partner in the Birmingham employment team, successfully defended the NHS trust in the Employment Tribunal. The claimants appealed to the Employment Appeal Tribunal and then to the Court of Appeal.

The Court of Appeal dismissed the supervisors' claim, finding that the correct construction of the contract supported the trust's argument and that although the supervisory role may have required the same qualifications as the maintenance workers', that did not entitle supervisors to the RRP.

The Department of Health and NHS Employers have worked with us closely on this case given its impact, and clearly the outcome represents a considerable saving to the NHS purse.

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

For further information or advice please contact [Martin Brewer](#) on 0121 456 8357 and [Anna Youngs](#) on 0121 456 8359.

CONTRACTS

Replacing a subcontractor might be a breach of equality and transparency

In the case *Wall AG v City of Frankfurt* (Case no. C-91/08), the European Court of Justice (ECJ) has handed down a ruling on the general principles of equality and non-discrimination and the application of the obligation of transparency in connection to a services concession contract.

The city of Frankfurt had advertised the service concession contract relating to the operation, maintenance, servicing and cleaning of public lavatories and the consideration for those services was solely the right to charge a fee for the use of the lavatories and to make use of the advertising space in the lavatories and other public spaces. A copy of the service concession contract was annexed to the invitation to bid and the contract specifically included a clause that permitted a change of subcontractor with the consent of the contracting authority.

Despite the contract providing a process of approval for changing subcontractors, the ECJ ruled that where amendments to a services concession contract are materially different in character from those on the basis of which the original services concession contract were awarded then such amendments may amount to the parties renegotiating an essential term of the contract. In such circumstances, a contracting authority is required to take all necessary measures to restore the principle of transparency of the procedure (potentially conducting a new award procedure).

Despite the fact that services concessions contracts are not covered by EU public procurement, the *Wall AG* case is an important decision for NHS bodies as it highlights that requirements on public bodies when procuring goods, services or works are increasing and that such contracts **must** be awarded in accordance with the principles of equal treatment, transparency and non-discrimination in the Public Contracts Regulations 2006.

For further information or advice please contact [Julie Jordan](#) on 01223 2222478 or [Emma Tully](#) on 01223 222485.

Retention and defects

An NHS trust as employer under a building contract may wish to retain a percentage (usually three or five per cent) of certified payments to the building contractor to incentivise the contractor to finish the works and remedy any defects. The standard form building contracts all create a right for the employer to hold such retention.

Retention is released in two halves. The first half is released on practical completion. The Joint Contracts Tribunal, commonly known as JCT and NEC forms deal with the release of the second half in subtly different ways.

JCT provides for a fixed period after practical completion (usually six months or a year) during which time the contractor must rectify any defects notified to it the defects liability period (DLP). At the end of the DLP, if, but only if, all of the notified defects have been rectified a “certificate of making good defects” is issued. The issue of the certificate of making good defects triggers the release of the second half of the retention.

NEC3 also provides for a fixed period for the rectification of defects, ending on the “defects date”, which is usually six months or a year after the completion date. At or shortly after the defects date, a “defects certificate” is issued which sets out any defects which the contractor has not corrected. The issue of the defects certificate triggers the release of the second half of retention. If there are outstanding defects noted on the defects certificate, the employer must serve a withholding notice in order to continue to hold the retention until all notified defects are rectified.

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

High Court ruling on time limits for starting a claim

The end of March saw the ruling in the ECJ *Uniplex* case (on which we have previously reported) regarding time allowed for bringing a claim, applied for the first time in a UK court. SITA UK Ltd (SITA) issued a claim against Greater Manchester Waste Disposal Authority (GMWDA) claiming breach of the Public Services Contract Regulations 1993 (the Regulations). SITA’s claim was struck out for having been made later than permitted under the Regulations.

SITA were awarded reserve bidder status in a “negotiated process” procurement for a waste contract (worth £3.8billion) to be awarded by GMWDA to the most economically advantageous tender (MEAT). Reserve bidder status meant that if negotiations between GMWDA and the preferred bidder fell through, GMWDA would offer SITA the chance to take the preferred bidder’s place. SITA issued proceedings in August 2009 - over four months after the contract negotiations with the preferred bidder had been concluded. SITA claimed that the bid submitted by the preferred bidder was not the MEAT as by the time the contract was signed, the winning bid had changed significantly from the original bid which had won the contract. GMWDA countered this by applying to have SITA’s claim struck out for having been issued too late.

SITA based its right to start the claim when it did on its interpretation of Regulation 32(4)(b) of the Regulations which states that proceedings under Regulation 32 must be brought “promptly and in any event within three months from the date when grounds for the bringing of the proceedings first arose” – wording considered in detail in *Uniplex*. The court had firstly to decide what the limitation period actually was. *Uniplex* had ruled that the concept of “promptly” did not reflect EU law and that the limitation period began only once a claimant had, or ought to have had, knowledge of any breach, not on the date the breach occurred.

In order to reflect the *Uniplex* ruling, the court stated that the three month time period should run from the moment that SITA had knowledge of the breach. SITA, however, considered

that the concept of “grounds” included knowledge of any loss that might be claimed and that SITA should not have started its proceedings until it had gained such knowledge.

The court disagreed. It ruled that the three month time period for issuing claims ran from the point of knowledge of a breach, not from knowledge of possible loss. SITA had written to GMWDA on several occasions during the period from 8 April to 27 August 2009 (the date of the claim) threatening court action if GMWDA would not provide information requested by SITA. It was clear from the correspondence that SITA knew enough to “threaten and commence proceedings” from as early as 8 April 2009 (or just afterwards). The time for bringing a claim had expired round about 7 July 2009 and therefore SITA’s claim should be struck out for being out of time.

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

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

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